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Andrew M. Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert Humphrey Building
200 Independence Ave., S.W.
Washington, DC 20201

Submitted electronically

RE: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2016 Rates; Revisions of Quality Reporting Requirements for Specific Providers, Including Changes Related to the Electronic Health Record Incentive Program; Proposed Rule

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) submits the following comments regarding the Centers for Medicare and Medicaid Services (CMS) Fiscal Year (FY) 2015 Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment Systems (IPPS) proposed rule. 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 therapy is an integral service provided to patients in the inpatient acute care and long term care settings. Therefore, we appreciate the opportunity to provide the following comments regarding the inpatient and long term care policy updates for FY 2016.

In this proposed rule, CMS proposes to update the IPPS payments for FY 2016 by a market basket increase factor based upon the most current data available. After the applicable adjustments, the proposed FY 2016 IPPS market basket is 1.1 percent. APTA supports this positive increase in payment and urges CMS to conduct regular payment impact analysis to ensure appropriate payment levels for inpatient services.

We ask that the Agency carefully consider the comments that we have articulated below regarding pertinent sections of the proposed rule.

Changes to the Hospital Readmissions Reduction Program

Section 3025 of the Affordable Care Act added section 1886(q) to the Social Security Act establishing the Hospital Readmissions Reduction Program, which requires CMS to reduce payments to IPPS hospitals with excess readmissions, effective for discharges beginning on October 1, 2012. APTA supports the Hospital Readmissions Reduction Program as approximately 20% of all Medicare patients are readmitted within 30 days of an acute care discharge and readmissions account for an estimated $17 billion in health care spending.

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.

CMS is proposing the implementation of a refinement of the pneumonia (PN) readmission measure to expand the measure cohort and the formal adoption of an extraordinary circumstance exception (ECE) policy. APTA supports both the proposed methodology changes for the pneumonia readmission measure and the formal adoption of an extraordinary circumstance exception (ECE) policy.

Changes to the Long Term Care Hospital Quality Reporting (LTCHQR) Program

The Secretary established the Long-Term Care Hospital Quality Reporting (LTCHQR) Program in accordance with section 1886(m)(5) of the Act, as added by section 3004 of the Affordable Care Act. The IMPACT Act also requires that the Secretary specify quality measures and resource use and other measures with respect to certain domains not later than the specified application date that applies to each measure domain and post-acute care provider setting.

The IMPACT Act requires that post-acute care (PAC) providers use standardized assessment tools as the data source for quality measures that shall be risk adjusted (as determined appropriate by the Secretary) and endorsed by NQF. These standardized assessment tools need to be incorporated into existing setting specific assessment tools (OASIS, IRF-PAI and MDS).

CMS proposes 3 new quality measures for the FY 2018 LTCH QRP and subsequent years, addressing 3 quality domains identified in the IMPACT Act:

- Skin integrity and changes in skin integrity (outcomes measure): Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short-Stay) (NQF #0678)
- Incidence of major falls (outcomes measures): Application of Percent of Residents Experiencing One of More Falls with Major Injury (Long Stay) (NQF #0674)
- Functional status, cognitive function, and changes in function and cognitive function (process measure): Application of Percent of Patients or Residents With an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF#2631; under review)

APTA supports the goal of improving 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. Furthermore, APTA feels that it is essential that we move towards a core set of functional items to assess patients across the continuum of care. APTA is pleased to see that these measures proposed for LTCHs which move in that direction in accordance with the IMPACT provisions. However, APTA does have some concerns about these measures, discussed below.

Skin integrity and changes in skin integrity (outcomes measure): Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short-Stay) (NQF #0678)

APTA supports this measure. APTA believes that measuring skin integrity and changes in skin integrity is important in the post-acute care setting. This measure has been endorsed by NQF in the LTCH, as well as in the SNF short-stay and IRF settings. Although this measure is currently risk adjusted, this methodology is based on data obtained from the data collection tools specific to each PAC setting. As CMS moves toward a standard data set under IMPACT, APTA would advocate for continued ongoing evaluation of the risk adjustment methodology.

Incidence of major falls (outcomes measures): Application of Percent of Residents Experiencing One of More Falls with Major Injury (Long Stay) (NQF #0674)

APTA supports this measure in concept. Although this measure is endorsed by NQF for long stay nursing residents and does satisfy the requirement of a major falls domain measure under IMPACT, this measure is not yet endorsed in the LTCH or IRF settings. Additionally, this measure does not include a risk adjustment methodology as required under IMPACT. APTA recognizes that the IMPACT timeline for implementation of the major falls measure for SNFs, IRFs and LTCHs is October 2016, however, we are concerned that this measure needs to include an appropriate risk adjustment methodology.

The other widely used falls with injury measure (NQF #0202), which is currently in use in the acute care setting, employs a risk stratification methodology by nursing unit. The risk stratification utilized in the acute care setting for measure #0202 does allow for the identification of different patient populations, based on nursing unit type, for more

accurate reporting of falls with injury in higher risk patient populations. There is a concern that implementing the long stay major falls measure into other PAC settings may result in wide variations in reported falls without taking into account patient acuity or other variables that may impact falls risk. Additionally, using this measure in the home health setting will pose even greater challenges as the setting is not structured like the other PAC settings, with the patients residing in their home without continual monitoring. For these reasons APTA would encourage CMS to continue to work on refining this measure to incorporate a risk stratification or adjustment methodology.

Functional status, cognitive function, and changes in function and cognitive function (process measure): Application of Percent of Patients or Residents with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF#2631; under review)

APTA supports this measure in concept. APTA believes that measuring function is important in every care setting. APTA is pleased to see this measure being proposed for multiple PAC settings in accordance with the IMPACT requirements. Additionally, we feel that facilities should be monitoring the percentage of complete functional assessments, and we note that this measure does align conceptually with the finalized changes to the home health quality reporting requirements for the submission of OASIS data in an attempt to capture "Quality Assessments Only".

However, APTA has significant concerns as the proposed rule indicates that CMS intends to use "an application" of this measure for the purposes of the LTCH (as well as IRF and SNF) quality reporting program. While we understand that CMS has latitude in implementing endorsed measures in settings for which measures have not yet received endorsement, we are concerned that this measure, as proposed, is inconsistent with the measure that is still under review by NQF. Specifically, we noticed the following differences in the proposed CARE item set (*in italics*):

Long Term Care Hospital Quality Reporting Program - Quality Measure Specifications for FY 2016 Notice of Proposed Rule Making	**NQF Application (NQF#2631) Percent of Patients or Residents with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function**
Self-Care Items	
• Eating • Oral hygiene • Toileting hygiene	• Eating • Oral hygiene • Toileting hygiene • *Wash upper body*
Mobility Items	
• Sit to lying • Lying to sitting on side of bed • Sit to stand • Chair/bed-to-chair transfer • Toilet transfer	• *Roll left and right* • Sit to lying • Lying to sitting on side of bed • Sit to stand • Chair/bed-to-chair transfer

For patients walking: • Walk 50 feet with two turns • Walk 150 feet For patients who use a wheelchair: • Wheel 50 feet with two turns • Wheel 150 feet	• Toilet transfer For patients who walk: • *Walk 10 feet* • Walk 50 feet with two turns • Walk 150 feet For patients who use a wheelchair: • Wheel 50 feet with two turns • Wheel 150 feet
Cognitive Function	
•	*Signs and Symptoms of Delirium (CAM © [Confusion Assessment Method]):* • *Acute onset and fluctuating course* • *Inattention* • *Disorganized thinking* • *Altered level of consciousness*
Communication: Understanding and Expression	
•	• *Expression of ideas and wants* • *Understanding of verbal content*
Bladder Continence	
•	• *Bladder Continence*

Additionally, as submitted for NQF review, measure #2631 requires the collection of other data not initially required by the CARE demonstration project such as projected goal information. While APTA appreciates the need to easily identify patients/ residents who have a care plan that addresses function, we are worried that collecting an estimated goal for a single CARE item is a poor proxy for the functional plan of care for patients/ residents as the plan of care typically addresses multiple functional limitations in the PAC settings. Furthermore, as this is a limited item set compared to the full self-care and mobility item set in the PAC CARE demonstration, there is a possibility that the functional issues that are being addressed may not be represented in this measure. Lastly, it is also important to recognize that for many patients the goal of therapy is restorative, however in some instances skilled therapy services may focus on maintenance of a patient's function. Again, APTA recognizes that as the IMPACT measures are implemented and as we move to standardized assessment tools across the PAC settings, these measures may need modifications. We are hopeful that CMS will address these concerns in the final rule.

Although this measure does address the required domain of functional status it does not capture functional outcome. CMS has in fact proposed functional outcome measures for IRFs in this rulemaking cycle (IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633, under review), IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634, under review), IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635, under review), IRF Functional Outcome

Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636, under review)), however, none of these outcome measures were included for the LTCH or SNF settings. Additionally, NQF has recently reviewed functional outcome measures for the SNF setting based on items from the CARE tool (CARE: Improvement in Mobility (NQF #2612, under review), and CARE: Improvement in Self-Care (NQF #2613, under review)). None of these outcomes measures were put forth for consideration during the Measures Application Partnership (MAP) ad hoc measures for the Improving Medicare Post-Acute Care Transformation Act process. APTA encourages CMS to incorporate functional outcome measures in future years in the other PAC quality reporting programs, including SNF and home health settings, as timely comprehensive functional data will be needed in order to make informed decisions about quality of care and future payment systems for PAC settings.

APTA recognizes that the overall goal of IMPACT is for PAC providers (HH, IRF, SNF and LTCH) to collect and report standardized and interoperable patient assessment data, quality and resource use measures. We acknowledge that during the initial IMPACT implementation years that there will be a transition period from existing data collection tools to incorporate standardized assessment tools. For other PAC settings, there are concerns about the duplicity in data collection that this measure introduces and the burden of data collection for the providers given the current data collection tools in the PAC settings. In the LTCH setting this burden is lower as the collection of CARE items is part of the existing assessment tool. APTA encourages CMS to consider a short transition period to standardize the patient assessment data in order to decrease the issues around duplicity and provider burden in data collection, this includes considering the removal of items from the existing data sets where possible. Additionally, we believe that achieving a standardized and interoperable patient assessment data set as quickly as possible will allow for better cross-setting comparisons as well as the evolution of better quality measures with uniform risk standardization, thus achieving the true aim of IMPACT.

Additionally, APTA would like to encourage CMS to continue ongoing stakeholder engagement in this process as we move toward PAC data standardization; this includes changes that are made through the regulatory process as well as the measures endorsement process through NQF. We anticipate that the functional measures will evolve over time to include additional CARE self-care and mobility items that are not included in this first functional measure. The inclusion of new items should help to ensure true representation of patient function at the low, as well as the high ends of the spectrum. Additionally, we would encourage CMS and other measure developers to consider functional items such as velocity or gait speed which may provide a more meaningful picture of the quality of mobility performance versus ambulation distance which is a measure of tolerance. APTA and its members appreciate the opportunity to work with CMS during the implementation phase of IMPACT.

Lastly, APTA encourages CMS to make every effort to align quality metrics and discharge information from the inpatient hospital with the goals and objectives of IMPACT. IMPACT mandates the development and use of measures to assist providers

with discharge planning from the inpatient setting. Specifically, the law requires the Secretary of Health and Human Services to promulgate regulations that modify the Medicare Conditions of Participation (COP) for Hospitals to incorporate the use of measures into the discharge planning process. There has not been any substantive information released from CMS on how this process would take place. APTA urges CMS to put forth a proposal on how it plans to revise the COPs to accommodate the new law as soon as possible. We strongly believe that discharge information from the inpatient hospital is critical to determining the most appropriate post-acute care setting for the patient based on their unique clinical condition.

Medicare Payment for Short Inpatient Hospital Stays

In the proposed rule, CMS continues its discussion about stakeholder concerns with the agency's policies regarding short inpatient hospital stays and long outpatient hospital stays that include observation services. Additionally, CMS notes that it is still determining policies to distinguish when Part A payment is appropriate for short stays.

CMS describes some changes that have been implemented to address these issues such as the Recovery Auditor look-back period, limits on additional documentation requests, complex reviews and timeframe for claims being sent to the Medicare Administrative Contractor for payment adjustments. While, APTA appreciates all of these interim revisions, we strongly believe that there is still major refinement that needs to take place in this area in a more expedient manner. We understand that CMS intends to address this issue in more detail within the Medicare Outpatient Hospital Prospective Payment Calendar Year (OPPS CY) 2016 proposed rule, but we respectfully ask that you consider the following comments in the context of this proposed rule as well.

APTA is opposed to the two-midnight policy implemented in the FY 2014 IPPS/LTCH PPS final rule. The two-midnight policy presumes that a hospital inpatient admission is appropriate for a Medicare beneficiary who requires a hospital stay that spans at least two midnights. Thus, a hospital stay that is less than two midnights should be considered outpatient and billed under Medicare Part B, with limited exceptions. APTA believes that the decision to admit a patient for an inpatient stay should be made by the physician and interdisciplinary team, including the physical therapist, and solely based on the clinical condition of the patient. Setting an arbitrary two-midnight rule can be harmful to patients, particularly those who are short stay with acute illnesses. Therefore, we strongly urge CMS to craft an alternative policy that is based on patient characteristics and allows for the flexibility of the clinician to make appropriate decisions regarding inpatient admissions based on the unique clinical condition of the patient.

Alternative Payment Category

APTA recommends that CMS establish an alternative payment category to allow coverage for a designated period of time for hospitals to assess and treat patients that fall outside of the CMS criteria for admission to an inpatient stay. We believe that certain patient populations would benefit from a new hospital coverage category, and hospitals

will be able to make more educated inpatient admission and outpatient stay determinations.

In many instances, physical therapists are called upon in the emergency room to assist the physician and others in making clinical determinations of whether the patient should be admitted to the hospital as an inpatient. Often, this determination is based on whether the patient has an acute condition. Commonly, patients that come to the hospital are faced with limitations in function caused by a fall or some other accident. For example, a patient with severe lymphedema that is exacerbated has a fall and resulting functional limitations. While these patients do not have an acute condition that would necessitate an inpatient admission, they are unable to leave the hospital and return home due to their condition, home environment, absence of a caretaker, and other factors.

For this category of patients, it would be beneficial if CMS provided a third option to hospitals of an assessment and intervention period, that could last up to three days, to provide appropriate treatment to these patients and to make preparations for these patients to be admitted to the appropriate care setting. During this time frame, these patients would not be considered an inpatient admission or on observation status and payment to the hospital would be set at a different rate determined by CMS. This expanded assessment period would allow physicians, physical therapists, and other health care professionals a sufficient time period to evaluate the patient and recommend the appropriate settings for continued treatment (e.g. acute, sub-acute or long-term care).

As with inpatient stays, therapy provided during the assessment and intervention stay should not be subject to any outpatient therapy requirements, such as functional limitation reporting and the therapy cap. We believe that by providing this alternative payment category, hospitals will not be faced with the dilemma of turning patients away because they do not qualify for admission to the inpatient hospital, and it will minimize financial liability for patients due to lengthy observation stays. In addition, we believe the policy change will result in better use of hospital resources to manage patients in the emergency room and acute care facilities.

APTA also believes that CMS should set parameters regarding the amount of time a patient can remain on observation status. We recommend setting a timeframe for an observation period of no more than 24 hours. After that time period, patients should be either admitted if appropriate or placed into the aforementioned alternative payment category. This will help to set a bright line standard for hospitals as well as post-acute care providers such as home health agencies and skilled nursing facilities (SNFs). In SNFs, it is required that patients have a qualifying three-day hospital stay to receive services under the Medicare SNF Part A benefit. Often times, SNFs find it challenging to discern whether this requirement has been met because of prolonged hospital observation periods without an ultimate admission. As a result, thousands of Medicare beneficiaries are denied access to medically necessary services under the SNF Part A benefit each year.

The same holds true for home health agencies that are trying to distinguish inpatient hospital admissions to determine whether the patient has been discharged or readmitted to the home health agency during the 60 day home health episode. The increasing length of the observation period is creating administrative burden for post-acute care providers to comply with quality measurement programs regarding the prevalence of hospital readmissions for their patient populations and other regulatory requirements such as functional reassessments in the home health setting.

Exception to Outpatient Therapy Requirements for Inpatient Therapy

Due to the confusion that still exists around inpatient admission criteria, APTA continues to be concerned about therapy provided on an inpatient basis that is later denied by auditors and rebilled under Part B. Policies such as the therapy cap and functional limitation reporting were intended for patients receiving therapy in the outpatient setting, and are nonsensical in their application to inpatient or observation stays. It is critical that the hospital have a clear understanding of inpatient or observation status due to the inability to retroactively achieve compliance with the Part B outpatient therapy requirements. Therefore, we recommend that CMS establish an exception to the outpatient therapy requirements, as outlined in the Medicare Benefit Policy Manual, for observation status patients as well as patients that fall in the recommended assessment and intervention category above.

Per statutory requirements, CMS places an annual per beneficiary Medicare financial limitation on outpatient therapy services ("therapy cap"). Each year this annual amount is updated, and the 2015 therapy cap amount is $1940 for physical therapy and speech language pathology services combined. There is a separate $1940 amount allotted for occupational therapy services in 2015. In 2015, the $1,940 therapy cap with an exceptions process applies to services furnished in the following outpatient therapy settings: physical therapists in private practice, physician offices, skilled nursing facilities (Part B), outpatient rehabilitation agencies (ORFs), comprehensive outpatient rehabilitation facilities (CORFs), outpatient hospital departments, and critical access hospitals. For claims exceeding $3700, Congress has mandated that therapy claims go through a targeted manual medical review process in which providers are required to send specific documentation to CMS contractors for review.

When considering payment implications, APTA strongly recommends that CMS consider the effect that payment for inpatient hospital services under Medicare Part B such as during the observation period, may have on calculations of the therapy cap. Due to risk of denials when classifying patients for an inpatient stay, there are instances where a patient's entire stay in the hospital, which sometimes spans as much 16 days, is classified as an outpatient hospital stay. Therefore, all physical therapy services received during this period are counted toward the cap. We believe that this is unfair to the patient as it may limit their access to physical therapy in the outpatient setting, when in fact these services should have been billed as inpatient services. Further, acute care hospital systems are designed for compliance with IPPS Part A requirements. It is administratively burdensome and requires extensive staff and financial resources to implement new

processes and electronic software to manage Part B cases. Moreover, the additional cost of compliance with Additional Documentation Requests (ADRs) for manual medical review and other audit requests can be untenable.

In addition, the Middle Class Tax Relief Act mandated that CMS, as of July 1, 2013, collect information on the claim forms regarding the beneficiaries function and condition. All practice settings that provide outpatient therapy services must include this information on the claim form. Specifically, the policy applies to PT, OT, and SLP services furnished in hospitals, critical access hospitals, skilled nursing facilities, CORFs, rehabilitation agencies, home health agencies (when the beneficiary is not under a home health plan of care), and in private offices of therapists, physicians and non-physician practitioners. Under the functional limitation reporting requirement for outpatient therapy services, nonpayable G-codes and modifiers is mandated on the claim forms to capture data on the beneficiary's functional limitations at the outset of the therapy episode, a minimum every 10th visit and discharge. By collecting data on beneficiary function over an episode of therapy services, CMS hopes to better understand the beneficiary population that uses therapy services and how their functional limitations change as a result of therapy services. As stated in the Middle Class Tax Relief Act, the purpose of the claims-based data collection strategy is "to assist in reforming the Medicare payment system for outpatient therapy services". Clearly, inpatient stay and observation status patients do not serve this purpose to inform data that should assist in reforming outpatient therapy payment.

To the contrary, APTA believes that the data gained from observation status patients does not exemplify the typical outpatient therapy episode and may make data analysis more difficult, as these patients may be impossible to distinguish through the current claims-based data collection methodology. Therefore, the data gained from observation status patients will likely not contribute to or benefit the reform of the outpatient therapy service benefit. Likewise, the functional data from the Medicare Part A patients who are rebilled as Part B patients would not be relevant in reform of an outpatient therapy payment system given the fact that these would primarily be short stay patients. For this reason, APTA strongly urges CMS to exempt observation status patients and Medicare Part A patients rebilled under the Part B benefit from reporting functional limitation data.

The ability to clearly discern whether the patient is receiving services under the outpatient therapy benefit or physical therapy services provided as part of the patient's inpatient stay is critical to compliance for hospitals under these new functional limitation reporting requirements and with regard to the therapy cap. Therefore, APTA recommends that CMS exempt hospitals from the therapy cap and the functional limitation reporting requirements for physical therapy services that are furnished under the inpatient stay, even if the services provided during the inpatient stay are later denied and subsequently rebilled under the Part B Inpatient Billing policy. CMS could easily establish this exemption with the use of a modifier when billing. This same modifier could be affixed to therapy services billed under observation status as well as when rebilled under Part B for denied admissions.

APTA strongly believes that hospitals should be appropriately reimbursed for the services they provide during the observation period and the inpatient short stay. The decision to admit should be solely based on the clinical condition of the patient and in which setting their medical needs can be safely and effectively addressed. Therefore, we recommend that CMS take the necessary steps to ensure that payments are accurately aligned in tandem with setting parameters for short stays, observation stays, and the creation of an assessment and intervention stay. We believe that addressing payment and defining these categories will help hospitals who are operating with limited resources while resolving issues regarding the three-day qualifying hospital stay for SNFs and other complicating factors. In addition, we recommend an exception to outpatient therapy requirements for those services provided to patients in the inpatient, observation, and assessment and intervention stay.

Potential Expansion of Bundled Payments

In 2011, the Centers for Medicare and Medicaid Innovation (CMMI) launched the Bundled Payments for Care Improvement (BPCI) initiative. This initiative is made up of 4 models of care that link payments for multiple services beneficiaries receive during an episode of care. Model 1 includes an episode of care focused on the acute care inpatient hospitalization. Awardees agree to provide a standard discount to Medicare from the usual Part A hospital inpatient payments. Models 2 and 3, which focus on inpatient and post-acute care services, involve a retrospective bundled payment arrangement where actual expenditures are reconciled against a target price for an episode of care. Model 4, which focuses on inpatient and physician services, involves a prospective bundled payment arrangement, where a lump sum payment is made to a provider for the entire episode of care. In this proposed rule, CMS is seeking comments on policy and operational issues that should be addressed in consideration of future expansion of the program into the permanent Medicare system.

APTA supports the overall concept of bundled payment and specifically the work that has been undertaken by CMMI's BPCI project, but we still have major concerns about permanent implementation of this project in the Medicare system. First, there has not been any substantive data released to the public regarding the outcomes of this project. To make an informed decision about implementation, we feel that it is imperative that all affected providers are given the opportunity to analyze the initial findings regarding ease of administrative compliance, outcomes, and payment implications. Therefore, we urge CMS and CMMI to release this information as soon as possible.

Furthermore, we believe that an appropriate bundled payment system cannot be achieved in a single step. There needs to be an incremental approach. First, what should be included in the bundle needs to be better defined. APTA recommends that CMS build upon the work of BPCI and implement a bundled payment amount for the post-acute care episode before incorporating payment for acute care and other outpatient therapy services. The current Medicare PPS' are already structured around episodic payment, therefore, it will be easier to capture and better define the bundled payment for these services first before incorporating other payment systems based on interventions.

Bundled payment models must have the requisite infrastructure including health information technology, quality reporting and outcomes assessment and should always consider the patients freedom of choice. Therefore, we strongly urge the implementation of the aforementioned reforms before bundled payment is addressed – namely implementation of standardized patient assessment instrument and advances in health information exchanges.

Consistency in Regulations across PAC Settings

We urge CMS to be mindful that in order to create a cohesive post-acute care payment system there must consistency among documentation and billing requirements. Therefore, post-acute care reform must be supplemented by meaningful and carefully crafted regulations that reduce redundancies, eliminate administrative burden, and increase efficiency. In tandem with quality measure development, CMS should conduct a comprehensive analysis of existing rules and regulations. As a result of this analysis, CMS must eliminate or significantly revise current regulations, included but not limited to the home health functional reassessment, SNF Change of Therapy OMRA, SNF 3-day hospital stay admission requirement, definitions of group and concurrent therapy, IRF short stay policy and IRF 60 percent rule. The elimination or revision of onerous regulations should take place prior to full implementation of the new payment model.

Conclusion

Once again, we thank CMS for the opportunity to comment on these policy changes. We look forward to working with the agency to make substantial revisions to the proposed policies in this regulation prior to its finalization to ensure that Medicare beneficiaries have access to medically necessary physical therapy services in the inpatient and long-term care hospital setting. If you have any questions regarding our comments, please contact Roshunda Drummond-Dye, Director of Regulatory Affairs at roshundadrummond-dye@apta.org or Heather Smith, Director of Quality at heathersmith@apta.org. Thank you for your time and consideration.

Sincerely,

Sharon L. Dunn, PT, PhD, OCS
President

SLD: rdd, hls