

September 8, 2015

Andrew Slavitt, Acting Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: Proposed Rule: Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Service (CMS-5516-P)

Dear Acting Administrator Slavitt:

On behalf of our 90,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) is pleased to submit comments on the Proposed Comprehensive Care for Joint Replacement Model (CCJR) published in the July 14, 2015 date *Federal Register*. APTA's goal is to foster advancements in physical therapy practice, research, and education. 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 licensed health care professionals who are devoted to restoration, maintenance, and promotion of optimal physical function. Physical therapists help patients maintain their health by preventing further deterioration or future illness. For this reason, physical therapists play an integral role throughout the healthcare continuum.

Physical therapists are an essential member of the health care team who provide evaluation and treatment for individuals following total hip and/or total knee arthroplasty (THA and or TKA). 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 with THAs and TKAs, 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.

Physical therapy interventions are designed to restore and promote maximum physical function for patients following THAs and TKAs. The physical therapy model of practice as delineated in

the Guide to Physical Therapist Practice is patient-centered and incorporates patient needs and goals across a continuum of care. Physical therapist interventions for people following THAs and TKAs aim to reduce pain; increase and maximize joint mobility, muscle strength, flexibility, and aerobic capacity; and prevent functional loss. Interventions may include: therapeutic exercise; manual therapy; functional training in self-care, home management, and work; physical agent modalities; and use of orthotic, assistive, adaptive, protective, and supportive devices, combined with patient-related instruction/education.

The American Physical Therapy Association (APTA) strongly supports initiatives to improve the quality of patient care and to ensure access to high quality care. We are committed to encouraging physical therapists to participate in the innovative delivery reforms authorized under the Affordable Care Act (ACA) if the models preserve access to quality rehabilitation services in the right place at the right time. It is critical for any delivery and payment reform policies that are implemented to enable physical therapists, including those who work in small practices, to participate effectively. Improving the quality of care while also decreasing costs will require participation by all providers.

Recommendations

Specifically, we recommend the following:

- 1) Participation by hospitals should be voluntary until the CCJR model can be based on sound evidence with appropriate risk adjusters.
- 2) At a minimum, CMS should delay implementation of the CCJR payment model for one year to allow hospitals and other providers to prepare.
- 3) CMS should develop risk adjustment to account for the differences among patients within the DRGs based on functional status and other comorbidities and conditions.
- 4) CMS must incorporate safeguards into this model to ensure that these patients with complex surgeries or chronic conditions have access to the full spectrum of hospitals, physicians, post-acute care providers, physical therapists, and others needed for their care.
- 5) CMS should require measures of patient function in order to ensure that patients achieve their maximum functional potential.
- 6) CMS should include both patient reported outcomes and performance based outcomes, such as the 6 minute walk test, to capture a more accurate assessment of the patient's functional abilities.
- 7) The model should recognize the critical role of other health care providers involved in the care of these patients and enable them to share reconciliation payments or take on risk under this model.
- 8) CMS should provide appropriate resources and support to enable small practices, such as physical therapy practices, to participate in this model.
- 9) CMS, the FTC, the OIG, and DOJ should take steps to safeguard against unfair competition and restrictions on patient choice of providers that can arise under the CCJR model.
- 10) The model should include waivers of the 3 day prior hospital stay for SNFs, telehealth, the 60% IRF rule, the IRF "3 hours of therapy rule," and the outpatient therapy limit to

try new treatment approaches that reflect a patient-centered, rather than regulation based approach to care.

- 11) The telehealth waiver should be expanded to allow the coverage of telehealth physical therapy services provided by physical therapists under the CCJR program.

Our detailed comments on the proposed rule and rationale follow.

General Comments Regarding Implementation of CCJR model

CMS proposes, under the authority of section 1115A of the Social Security Act, to establish a new episode-based payment model for lower extremity joint replacement (LEJR) that would apply to 75 Metropolitan Statistical Areas (MSA's). CMS proposes that this model would be effective January 1, 2016 for 5 years and participation by all IPPS hospitals would be mandatory. The model would include all Medicare Part A and B items and services in the episode beginning with the anchor hospitalization under MS-DRGs 469 or 470 through the end of the episode, which would be 90 days post-discharge from the anchor hospitalization. This CCJR proposed payment model represents a significant change for beneficiaries and providers in payment and delivery of health care in many regions of the country.

As CMS develops alternative payment models that bundle post-acute care, including the Comprehensive Care for Joint Replacement Payment (CCJR) model, it is essential that Medicare beneficiaries continue to have access to quality rehabilitation services provided in the right setting and at the right time to meet their individual needs. In order to achieve this goal, payment policies should be based on reliable data that enables a comparison of one setting to another based on quality, cost and other measures. Standardized post-acute assessment data is a necessary building block in any future payment reform of post-acute care. Without comparable information across PAC settings, it is not feasible to evaluate providers to determine appropriate care settings for patients based on clinical evidence and quality metrics. CMS is in the midst of testing bundled payment models as part of the BCPI initiative but has not yet fully analyzed the data from these models. Absent this information, we believe it is premature to move forward with mandatory bundled payment models, such as CCJR.

The IMPACT Act recognized that this gap existed and addressed the problem by requiring collection and analysis of data that will enable Medicare to 1) compare quality across PAC settings; 2) improve hospital and PAC discharge planning; and 3) use this information to reform PAC payments in the future while ensuring continued beneficiary access to the most appropriate settings. CMS has begun to implement the provisions in IMPACT but this work is still several years from completion as directed by statute. **We believe that CMS should implement a uniform assessment instrument, and collect and analyze the data required under the IMPACT Act and the BCPI initiative prior to proceeding with mandatory bundling initiatives, such as CCJR. Until the CCJR model can be based on sound evidence with appropriate risk adjusters, we believe participation should be voluntary.**

Given the required time frame for public comment and response by the Agency, we anticipate that this rule will not be finalized until at least November 2015, giving providers very little time to prepare for the changes in payment and care delivery that will be required. Hospitals and

providers need to be able to make sound decisions for care redesign and to identify protocols that will work. Hospitals will have an insufficient amount of time to engage in discussions and contractual relationships with other health care providers as collaborators under the model. There would be a need to collaborate and coordinate care with home health agencies, physician offices, independent outpatient therapy practices, skilled nursing facilities, and other settings.

Many of these providers in the impacted regions may be unaware of the new model given the short time frame for education and outreach. **Therefore, we ask that at a minimum, CMS delay the implementation of the CCJR payment model for one year.** CMS could use this additional time to inform hospitals, post-acute care providers, physicians, and outpatient therapy practices in regions that would be impacted by the new the change.

Notification to Hospitals and Post-Acute Care providers

CMS proposes a number of requirements for financial arrangements and beneficiary incentives among hospitals and other providers of services and suppliers caring for beneficiaries in CCJR episodes of care. In this discussion CMS defines a CCJR collaborator to include: skilled nursing facility, home health agency; long-term care hospitals; inpatient rehabilitation facility; physician, nonphysician practitioner, outpatient therapy provider, and physician group practice. We commend CMS on identifying a comprehensive set of health care providers that might be treating the patients with joint replacements.

As CMS moves forward with implementation of this program, we strongly recommend that CMS reach out to all providers who might be involved in the care of these patients to inform them about the CCJR program. This notification should give a detailed explanation of the CCJR model and contact information in case providers and suppliers have questions. In addition, CMS should provide a list that is available to the public of all the providers that are part of the program in each region. It is unclear to beneficiaries and other providers which hospitals would be participating in the model because some would be excluded due to participation in other initiatives, such as the BCPI program. This will enable them to determine which hospitals to engage with in preparation for the new delivery and payment model for these patients.

Episode Definition for Comprehensive Care for Joint Replacement Model

CMS proposes that an episode of care in the CCJR model would be triggered by an admission to an acute care hospital stay (hereinafter anchor hospitalization) paid under MS-DRGs 469 or 470. As proposed, all Medicare Parts A and B items and services would be included in the episode. CMS proposes to exclude only those Medicare items and services furnished during that episode that are unrelated to LEJR procedures based on clinical justification.

CMS provides a list of proposed excluded ICD-9-CM codes for Part B services on the CMS website. We are concerned that this list is not comprehensive enough to reflect many of the conditions that may be treated by health care professionals, such as physical therapists, that are unrelated to the lower extremity joint replacement procedure. For example, if a physical therapist is treating a patient with a shoulder dislocation who has also had a knee replacement, it

would not make sense for the cost of the treatment for the shoulder dislocation to be considered part of the episode for the knee replacement. In addition, we are also concerned that the list on the CMS website at this time contains only ICD-9 CM codes. Effective October 1, 2015 ICD-10 codes must be used for billing purposes. It will be important for providers to have the list of ICD-10 codes that are excluded available to them prior to finalizing this program.

Payment and Pricing: Risk Structure

CMS proposes to establish target prices for each participant hospital for each performance year and to employ a retrospective two-sided risk model. Under the model, providers and suppliers would continue to be paid via the Medicare fee for service program as usual. After a performance year, actual episode spending would be compared to episode target prices. If aggregate target prices are greater than actual episode spending, the hospital may receive reconciliation payment as long as quality performance thresholds are met. If the aggregate target prices are less than actual episode spending, hospitals would be responsible for making a payment back to Medicare. The target prices are established for each participant hospital and based on 3 years of historical data. It includes a blend of hospital-specific and regional episode data, transitioning to regional prices.

There is considerable variation in spending within joint replacement—particularly between hip and knee replacements and partial and total hip replacements (see MedPAC report on site neutral payments). Therefore, we recommend that CMS compare the hospital’s actual spending to its target price after adjusting for the procedure mix within the DRG. We are concerned that hospitals and physicians would be deterred from admitting patients that have high cost procedures (partial hip replacements). They may be more likely to admit patients for lower-cost procedures (knee replacements and total hip replacements). The information that would enable differentiation of total hip, partial hip, and knee replacements is readily available from claims.

In addition, we are concerned that patients who suffer from multiple chronic conditions or comorbidities, may find it more difficult to find hospitals willing to serve them since there will be a greater risk of complications and/or a higher level of post-acute care needed for this condition. Accepting these types of patients would most likely be viewed by the hospitals as increasing their financial risk under the CCJR model. **We recommend that CMS develop risk adjustment to account for the differences among patients within the DRGs based on functional status and other comorbidities and conditions. CMS must incorporate safeguards into this model to ensure that these patients with complex surgeries or chronic conditions have access to the full spectrum of hospitals physicians, post-acute care providers, physical therapists, and others needed for their care.** CMS will need to monitor to make sure patients continue to have access to care.

We support CMS’s proposal that entails retrospective payment to providers. This model would allow providers to experiment with the bundling approach without altering existing revenue cycle practices. Fee for service payments maintain a predictable cash flow for all providers who may be treating patients with lower extremity joint replacements. It would be difficult for providers to change their billing practices for a subset of their cases that have joint and knee replacements. It is also preferable for providers to continue to bill CMS directly for

their services for patients that fall under the program. Familiarity with the payer and the process for submission of claims adds more stability to the program.

Quality Performance and Measures in the CCJR Model

APTA supports the goal of improving the quality of health care. Physical therapists are committed to providing high-quality, timely care and to the promotion of evidence-based practice and patient-centered practice. As we discussed above, physical therapists are an essential member of the health care team who provide evaluation and treatment for individuals following total hip and/or total knee arthroplasty across the continuum of care.

APTA supports the inclusion of quality measures in the proposed CCJR model. The three required measures that CMS proposes for inclusion in this model are:

- Hospital-level 30-day, all-cause RSRR following elective primary THA and/or TKA (NQF #1551), an administrative claims-based measure
- Hospital-level RSCR following elective primary THA and/or TKA (NQF #1550), an administrative claims-based measure
- HCAHPS Survey measure

Currently, all three measures are being collected and reported by acute care hospitals which eliminates an increased burden for reporting by these facilities.

Hospital Readmission Measure (NQF #1551)

Physical therapists play an integral role in the prevention of acute hospital readmissions as essential members of the health care team facilitating transitions in care for patients. Physical therapists, in conjunction with other of the health care professionals, assist in discharge planning, including the determination of the most appropriate setting for a patient, taking into account their medical status, functional status, prognosis and other factors, such as their home environment and family support. The need for coordinated efforts across the continuum of care is imperative in reducing preventable readmissions.

APTA has previously commented in support of NQF measure # 1551. Reducing potentially preventable acute hospital readmissions for all TKA and THA patients will decrease cost, improve patient safety and promote the best possible outcomes for this patient population. As CMS includes all patients who fall into MS-DRGs 460 and 470 in this proposed model, APTA believes that Medicare should look at the impact of socioeconomic status on this measure. Currently, the National Quality Forum is conducting a two-year trial of a temporary policy change that will allow risk-adjustment of performance measures for socioeconomic status (SES) and other demographic factors. We believe that given the geographic diversity of the MSA's included in the is model and the variation in patient severity in the MS-DRG's 469 and 470, the use of this additional risk adjustment may be essential in making true comparisons in readmission performance. CMS should also consider this additional risk adjustment for NQF measure #1550.

Patient Reported Outcome (PRO) Measures for THA/ TKA

APTA feels that it is essential that we capture the patient's perspective regarding the outcomes of care and supports the use and inclusion of patient-reported outcome measures. APTA is

pleased to see these proposed measures for the THA/ TKA patient population. APTA does have some concerns and comments regarding the included PRO measures which we outline below.

PROMIS Global Short Health Form and Veterans Rand (VR) 12

Both PROMIS and the VR 12 measure components of physical and mental health to attain a measure of health related quality of life. Recent evidence indicates that scores from the VR12 can be expressed on the PROMIS global health metric (Schalet, et al. J Gen Intern Med 2015). The use of both of these measures is duplicative in nature and APTA would recommend that CMS choose one measure. We would recommend the PROMIS global health instrument, to implement in this model in order to reduce the burden of data collection on facilities and patients.

KOOS and HOOS

The KOOS and HOOS questionnaires were developed to be used in knee and hip disability patient populations respectively. Both the KOOS and the HOOS PRO measures contain 40 or more items and consist of 5 subscales; pain, other symptoms, function in activity of daily living (ADL), function in sport and recreation (sport/rec) and knee related quality of life (QOL). The measures allow for the subscale scores to be aggregated and averaged as the primary outcome. A total score has not been validated and is not recommended for these tools. Given this scoring methodology, APTA is concerned about how CMS will interpret functional improvements in the knee and hip patients. We are also concerned that given this scoring instructions, practitioners may also have a difficult time evaluating the results. APTA feels that there are other functional measures that may be better suited for these patient populations.

The evolution of measurement theory has led to the development and use of item response theory (IRT) in a number of functional measures. Examples include the PROMIS Physical Function Scale (Bruce B et al Arthritis Research & Therapy, 2009) and the Activity Measure for Post-Acute Care (AM-PAC) Basic Mobility Scale (Haley SM et al. Medical Care 2004; Jette AM Physical Therapy 2007). IRT uses the patient's response to link to another item based on difficulty and the patient's ability which produces a targeted administration of the items to the patient's unique level of physical function and mobility. This can be achieved with either computer adaptive testing or short forms that target specific ranges of mobility, enabling more efficient and precise measurement of mobility through a wider range of mobility than offered with the KOOS or HOOS. APTA would recommend that CMS consider one of these measures for implementation in the model to assess patient function.

In order to finalize a risk adjustment methodology for the PRO's, CMS has proposed to collect a list of risk adjustment variables at the pre-operative data collection and post-operative data collection points. CMS has listed 25+ variable for collection pre-operatively and 10 variables post operatively. Some of the variables included in this list are clearly defined including variables such as age and gender, however, other variables will require specific operational definitions such as quantified spinal pain, joint range of motion in degrees, abductor muscles strength, and knee extensor strength. APTA recommends that CMS publish these measurement definitions with the final rule in order to allow facilities to be able to educate their staff prior to data collection.

Additionally, APTA has concerns about the data submission requirement for the PRO's. CMS has proposed that facilities must collect the PRO data on 80% of patients pre-operatively and post-operatively in order to qualify for the PRO financial incentive. APTA feels that most hospital organizations will find it extremely difficult to achieve 80% follow-up for collection of PRO data as part of routine clinical practice without additional resources allocated for the active surveillance that will be necessary to achieve this follow-up rate. APTA recommends that CMS consider lowering the necessary follow-up rate to receive the financial incentive for voluntary collection of PRO data, especially in the early years of the model.

Lastly, APTA recommends that CMS also give consideration to the ability of the PRO measure(s) to be administered via proxy. Given the typical age of the THA/TKA population, it is not uncommon for patients to need assistance with self-report measures due to cognitive issues, language or vision barriers, or other issues that may interfere with the completion of the measure(s). Therefore, CMS should consider the reliability of the selected measure(s) in situations where a patient surrogate or caregiver completes or assists with completion of the PRO for a patient. CMS should include measures that have been validated with patient proxies.

Future Quality Measures Considerations

APTA believes that capturing functional outcomes is a critical component of assessing outcomes of the overall quality of care for these patient populations. Additionally, in the long term, understanding the functional outcomes of these patients may lead to treatment algorithms that produce higher quality outcomes at a lower cost. **For these reasons, APTA strongly recommends that CMS require functional outcome measures for the CCJR model.**

As CMS indicates in this proposed rule “the intent of the CCJR model is to promote quality and financial accountability for episodes of care surrounding a lower-extremity joint replacement (LEJR) or reattachment of a lower extremity procedure.” Two of the primary outcomes of elective total joint replacement are to decrease pain and restore patient function. CMS has proposed the inclusion of 3 required measures which focus on unintended harm events (readmissions and complications) and patient satisfaction, however, the inclusion of PRO measures in the CCJR model is voluntary. CMS did not propose to include any performance based functional measures at this time.

While APTA is excited to see the inclusion of PRO measures that look at patient function, research has shown differences in self-perceived patient function, as captured through PROs, and functional performance measures (Van den Akker-Sheek I, et al. Physical Therapy 2015; Unnanuntana A, et al. J Arthroplasty 2012; Statford PW, et al. Physical Therapy 2006). Research studies have indicated that variables such as pain can affect a patient's self-perceived rating of function (Van den Akker-Sheek I, et al. Physical Therapy 2015). Additionally, research has shown that performance based tests provide information about function not captured through PRO's (Unnanuntana A, et al. J Arthroplasty 2012). **APTA recommends that CMS consider performance based measures of function for these patient populations, such as the six-minute walk test. By including a functional performance measure, CMS will get better data on the functional outcomes of these patient populations.**

Lastly, APTA would recommend CMS consider including a total joint measure set for the model in order to look at other aspects of the quality of care delivered. Currently, in the

Physician Quality Reporting System (PQRS), providers are able to report on the Total Knee Replacement Measures Group. The measures group includes measures that promote current best practices for total knee replacement patients. APTA would recommend that CMS consider creating a similar measure set for this payment model. Implementation of a measure set would allow CMS to look at adherence to best practices with this patient population.

Financial Arrangements: Gain Sharing

CMS proposes that participant hospitals may have certain financial relationships with collaborators to support their efforts to improve quality and reduce costs. These collaborators could share in the reconciliation payments and internal cost savings realized through care redesign activities. Collaborators would be required to engage with the hospital in its care redesign strategies and to furnish services during a CCJR episode in order to be eligible for the reconciliation payments. Collaborators may include the following provider and supplier types: Physicians and nonphysician practitioners; Home Health Agencies; Skilled Nursing Facilities; Long Term Care Hospitals; Physician Group Practices; Inpatient Rehabilitation Facilities; and Outpatient physical and occupational therapists. CMS proposes that the hospital would be required to retain 50% of the downside risk and that the hospital could not share more than 25% of its repayment responsibility with any one provider or supplier.

We support the CMS proposal that recognizes the critical role of other health care providers involved in the care of these patients and enables them to share reconciliation payments or take on risk under this model. As CMS shifts to alternative models, such as this one, we think it is important that the models as well as the regulatory framework surrounding the models, allow for diversity with regard to the types of providers that are able to participate in these arrangements. We believe it is important that a wide spectrum of providers—SNFs, home health, IRFs, solo and small practices be able to participate effectively in these models. Participation by these providers is essential to preserving patient choice regarding from whom they wish to access care. APTA also supports the inclusion of collaborators in CCJR model lower extremity joint replacement redesign activities, such as attending CCJR meetings, and learning activities; drafting LEJR episode care pathways; reviewing CCJR beneficiaries' clinical courses; developing episode analytics; and preparing reports of episode performance.

However, we are concerned that smaller practices and specialty practices may face barriers to participating in the CCJR model and other alternative payment models. One barrier is that taking on the additional risk and care coordination in this model requires complex infrastructure related to data sharing and clinical integration to achieve the goals of this model. For example, many small practices are still in the process of adopting and implementing electronic health records. **While we recognize the need for care coordination, we encourage CMS to enable providers to participate in these models as collaborators without requiring major investments in infrastructure and electronic health records.** The focus should be on ensuring that the providers caring for the patient furnish high quality care, and do the best job of coordinating with the hospital and other post-acute care providers. **APTA strongly urges CMS to provide appropriate resources and support to enable small practices, such as physical therapy practices, to participate in this model.**

We recommend that CMS take steps to ensure that any reconciliation payments are distributed in a fair and equitable manner to collaborators. We believe CMS should monitor activities involving distribution of payments to guard against unfair business practices and to promote a fair and equitable distribution of shared savings for all providers who are involved as collaborators. In addition, CMS should also mandate that hospitals distribute any reconciliation payments to collaborators in a timely manner.

Beneficiary Protections and Incentives to Steer Patients

In the proposed rule, CMS includes some beneficiary protections, including the beneficiary's right to select any provider of choice without restrictions and a requirement that the hospitals must provide a complete list of all available post-acute care options in the service area. While we are supportive of these beneficiary protections, we remain concerned that hospitals still may have strong incentives under the CCJR model to steer patients to the least costly settings as long as the patients are not readmitted to the acute care hospitals. As we discuss in further detail in our quality section of these comments, the measures of quality under the proposed CCJR model do not accurately measure functional outcomes post-discharge. Without appropriate measures of patient functional outcomes, patients will be at risk under this model of not achieving their maximum functional potential. Based on the quality measures chosen, this model is more focused on controlling costs than improving quality, thus leaving incentives to "stint" on care to retain a greater share of the savings.

We are also concerned that the CCJR model appears to create a strong incentive for hospitals to acquire post-acute care facilities, orthopedic surgery practices, and to steer patients to therapy in their outpatient hospital departments. This could create a "monopoly" and restrict patient choice. Hospitals or health systems, participating in this new delivery model could have considerable power and choose to provide all services through their entities rather than sending them to any other settings that provide physical therapy services. Another concern is that hospitals and health systems could choose to enter into collaborations with physicians who are important as referral sources and limit participation of other health care professionals, such as physical therapists in private practice, who are not referral sources. **We strongly encourage CMS, the FTC, the OIG, and DOJ to take steps to safeguard against unfair competition and restrictions on patient choice of providers that can arise under the CCJR model.**

We are pleased to see that CMS plans to monitor for potential risks, such as attempts to increase profit by delaying care, attempts to decrease costs by avoiding medically indicated care, attempts to avoid high cost beneficiaries, and evidence of compromised quality or outcomes. CMS should collect data and analyze it to make utilization comparisons and outcomes and detect aberrant billing patterns. CMS should track readmission rates, complication rates, use of observation stays, emergency room visits, length of stay, and changes in patient function. CMS should compare rates of joint replacements and outcomes in markets that are included and excluded from the CCJR model. In addition to monitoring for these risks, it is critical for CMS to take enforcement action if problems are identified. CMS should also ensure that beneficiary education materials regarding CCJR clearly inform beneficiaries that there are no barriers to their receiving care from a provider of choice and that hospitals are not allowed to impose any barriers.

Waivers of Medicare Program Rules

CMS proposes to waive certain Medicare program rules in order to test the CCJR model. Specifically, CMS proposes the following 3 primary waivers:

- 3-day inpatient hospital stay waiver for eligibility for SNF stay
- Telehealth Services Waiver
- Direct supervision requirement for certain post-discharge home visits for non-homebound beneficiaries.

In general, we believe that certain waivers of regulations are necessary to try new treatment approaches that reflect a patient-centered, rather than regulation based approach to care. Episode costs for lower extremity joint replacements could vary dramatically depending on the post-acute care placement of the patient following the acute hospital stay. Under the current system, these differences in costs may be due more to the “siloeed” nature of Medicare’s post-acute care payment systems and conditions of participation requirements rather than the efficiency or quality of care. As CMS embarks on this new model, it is important to ensure that regulatory barriers do not hinder patients from placement in the most clinically appropriate cost-effective settings.

Specific comments on each of these waivers follow:

Waiver of SNF 3-day rule

CMS proposes to waive the 3-day inpatient hospital stay requirement for eligibility for a covered SNF stay (the SNF 3-day rule) for all episodes tested in the CCJR model as long as the patient is discharged to a SNF that has a rating of 3 stars or better based on publicly available information at the time of discharge on the Nursing Home Compare website. CMS proposes that this waiver not apply during performance year one.

We support a waiver of the SNF 3-day stay as we believe that it is important for hospitals to have the ability to decide whether it is appropriate to discharge the patient to a SNF based on clinical need rather than a regulatory requirement. The average stay for MS DRG 470 is typically 3 days. Because of progressive post-surgery treatment regimens, many hospitals have the ability to migrate toward a shorter length of stay for certain patients. This waiver would allow hospitals to identify patients who could be discharged in less than 3 days from the hospital without eliminating Medicare coverage for their SNF stay. **We recommend that CMS allow for this waiver beginning in performance year 1 of the model.** This will allow hospitals to immediately begin to redesign care to maximize quality and efficiency and place patients in the most clinically appropriate setting. It would reduce pressure on doctors to hospitalize patients unnecessarily or send them home too soon. We believe that this model eliminates incentives to overuse SNF benefits and promotes coordination of care with SNFs and other post-acute care settings. Therefore, it would be appropriate to make this waiver effective in year one.

While we understand the desire of CMS to ensure that patients receive high quality services in the SNF settings, we have serious concerns with the requirement that the SNF has a rating of 3 stars or better on Nursing Home Compare in order to qualify for this waiver. The five star system has some weaknesses and therefore it is possible that the rating may be an inaccurate representation of provider quality. There has been concern that individual

ratings are based on fixed quotas to determine provider performance by state. For example, within the health inspection domain, the bell curve requires each state to have 20 percent of its facilities ranked as the poorest (one star) while 10 percent are ranked best (five star) and the in-between 70 percent share the remaining ratings (with approximately 23.33% in each category). This means a low ranked facility in one state could be providing superior quality to a similarly ranked nursing home in a different state, and may not be an accurate representation of quality.

A recent Kaiser Family Foundation study identified the geographic variation in SNF ratings. According to this study, in 11 states at least 40 percent of nursing homes have one or two star ratings, including states such as Texas, Louisiana, Tennessee, Georgia, and Ohio. These states have MSAs that are included in the CCJR model and therefore beneficiaries in these states will have fewer choices of SNFs as hospitals increasingly partner with SNFs that are eligible for the waiver.

In addition, the five star rating system does not address all of the important considerations that go into a decision about which nursing home may be best for a particular person. In fact, CMS has pointed out on its website that other factors may be considered, such as the extent to which specialty care is available or how easy it will be for family to come visit. Visits from family members can improve the resident's quality of life and quality of care and therefore often proximity may be very important. It is possible that there may not be nursing homes near to a patient's home that have a 3 star rating, particularly in certain regions of the country.

Waiver of Certain Telehealth Requirements

CMS proposes to waive current law limitations on payment for Medicare telehealth services under section 1834(m) of the act that relate to the geographic area in which telehealth originating sites may be located. CMS also proposes to waive current law limitations on originating sites for all episodes under CCJR model; however these waivers only apply when the telehealth service is furnished in the beneficiary's home or place of residence. CMS also states that these waivers would not permit coverage and payment for telehealth services that are not currently covered and paid for under section 1834 (m) and regulations. CMS notes that all other requirements for Medicare coverage and payment of telehealth services continue to apply, including the list of specific services approved to be furnished via telehealth.

As payment shifts to innovative, valued based payment methods, telehealth is a valuable tool for providers to improve the quality of care. Telehealth can improve care, access, cost and quality. It can help with care coordination and prevention and therefore is cost innovation. As an example, a telehealth program recently tested at Bon Secours hospital in Richmond, VA helped patients prepare for and recover from joint replacement surgery for 30 days before surgery and for 60 to 90 days afterward by providing educational content, notes on potential symptoms that can be connected to a patient-customized alert system, and reminders. A study of the use of this telehealth system showed that the average length of stay in the hospital was shorter (1.6 days compared to the hospital average of 2 days and national average of 3.7 days) and no patients were readmitted within 30 days compared with a national readmissions rate of 6%. Telehealth can offer patients access to providers that might not be available otherwise, as well as medical services without the need to travel long distances. Therefore, we believe that providers in valued-based payment models, such as the CCJR model, should have the flexibility to fully use telehealth.

APTA encourages CMS to maximize the ability of multiple types of providers to use telehealth services to effectively manage patients who have had lower extremity joint replacements. Medicare provides for limited coverage of telehealth services and physical therapists are not currently eligible providers under Medicare for reimbursement of these services. Physical therapy is an integral part of the care for patients who have had lower extremity joint replacements. When a patient is undergoing a joint replacement, such as hip or knee, physical therapy plays a critical role in every stage of the process, and particularly is effective and enabling the patient to achieve optimal physical function after the operation. Physical therapists can effectively conduct telehealth consultations with appropriate patients and caregivers. An example of a Medicare beneficiary who had a total hip replacement and benefitted from the use of telehealth physical therapy services follows:

Case Description

Barbara is a 74-yr-old woman with a medical history of peripheral vascular disease, thyroid cancer, age-related vision dysfunction and systemic osteoarthritis. She lives with her husband in a large one level home in a metro area of a large city, continues to work full time in her family's business, and actively participates in community and work related events.

Barbara suffered a fall resulting in a right hip fracture. She underwent a total hip replacement and was sent home to recover and begin in-home therapy. Traveling was not allowed for several weeks due to medical restrictions and the physician checked in with her remotely through the hospital's "telemedicine" department using encrypted software. Barbara connected with the physician via her personal computer or iPad.

Use of Telehealth

Barbara was evaluated during her inpatient stay after her THR surgery. The physical and occupational therapists trained Barbara to utilize a walker, educated her about her procedure and precautions and imitated a home exercise program during her hospital stay. Barbara's spouse was given an iPad with an encrypted software program to take home in order to video the bedroom, bathroom and walkways leading to and within the house. The occupational therapist viewed the video and determined the need for ADL equipment and home modifications to promote patient safety. Equipment was ordered and sent to the home prior to discharge.

Barbara was seen 1-2 x weekly by the home health occupational and physical therapist either "in person" when necessary or by "face to face" videoconferencing on days and sessions where either the therapist determined that intervention (ADL training, transfer training, mobility training, progressive home exercise program-HEP) could be delivered appropriately through mobile technology or because barriers such as traffic delays, area construction, or inclement weather (e.g., heavy rain, snow, ice) prevented the in person home visit from taking place.

Outcomes

Because Medicare does not recognize occupational and/or physical therapists as eligible providers for telehealth services, Barbara and the therapists negotiated with the secondary insurance company to cover both the in-person and remote therapy visits. Barbara agreed to pay out of pocket for any “uncovered services” to avoid having to travel for therapy and to receive therapy in her home in a timely manner per her physician’s prescription and protocol. This financial burden was incurred to assure Barbara’s recovery and to comply with her physician’s orders.

Barbara was able to fully recover from her THR per protocol and without secondary complications or re-hospitalization. Barbara and her spouse reported comparable care, support and satisfaction between both in-person and remote teletherapy visits. The physician was satisfied with the surgical outcomes.

Physical therapy provided via telehealth can reduce costs, increase access to necessary care, enhance the patient’s rehabilitation experience in the home environment, and prevent hospital readmissions. **Therefore, we urge CMS to expand this waiver to allow the coverage of telehealth physical therapy services provided by physical therapists under the CCJR program.** Although physical therapy is not included as a covered telehealth service under the Social Security act 1834(m), we believe CMS has the authority to allow coverage and reimbursement for these telehealth services under this new model.

Congress has expressed an interest in allowing coverage under Medicare for physical therapy services delivered through telehealth. Specifically, legislation introduced in the 113th Congress, the Medicare Telehealth Parity Act of 2014 (H.R. 5380), would require Medicare to reimburse physical therapists, speech-language pathologists, occupational therapists, audiologists, and respiratory therapists for services furnished to Medicare beneficiaries. This legislation is broadly supported by many stakeholders in the health care community and is expected to be reintroduced this summer.

Additional Waivers

In addition to the waivers proposed in the rule, APTA recommends CMS make additional waivers of regulations to enable new treatment approaches under the CCJR model that are patient-centered rather than driven by regulations. There are other existing regulations that would prevent hospitals from fully testing the CCJR model and redesigning service delivery. The hospitals and other providers furnishing care within the CCJO model are incentivized to better coordinate care, increase quality, reduce readmissions, and place the patient in the most cost-effective setting. Therefore, APTA believes these regulatory requirements are unnecessary under the CCJR model. Specifically, we recommend that CMS waive the following existing regulations:

- The inpatient rehabilitation facility (IRF) “3-hour rule,” which requires that IRF patients require and receive at least three hours of therapy at least five days per week

- The IRF “60% Rule,” which requires that at least 60 percent of an IRF’s patients have one of 13 qualifying conditions;
- The financial limitation outpatient therapy services (i.e. therapy cap).

The IRF policies limit admissions based on outdated, restrictive, and ineffective diagnosis-based criteria that can ultimately obstruct a patient’s access to services. The financial limitation on outpatient therapy services, which is currently \$1940 for physical therapy and speech combined and a separate \$1940 for occupational therapy could prevent beneficiaries with joint replacements from receiving coverage for needed outpatient therapy services. It is particularly problematic in instances where beneficiaries had a prior condition during the year for which they received outpatient physical therapy. Because the therapy cap is an annual per beneficiary limit on outpatient therapy services, it is possible a patient could have exceeded the cap prior to their joint replacement surgery. In addition, it would be typical for patients who ultimately have joint replacements to initially receive physical therapy in efforts to prevent surgery or to improve patient outcomes post-surgery. It is important to ensure that policies, such as the therapy cap, do not restrict patients from receiving pre-operative and post-operative physical therapy. These waivers would allow hospitals to redesign care and ensure that the patient goes to the right setting at the right time.

Conclusion

Once again, we thank CMS for the opportunity to comment on these policy changes. If you have any questions regarding our comments, please contact Gayle Lee, Senior Director Health Finance and Quality at (703) 706-8549 or gaylelee@apta.org or Heather Smith, Director of Quality at 703-706-3140 or heathersmith@apta.org. Thank you for your time and consideration.

Sincerely,



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SLD: grl, hls

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