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Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1694-P
PO Box 8011
Baltimore, MD 21244-1850

Submitted Electronically

Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2019 Rates (CMS-1694-P)

Dear Administrator Verma:

On behalf of our more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) is pleased to submit comments on the Centers for Medicare and Medicaid Services' (CMS) Hospital Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals and Long-Term Care Hospital (LTCH) Prospective Payment System proposed rule for Fiscal Year (FY) 2019. The mission of APTA is to build a community to advance the physical therapy profession to improve the health of society. Physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability by serving as a dynamic bridge between health and health services delivery for individuals across the age span. While physical therapists are experts in rehabilitation and habilitation, they also have the expertise and the opportunity to help individuals improve overall health and prevent the need for otherwise avoidable health care services. Physical therapists' roles may include education, direct intervention, research, advocacy, and collaborative consultation. These roles are essential to the profession's vision of transforming society by optimizing movement to improve the human experience.

In its proposed rule, CMS plans to increase payments to acute care hospitals by 3.4%, which accounts for the hospital market basket update, a productivity adjustment, changes to low-volume hospital payments, and other proposed policy changes to the IPPS. APTA supports this 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).

Promoting Interoperability Program

APTA supports CMS's proposal to restructure the Medicare and Medicaid electronic health records (EHR) incentive programs with the goal of improving interoperability among providers. While we support the agency's focus on enhancing communication and information sharing between providers, we request that CMS include in the final rule clarification on the types of providers who will be eligible to report under the new Promoting Interoperability program, as physical therapists were not previously eligible to report under the Meaningful Use program.

Reducing Administrative Burden in Quality-Reporting Programs

APTA supports CMS's proposal to remove duplicative and overly burdensome measures from the Hospital Inpatient Quality Reporting Program (QRP) and Value-Based Purchasing Program (VBP). The goal of capturing quality measures should be to improve patient care and outcomes. To that end, we agree with the agency's decision to remove measures to eliminate redundancy, thereby allowing providers more time to focus on providing efficient and effective care to their patients. This reduced administrative burden will be of particular use in rural and critical-access hospitals, which already have limited staff and resources to fulfill administrative activities.

APTA is committed to exploring more methods to achieve administrative simplification for physical therapists, ensuring that they have the flexibility to provide high-quality care and ensuring that patients have access to medically necessary care. We look forward to working with CMS to identify policies that will further reduce administrative burden for physical therapists and other providers.

Rural Community Hospital Demonstration

CMS included within the rule a proposed policy to carry out the Rural Community Hospital Demonstration, which was extended by the 21st Century Cures Act for another 5 years from December 2016. The demonstration was originally established under the Medicare Prescription Drug, Improvement and Modernization Act of 2003 and later extended under Sections 3123 and 10313 of the Affordable Care Act. To participate in the demonstration, hospitals must be located in a rural geographic location, have fewer than 51 acute-care beds, provide 24-hour emergency services and not be eligible for designation as a critical-access hospital. As of December 2017, 30 hospitals participate in the demonstration. CMS plans to maintain a budget-neutral implementation of the

demonstration by adjusting payment to participating rural community hospitals each payment year based on the difference between the actual and estimated costs of the demonstration.

APTA supports CMS's plans to continue the Rural Community Hospital Demonstration and allow hospitals in areas with low-density populations to offset their costs of furnishing health care. Since 2010, more than 80 rural hospitals have been forced to close their doors due to high operating costs. It is estimated that the nation is at risk of losing one-third of its rural hospitals over the next few years, which stands to leave patients in these geographical areas in critical need of health care services.¹ This demonstration helps to maintain patient access to high-quality care by alleviating some of the financial burden put on community hospitals in areas with low populations.

Request for Information on Interoperability

APTA appreciates the opportunity to provide feedback in response to CMS's RFI on interoperability. After careful consideration, we offer the following suggestions:

1. If CMS were to propose a new CoP/CfC/RfP standard to require electronic exchange of patient medical records, would this help to reduce information blocking as defined in section 4004 of the 21st Century Cures Act?

The proposed standards to require the electronic exchange of patient medical records would help to prevent information blocking by providers, and ensure patient access to their records and the sharing of information with other providers. However, the proposed policies fail to create the same obligations for EHR vendors to ensure that vendors make patient information readily accessible to patients and providers. This unbalanced treatment of health care providers and EHR vendors can make it difficult, if not impossible, for providers to satisfy the proposed requirements to increase interoperability.

APTA supports CMS's proposals to ensure that providers make health information accessible to patients and other providers. However, we recommend that the agency, along with the Office of the National Coordinator (ONC), explore similar standards for EHR vendors as conditions for their certification. We recommend that CMS and ONC update EHR certification criteria to require EHR vendors to attest that they will not interfere with the exchange of patient data between providers and patients; and they will address in a timely manner complaints from providers and patients regarding the exchange of and access to patient data.

¹ 83 Rural Hospital Closures: January 2010-Present. The Cecil G. Sheps Center for Health Services Research, University of North Carolina. 2017. <http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>. Accessed May 17, 2018.

2. Are new or revised CMS CoPs/CfCs/RfPs for interoperability and electronic exchange of health information necessary to ensure patients/residents and their treating providers routinely receive relevant electronic health information from hospitals on a timely basis or will this be achieved in the next few years through existing Medicare and Medicaid policies, HIPAA, and implementation of relevant policies in the 21st Century Cures Act?

Rather than revise the existing CoPs, we recommend that CMS require acute care hospitals to comply with the QRP requirements of the IMPACT Act, along with the applicable penalties for failure to comply. Doing so would extend the current interoperability steps seen in post-acute settings to the entire continuum of care. At the same time, a hospital would not “lose the right” to accept patients (not a CoP); and they would still have penalties for not sharing this information across the continuum. Related to this, it is worth a reminder that hospitals and ambulatory doctors have received meaningful-use dollars that were not provided to PAC settings. Even so, post-acute settings are now required to increase interoperability via the IMPACT Act, whereas hospitals and ambulatory clinics are not identified in the IMPACT Act. In essence, there are unfunded mandates placed on post-acute settings. Even so, the greatest risk during transition of care is from the acute hospital setting to any other setting. Post-acute providers’ EHRs are capable of receiving data; however, it is difficult for hospitals to share the data. While we disagree with the idea of mandating interoperability via the CoPs, we agree that CMS should put forth a policy to incentivize this data transaction, with no cost to post-acute providers.

With that said, we have concerns as to whether this would benefit or harm private physical therapy practices. For instance, the physical therapy practice could be pressured by the hospital to become part of the health information exchange if the practice wants access to the data. However, the fees to join the health information exchange could be too high for the private practice; hence, the private practice could be faulted for blocking information sharing, due to circumstances out of its control.

Moreover, we recommend harmonization of data elements across all settings with the ability to capture the functional status of the patient and the outcome based on the care provided. We believe hospitals and other providers should be able to share information on (1) the patient’s goals and preferences and on preparing patients and, as appropriate, their caregiver(s)/support person(s) to be active partners in their post discharge care; (2) ensuring effective patient transitions from hospital to post-acute care while planning for post-discharge care that is consistent with the patient’s goals of care and treatment preferences; and (3) reducing the likelihood of hospital readmissions.

We therefore recommend that CMS create standardized data elements for discharge and transfer that incorporate information regarding functional status

across settings. The patient's ability to function and participate in society is critical to obtaining positive outcomes. A growing number of people in the US have disabling conditions that limit their ability to carry out the major activities of their age group. As the number of older adults increases, their vulnerability to injury and limitations of their activities of daily living increases as well. The result is an escalation of the utilization of health care resources. A focus on ensuring that individuals remain independent and functioning members of society throughout their lives will lessen the burden of disability on health care resources.

- 3. Under new or revised CoPs/CfCs/RfPs, should non-electronic forms of sharing medically necessary information (for example, printed copies of patient/resident discharge/transfer summaries shared directly with the patient/resident or with the receiving provider or supplier, either directly transferred with the patient/resident or by mail or fax to the receiving provider or supplier) be permitted to continue if the receiving provider, supplier, or patient/resident cannot receive the information electronically?**

Depending on the timeframe for implementation, the use of non-electronic forms of sharing information should be permitted, and we suggest that CMS offer a transition period to allow providers adequate time to adopt and implement interoperability. As CMS implements new and revised CoPs, we also recommend that the agency consider the variety of care settings in which interoperability will be adopted, as this type of mandate could negatively impact providers that are rural and lack Internet connectivity. For example, some rural providers use a satellite dish for their internet connectivity, and the speeds are not fast enough to support EHR systems; the cost to acquire a cable connection can be more than \$50,000 in some geographic locations. Other providers, such as physical therapists, will also require a transition timeline to obtain and integrate EHR technology for their practices.

- 4. What types of exceptions, if any, to meeting new or revised interoperability and health information exchange requirements, should be allowed under new or revised CMS CoPs/CfCs/RfPs if they are proposed and finalized in the future? Should exceptions under the QPP including CEHRT hardship or small practices be extended to new requirements? Would extending such exceptions impact the effectiveness of these requirements?**

APTA recommends that CMS provide small and rural practitioners and practices an exception to the interoperability and health information exchange requirements. Providers and practices in rural areas often experience difficulties in acquiring the necessary technology to support EHR systems at a reasonable cost. We do recognize, however that CMS's goal is to encourage as many providers as possible to improve interoperability across care settings. To incentivize more providers beyond hospitals and post-acute care facilities to satisfy the interoperability and health information exchange requirements, we

recommend that CMS offer financial incentives to providers who can show a financial hardship.

- 5. We would also like to directly address the issue of communication between hospitals (as well as the other providers and suppliers across the continuum of patient care) and their patients and caregivers. MyHealthEData is a government-wide initiative aimed at breaking down barriers that contribute to preventing patients from being able to access and control their medical records.**

While APTA supports CMS efforts to increase patient access to their health data, we also have concerns that increasing access simultaneously increases the risk of unwanted disclosure of that health data. We therefore encourage CMS to implement increased safeguards to prevent data breaches and educate patients on protecting the privacy of their health data.

- 6. To fully understand all of these health IT interoperability issues, initiatives, and innovations through the lens of its regulatory authority, CMS invites members of the public to submit their ideas on how best to accomplish the goal of fully interoperable health IT and EHR systems for Medicare- and Medicaid-participating providers and suppliers, as well as how best to further contribute to and advance the MyHealthEData initiative for patients. We are particularly interested in identifying fundamental barriers to interoperability and health information exchange, including those specific barriers that prevent patients from being able to access and control their medical records. We also welcome the public's ideas and innovative thoughts on addressing these barriers and ultimately removing or reducing them in an effective way, specifically through revisions to the current CMS CoPs, CfCs, and RfPs for hospitals and other participating providers and suppliers.**

APTA recommends that CMS describe in detail what is intended by “fully interoperable health IT and EHR systems for Medicare.” We would encourage the agency to ensure that all patient health data could be stored and accessed from a single database, to avoid inconsistencies that may occur with multiple databases of patient information. Further, we recommend that the IT and EHR system include secure verification processes and systems to verify providers and patients who wish to retrieve patient data. Finally, we recommend that the agency work with state Medicaid agencies to resolve any barriers that exist for the sharing of health data across state lines. We support the move to a fully interoperable health system; however, many federal and state regulatory barriers would first need to be addressed to allow for data sharing between states, providers, patients, and their families.

- 7. We have received stakeholder input through recent CMS Listening Sessions on the need to address health IT adoption and interoperability among providers that were not eligible for the Medicare and Medicaid EHR Incentives program, including long-term and post-acute care providers, behavioral health providers, clinical laboratories and social service providers, and we would also welcome specific input on how to encourage adoption of certified health IT and interoperability among these types of providers and suppliers as well.**

Physical therapists and physical therapy practices are a critical component of the medical network across the care continuum. Hence, physical therapists may need additional time to obtain EHR systems and the technical and financial capacity to collect and share electronic health care data. Notably, physical therapists in private practice have not formally been included in the meaningful use/advancing care information program. As such, facility-based physical therapists have not yet been exposed to regulations that govern meaningful use in the facility setting. Our comments reflect the issues we have identified as a profession with respect to information technology adoption and interoperability.

APTA encourages CMS to address the unique health IT adoption and interoperability needs of physical therapists and physical therapy practices as the agency moves to adopt the new and revised standards. We urge the agency to consider financial incentives to alleviate the costs that physical therapists will no doubt face in complying with new interoperability requirements. We look forward to more opportunities to work with CMS to address solutions to alleviate the burden on specialty providers who have not yet been included in previous EHR incentive programs.

Conclusion

Again, we thank CMS for the opportunity to comment on the FY 2019 IPPS and LTCH PPS proposed rule. We look forward to working with the agency in making revisions to the proposed policies prior to their finalization to ensure that Medicare beneficiaries have access to medically necessary physical therapy services in the inpatient and LTCH 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

Board-Certified Orthopaedic Clinical Specialist
President

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