PRIVATE PRACTICE SECTION, APTA

American Physical Therapy Association

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September 9, 2019

Seema Verma, MPH
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert Humphrey Building
200 Independence Ave, SW
Washington, DC 20201

Attn: CMS-1711-P

***Submitted electronically***

**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 Requirement (CMS-1711-P)**

Dear Administrator Verma:

PPS is an organization of physical therapists in private practice who use their expertise to restore function, improve mobility, relieve pain, and prevent or limit permanent physical disabilities in patients with injury or disease. The rehabilitative and habilitative care they provide restores, maintains, and promotes overall fitness and health to a range of patient types. On behalf of the over 4,000 members of the Private Practice Section (PPS) of the 100,000 member American Physical Therapy Association, I write to provide feedback on the Centers for Medicare and Medicaid Services' (CMS) Calendar Year (CY) 2020 Home Health Prospective Payment System (PPS) Rate Update proposed rule, CMS-1711-P.

Representing independent small business owners, PPS encourages policies that enable our members to focus on providing high-quality and clinically appropriate outpatient physical therapy. Our members are proud of the quality of care they provide, but as small business owners are also keenly aware of burdensome and duplicative administrative tasks; the time they spend chasing ultimately inaccurate patient status updates is time they are not able to be caring for their patients.

Accordingly, PPS is thrilled that the Agency has been responsive and was able to use the information we supplied regarding the proactive yet burdensome administrative steps taken by our members to obtain accurate and timely information on whether or not potential patients were currently admitted under a home health plan of care. Similarly, PPS thanks CMS for evaluating the magnitude of claim denials our members experience as a result of the beneficiary later being identified as being under a home health plan of care. PPS praises CMS for seeking to alleviate the unnecessary administrative burdens that our members encounter.

Below please find suggestions and feedback based upon experiences of private practice physical therapists. PPS strongly urges the CMS to consider the following recommendations to the home health PPS rule:

**Notice of Admission (NOA)**

PPS appreciates that CMS responded to the realities of physical therapists in private practice who had received claim denials because the beneficiary was later revealed to be under a home health plan of care. Under the current system, private practice physical therapists have gone to great lengths and spent significant time and resources to check patient status in order to avoid this problem; however, the system as it stands is not able to provide accurate information and therefore a significant number of claims have been denied. PPS thanks CMS for "proposing that all HHAs submit a one-time submission of a Notice of Admission (NOA) within 5 calendar days of the start of care to establish that the beneficiary is under a Medicare home health period of care. The NOA would be used to trigger HH consolidated billing edits, required by law under section 1842(b)(6)(F) of the Act, and would allow for other providers and the CMS claims processing systems to know that the beneficiary is in a HH period of care." PPS commends the introduction of a process which will provide important updates to patient status in a timely manner. Upon elimination of the Request for Anticipated Payment (RAP), in order to ensure that the claims processing system is alerted promptly that a beneficiary is receiving home health services, PPS also requests that CMS consider adopting a simple mechanism such as with a notation in the Common Working File (CWF) or through the Electronic Data Interchange (EDI) by which HHAs can indicate that the beneficiary has been admitted under a home health plan of care.

Seeking administrative simplification where possible, PPS strongly supports the proposal that the "NOA be submitted only at the beginning of the first 30-day period of care to establish that the beneficiary is under a home health period of care. However, if there is any beneficiary discharge from home health services and subsequent readmission, a new NOA would need to be submitted within 5 calendar days of an initial 30-day period of care."

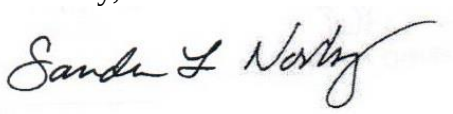
The proposed rule also states that, "because of the reduced timeframe for the unit of payment from a 60-day episode of care to a 30-day period of care and the proposed elimination of RAP, NOAs would be needed for home health period of care identification (83 FR 32390). Without such notification triggering the home health consolidated billing edits establishing the home health period of care in the CWF, there could be an increase in claims denials. Subsequently, this potentially could result in an increase in appeals and an increase in situations where other providers, including other HHAs, would not have easily accessible information on whether a patient was already being treated by another HHA…We are proposing that failure to submit a timely NOA would result in a reduction to the 30-day Medicare payment amount, from the start of care date to the NOA filing date, as is done similarly in hospice." While PPS greatly appreciates CMS' goal to reduce failures to submit timely NOAs, instead of instituting a financial penalty, PPS recommends that CMS consider making the "admission notification" a survey requirement. However, if CMS does move forward with the NOA process described in

the proposed rule, PPS recommends that CMS not require HHAs to complete the OASIS or obtain a signed plan of care before accepting the NOA.

**Notice of Discharge**
Similar to the suggestion for the Notice of Admission, PPS recommends that CMS consider adopting a simple mechanism for HHAs to use to promptly notify the claims processing system that the beneficiary has been discharged, for example, by requiring HHAs to make a notation in the CWF or through the EDI to indicate the patient has been discharged. It is important that a beneficiary's eligibility status can be updated efficiently and within a reasonable amount of time following discharge. Ensuring each patient's needs are met in a timely manner will promote continuity of care.

**Conclusion**
PPS appreciates CMS' efforts and anticipates that these policy changes are likely to reduce the administrative burden of private practice physical therapists seeking to care for patients in need. PPS appreciates the opportunity to comment on the CY 2020 Home Health PPS proposed rule. We hope our insight and perspective will be helpful as CMS finalizes these regulations.

Sincerely,



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