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Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Attn: CMS-1677-P
Hubert Humphrey Building
200 Independence Ave, SW
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 and Fiscal Year 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals; Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices (CMS-1677-P)

Dear Administrator Verma:

On behalf of our more than 95,000 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) 2018 Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System (LTCH PPS) proposed rule. APTA's goal is to foster advancements in physical therapist 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 2018.

In this rule, CMS proposes to increase acute care hospitals' operating payment rates by 2.9%, after accounting for the hospital market basket update, proposed changes in uncompensated care payments, and other proposed changes to the IPPS payment policies. APTA supports this positive increase in payment and urges CMS to conduct regular payment impact analyses to ensure appropriate payment levels for inpatient services.

We ask that the agency carefully consider the comments we have articulated below regarding pertinent sections of the proposed rule as well as our response to the request for information (RFI).

Accounting for Social Risk Factors

APTA recognizes that adjusting for social risk factors in certain outcome measures is a complex issue. APTA appreciates that the lack of adjustment for these factors in value-based payment programs and models negatively impacts providers and facilities in certain geographic areas where the incidence of specific social risk factors are highest. However, we also acknowledge that adjusting for social risk factors may increase health disparities by essentially masking these factors. Currently, outcomes measures are not adjusted for social risk factors which has led to reduced payments for providers and facilities caring for large numbers of disadvantaged patients. In addition to financial repercussions, these publically reported outcome measures can be misleading to consumers.

As an active member of the National Quality Forum (NQF), APTA has been following the social risk factor adjustment project and also has reviewed the work done by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the National Academies of Sciences, Engineering, and Medicine. APTA supports the overarching strategies outlined in the ASPE report, which include measuring and reporting quality for beneficiaries with social risk factors; setting high, fair quality standards for all beneficiaries; and rewarding and supporting better outcomes for beneficiaries with social risk factors. APTA encourages CMS to take immediate action on these recommendations. We support testing of social risk factor adjustment models as well as reporting stratified outcomes measures to providers to enable them to better understand the effects that social risk factors have on their performance. Once the risk-stratified data has been shared with providers, CMS should work with stakeholders to share this data with the public.

APTA believes that the understanding of social risk factors and their impact on the health care system will continue to evolve over time. We encourage Medicare to be responsive to future developments and strategies that provide solutions for adjustment of social risk factors in outcome measures.

Hospital Readmissions Reduction Program

We support CMS's proposal to include dual-eligibility status as a component in calculating penalties under the Hospital Readmissions Reduction Program (HRRP). Dual-eligible beneficiaries account for a disproportionate share of Medicare expenditures. On

average, Medicare fee-for-service spending is more than twice as high for dual-eligible beneficiaries as for non-dual-eligible beneficiaries.¹ Dual-eligible beneficiaries also are more likely to be under age 65 and disabled.¹ Given the extent by which dual-eligible status impacts overall spending as well as scoring on quality measures—unrelated to the quality of care provided—APTA encourages CMS to include dual-eligibility as a social risk factor across all hospital quality and reporting programs.

APTA appreciates CMS’s proposal to implement changes to the payment adjustment factor under the HRRP to account for the proportion of dual-eligible patients. This adjustment should allow for a more comprehensive and precise comparison of a hospital’s performance with other hospitals that have a similar proportion of dual-eligible patients.

Additionally, we encourage CMS to consider including functional status of a patient as a social risk factor. A patient’s level of function impacts their ability to transition successfully back into the community. Recent evidence indicates that patient function is associated with increased risk of hospital readmissions. Functional level may be an important factor in preventing readmissions for Medicare beneficiaries that is not currently accounted for in measure methodologies. APTA recommends that CMS evaluate whether it is feasible to account for functional level within the HRRP.

Physical therapists play an integral role in the prevention of acute care hospital readmissions. As essential members of the health care team facilitating transitions in care for patients, physical therapists collaborate with other health care professionals to assist in discharge planning, including the determination of the most appropriate setting for patients based on their medical status, functional status, prognosis, and other factors such as home environment and family support.

As the health care delivery system evolves and incorporates strategies and methods to reduce readmission rates, increased coordinated efforts across the continuum of care are imperative, as is a stronger emphasis on the development of robust transitional care programs. Reducing acute care hospital readmissions for the Medicare patient population will decrease cost, improve patient safety, and promote the best possible outcomes.

Hospital VBP Program

APTA supports CMS’s proposal to remove the current Patient Safety for Selected Indicators measure (PSI 90) and in its place adopt a modified version of a previously adopted measure, Patient Safety and Adverse Events Composite (NQF #0531), beginning with the FY 2023 program year. We believe that using an adapted NQF #0531 will capture additional adverse events, thereby more accurately depicting patient harm that results from a patient safety event.

¹ Medicare Payment Advisory Commission June 2016 Data Book Section 4. <http://www.medpac.gov/docs/default-source/data-book/june-2016-data-book-section-4-dual-eligible-beneficiaries.pdf?sfvrsn=0>. Accessed April 24, 2017.

Hospital-Acquired Conditions Reduction Program

APTA supports CMS's proposal to adopt outcomes-focused patient safety measures within the Hospital-Acquired Conditions (HAC) Reduction Program that focus on certain topic areas, including falls with injury, adverse drug events, glycemic events, and ventilator-associated events. According to the Centers for Disease Control and Prevention (CDC), millions of individuals ages 65 and over experience a fall each year, and 1 out of 5 falls causes a serious injury.² Physical therapists can help in risk reduction and prevention of falls. In acute care settings, physical therapists provide their services to patients through a plan of care that engages and optimizes the patient's participation in achieving shared goals of improved functional performance, reduced risk of injurious falls, and reduced risk of acute hospitalization and readmission, thereby promoting long-term health, independence, and wellness.

Patient falls are one of the most frequently reported adverse events. We appreciate CMS's efforts to capture data on such events with the development of patient safety measures focused on falls with injury, among other events.

Adjustment to IPPS Rates Resulting From 2-Midnight Policy for FY 2018

In FY 2017, CMS prospectively removed the 0.2% reduction to hospital payment rates that had been put in place in FY 2014 to offset the estimated increase in IPPS expenditures as a result of the 2-midnight policy. Additionally, CMS made a 1-time prospective increase to the FY 2017 standardized hospital-specific payment rate by including a factor of 1.006 in the rate calculation. For FY 2018, CMS proposes to remove this 1.006 factor. APTA supports this proposal and commends CMS on the transparency of its accounting. APTA would support any future rate adjustments that better reflect economic realities.

Hospital Inpatient Quality Reporting Program

APTA supports CMS's proposal to modify several of the existing Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey questions to focus more directly on communication with patients about their pain during the hospital stay. These revised questions would then be used to form the composite measure "Communication about Pain."

The CDC has identified physical therapy as a preferred nonpharmacologic treatment for chronic pain. Physical therapists treat patients' pain through exercise, manual therapy, education, and teamwork. APTA is committed to ensuring that patients have access to safe, effective nonpharmacologic pain-management solutions. Enhancing communication between providers and patients on the topic of pain will lead to more successful pain management as well as increased patient adherence to treatment.

² Centers for Disease Control and Prevention.
<https://www.cdc.gov/homeandrecreationalsafety/falls/adultfalls.html>. Accessed May 15, 2017.

We also support CMS's proposal to modify the stroke 30-day mortality rate measure beginning with the FY 2023 payment determination year by including the NIH Stroke Scale in the risk-adjustment model. Using the stroke scale to adjust risk for the stroke 30-day mortality rate measure will increase the accuracy and reliability of the measure, improving comparability of the risk of mortality among patients with stroke.

Critical Access Hospitals

APTA supports CMS's proposal to direct Quality Improvement Organizations, Medicare Administrative Contractors, the Supplemental Medical Review Contractor, and Recovery Audit Contractors to make the critical access hospital (CAH) 96-hour certification requirement a low priority for medical record reviews beginning October 1, 2017. We appreciate that CMS is developing policies designed to minimize the administrative burden on providers. Administrative requirements imposed on physical therapists and other health care professionals divert resources and time away from delivering direct patient care. APTA strongly encourages CMS to enact additional policies that reduce administrative duties across the continuum of care.

CAHs play a crucial role in the health care delivery system, providing access to health care services in rural communities; unfortunately, many of these hospitals are susceptible to closure, particularly in states that have not expanded Medicaid. CAHs deliver high-quality, effective care to some of the nation's most vulnerable patients and offer an essential safety net. We recommend that CMS continue to develop policies to augment the financial viability of these hospitals to ensure that patient access in rural areas is maintained.

Long-Term Care Hospitals PPS

In the rule, CMS is proposing to update the LTCH PPS by 1%; however, based on changes included within the rule, CMS projects that LTCH PPS payments would decrease by approximately 3.75% as a result of the phase-in of the dual payment rate system. The dual-payment system pays LTCHs under the LTCH PPS if the patient meets specified criteria; for patients who do not meet the criteria, LTCHs receive a site-neutral rate, based on the lesser of an IPPS-comparable amount or 100% of cost for the case.³ Compared with all Medicare beneficiaries, those admitted to LTCHs are disproportionately disabled (those under age 65), over age 85, or diagnosed with end-stage renal disease. They also are more likely to be African American.⁴

LTCHs play an important role within the Medicare program by treating patients with complex medical conditions and who need prolonged hospital stays. While we acknowledge and appreciate that the dual-payment system is being phased in and

³ Medicare Payment Advisory Commission Report to Congress Chapter 11: http://medpac.gov/docs/default-source/reports/mar17_medpac_ch11.pdf?sfvrsn=0 (Last Accessed April 20, 2017).

⁴ *Id.*

payment decreases are expected, APTA has concerns that the proposed FY 2018 decrease has the potential to negatively impact patient access to care in LTCHs.

LTCH Quality-Reporting Program

Physical therapists are educated and trained to provide wound care, and often are involved in selecting and delivering the most appropriate treatment for the patient. This may include debridement, caregiver training, strengthening exercises, improvements to the seat or bed, and coordination with other health care providers to ensure proper healing as well as to prevent the development of new pressure ulcers.

APTA supports CMS's proposal to remove the current pressure ulcer measure titled Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678) and replace it with a modified version of the measure titled Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury. APTA also supports the adoption of 2 new measures (1 process and 1 outcome) related to ventilator weaning. We agree with CMS's assessment that the adoption of new ventilator weaning measures will encourage implementation of evidence-based weaning guidelines, thereby enhancing the quality and safety of care delivered to Medicare beneficiaries.

Request for Information

APTA appreciates CMS's efforts to transform the health care delivery system, including the Medicare program, by emphasizing a strong focus on patient-centered care. We are encouraged by CMS's efforts to solicit ideas from stakeholders on policies and practices to help the Medicare program achieve transparency, flexibility, program simplification, and innovation. In response to the RFI, APTA recommends the following:

Telehealth

As Medicare payment shifts to innovative, valued-based payment methods, it is important to recognize the use of telehealth as a valuable tool for providers to use in improving the quality of care. Telehealth also offers patients increased access to providers and medical services that might not be available otherwise; for example, because of the need to travel long distances. Telehealth consists of electronic communications to deliver a host of health-related information and health care services including, but not limited to, physical therapy-related information and services. Telehealth encompasses a variety of health care and health promotion activities ranging from education, advice, reminders, interventions, and monitoring of interventions. Telehealth is projected to reach 12 million users in 2022, according to the World Market of Telehealth.

With the increasing reliance of technology to improve access to quality care, APTA urges CMS to revisit its policies that address coverage of telehealth services to include services provided by physical therapists. Applications of telehealth in physical therapy expand throughout patient care and consultation, as they allow physical therapists to effectively communicate with patients and provide more flexible care. Expanding Medicare

coverage of telehealth services to include physical therapy will ultimately allow physical therapists to provide services in a greater capacity.

Moreover, as CMS pursues the development of future alternative payment models that emphasize both quality and multi-disciplinary service delivery, CMS should address gaps in its policies to provide increased Medicare coverage for telehealth services. Expansion of telehealth coverage to include physical therapy and other specialized health services would allow for more flexible care delivery to Medicare beneficiaries in need of comprehensive care from a team of providers. In addition, coverage for telehealth across a variety of providers can improve patient outcomes, decrease families' out of pocket spending, and promote greater adherence to rehabilitation programs. Telehealth also can promote increased collaboration among providers and social service institutions to better address the specific needs of patients across the complete care continuum, from the primary care visit to the rehabilitation services necessary to promote and maintain positive 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. 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 new alternative payment models. Therefore, as CMS continues to develop new and innovative models, we encourage the agency to maximize the ability of multiple types of providers, including physical therapists, to use telehealth services to effectively manage patient care.

Congress also has expressed an interest in allowing coverage under Medicare for physical therapy services delivered through telehealth. We are hopeful that Congress will pass legislation in the near future that permits Medicare coverage of telehealth services furnished by physical therapists, speech-language pathologists, occupational therapists, audiologists, and respiratory therapists.

Therapy Cap

APTA strongly believes that hospitals should be appropriately reimbursed for the services they provide during the inpatient and observation periods. The decision to admit should be based solely on the clinical condition of the patient and the setting in which their medical needs can be safely and effectively addressed. However, one policy that continues to impact this decision-making is the therapy cap. Per statutory requirements, CMS places an annual per-beneficiary Medicare financial limitation on outpatient therapy services. Each year this annual threshold is updated, and the 2017 therapy cap amount is \$1,980 for physical therapy and speech language pathology services combined.

Due to the confusion that still exists around inpatient admission criteria, APTA continues to be concerned about coverage for therapy provided on an inpatient basis that is later denied by auditors and rebilled under Part B. Often, due to the risk of denials when classifying patients for an inpatient stay, a patient's entire stay in the hospital(s), which

can span as many as 16 days, sometimes is classified as an outpatient hospital stay. Therefore, all physical therapy services received during this period are counted toward the cap. We believe this is unfair to these patients, 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.

Policies such as the therapy cap and functional limitation reporting were intended for patients receiving therapy in the outpatient setting, and they are nonsensical in their application to patients in observation status. We strongly encourage CMS to establish an exception to the outpatient therapy requirements, as outlined in the Medicare Benefit Policy Manual, for observation-status patients.

Another Part B payment policy that poses serious implications for patients and providers during an outpatient hospital stay is therapy functional limitation reporting. The Middle-Class Tax Relief Act mandated that as of July 1, 2013, CMS collect information on claim forms regarding beneficiaries' function and condition. All practice settings that provide outpatient therapy services must include this information on their claim forms. Specifically, the policy applies to physical therapy, occupational therapy, and speech-language pathology services furnished in hospitals, CAHs, skilled nursing facilities (SNFs), comprehensive outpatient rehabilitation facilities, 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 nonphysician practitioners.

Under the functional limitation reporting requirement for outpatient therapy services, nonpayable G-codes and modifiers are mandated on the claim forms to capture data on the beneficiary's functional limitations at the outset of the therapy episode, at a minimum of every 10th visit, and at discharge. The ability to clearly discern whether the patient is receiving services under the outpatient therapy benefit or as part of the patient's inpatient stay is critical to compliance for hospitals under functional limitation reporting requirements, which makes reporting under observation status all the more complicated. Therefore, we strongly urge CMS to waive functional limitation reporting for observation-status patients. CMS could 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.

We believe that addressing payment and defining these categories will help to ensure that patient access to outpatient therapy is not unreasonably limited, while also helping hospitals maintain continuous compliance with Medicare rules and regulations.

SNF 3-Day Waiver

APTA strongly recommends that CMS modify the SNF 3-day inpatient stay requirement to include days spent in observation for satisfying the 3-day inpatient hospital stay requirement for Part A coverage of SNF care. Congress also has expressed support for such a policy change, as members in both the House and Senate have introduced the Improving Access to Medicare Coverage Act of 2017 (H.R. 1421/S. 568). The legislation

expands the definition of “inpatient” for purposes of the 3-day inpatient stay requirement, and allows time spent in observation to count toward satisfying the requirement.

Direct Access

APTA recommends that CMS revisit its referral requirements for physical therapy services. The physician authorization requirements inadvertently create significant delays in the provision of physical therapy services to individuals who would benefit from treatment by a physical therapist. These delays often lead to higher costs, decreased functional outcomes, and frustration to patients. Based on their extensive education and clinical training in the examination, evaluation, diagnosis, and intervention of patients with a variety of clinical conditions, physical therapists are qualified to furnish therapy services that improve patient outcomes independent of a referral. CMS should adopt a broad policy that eliminates physician referral requirements for physical therapy services to improve patients’ access to such medically necessary care.

Conclusion

Once again, we thank CMS for the opportunity to comment on the FY 2018 IPPS and LTCH PPS proposed rule. We look forward to working with the agency in making revisions to the proposed policies in this rule 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 Kara Gainer, director of regulatory affairs, at karagainer@apta.org or 703/706-8547. Thank you for your time and consideration.

Sincerely,



Sharon L. Dunn PT, PhD
President

SLD: krg