

September 29, 2017

Seema Verma, MPH
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Attn: CMS-5524-P
Hubert Humphrey Building
200 Independence Ave, SW
Washington, DC 20201

Submitted electronically

RE: Medicare Program; Cancellation of Advancing Care Coordination Through Episode Payment and Cardiac Rehabilitation Incentive Payment Models; Changes to Comprehensive Care for Joint Replacement Payment Model (CMS-5524-P)

Dear Administrator Verma,

On behalf of our more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) submits the following comments regarding the Centers for Medicare and Medicaid Services (CMS) Medicare Program; Cancellation of Advancing Care Coordination Through Episode Payment and Cardiac Rehabilitation Incentive Payment Models; Changes to Comprehensive Care for Joint Replacement Payment Model (CJR) proposed rule. The mission of APTA is to further the profession's role in the prevention, diagnosis, and treatment of movement dysfunctions and the enhancement of the physical health and functional abilities of members of the public. Physical therapists are essential members of the health care team for total hip and/or knee arthroplasty (THA and TKA), providing evaluation and treatment for individuals following these procedures.

Physical therapists treat individuals in a variety of practice settings, including hospitals, skilled nursing facilities, home health agencies, rehabilitation agencies, and private practice outpatient clinics. Physical therapists integrate essential elements of evaluation and management with a person-centered focus based on the best available evidence to optimize outcomes. For individuals undergoing THA and TKA, physical therapists provide various interventions with the goals of

improving muscle performance, activity, and participation, and promoting physical activity to avoid subsequent impairments, activity limitations, and/or participation restrictions.

Proposed Cancellation of Episode Payment Models (EPMs) and Cardiac Rehabilitation (CR) Incentive Payment Model

CMS has concluded that certain aspects of the EPMs and the CR incentive payment model should be improved and more fully developed prior to the start of the models. As such, CMS is proposing to cancel the EPMs and CR incentive payment model before they are set to go into effect. The agency also has inferred that the Center for Medicare and Medicaid Innovation (CMMI) intends to develop new voluntary bundled payment model(s) during calendar year 2018 that would be designed to meet the criteria of an Advanced Alternative Payment Model (APM) under the Quality Payment Program (QPP).

APTA appreciates CMS's proposal to cancel the cardiac EPMs and CR incentive payment model while CMMI undertakes the development of new voluntary models. We fully support value-based payment models that promote increased quality of care and guarantee patient access to rehabilitation services that fit their individual needs. APTA agrees with the agency that the mandatory nature of the EPMs could prove to be difficult for providers who are not equipped via training, experience, or infrastructure to effectively participate. In turn, this could lead to restricted patient access as well as a decline in the quality of care delivered to patients.

ATPA encourages CMS to develop new value-based payment models that promote access to rehabilitative services. We urge CMS to work with APTA and other stakeholders in creating innovative models that focus on rehabilitation and care provided by nonphysicians and explore options for certifying these models as Advanced APMs. Numerous physical therapy practices and rehabilitation entities are at the forefront of innovation, and APTA strongly believes these entities should be able to become key players in health care transformation. We also encourage CMS to consider including specialty services, such as rehabilitation (physical therapy, occupational therapy, and speech-language pathology) within APM criteria. At a minimum, APMs should demonstrate that essential services such as physical therapy are provided within the APM or that the APM has the appropriate referral relationships in place to give patients access to these services. Moreover, we urge HHS to ensure that a robust set of quality measures applies to APMs to reduce any financial incentives to decrease utilization and to ensure that APMs are meeting the goals of the QPP. We encourage CMS to consider a more thorough integration of nonphysician practitioners, such as physical therapists, in the design and implementation of future value-based payment models.

Additionally, we encourage CMS to solicit input and engage in meaningful dialogue with stakeholders, including APTA, when creating new APMs. We also recommend that the agency solicit input from small practices when creating future payment models to ensure that a key demographic of providers is adequately represented. This will help to ensure that current challenges associated with APMs are resolved in future model iterations. We also recommend that CMS not advance any new payment model until it can ensure that the model would not perpetuate, or intensify, patient access issues. Further, implementation of any new model should

not occur until CMS can confirm that all stakeholders are adequately prepared to participate in the model.

APTA also requests that CMS structure future APMs to enable providers to participate as collaborators without requiring them to make major investments in infrastructure or adopt certified electronic health records (EHRs). The focus should be on ensuring that the providers caring for the patient furnish high-quality care and do the best possible job of coordinating with other providers. APTA strongly urges CMS to provide appropriate resources and support to enable small practices, such as physical therapy practices, to participate in future models.

Physical therapists have been exempt from EHR meaningful use and have not been afforded the same resources as physicians and hospitals for health information technology (HIT) adoption. No physical therapy EHR vendors have Certified EHR Technology (CEHRT) status, and CMS has not yet addressed how these vendors would meet CEHRT requirements. Further, while the Office of the National Coordinator of Health Information Technology certification process has established standards and other criteria for structured data that EHRs must use, there is no standard certification criteria for EHRs for physical therapists.

Many physical therapists operate in small practices. While there have been many advances in health IT in recent years, implementing a health IT system remains a challenge for some small providers. There have been funding opportunities for health IT systems, but some providers still do not have the financial resources to implement a health IT system. Without such a system, providers have a harder time tracking patients throughout episodes, which leaves them less equipped to assume financial responsibility in potential future APMs. We recommend that CMS consider this hardship in making any final decision regarding providers taking on financial responsibility.

Proposed Changes to the CJR Model Participation Requirements

CMS proposes to decrease the number of metropolitan statistical areas (MSAs) required to participate in the CJR model from 67 to 34. CMS would permit hospitals located in the remaining 33 MSAs to voluntarily participate in the program; the agency also would allow low-volume and rural hospitals in all 67 MSAs to voluntarily participate in the CJR model.

APTA supports CMS's efforts to expand opportunities to voluntarily participate in the CJR model. Mandating hospitals to participate in an APM, whether or not the providers have the proper infrastructure to successfully participate in the program, could result in significant financial harm to the providers. Affording more hospitals the option to voluntarily participate in the CJR model enhances the capability of CMS to evaluate the program's effectiveness by focusing its analysis on participants who seek to be active participants.

APTA recommends that once the 5-year mandatory participation period ends, CJR become a fully voluntary program that allows providers who have been successful under the program to continue participation. We also recommend that CMS modify the program to allow multiple options for defining the episode. For example, CMS should enable conveners to have a bundled payment episode that excludes the inpatient stay, similar to that of Model 3 within the Bundled Payment

Care Improvement Model (BPCI). These modifications would encourage more participation in CJR while adding to the portfolio of APMs and the participation of providers within these APMs.

Additionally, APTA encourages CMS to ensure that a robust set of quality measures applies to APMs to reduce any financial incentives to decrease utilization and to ensure that APMs are meeting the goals of the program. It is imperative that CMS ensure that rehabilitation services such as physical therapy are integral components of APM quality programs. If strong measures are not in place, there is potential for lack of beneficiary protection against underservice.

Affiliated Practitioner Lists

APTA supports CMS's proposal to broaden the scope of the Affiliated Practitioner List. We agree that the clinician engagement list should include practitioners who are not CJR collaborators during the CMS-specified period of the CJR model performance year, but who do have a contractual relationship with the participant hospital based at least in part on supporting the hospital's quality or cost goals under the CJR model during the specified performance year period. The practical effect of this proposal would be to increase the number of providers who are considered qualifying APM participants.

We support the inclusion of additional qualified providers in the CJR model. A significant number of health care providers support participant hospitals but are not included on the initial Affiliated Practitioner List, despite the critical importance of the care these providers deliver to patients included within the CJR model. As such, it is imperative to enable these providers to share in the rewards of participating in an Advanced APM. We also believe that expanding the number of eligible providers will enhance access to care under the CJR model.

Postoperative Telehealth Visit Price Adjustment for Practice Expense

CMS proposes to increase payment for postoperative visits via telehealth to beneficiaries in their residences to account for unreimbursed practice expense. CMS proposes to accomplish this by pricing CJR model postoperative home telehealth visits using facility-level practice expense (PE) values for the corresponding in-person visits. APTA supports CMS's decision to account for PE.

Patients who have had lower extremity joint replacements benefit from therapy services as part of their rehabilitation. Many states permit therapists to furnish telehealth services, and those therapists do so safely and effectively. As such, APTA recommends that CMS exercise its discretionary authority to allow physical therapists to perform telehealth services while participating in bundled payment models. We also recommend that CMS establish a demonstration program to evaluate the clinical benefit of physical therapists delivering telehealth services to Medicare beneficiaries. Proper application of telehealth rehabilitation services, particularly in underserved areas, can potentially have a dramatic impact on improving care and reducing negative consequences and costs of care. For example, telehealth services may help to ensure access to specialized care in isolated rural areas facing difficulties in maintaining and staffing full-service hospitals. Telehealth therapy services can make the difference in preventing falls, functional decline, costly emergency room visits, and hospital admissions and readmissions.

Therefore, we strongly recommend that CMS use its waiver authority to allow physical therapists to deliver telerehabilitation in current or future APMs.

Conclusion

APTA thanks CMS for the opportunity to comment on the proposed Cancellation of Advancing Care Coordination Through Episode Payment and Cardiac Rehabilitation Incentive Payment Models; Changes to Comprehensive Care for Joint Replacement Payment Model rule. We look forward to working with the agency in the future to help craft new models that improve the quality of patient care while also ensuring that the models preserve access to quality rehabilitation services. Should you have any questions regarding our comments, please contact Kara Gainer, Director of Regulatory Affairs, at karagainer@apta.org or 703/706-8547. Thank you for your consideration.

Sincerely,

A handwritten signature in black ink that reads "Sharon L. Dunn". The signature is written in a cursive, flowing style.

Sharon L. Dunn, PT, PhD
Board-Certified Clinical Specialist in Orthopaedic Physical Therapy
President

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