August 27, 2021

SUBMITTED ELECTRONICALLY VIA www.regulations.gov

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CY 2022 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model Requirements and Proposed Model Expansion; Home Health Quality Reporting Requirements Proposed Rule [CMS-1747-P; RIN: 0938-AU37]

Dear Administrator Brooks-LaSure:

The undersigned members of the Coalition to Preserve Rehabilitation (CPR) appreciate the opportunity to comment on the Calendar Year 2022 Home Health Prospective Payment System proposed rule. Our comments focus on the proposal to expand the Home Health Value-Based Purchasing Model (HHVBP) nationwide and the broader impact of the recently implemented Patient-Driven Groupings Model (PDGM) on access to care for Medicare beneficiaries in the home health setting.

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 Quality Reporting Program (QRP). We do not offer comment on those proposed policies at this time. The rule also includes a proposal to expand the Home Health VBP Model, previously implemented for nine states in 2016, nationwide and mandate all Medicare-certified Home Health Agencies (HHAs) to participate. We have significant concerns with this proposal, detailed below. Finally, the rule provides further details and analyses on the impact of the PDGM, implemented in the Home Health PPS beginning in 2020. The Coalition has long expressed serious questions about the potential negative impact of the PDGM on access

to therapy, which we are now seeing in the data reported by the Centers for Medicare and Medicaid Services (CMS). We urge CMS to prioritize patient access to care in the home health system and to address existing barriers and negative incentives as expeditiously as practicable.

Home Health Value-Based Purchasing Model

In this rule, CMS proposes to expand the HHVBP nationwide to all Medicare-certified home health agencies beginning January 1, 2022. This model has been in effect since 2016 for home health agencies in nine states, providing participating agencies with an upside/downside reimbursement adjustment based on performance on certain quality measures, benchmarks, achievement thresholds, and improvement thresholds. CMS states that the model has resulted in improved quality of care, which the agency measures through increasing "Total Performance Scores," as well as no changes to coverage or provision of benefits for Medicare beneficiaries.

However, the fundamental design of the HHVBP does not appropriately account for, and actually discriminates against, certain patients who do not neatly fit into the quality measures used in the model. CPR has long been concerned about the provision of maintenance therapy in the home health system, which is covered by Medicare as affirmed under the *Jimmo v. Sebelius* class action settlement but is often at risk of being cut or provided insufficiently by home health agencies. "Maintenance" therapy assists a patient to maintain or prevent deterioration of their functional status, as opposed to improving their functional abilities. Unfortunately, this critical aspect of the Medicare home health benefit is largely ignored by the quality measures and by extension, the entire HHVBP.

CMS explicitly acknowledges in the proposed rule that "skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition." However, CMS still refrains from including any stabilization measures in the HHVBP, despite stakeholders' longstanding recommendations to include such metrics in the model. This omission incentivizes home health agencies to discharge, underserve, or deny care altogether for patients who are in need of maintenance therapy and thus who will not support the agencies' performance in a newly mandatory HHVBP model.[1]

Under the current home health payment system, Medicare beneficiaries receiving home health care have faced increasing barriers to accessing maintenance therapy or other complex care for serious, chronic conditions and/or disabilities, which will only be exacerbated by the nationwide expansion of the HHVBP. **We urge CMS not to move forward with this proposal unless and until *Jimmo* beneficiaries are appropriately incorporated into the model and steps are taken to ensure their access to care to which they are entitled.**

[1] We direct CMS to detailed comments submitted by the Center for Medicare Advocacy, a CPR Steering Committee member, for further information on specific gaps in the quality measures utilized under the HHVBP.

Concerns with the Patient-Driven Groupings Model

CPR continues to be concerned with the observed and ongoing impact of the 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.

In this year's rule, CMS cites "preliminary monitoring analysis" of the first year of the PDGM, marking the first reporting of hard data from the agency on the new payment model. Unfortunately, these data reinforce our previously stated concerns and raise further questions about the impact of this payment system on patient access to care, particularly for individuals with the most complex and/or chronic conditions.

Observed and Reported Impact of Early PDGM Implementation

The PDGM has been in effect for less than two years, and most of that time has been under the extenuating circumstances of the COVID-19 pandemic. CMS has not yet published sufficient data to fully understand the impact of this model on patients' ability to access therapy in the home health setting, though the new rule includes the first hard data reported from the agency on the implementation of this system. CPR and other stakeholders have long aired concerns about reports from the field suggesting that PDGM has almost immediately impeded 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 therapist 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. Additionally, patients are being discharged earlier, after the higher-paid, early period of care expires. These reports are troubling and may indicate that the new model is driving decisions based on financial considerations, rather than patient care needs.

CMS Must Issue a Final Rule that Does More to Protect Patient Access to Home Health Care

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 communities to work with CMS to develop improvements to the system to properly serve beneficiaries and allow the reimbursement system to appropriately compensate providers for the skilled rehabilitative care patients need.

Beyond expanded reporting of data around the PDGM, we urge CMS to prioritize the needs of Medicare beneficiaries that face the highest barriers to care in the CY 2022 final rule and in future policymaking regarding the home health system. The agency should closely examine the incentives and barriers created by the PDGM, collaborate with stakeholders representing patients and providers, and identify patient-centered solutions. It is critical that CMS recognize the importance of ensuring access to maintenance therapy for those who are unable or unlikely to improve their condition(s) but stand to maintain their functional status, or prevent the deterioration of their functional status through maintenance therapy. Finally, we urge CMS not to move forward with the nationwide expansion of the Home Health Value-Based Purchasing Model until the Model appropriately incorporates maintenance therapy-related measures and protects the needs of *all* patients when measuring HHA performance.

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We greatly appreciate your consideration of our comments on the CY 2022 Home Health PPS Proposed Rule. Should you have any further questions regarding this letter, 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 Undersigned Members of the Coalition to Preserve Rehabilitation

ACCSES
American Association on Health and Disability
American Congress of Rehabilitation Medicine
American Music Therapy Association
American Network of Community Options and Resources
American Occupational Therapy Association

American Physical Therapy Association
American Speech-Language-Hearing Association
American Spinal Injury Association
American Therapeutic Recreation Association
Association of Rehabilitation Nurses
Brain Injury Association of America*
Center for Medicare Advocacy*
Christopher & Dana Reeve Foundation*
Disability Rights Education and Defense Fund
Falling Forward Foundation*
Lakeshore Foundation
National Association for the Advancement of Orthotics & Prosthetics
National Association of State Head Injury Administrators
National Multiple Sclerosis Society*
Rehabilitation Engineering and Assistive Technology Society of North America
Spina Bifida Association
United Spinal Association*

CPR Steering Committee Member