



October 3, 2016

Andrew Slavitt, Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
9500 Security Boulevard
Baltimore, MD 21244-1850

Attention: CMS-5519-P

Re: File Code-CMS-5519-P; Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model (CJR); Proposed Rule

Dear Acting Administrator Slavitt:

The Private Practice Section (PPS) of the American Physical Therapy Association (APTA) respectfully submits these comments on CMS-5519-P, Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model (CJR).¹ The over 4,200 members of the Private Practice Section of the 90,000 member American Physical Therapy Association are physical therapists across the nation who are primarily owners or partners in independent private practice. Their patient-focused clinics are conveniently located throughout the community where therapists and patients form a bond over the course of treatment. Community-based physical therapists in private practice are an integral member of the patient's health care team and as such have regular communications with other members of the patient's health care team.

This proposed initiative is yet another step in support the Center for Medicare and Medicaid Services' (CMS) move away from fee-for-service and toward value-based payment systems. While this proposed rule focuses primarily on implementing a mandatory bundling program of retrospective episode payment models (EPMs) for care associated with bypass surgery and heart attacks, including provisions that would incentivize the use of cardiac rehabilitation, it also contains modifications to the Comprehensive Care for Joint Replacement (CJR) model implemented this year². This proposed rule extends the current CJR bundling provisions beyond total hip (THA) and knee (TKA) arthroplasty to include patients

¹ Federal Register, Vol. 81, No. 148, Tuesday August 2, 2016, Proposed Rules, <https://www.gpo.gov/fdsys/pkg/FR-2016-08-02/pdf/2016-17733.pdf>

² Federal Register, Vol. 80, No. 226, Tuesday November 24, 2015, Rules and Regulations, <https://www.gpo.gov/fdsys/pkg/FR-2015-11-24/pdf/2015-29438.pdf>

undergoing surgical hip and femur fractures treatment (SHFFT) episodes, seeking to “complete the transition to episode payment for the surgical treatment and recovery of the significant clinical condition of hip fracture”. This model hopes to encourage hospitals, physicians, and post-acute care providers to work together to improve the quality and coordination of care from the initial hospitalization through recovery.

PPS will share views and comments with CMS about its experience with the current CJR model as well as the following topics that are relevant to our membership:

- Choice of Surgical Hip and Femur Fracture Treatment (SHFFT) Episode
- Mechanics of the Program
- Measuring Quality
- Hospital Collaboration with Providers and Suppliers
- Beneficiary Choice
- Telehealth
- Participation in Advanced Alternative Payment Models

Choice of Surgical Hip and Femur Fracture Treatment (SHFFT) Episodes

Whereas the previous CJR model focused on common yet usually elective procedures of hip or knee replacement, this proposed rule features hip and femur fracture which is a serious and often catastrophic event for Medicare beneficiaries. In 2010, 258,000 people aged 65 and older were admitted to the hospital for hip fracture, with an estimated \$20 billion in lifetime cost for all hip fractures in the United States in a single year.³ In 2013, fracture of the neck of the femur (the most common location for hip fracture) was the eighth most common principal discharge diagnosis for hospitalized Medicare fee-for-service beneficiaries, constituting 2.7 percent of discharges.⁴

CMS states that current incentives to coordinate the whole episode of care – from surgery to recovery – are not strong enough, and a patient’s health can suffer as a result. The Agency believes when care is approached without regard to the big picture, there is a risk of missing crucial information or not coordinating across different care settings; furthermore, the lack of coordinated care leads to more post-surgery complications, high readmission rates, and inconsistent costs.

PPS Comment:

Hip fractures are commonly the results of a traumatic event, not a planned or elective surgical procedure. Typically hip fracture patients are older, more frail, and have more complicated factors at play than lower extremity joint replacement (LEJR) patients. The number of co-morbidities and therefore the level of necessary therapeutic intervention is much higher for hip and femur fracture patients. Therefore, unlike the more predictable healthy joint replacement group of the current CJR model, the cost factor is likely to be higher and more difficult to constrain for SHFFT episodes.

³ Smith et al. Increase in Disability Prevalence Before Hip Fracture. J Am Geriatr Soc. 2015 Oct;63(10):2029–35.

⁴ Krumholz HM, Nuti SV, Downing NS, Normand ST, Wang Y. Mortality, Hospitalizations, and Expenditures for the Medicare Population Aged 65 Years or Older, 1999–2013. JAMA. 2015; 314(4):355–365.

PPS agrees that there is excessive variation in quality and cost, but we believe the expanded CJR model will fall short of the intended goal while being overly burdensome to the providers.

While addressing fragmentation of care by focusing on coordinated, patient-centered care is an admirable goal, PPS believes the proposed model does not include enough safeguards to substantially improve the care experience for the many and growing numbers of Medicare beneficiaries who undergo SHFFT. Making the patient's successful surgery and recovery the top priority of the health care system requires a more robust emphasis on the beneficiary's functional outcomes, including requiring functional status measurement through the use of existing tools that employ rigorous psychometrics and whose resulting data can be risk-adjusted.

Mechanics of the Program

This proposed expansion of the CJR model would apply to acute care hospitals in the same 67 geographic areas selected for the THA/TKA model.⁵ Under the proposed episode payment models, the anchor inpatient prospective payment systems (IPPS) hospital in which a patient is admitted for care for surgical hip/femur fracture treatment⁶ would be accountable for the cost and quality of care provided to those Medicare fee-for-service (FFS) beneficiaries during the inpatient stay and for all related care within 90 days of hospital discharge.

Throughout the year, acute care hospitals, providers, and suppliers would be paid according to the usual Medicare FFS payment systems. However at the end of the year, the actual episode payment would be reconciled against an established EPM quality-adjusted target price.⁷ This is similar to last year's CJR model where at the end of a model performance year actual spending for the episode (total expenditures for related services under Medicare Parts A and B) is compared to the target price for the responsible hospital. The hospital could either earn a financial reward or be required to repay Medicare for a portion of the costs—this would be determined by the hospital's quality and cost performance during the episode. Bonus payments would be received by the hospitals that work with physicians and other providers to deliver the needed care for less than the quality-adjusted target price, while meeting or exceeding quality standards. Hospitals with costs exceeding the quality-adjusted target price would be required to repay the difference to Medicare. Like in the original CJR, hospitals are able to contract with community-based providers to include them in the gainsharing or shared-risk portions of the payment model. Community-based providers would not receive these payments directly from Medicare; the hospital is the bundled payment transaction partner with Medicare.

PPS Comment:

PPS believes CMS grants excessive financial and programmatic control to the participating hospitals, thereby overlooking the value of a more balanced distribution of control among all those providing care. Participating hospitals also have insufficient incentives to ensure inclusion of the highest quality

⁵ <https://www.gpo.gov/fdsys/pkg/FR-2015-11-24/pdf/2015-29438.pdf>, 73229 Table 4, 73276.

⁶ Surgical hip/femur fracture treatment (SHFFT) model episodes would be initiated by claims for hip and femur procedures, except major joint, MS-DRGs 480-482.

⁷ <https://www.gpo.gov/fdsys/pkg/FR-2016-08-02/pdf/2016-17733.pdf>, pp 50801.

independent clinicians and private practitioners who they view as competitors to the hospitals' physical therapy departments. Furthermore, we are concerned that the incentives and safeguards are insufficient to accomplish meaningful coordination of care and optimal patient outcome.

Measuring Quality

The proposed rule calls for hospitals to be assessed based on quality metrics appropriate to each episode, using performance and improvement on required measures for hip/femur fractures that are already used the CJR model⁸ as well as submission of voluntary data for other quality measures in development or implementation testing.

CMS is eager to extrapolate results from other tests of bundled payments for orthopedic care that suggest CJR models have strong potential to improve patient care while reducing costs. Because of the geographic diversity of the 67 geographic areas where the CJR expansion will be implemented, these new models will allow CMS to test the impact of bundled payment on quality and cost when implemented at scale.

CMS's evaluation of the models will examine quality during the episode period, after the episode ends, and for longer durations such as one-year mortality rates. CMS plans to examine outcomes and patient experience measures such as mortality, readmissions, complications, and other clinically relevant outcomes. The evaluation will include both quantitative and qualitative data and will use a variety of methods and measures in assessing quality. The outcomes examined will include claims-based measures such as hospital readmission rates, emergency room visits rates, and the amount of care deferred beyond the 90-day post-hospital discharge episode duration; Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) satisfaction and care experience measures; and functional performance change scores from the patient assessment instruments in home health agencies and skilled nursing facilities. CMS also plans for the evaluation to include a beneficiary survey that will be used to assess the impact of the model on beneficiary perceptions of access, satisfaction, mobility, and other relevant functional performance measures.

In addition to the formal evaluation, CMS is also proposing continuous monitoring of arrangements between participants and collaborators and the auditing of patients' medical records to allow early detection of, and intervention in, any quality concerns.

PPS Comment:

We commend CMS for assessing the quality of care received by Medicare beneficiaries. However, the references to measurement in the entire proposal are hospital-centric and contain a dangerously negligible mention of patient functional status, let alone the measurement of functional status using tools that employ strong psychometrics. To wit:

- *Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #1550)*

⁸ *Ibid.*, pp 50802.

- *Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey (NQF #0166)*
- *Successful voluntary reporting of patient-reported outcomes.*

PPS applauds CMS for including clinically relevant outcomes in its scope of evaluations. We urge the Agency to avoid placing excessive emphasis on hospital and physician services and place an equal emphasis on rehabilitation therapy and functional outcomes experienced by the patients. Furthermore, PPS believes that the references to quality and even “outcomes” throughout the proposal are insufficient and less than rigorous. PPS notes that numerous functional outcome measures possessing robust psychometrics—many of which are risk-adjusted—are available and in use across the country.

Likewise, PPS is puzzled and dismayed that the Agency is limiting the analysis of functional performance change scores to home health agencies and skilled nursing facilities. Many Medicare beneficiaries seek post-acute care physical therapy by their physical therapist, in their community based private practice settings. Private practice physical therapists provide high quality care to patients receiving rehabilitation services as part of a SHFFT episode and welcome the opportunity to be evaluated for the functional outcomes of patients for whom they provide care.

Patients are often eager to help improve their experience and the outcome of their care. PPS is pleased that CMS plans to survey Medicare beneficiaries to capture patient reported assessment of access, satisfaction, mobility and other relevant functional performance measures. Patient surveys have been found to be meaningful to both patients and clinicians, as well as to possess performance characteristics (robust psychometrics) such as reliability, responsiveness, and validity. These measures are not perceived as burdensome by patients or providers. To be most impactful, the collection and submission of patient-reported functional outcome measures should be standardized.

PPS strongly supports CMS’s proposal to continuously monitor arrangements between participants and collaborators as well as auditing of patients’ medical records to allow early detection and intervention in the case of quality concerns. We suggest that the monitoring process be done through the analysis of already submitted documentation, and not through an additional reporting requirement.

Hospital Collaboration with Providers and Suppliers

One of CMS’ primary goals for implementing bundled payments is to encourage coordination among all providers involved in a patient’s care—one aspect of which is collaboration between hospitals, physicians, and community-based providers. Therefore, as in the first CJR model, CMS makes it clear that Medicare beneficiaries retain the right to obtain health services from any eligible Medicare provider.⁹

While the initiative still provides the primary financial incentive to the hospital, CMS explicitly states that participant hospitals may wish to enter into financial arrangements with providers and suppliers caring for beneficiaries in CJR episodes in order to align the financial incentives of those providers and

⁹ *Ibid.*, pp50803.

suppliers (private practice physical therapists for example) with the model goals of improving quality and efficiency for SHFFT episodes. The providers and suppliers may include physicians, physician group practices, skilled nursing facilities (SNFs), home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), long term care hospitals (LTCHs), outpatient therapy providers, and others. The arrangements would allow participating hospitals to share reconciliation payments, internal cost savings, and the responsibility for repayment to Medicare with other providers and entities who choose to enter into these arrangements, subject to the limitations outlined in the proposed rule and the terms of the individual contracts between participating hospitals and collaborating entities.

The current CJR model requires that physician, non-physician, and physician group practice CJR collaborators must directly furnish services to CJR beneficiaries in order to receive Physician Fee Schedule (PFS) payment under their financial arrangement with the participant hospital. No explicit mention is made of how to treat non-physician group practices (such as private practice physical therapists practicing as a group) who desire to contract with participant hospitals as collaborators.

PPS Comment:

The CJR model should provide the appropriate safeguards and operational details needed to create a comprehensive care model that is quality-driven, inclusive of all medically necessary services, and fosters patient choice.

PPS members have found the CJR collaboration guidelines to be vague and insufficient to ensure that non-physician group practices—such as private practice physical therapy groups—may be collaborating agents with a participant hospital. It is currently unclear whether the regulations permit collaboration agreements between non-physician practice groups and participating IPPS hospitals. The regulation states that “physician, non-physician, and physician group practice” CJR collaborators must directly furnish services to CJR beneficiaries in order to receive payment as result of their financial arrangement with the participant hospital. The CJR regulations specifically list physician group practices as an eligible CJR collaborator but do not do the same for physical therapy group practices. As a result, some are interpreting the regulation’s explicit and singular listing of physician group practices as eligible group CJR collaborators to mean that only physician group practices may enter into collaborator agreements as a group, and therefore believe that all non-physician providers must enter into individual collaborator agreements in order to be part of a financial relationship under the CJR model.

Others interpret the regulations to allow for group practice contracts because those same CJR regulations empower “providers and suppliers of outpatient therapy” to participate as collaborators. Physical therapy group practices are defined as a supplier in 42 CFR 400.202; therefore, physical therapy group practices should be included as eligible collaborators in the CJR model.

PPS requests the Agency clarify the regulations to explicitly permit non-physician practice groups to enter into collaborator agreements with participating hospitals. Once a therapy practice group contracts with a hospital as a collaborator, it would be up to the practice group to ensure that financial exchanges with the participating hospital were attributed to the physical therapists who directly

furnished services to CJR beneficiaries. Limiting access to individual therapists only and excluding practice groups from collaborative agreements is shortsighted, unfounded and outdated; it also adds an unreasonable and detrimental obstacle for patients to be able to access their choice of providers. Group rehabilitation therapy practices and independent therapists can and should be significant contributors to SHFFT episodes of care.

Beneficiary Choice

The Agency emphasizes that the CJR model is not intended to interfere with nor impact a beneficiary's freedom of choice to obtain health services from any individual or organization qualified to participate in the Medicare program. While eligible Medicare beneficiaries who choose to receive services from a participant hospital must participate in the CJR model, they still retain the ability to decide where to receive their post-discharge care for the duration of the SHFFT episode of care. Patients may receive their post-discharge care with the provider of their choice; outpatient providers need not have a contractual relationship with the originating hospital. The CJR model allows hospitals to enter into risk-sharing arrangements with certain other providers. Hospitals may recommend preferred post-discharge providers to the beneficiary, but hospitals may not prevent nor restrict beneficiaries to any list of preferred or recommended providers. Providers are required to supply beneficiaries with written information regarding the design and implications of the CJR model as well as their rights under Medicare, including their right to use their provider of choice.

PPS Comment:

Unfortunately in this expansion of the CJR model, CMS has retained its hospital-centric focus. This places an unreasonable amount of power in the hands of hospitals, thereby allowing these large facilities to direct patient care in a way that could functionally exclude the use of community-based providers. PPS urges CMS to pursue a more balanced model that achieves shared control of the finances and programmatic features.

PPS commends the Agency for attempting to protect the patient's freedom of choice but simultaneously, PPS sees weak safeguards to ensure that the freedom of choice of providers is protected for these vulnerable patients and their families. The mere mention of this choice in the regulation has been insufficient to overcome the hospital's inherent bias to resist referring out-of-system to independent rehabilitation professionals who may be more cost-effective and achieve higher functional outcomes with SHFFT patients. PPS has grave concerns that the current controls in place to ensure unencumbered patient choice are lacking. For example, it has been reported by PPS members who provide quality, community-based outpatient physical therapy that they have experienced an up to 30 percent drop in referrals from hospitals participating in the CJR model for THA and/or TKA. PPS requests that greater safeguards be implemented to ensure the inclusion of professionals and providers who have demonstrated, or can demonstrate, effectiveness and efficiency of care. At minimum, beneficiaries should be provided a written list of all of the local providers from whom they can choose to receive their SHFFT rehabilitation therapy.

Additionally, the Agency released a template beneficiary notification¹⁰ that explicitly lists types of post-discharge providers: “nursing homes (skilled nursing facilities), home health agencies, inpatient rehabilitation facilities, and long term care hospitals.” Outpatient physical therapy is not listed as an option on this CMS produced Beneficiary Notification and it is paramount that this omission be remedied in the final rule. It could be interpreted by a lay Medicare beneficiary and health care consumer to exclusively suggest residential post-acute care settings and purposefully exclude outpatient rehabilitation therapy as an option. The failure to explicitly mention any outpatient rehabilitation therapy setting is a repeat of other areas in the proposed rule where the important contribution of physical therapists goes unnoticed and unmentioned. Physical therapy is a necessary component of treatment in order for a patient recovering from a THA, TKA, or SHFFT episode to regain function and achieve optimal outcome. Outpatient facilities, including private physical therapy practices can significantly contribute to the quality of care, improve functional outcomes and patient satisfaction.

Telehealth

CMS recognizes that there are limitations on the use of telehealth for Medicare beneficiaries and therefore has proposed to use its waiver authority to “adopt waivers of the telehealth originating site and geographic site requirement and to allow in-home telehealth visits for all three proposed episode payment models (EPMs), as well as the general waiver to allow post-discharge nursing visits in the home”¹¹.

PPS Comment:

PPS strongly supports the expanded use of telehealth to increase Medicare beneficiary access to quality and community-based care. Therefore PPS commends the Agency for using its waiver authority to waive the originating site and geographic site requirements and allowing in-home telehealth visits for all three proposed EPMs.

Participation in Advanced Alternative Payment Models

In addition to proposing new bundled payment models for SHFFT episodes, the proposal also provides for new pathways to enable physicians who participate in bundled payment models to qualify for financial rewards through the proposed Quality Payment Program and the Merit Based Incentive Payment System (MIPS) provisions of the bipartisan Medicare Access and CHIP Reauthorization Act (MACRA). For physicians who work in or collaborate with hospitals participating in the models, CMS’ bundled payment models—as well as the CJR model which began this year—could qualify as Advanced Alternative Payment Models (APMs) beginning in 2018. However, this mechanism for qualifying as an Advanced APM is not available for physical therapists.

¹⁰ <https://innovation.cms.gov/files/x/cjr-beneletter-hospital.pdf>

¹¹ <https://www.gpo.gov/fdsys/pkg/FR-2016-08-02/pdf/2016-17733.pdf>, pp.50804.

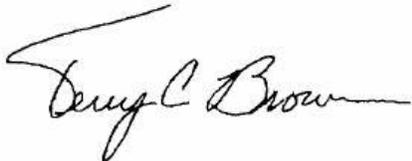
PPS Comment:

PPS is pleased that the Agency has proposed additional pathways towards qualifying as an Advanced Alternative Payment Model. However, we are dismayed that these additional pathways are only open to physicians. PPS therefore requests that physical therapists be included in the provision to allow CJR and other bundled payment models to qualify as Advanced APMs under MACRA as it could give our members more opportunities to participate in APMs and quality programs under MACRA and provide quality care to Medicare beneficiaries.

Should physical therapists be included in Advanced APMs, they would require both flexibility and support for the electronic health record (EHR) requirement element of being part of an Advanced APM. PPS encourages its member clinics to adopt EHRs. However, the cost of acquisition, implementation, and maintenance of an EHR is a significant barrier to adoption, particularly for small practices. We must point out that physical therapists, unlike physicians, have yet to receive any incentive, support, or accommodations for the adoption of an EHR system; therefore it would be unreasonable to require the use of EHR to qualification for participation. PPS urges CMS to redefine the qualifications for participating in an Advanced APM to say that participants who were included in Meaningful Use (MU) (i.e., incentivized by CMS to utilize a Certified EHR), must use EHRs, but other participants such as non-physician providers who were not included in MU are not impacted by such a requirement.

PPS thanks the Agency for the opportunity to provide these comments on the proposed rule for expanding the Comprehensive Care for Joint Replacement Model to include surgical hip and femur fracture episodes. PPS is committed to continue its cooperation and collaboration with CMS and we look forward to more opportunities to partner with the agency in pursuit of meaningful and effective innovation in the Medicare program.

Sincerely,

A handwritten signature in black ink that reads "Terence C. Brown". The signature is fluid and cursive, with a long horizontal line extending from the end of the name.

Terence C. Brown, PT, DPT
President, PPS/APTA