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September 8, 2015

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

***RE: CMS 5516-P, Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services (Vol 80, No. 134) July 14, 2015.***

Dear Mr. Slavitt:

The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule on the Comprehensive Care for Joint Replacement Model (CCJR).

AHCA is the nation's largest association of long term and post-acute care providers with more than 12,000 members who provide care to approximately 1.7 million residents and patients every year. AHCA and the skilled nursing professionals we represent look forward to continuing our work with policymakers to advance long-needed post-acute care (PAC) delivery and payment reforms, including bundled payments.

**While AHCA supports the concept of bundled payments generally, we believe it is too early for CMS to propose a mandatory model and too premature to design a model with the hospital as the bundle owner. If CMS believes a mandatory design is necessary, we believe that significant involvement of PAC providers, especially skilled nursing facilities (SNFs) in the Bundled Payment for Care Improvement (BPCI) initiative, suggests that CMS should test a "Model 3-like" design in addition to a hospital-based program.**

If CMS moves forward with a mandatory bundled payment design like the CCJR, we believe two modifications are critical. First, CMS should explicitly affirm that the model protects beneficiary freedom of choice of provider, and CMS should not grant any waivers that allow hospital steering or closed networks. Second, while AHCA applauds CMS' willingness to grant a waiver of the 3-day rule for SNF admission, we do not believe it is appropriate to tie the use of the waiver to performance on the 5-Star Rating system. We outline the reasons for this and alternatives that promote CMS' goals of cost savings and improving beneficiary quality of care later in this letter.

In this letter, we also make specific policy recommendations that would improve the design of the CCJR program as proposed.

## I. AHCA'S OVERALL COMMITMENT TO BUNDLED PAYMENTS

AHCA believes that implementing true bundled payments will, and should, take several years to test and implement, if done properly. Based on our members' experience in BPCI, we have adopted a set of six guiding principles against which bundled payment models should be evaluated:[1]

1. The policy must place the management of the episode with post-acute care providers.
2. The policy must preserve a patient's freedom of choice of provider.
3. The policy must allow providers the flexibility to deliver patient-centered care in order to achieve the patient's highest practicable level of function and outcome.
4. The policy must establish episodes that bundle PAC services only and do not include the immediately preceding acute care hospitalization.
5. The policy must establish "virtual" bundles as opposed to "actual" bundles.
6. The policy must not inadvertently create access barriers for patients with complex or chronic diseases.

We believe that savings should come from more efficient delivery of services and care coordination, rather than from merely shifting the site of care.

## II. GENERAL MODEL DESIGN

In the CCJR model, CMS proposes a mandatory program for all IPPS hospitals in select geographic areas. These episodes are initiated by admission to an acute care hospital stay paid under MS-DRG 469 or 470 and end 90 days after discharge from the anchor hospital.

**AHCA believes it is too early for a mandatory model and premature to design a model with the hospital as the bundle owner.** CMS recently announced that nearly 1,200 post-acute care providers are participating in the risk-bearing phase of BPCI Model 3, including 1,071 SNFs, 101 home health agencies (HHAs), 9 inpatient rehabilitation facilities (IRFs), and 1 long-term care hospital. [2]

Early results indicate that Model 3 can work. CMS' evaluation of the initial year of the model found that Model 3 participants said that they associated their involvement with the BPCI initiative with their investment in improvements across the continuum of care.

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[1] For more information, please see the testimony of Leonard Russ, Chair, Board of Governors from April 16, 2015, before the House Energy and Commerce Health Subcommittee: http://democrats.energycommerce.house.gov/sites/default/files/documents/Testimony-Russ-HE-Post-Acute-2015-4-16.pdf

[2] See http://innovation.cms.gov/initiatives/bundled-payments/ Accessed 20 August 2015.

Participants noted that they wanted to be valued partners with hospitals in particular and they engaged with hospitals while deciding whether to participate in the initiative.[3]

However, additional testing and evaluation is needed. The research to date **has not** provided any conclusive evidence on which types of bundles are successful. CMS should ensure that models test all reasonable options to make sure that any policy eventually adopted maintains beneficiary access to high-quality care.

If CMS continues with the proposal to implement a mandatory model for Lower Extremity Joint Replacement (LEJR) episodes, AHCA believes that the scope of the model should be expanded to include a PAC-only model like Model 3 of BPCI. A Model 3-like track of CCJR would allow continued testing of bundled payments without restricting participation to hospitals. AHCA believes continued testing of PAC-only bundles is a critical piece of CMS' shift to value-based payment design. Additionally, in its August 19, 2015 letter, the Medicare Payment Advisory Commission (MedPAC) recognized the important role that PAC providers play in LEJR episodes, and recommended that CMS design a bundled payment model that includes direct risk arrangements with PAC providers and CMS, rather than limiting risk and reward to arrangements that pass through a hospital.[4]

## III. RECOMMENDED REFINEMENTS TO CCJR MODEL AS PROPOSED

If CMS decides to continue with a mandatory bundled payment model as proposed, AHCA recommends that CMS make a number of specific changes in order to protect beneficiary access to high quality care.

### *A. PAYMENT POLICY WAIVERS*

In this rule, CMS proposes three primary payment policy waivers:

- Post-discharge home visits waiver: which allow a physician or non-physician practitioner to bill for up to 9 home visits for a non-homebound beneficiary;
- Telehealth services waiver: which waives the geographic requirement and the requirement that a beneficiary receives telehealth services from an eligible "originating site" as long as the beneficiary receives the services in their home or place of residence; and
- 3-Day SNF rule waiver: which allows hospitals to discharge to a SNF after fewer than 3 days of a hospital inpatient stay, beginning in year 2 of the model.

AHCA appreciates CMS' flexibility and strongly supports all three waivers. **However, we have serious concerns with the requirement that the 3-day rule waiver is tied to the SNF 5-Star Ratings system.**

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[3] CMS BPCI Models 2-4: Year 1 Evaluation and Monitoring Annual Report, Lewin (2015)

[4] Medicare Payment Advisory Commission. Comment Letter to CMS on CCJR Proposed Rule. August 19, 2015. http://medpac.gov/documents/comment-letters/medpac-comment-on-cms's-proposed-rule-on-the-comprehensive-care-for-joint-replacement-payment-model-for-acute-care-hospitals.pdf?sfvrsn=0

CMS is proposing to require that a SNF have three stars or greater on the Five Star rating system in order to waive the 3-day stay requirement for SNF participants of the CCJR program. The proposed policy mirrors the 3-day stay waiver policy currently being utilized in certain models and tracks of the Bundled Payments for Care Improvement (BPCI) initiative and Accountable Care Organization (ACO) programs, respectively. While AHCA appreciates and supports the application of certain criteria to waive the 3-day stay requirement, we have serious concerns regarding CMS' proposal to tie the waiver to a SNF's Five Star rating. AHCA's primary concerns are as follows:

1. The Five Star measures are not tailored to post-acute care, and do not focus on elective lower extremity joint replacement patients;
2. This policy will have unintended negative consequences on beneficiary freedom of choice of provider and access to care; and
3. The frequent fluctuation in a SNF's overall rating above or below 3 stars will make program implementation difficult and could place beneficiaries in financial jeopardy.

**We recommend CMS adopt an alternative approach to allowing SNFs and Hospitals to use this waiver.**

CMS should waive the 3-day stay requirement for *all* SNFs in the proposed 75 MSA and require hospitals to provide information to consumers at time of discharge on quality of the PAC provider (e.g. SNF) that includes not only Five Star, but also quality measures more applicable to PAC, particularly those related to lower extremity joint replacement.

AHCA believes that CMS should tie SNF performance to waiving the 3-day stay requirement by using performance thresholds on SNF quality measures that are more directly applicable to post-acute care, particularly care furnished to beneficiaries who have had a lower extremity joint replacement, such as hospital readmission rates, discharge to community rates, improved function and patient satisfaction rates. Reliable and valid measures on SNF performance exist for all of these domains.

**AHCA recommends that CMS modify the proposed criteria of "at least 3 stars" to "at least 3 stars overall OR at least 3 stars on both the staffing and quality measure components."** This approach would create the incentive to achieve higher staffing levels and improved performance across the 11 quality measures in the Five Star rating system.

Below, we have provided additional background on our stated concerns, as well as additional rationale for our recommendations:

**1. The Five Star measures are not tailored to post-acute care, and do not focus on elective lower extremity joint replacement patients**

The Five Star rating system is principally based on measures that apply to long-stay nursing home residents rather than short-stay rehabilitation residents. A SNF's survey

score is derived from regulations that were designed for long-stay residents. In fact, CMS currently is seeking comment on how to revise the requirements of participation to apply to short-stay residents[5]. The staffing levels are a based on time and motion studies and risk adjustment from a study of care that principally used long-stay residents. Of the 11 quality measures in the Quality Measures component, only three apply to short-stay residents. Given the limited quality information about short-stay residents in Five Star, we do not believe the Five Star system should be used as a quality gatekeeper to waving the 3-day stay requirement. In addition, the way in which CMS calculates the survey score used to rate a SNF's Five Star ranking can be heavily influenced by one incidence of non-compliance that may *not* have resulted in an adverse event. As such, it is not uncommon for a SNF to receive a low rating on the survey component yet receive high ratings on both the staffing and QM components. This phenomenon is one of the reasons that the Five Star rating system is often poorly correlated with other clinical outcome measures of quality. The survey score is necessarily reflective of a SNF's overall quality performance across all residents, but rather reflects single incidences of non-compliance.

If CMS believes that it is critical to use a quality rating system for the waiver, we would recommend using quality measures directly related to post-acute care (such as hospital readmission rates, discharge to community rates, improved function, and SNF satisfaction) rather than an overall Five Star rating that is less applicable to this population.

**2. This policy will have unintended negative consequences on beneficiary freedom of choice of provider and access to care**

CMS also recognizes there are a number of valid reasons that a beneficiary would select a lower-star nursing facility over a higher-star rating, including proximity to family. By excluding 1- or 2-star rated SNFs from post-acute care networks, CMS will restrict a resident's ability to use other factors, such as geographic proximity to their home or family, in making a decision about SNF admission. An analysis conducted by AHCA shows that among the 75 MSA regions CMS is proposing for inclusion in CCJR, 35% of SNFs, on average, received a 1- or 2-star rating as of August 2015 (see Table 1). However, over the last six months of CMS's new Five Star rating system, 40% of SNFs in the 75 MSA regions have been rated as 1- or 2-star. The distribution is not even across MSAs, as some MSAs have a much larger proportion of SNFs being rated as 1- or 2-star. Fourteen of the 75 MSAs have at least 60% of their SNFs rated as 1- or 2-star; and 26 of the 75 MSAs have at least 50% of SNFs rated as 1- or 2-star (see Table 1).

We anticipate that hospitals will discharge only to SNFs with 3 or more stars since it will be difficult for hospitals to coordinate discharges with fewer than three inpatient days to only 3-star rated facilities and beneficiaries with more than three inpatient days to any SNF. This proposed requirement *de facto* forces the creation of post-acute care SNF networks that include only facilities rated 3-star or higher. Therefore, this policy will

[5] "Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities," 80 Federal Register 136 (16 July 2015), pp.42168-42269.

have the unintended effect to significantly limit the access and choices available to beneficiaries and their families. They will no longer be able to select the most appropriate post-acute care setting based on all the information available to them, rather they can select only from SNFs based on CMS-imposed criteria. This is contrary to the language used on Nursing Home Compare to describe Five Star ratings as one piece of information consumers should use when selecting a SNF. Therefore, we would recommend that CMS allow all SNFs to participate in the 3-day stay waiver but require hospitals in the 75 MSA to provide quality information about the PAC providers, which could include but not limited to Five Star ratings.

**3. The frequent fluctuation in a SNF's overall rating above or below 3 stars will make program implementation difficult and could place beneficiaries in financial jeopardy**

Since the Five Star rating system is updated on a monthly basis, it is possible that a SNF's rating fluctuates every month. Analyzing data for two-year period (prior to the February 2015 rebasing of Five Star), we observe a 15% chance that a SNF who is rated 3 stars or higher will drop below 3 stars in the following 12 months. Not only will this level of fluctuation impact beneficiary choice of provider, but it also will make implementation of the program logistically challenging for hospitals as they try to establish a network of exclusive 3-star-or-higher SNFs. Although CMS states that the waiver will be honored based on the SNF's status at the time of discharge, hospitals may operate on information that is a month or more old, which could result in beneficiaries inadvertently admitted to what the referring hospital believed to be a 3-star or greater SNF to only find that it dropped to a 2-star. If the SNF does not meet the criteria, the stay would not be covered and the beneficiary could be financially liable for their stay. And finally, we suspect that hospitals will drop SNFs from their networks because of a drop in Five Star score despite the fact that nearly half could quickly regain a 3-star or greater rating. We anticipate this fluctuation will create unintended, unnecessary restrictions in beneficiary choice of provider, even if that provider becomes eligible for the waiver.

Because of the challenges with the proposed policy that we have outlined above, **AHCA recommends applying the 3-day stay waiver to SNFs that EITHER have an overall 3-star rating OR who have maintained at least a 3-star rating on <u>both</u> the Staffing and Quality Measure components of the Five Star rating system.** We believe this approach more appropriately takes into consideration the fluctuations in Five Star ratings that create operational challenges for providers and unnecessarily limit beneficiary access to care. Our approach recognizes the importance of the Five Star rating system while creating an incentive to achieve staffing levels and quality care levels associated with at least a 3-star rating or higher. We believe this approach would ensure that those facilities who may be rated at the 1- or 2-star level are providing a reasonable level of staff and achieving desired quality outcomes.

**Table 1. 75 MSAs in CCJR with Number and Proportion of SNFs Excluded from the 3-Day Stay Waiver (Feb to Aug, 2015).**

| CBSA | CBSA Name | Total SNFs | 1 or 2 Star On Any Given Month | | For at least 1 month during 6 months | |
|---|---|---|---|---|---|---|
| | | | N | % | N | % |
| | ***Overall*** | ***4,014*** | ***1,394*** | ***35%*** | ***1,618*** | ***40%*** |
| 10420 | Akron, OH Metro Area | 50 | 25 | 50% | 28 | 56% |
| 10740 | Albuquerque, NM Metro Area | 20 | 5 | 25% | 7 | 35% |
| 11700 | Asheville, NC Metro Area | 35 | 12 | 34% | 15 | 43% |
| 12020 | Athens-Clarke County, GA Metro Area | 7 | 2 | 29% | 3 | 43% |
| 12420 | Austin-Round Rock, TX Metro Area | 62 | 36 | 58% | 38 | 61% |
| 13140 | Beaumont-Port Arthur, TX Metro Area | 26 | 14 | 54% | 19 | 73% |
| 13900 | Bismarck, ND Metro Area | 11 | 4 | 36% | 4 | 36% |
| 14500 | Boulder, CO Metro Area | 8 | 3 | 38% | 3 | 38% |
| 15380 | Buffalo-Cheektowaga-Niagara Falls, NY Metro Area | 48 | 16 | 33% | 21 | 44% |
| 16020 | Cape Girardeau, MO-IL Metro Area | 10 | 5 | 50% | 7 | 70% |
| 16180 | Carson City, NV Metro Area | 3 | 2 | 67% | 2 | 67% |
| 16740 | Charlotte-Concord-Gastonia, NC-SC Metro Area | 77 | 38 | 49% | 39 | 51% |
| 17140 | Cincinnati, OH-KY-IN Metro Area | 146 | 48 | 33% | 52 | 36% |
| 17820 | Colorado Springs, CO Metro Area | 23 | 8 | 35% | 9 | 39% |
| 17860 | Columbia, MO Metro Area | 9 | - | 0% | 1 | 11% |
| 18580 | Corpus Christi, TX Metro Area | 23 | 14 | 61% | 17 | 74% |
| 19500 | Decatur, IL Metro Area | 10 | 5 | 50% | 5 | 50% |
| 19740 | Denver-Aurora-Lakewood, CO Metro Area | 90 | 20 | 22% | 22 | 24% |
| 20020 | Dothan, AL Metro Area | 6 | 1 | 17% | 1 | 17% |
| 20500 | Durham-Chapel Hill, NC Metro Area | 20 | 8 | 40% | 8 | 40% |
| 21780 | Evansville, IN-KY Metro Area | 27 | 11 | 41% | 12 | 44% |
| 22420 | Flint, MI Metro Area | 15 | 7 | 47% | 7 | 47% |
| 22500 | Florence, SC Metro Area | 11 | 5 | 45% | 5 | 45% |
| 22660 | Fort Collins, CO Metro Area | 13 | 4 | 31% | 6 | 46% |
| 23540 | Gainesville, FL Metro Area | 10 | 6 | 60% | 6 | 60% |
| 23580 | Gainesville, GA Metro Area | 5 | 3 | 60% | 3 | 60% |
| 24780 | Greenville, NC Metro Area | 6 | 3 | 50% | 3 | 50% |
| 25420 | Harrisburg-Carlisle, PA Metro Area | 29 | 20 | 69% | 20 | 69% |
| 26300 | Hot Springs, AR Metro Area | 9 | 3 | 33% | 4 | 44% |
| 26900 | Indianapolis-Carmel-Anderson, IN Metro Area | 116 | 42 | 36% | 49 | 42% |
| 28140 | Kansas City, MO-KS Metro Area | 126 | 66 | 52% | 71 | 56% |

| CBSA | CBSA Name | Total SNFs | 1 or 2 Star On Any Given Month | | For at least 1 month during 6 months | |
|---|---|---|---|---|---|---|
| 28660 | Killeen-Temple, TX Metro Area | 21 | 6 | 29% | 8 | 38% |
| 29820 | Las Vegas-Henderson-Paradise, NV Metro Area | 31 | 14 | 45% | 14 | 45% |
| 30700 | Lincoln, NE Metro Area | 15 | 3 | 20% | 3 | 20% |
| 31080 | Los Angeles-Long Beach-Anaheim, CA Metro Area | 458 | 158 | 34% | 181 | 40% |
| 31180 | Lubbock, TX Metro Area | 18 | 14 | 78% | 15 | 83% |
| 31540 | Madison, WI Metro Area | 34 | 9 | 26% | 10 | 29% |
| 32780 | Medford, OR Metro Area | 5 | 2 | 40% | 3 | 60% |
| 32820 | Memphis, TN-MS-AR Metro Area | 45 | 25 | 56% | 27 | 60% |
| 33100 | Miami-Fort Lauderdale-West Palm Beach, FL Metro Area | 144 | 40 | 28% | 54 | 38% |
| 33340 | Milwaukee-Waukesha-West Allis, WI Metro Area | 67 | 22 | 33% | 28 | 42% |
| 33700 | Modesto, CA Metro Area | 20 | - | 0% | - | 0% |
| 33740 | Monroe, LA Metro Area | 15 | 12 | 80% | 13 | 87% |
| 33860 | Montgomery, AL Metro Area | 16 | 6 | 38% | 8 | 50% |
| 34940 | Naples-Immokalee-Marco Island, FL Metro Area | 10 | 3 | 30% | 5 | 50% |
| 34980 | Nashville-Davidson--Murfreesboro--Franklin, TN Metro Area | 63 | 29 | 46% | 32 | 51% |
| 35300 | New Haven-Milford, CT Metro Area | 60 | 20 | 33% | 26 | 43% |
| 35380 | New Orleans-Metairie, LA Metro Area | 44 | 16 | 36% | 18 | 41% |
| 35620 | New York-Newark-Jersey City, NY-NJ-PA Metro Area | 593 | 159 | 27% | 184 | 31% |
| 35980 | Norwich-New London, CT Metro Area | 18 | 5 | 28% | 6 | 33% |
| 36260 | Ogden-Clearfield, UT Metro Area | 20 | 5 | 25% | 8 | 40% |
| 36420 | Oklahoma City, OK Metro Area | 68 | 30 | 44% | 35 | 51% |
| 36740 | Orlando-Kissimmee-Sanford, FL Metro Area | 66 | 20 | 30% | 23 | 35% |
| 37860 | Pensacola-Ferry Pass-Brent, FL Metro Area | 17 | 3 | 18% | 3 | 18% |
| 38300 | Pittsburgh, PA Metro Area | 122 | 53 | 43% | 58 | 48% |
| 38900 | Portland-Vancouver-Hillsboro, OR-WA Metro Area | 72 | 20 | 28% | 22 | 31% |
| 38940 | Port St. Lucie, FL Metro Area | 16 | 8 | 50% | 9 | 56% |
| 39340 | Provo-Orem, UT Metro Area | 14 | 5 | 36% | 6 | 43% |
| 39740 | Reading, PA Metro Area | 15 | 1 | 7% | 1 | 7% |
| 40060 | Richmond, VA Metro Area | 40 | 17 | 43% | 20 | 50% |

| CBSA | CBSA Name | Total SNFs | 1 or 2 Star On Any Given Month | | For at least 1 month during 6 months | |
|---|---|---|---|---|---|---|
| 40420 | Rockford, IL Metro Area | 19 | 6 | 32% | 6 | 32% |
| 40980 | Saginaw, MI Metro Area | 12 | 6 | 50% | 6 | 50% |
| 41180 | St. Louis, MO-IL Metro Area | 185 | 71 | 38% | 81 | 44% |
| 41860 | San Francisco-Oakland-Hayward, CA Metro Area | 149 | 22 | 15% | 32 | 21% |
| 42660 | Seattle-Tacoma-Bellevue, WA Metro Area | 96 | 30 | 31% | 36 | 38% |
| 42680 | Sebastian-Vero Beach, FL Metro Area | 7 | 5 | 71% | 6 | 86% |
| 43780 | South Bend-Mishawaka, IN-MI Metro Area | 20 | 5 | 25% | 7 | 35% |
| 44420 | Staunton-Waynesboro, VA Metro Area | 7 | 3 | 43% | 3 | 43% |
| 45300 | Tampa-St. Petersburg-Clearwater, FL Metro Area | 124 | 39 | 31% | 45 | 36% |
| 45780 | Toledo, OH Metro Area | 55 | 14 | 25% | 19 | 35% |
| 45820 | Topeka, KS Metro Area | 24 | 7 | 29% | 11 | 46% |
| 46220 | Tuscaloosa, AL Metro Area | 10 | 4 | 40% | 4 | 40% |
| 46340 | Tyler, TX Metro Area | 17 | 9 | 53% | 11 | 65% |
| 47260 | Virginia Beach-Norfolk-Newport News, VA-NC Metro Area | 61 | 16 | 26% | 24 | 39% |
| 48620 | Wichita, KS Metro Area | 50 | 16 | 32% | 20 | 40% |

*B. ADDITIONAL PAYMENT POLICY WAIVERS*

AHCA recommends that CMS consider additional flexibility through the following regulatory waivers:

- **AHCA recommends a waiver for all outpatient therapy provider settings of the (Part B) therapy caps and related policies for beneficiaries that qualify for the CCJR payment model.**

Our rationale is best supported by the following CMS statement on p. 41254 of this proposed rule, *"…we expect significant episode efficiencies could be achieved in the 90 days following discharge from the anchor hospital stay through reductions in related hospital readmissions and increased utilization of lower intensity PAC providers, specifically increased utilization of home health services and outpatient therapy…"*

Artificial benefit cap limitations on outpatient therapy services for CCJR-eligible beneficiaries run contrary to this CMS expectation. While Congress has permitted some exceptions to the therapy caps through the end of CY 2017, there is no guarantee that these exceptions will be extended. In addition, the cap exceptions process includes several burdensome cost-containment administrative provisions, including mandatory

medical review, which if continued for CCJR-eligible beneficiaries, would create a disincentive for outpatient therapy providers to participate in CCJR.

For example, extended outpatient therapy episodes may be medically necessary for those beneficiaries bypassing more expensive PAC services under CCJR care management activities. Such increased outpatient therapy utilization will increase the likelihood that the beneficiary would surpass the therapy cap limits, as well as the likelihood of triggering complex manual medical review due to higher utilization patterns than similar beneficiaries that first received the higher cost PAC services. Waiving the therapy cap policy for CCJR-eligible beneficiaries will better incentivize creative approaches towards cost-effective care across all PAC providers.

AHCA suggests that this waiver could be implemented relatively easily in CMS systems through edits that would exclude CCJR-eligible outpatient therapy service claim lines from being counted against the cap limits.

AHCA also suggests that medical review contractor instructions be provided so that CCJR related claims are only reviewed within the context of the CCJR bundle, and not in the context of any isolated outpatient therapy policy.

- **AHCA recommends a waiver for regulatory constraints on how therapy services are delivered to CCJR-eligible beneficiaries.**

For example, waivers of limits on the use of concurrent and group therapy in the SNF as described in the Resident Assessment Instrument (RAI) User's Manual for CCJR-eligible beneficiaries would permit SNF therapists to provide quality care more efficiently. The relaxation of these requirements would permit SNF providers to focus on outcomes and design more creative and cost-effective programs for CCJR-eligible beneficiaries within the entire range of activities described in the treating therapists' scope of professional practice. Quality and value-based payments related to outcomes measures including mobility, self-care, hospital readmissions, discharge to the community, and others will be more effective at developing optimal therapy service delivery models rather than arbitrary constraints on how therapy services are delivered.

*C. QUALITY MEASUREMENT*

AHCA supports CMS' proposals to link reconciliation payments to performance on quality measures. However, we recommend that in addition to the readmission and complication measures, CMS should include a measure of functional improvement. Specifically, we recommend the use of two National Quality Forum (NQF) endorsed measures:

- CARE: Improvement in Mobility (NQF #2612)
- CARE: Improvement in Self-Care (NQF #2613)

These measures assess improvement in the self-care and mobility outcomes for beneficiaries, and align with the goals of the IMPACT Act of 2014, as well as the CMMI measure selection criteria identified in §1115A(b)(4)(C) of the Social Security Act[6]. The measures calculate the average change in mobility and self-care scores between admission and discharge for all residents admitted to a skilled nursing care center.

By using a patient-centered quality metric, CMS can ensure that model participants are providing appropriate care and that functional outcomes are not sacrificed as bundle owners try to meet target prices. This recommendation is consistent with MedPAC, who commented that CMS should collect information about a patient's change in function in a manner that is consistent with the IMPACT Act.[7]

*D. REFINEMENTS TO THE DEFINITION OF "OUTPATIENT THERAPY PROVIDER"*

- **AHCA recommends clarifications to the definition of outpatient therapy providers that would be included in the CCJR historical data used to set target prices and in the calculation of actual episode spending that would be compared against the target price to assess CCJR performance.**

- **AHCA recommends that CMS add the following term to the §510.62 Definitions (p.41307) proposed regulatory language so that it is clear as to all outpatient therapy settings that CCJR applies to:**

    - ***Outpatient therapy provider* means a physician, supplier, or provider furnishing (1) outpatient physical therapy services as defined in §410.60 of this chapter, and/or (2) outpatient occupational therapy services as defined in §410.59 of this chapter, and/or (3) outpatient speech-language pathology services as defined in §410.62 of this chapter.**

AHCA is concerned that the descriptions of the outpatient therapy service providers in the proposed rule are inconsistent, and we are uncertain whether this represents a lack of clarity in definitions, or a possible methodological error that requires correction before finalization of the rule. Outpatient therapy services, which include physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services, can be a significant component of post-acute surgical rehabilitation care delivery and outcomes for beneficiaries that would fall under the CCJR payment model. Outpatient therapy data is proposed to be included in the CCJR historical data used to set target prices and in the calculation of actual episode spending that would be compared against the target price to assess CCJR performance. Below, we provide specific examples where we believe the proposed rule language makes it unclear whether outpatient therapy services are properly identified for inclusion into the CCJR program.

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[6] This section reads: "To the extent feasible, the Secretary shall select measures under this paragraph that reflect national priorities for quality improvement and patient-centered care consistent with the measures described in 1890(b)(7)(B).

[7] MedPAC Comment Letter.

**Example 1: Definition of Related Services Included in the Episode (p. 41213)** states *" Related items and services included in CCJR episodes would be the following items and services paid under Medicare Part A or Part B, after the exclusions are applied:*

- *Physicians' services.*
- *Inpatient hospital services (including readmissions), with certain exceptions proposed later in this section.*
- *Inpatient psychiatric facility (IPF) services.*
- *LTCH services.*
- *IRF services.*
- *SNF services.*
- *HHA services.*
- *Hospital outpatient services.*
- *Independent outpatient therapy services.*
- *Clinical laboratory services.*
- *Durable medical equipment (DME).*
- *Part B drugs.*
- *Hospice."*

AHCA notes that this section specifically calls out *"independent outpatient therapy services",* which would appear to only represent therapists in private practice represented in CMS data under the following supplier specialty codes 65 = PT, 67 = OT, and 15 = SLP. **If the AHCA recommended definition of *"outpatient therapy provider"* is accepted by CMS, AHCA recommends that CMS replace the term *"independent outpatient therapy services"* with *"outpatient therapy provider"* in this list.**

**Example 2: Table 5 – Cost and Length of Stay Statistics for MS-DRG 470 For Various Episode Durations (p. 41218)** note and footnote 17 reference define data included as "PAC users are defined as beneficiaries discharged to SNF, IRF, or LTCH within 5 days of discharge from the index acute hospitalization, or discharged to HHA or hospital outpatient therapy within 14 days of discharge from the index acute hospitalization."

AHCA notes that this section, which reflects 2006 data from the prior PAC demonstration, specifically calls out *"hospital outpatient therapy,"* which would appear to only represent PT, OT, and SLP services furnished by hospital outpatient therapy providers represented in CMS data under the following provider claim bill types 12X or 13X.

**Example 3: Financial Arrangements under the CCJR Model (p. 41261)** includes a proposal to *"use the term "CCJR collaborator" to refer to such providers and suppliers, who may include the following:*

- *HHAs.*
- *LTCHs.*
- *IRFs.*

- *Physician Group Practices (PGPs).*
- *Physicians, nonphysician practitioners, and outpatient therapy providers."*

AHCA notes that the term *"outpatient therapy providers"* is not defined in this proposed rule. However, under Medicare law and CMS regulation elsewhere, outpatient therapy services and the physicians, suppliers and providers that are permitted to furnish and report these services are clearly defined. For example, 42CFR§410.59 defines outpatient OT services and conditions, §410.60 defines outpatient PT services and conditions, and §410.62 defines outpatient SLP services. Numerous studies and reports conducted by MedPAC, CMS (https://www.cms.gov/Medicare/Billing/TherapyServices/Studies-and-Reports.html), and others have applied the following data parameters to report outpatient therapy utilization. Further details are included in Chapter 5 of the Medicare Claims Processing Manual at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c05.pdf

**Outpatient Therapy Provider Setting/Professional Specialty:**
For provider facility claims, the Claim Bill Type code is used to differentiate setting for all services on the claim as follows;

- Hospital –12X or 13X,
- SNF – 22X or 23X,
- CORF – 75X,
- ORF – 74X, and
- HHA –34X
- CAH – 85X.

For professional office claims, there is not sufficient information on the claim to clearly differentiate setting. However, there is sufficient information in the Line Specialty Code to identify the specialty of the clinician responsible for the services submitted on each outpatient therapy claim line. They are;

- PTPP – 65,
- OTPP – 67,
- SLPP –15,
- Physician – 01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23,24 25, 26, 27, 28, 29, 30, 31, 33, 34, 36, 37, 38, 39, 40, 41, 44, and 46,
- NPP – 50, 89, and 97

**Example 4: §510.2 Definitions (p.41307)** includes formalizing the definition of CCRJ collaborator to mean "one of the following persons or entities that enter into a CCJR sharing arrangement:

(1) Skilled nursing facility.
(2) Home health agency.
(3) Long-term care hospital.

(4) Inpatient rehabilitation facility.
(5) Physician.
(6) Nonphysician practitioner.
(7) Outpatient therapy provider.
(8) Physician group practice.

AHCA again notes, as in Example 3 above, that the term *"outpatient therapy providers"* is not defined in this proposed rule.

**Example 5: §510.200 Time periods, included services, and attribution (p.41308)** includes under subheading (b) a the formalizing of *"Included Services"* for CCJR as follows; "All Medicare Parts A and B items and services are included in the episode, except as specified in paragraph (d) of this section. These services include, but are not limited to, the following:

(1) Physicians' services.
(2) Inpatient hospital services (including hospital readmissions).
(3) Inpatient hospital readmission services.
(4) Inpatient psychiatric facility (IPF) services.
(5) Long-term hospital care (LTCH) services.
(6) Inpatient rehabilitation facility (IRF) services.
(7) Skilled nursing facility (SNF) services.
(8) Home health agency (HHA) services.
(9) Hospital outpatient services.
(10) Independent outpatient therapy services.
(11) Clinical laboratory services.
(12) Durable medical equipment (DME).
(13) Part B drugs and biologicals.
(14) Hospice services.
(15) PBPM payments under models tested under section 1115A of the Act.

AHCA again notes, as in Example 1 above, that the term *"independent outpatient therapy services",* is specifically called out, which would appear to only represent therapists in private practice. **If the AHCA recommended definition of *"outpatient therapy provider"* is accepted by CMS, AHCA recommends that CMS replace the term *"independent outpatient therapy services"* with *"outpatient therapy provider"* in this list.**

*E. MONITORING AND BENEFICIARY PROTECTION*

CMS proposes to monitor within the CCJR model for beneficiary choice and notification, quality of care, delay of care, and access to care. AHCA firmly believes that **the rule does not go far enough to address serious concerns about beneficiary choice, skimping on care and conflict of interest.** CMS should provide greater detail on how it will protect beneficiaries from reduced access to care and patient steering.

In their comment letter, MedPAC recommended that CMS allow hospitals to differentiate between preferred and non-preferred post-acute care providers based on quality performance. We believe that this will lead to true "steering" of patients and directly conflicts with beneficiaries' right to freedom of choice under the Medicare program and should not be permitted.

The Lewin Group's evaluation of BPCI Year 1 outlines ways in which Awardees may reduce their costs, such as by avoiding high cost patients or steering them elsewhere. The report acknowledges that it is too soon to know whether these behaviors are occurring or not, stating "our evaluation of unintended consequences associated with BPCI will require more observations over longer periods than what is available for this report."[8]

### *F. ADJUSTMENTS FOR HIGH-COST OUTLIERS*

CMS proposes to establish high episode payment ceilings at two standard deviations above the regional mean. Providers will not be held responsible for any spending above the high episode payment ceiling. AHCA appreciates CMS' interest in reducing provider risk for beneficiaries that are truly outliers. However, AHCA believes that the payment ceiling will be insufficient to appropriately protect providers from random variation in beneficiary spending.

CCJR, like BPCI, sets target prices on the MS-DRG. MS-DRGs are not necessarily predictive of patient resource requirements in the days following a hospitalization. Participants bear financial risk for variation in utilization driven by clinical differences within MS-DRG classifications. Comorbidities and beneficiary characteristics (such as age, obesity, and dementia) lead to much different care plans and spending for a beneficiary. The variation in beneficiaries is especially problematic for lower volume providers who will not have enough CCJR cases to distribute the effects of high cost beneficiaries. Additional risk-adjustment is necessary to ensure that the target prices appropriately reflect the different care needed during the episode and will reduce incentives to cherry-pick patients or stint on necessary care.

An example of this variation occurs within MS-DRG 470 for major joint replacement of the lower extremity. This MS-DRG includes both fractures and osteoarthritis (often elective) procedures, which have very different utilization profiles over the 90-day post-discharge time period. On average, MS-DRG 470 episodes for fracture cases are nearly twice as costly as MS-DRG 470 episodes for osteoarthritis.[9] As a result, hospitals that disproportionately serve patients with fractures may perform poorly as the resource requirements for this population is, on average, greater. MedPAC acknowledged that it would be relatively easy to differentiate between certain high-cost (partial hip replacements) versus lower-cost (knee replacements and total hip replacements) based on

[8] CMS BPCI Models 2-4: Year 1 Evaluation and Monitoring Annual Report, Lewin (2015) http://innovation.cms.gov/Files/reports/BPCI-EvalRpt1.pdf.
[9] Avalere Health analysis of the 2013 Medicare Standard Analytic Files (SAFs).

information readily available on hospital claims. Their comment letter emphasized that adjusting for this procedure mix is critical to avoid selective patient admissions[10].

*G. FINANCIAL ARRANGEMENTS WITH OTHER PROVIDERS*

CMS proposes to allow participating hospitals to share reconciliation payments they receive from CMS, internal cost savings from care redesign, or repayments to CMS if funds are owed with providers and suppliers caring for beneficiaries in CCJR episodes in order to align financial incentives. CMS proposes two payment types:

- Gainsharing Payments (Payments made from participating hospital to CCJR collaborator) – Total gainsharing payments in a calendar year paid to a physician or non-physician practitioner may not exceed a cap of 50 percent of the total Physician Fee Schedule (PFS) payments for services furnished to the hospital's CCJR beneficiaries during an episode by that physician or non-physician practitioner.

- Alignment Payments (Payments made from CCJR collaborator to participating hospital) - Payments may not exceed 50 percent of the participant hospitals' repayment amount due to CMS in a calendar year. If no repayment amount is due, then no alignment payment may be received. The sharing arrangement must limit the amount a single CCJR collaborator may make in alignment payments to a single hospital to 25 percent of the repayment amount on a hospital's annual reconciliation report.

AHCA supports the use of gainsharing arrangements to allow providers to collaborate and benefit financially across provider sectors. However, AHCA believes that gainsharing alone does not recognize the importance of PAC providers in the episodes of care. In many cases, PAC represents a significant portion of the episode spending. However, CCJR hospitals are not required to gainshare with other providers. We believe that the proposed structure for these financial relationships risks excluding PAC providers from having a significant role in CCJR.

In its letter to CMS, MedPAC recommended an alternative risk-sharing arrangement in which all the major actors in the episode (i.e., hospitals, PAC providers, and hospital-based staff) share in the financial risk. We agree that bundled payment models should include a track in which PAC providers are directly responsible for the risk and gainsharing in Medicare alternative payment models.

CMS proposes that PAC providers would receive gainsharing payments based on the performance of the pool of PAC providers with which the CCJR hospital gainshares. AHCA believes that more flexibility should be granted in the gainsharing arrangements. While the pooling approach may be preferred by some participating providers, it will unfairly reward providers in some arrangements. PAC providers may have a range of

[10] MedPAC comment letter.

involvement in and contribution to care redesign. CCJR should allow hospitals to gainshare with PAC providers on a basis that rewards the individual provider's performance without excluding others. The numerous types of arrangements between providers are difficult to predict prior to the model's implementation. BPCI grants greater flexibility in gainsharing arrangements, allowing participants to select one of six savings pools options. While the exact same options are not appropriate for CCJR, a similar level of flexibility should be granted.

### *H. DATA SHARING WITH PROVIDERS*

CMS proposes providing beneficiary-level claims data for the historical period as well as ongoing quarterly beneficiary-identifiable claims data for each CCJR hospital in two formats to accommodate varying abilities for hospitals to analyze raw claims data. Data would contain information on claims for each CCJR beneficiary in a participating hospital. CMS proposed to limit this data distribution to participating hospitals.

AHCA appreciates CMS' continued and growing data distribution for certain programs. AHCA believes that any provider who treats a CCJR beneficiary during the episode should also have access to the claims data. As discussed in the proposed rule, hospitals will have varying capacity to analyze raw claims data. Further, many hospitals have different degrees of preparedness and interest in bundled payments. We do not believe that CMS should rely solely on the hospitals to share data with other providers.

Making data available to PAC providers and physicians will allow them to better collaborate with the hospitals in CCJR. Providers would be able to analyze the data and develop approaches to care redesign, especially when the hospital has not expended the resources to do such analytics. This analysis would allow PAC providers to demonstrate their value to a hospital. It would also allow PAC providers to better position themselves when entering into gainsharing arrangements with a participating hospital.

### *I. INTERACTIONS WITH BPCI AND OTHER CMS MODELS*

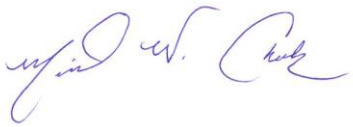
CMS proposes to exclude all hospitals that were participating in Phase 2 of BPCI for LEJR episodes as of July 1, 2015 from CCJR. If the hospitals withdraw from BPCI, they would be included in CCJR in the future. Further, Model 3 PAC providers who are participants in Phase 2 of BPCI for LEJR episodes as of July 1, 2015 would take precedence over CCJR hospitals. Model 3 providers will continue to initiate LEJR episodes in the selected MSAs, even when a CCJR hospital discharges the beneficiary. AHCA appreciates that CMS is developing policies that protect BPCI participants.

**AHCA believes that CMS should expand the proposed policy to BPCI participants who will be participating in LEJR episodes in BPCI by October 1, 2015.** BPCI participants have spent years and considerable resources investing in care redesign and improvements to successfully participate in BPCI, and were all participating in Phase 2 when the CCJR proposed rule was released on July 9, 2015. They had entered risk-bearing agreements with CMS with the understanding that they would have the

opportunity to select additional clinical episodes on July 13, 2015 to accept risk beginning in October 2015. AHCA continues to support these important partnerships with CMS to improve beneficiary care and more efficiently provide high quality care, and believes CMS should honor the deadlines that were in place at the time of the CCJR proposed rule publication.

AHCA appreciates the opportunity to comment on the important policy proposals in this proposed rule. If you have any questions or require clarification on our comments, please feel free to contact James Michel at (202)898-2809 or jmichel@ahca.org.

Sincerely,



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