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November 21, 2014

paymentmeasure@yale.edu

RE: Call for Public Comment - Development of Measures of Payment for Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)

Dear Dr. Kim:

The American Health Care Association (AHCA) appreciates the opportunity to respond to the Centers for Medicare and Medicaid Services (CMS) Quality Measures Public Comment Page call for public comment regarding two documents prepared under the *Development, Reevaluation, and Implementation of Hospital Outcome/Efficiency Measures* project being conducted by its contractor, Yale New Haven Health Services Corporation/Center for Outcomes Research & Evaluation (YNHHSC/CORE) under contract number HHSM-500-2013-12018I.

The specific report titles are:

- *Draft Summary of Technical Expert Panel (TEP) Evaluation of Measure Risk-Standardized Payment Measures: Hip/Knee Episode of Care, September 22, 2014*, and
- *Hospital-Level, Risk-Standardized Payment Associated with a 90-Day Episode of Care for Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (Version 1.0), 2014 Draft Measure Methodology Report, September 2014*

AHCA is the nation's leading long term care organization. AHCA and its membership of over 12,000 non-profit and proprietary centers are dedicated to continuous improvement in the delivery of professional and compassionate care provided daily by millions of caring employees to more than 1.5 million of our nation's frail, elderly and disabled citizens who live in nursing care centers, assisted living communities, subacute centers and centers for individuals with intellectual and developmental disabilities.

As CMS describes in its call for public comments, the Agency has contracted this project to develop an outcomes measure that can be used to support quality improvement, and that this public comment period provides an opportunity for the widest array of interested parties to provide input to the measure under development as comments from the public can offer critical suggestions in addition to those identified by the measure contractors and their technical expert panel (TEP).

AHCA appreciates CMS for its efforts in reaching out to stakeholders to solicit feedback regarding issues that may have been otherwise overlooked. As the proposed outcome measure includes post-acute services furnished within the episode of care window for the identified THA/TKA measure cohort, our AHCA member facilities play a critical role in the successful post-acute management of the subject patient population. From our unique perspective we have identified a number of issues within the two documents provided that we wish to offer in the following comments.

Comments Pertaining to *Draft Summary of Technical Expert Panel (TEP) Evaluation of Measure Risk-Standardized Payment Measures: Hip/Knee Episode of Care, September 22, 2014*

General Comments Pertaining to TEP Feedback

- **AHCA recommends that the 30-day outcomes measure window is not sufficient**

AHCA agrees with the TEP member feedback on page 8 that the 30-day outcomes measure window is not sufficient, particularly related to capturing post-acute services furnished for more complex THA/TKA cases that require services beyond the 30-day index hospitalization window. **Excluding costs associated with directly related post-acute services beyond 30 days would artificially deflate predicted expenditures associated with such patients, and could result in adverse patient selection for patients with complex needs if adopted.**

- **AHCA recommends the addition of post-acute provider representation to TEP**

The TEP comments on page 11 indicate that the TEP members did not expect the proportion of post-acute care payments for THA/TKA to be as high as it was (60%). This may be an indicator that the current TEP panel underrepresents the perspectives of post-acute providers, including skilled nursing facilities (19.5% of all post-acute payments). In today's healthcare environment, patients undergoing such elective procedures typically have a relatively short length of acute care stay. However, **THA/TKA patients often require extensive post-acute rehabilitation services, including SNF-based physical therapy (PT) and occupational therapy (OT) in order to restore functional mobility and self–care to prior levels to enable return home, or to the highest practicable level within the patient's facility-based living environment.** Post-acute provider insight on the TEP is necessary to inform the measure development contractor of the setting-specific patient care issues related to the study population.

Comments Pertaining to *Hospital-Level, Risk-Standardized Payment Associated with a 90-Day Episode of Care for Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (Version 1.0), 2014 Draft Measure Methodology Report, September 2014*

Calculation of the Payment Outcome

- **AHCA recommends clarification and/or revisions to the methodology of determining outpatient therapy expenditures as a component within the payment measure outcome**

AHCA is concerned about the described methodology of determining outpatient therapy expenditures as a component within the payment measure outcome. Outpatient therapy services can be a significant component of post-acute post-surgical rehabilitation care delivery and outcomes for THA/ TKA patients. We have identified specific areas where the described methodology makes it unclear whether outpatient therapy services are properly identified and calculated:

1. Medicare outpatient therapy services are identified under statute and regulation as physical therapy, occupational therapy, and/or speech-language pathology services that may be furnished in facility settings (hospital, skilled nursing facility (SNF), comprehensive outpatient rehabilitation facility (CORF), outpatient rehabilitation facility (ORF), critical access hospital (CAH), home health agency(HHA)) as well as by qualified clinicians in office-based settings (physical therapist in private practice (PTPP), occupational therapist in private practice (OTPP), speech-language pathologist in private practice (SLPP), physician, and non –physician practitioners [physician assistant, nurse practitioner, clinical nurse specialist]).

   The description of calculating payments for different care settings, services, supplies (section 2.5 pg. 19-30) describes various payment systems; however, the only sections that mention outpatient therapy services are 2.5.2.2 for CORFs and ORFs. Per the June 2013 MedPAC report to Congress[1], only eleven percent of outpatient therapy services in 2011 were attributed to CORF, ORF and HAA combined. He remaining 89 percent of outpatient therapy spending was attributed to SNF (37%), PTPP (30%), Hospital *[not OPPS]* (16%), Physician, non-physician practitioners, OTPP, and SLPP combined (7%). **Have the CORE investigators overlooked including payments from these outpatient therapy settings, or is the omission just in the report description details?**

2. If outpatient therapy procedures are included from all of the applicable settings described above, **have the CORE investigators properly attributed all outpatient therapy procedure practice expense RVUs at the non-facility rate?** Per Medicare regulations, outpatient therapy services furnished by facilities or office-based providers are reimbursed at the non-facility rate, regardless of the

[1] http://www.medpac.gov/documents/reports/jun13_ch09.pdf?sfvrsn=0

place of service. The description of the approach for stripping payments for physicians, physician extenders, and social work services (section 2.5.4 pg. 29-30) does not appear to permit this specific policy when attributed to outpatient therapy services as the section differentiates facility versus non-facility practice expense RVUs.

Risk-Adjustment Methodology

- **AHCA recommends that the approach to risk adjustment be modified to include prior use of health services, admission source, and available administrative data on support systems.**

The description of the approach to risk adjustment (section 2.7 pg. 31-32) describes that *the goal of risk adjustment for this measure is to account for patient and procedure characteristics and comorbid conditions that are clinically relevant and have strong relationships with the outcome, while illuminating important quality differences between hospitals.* The description further indicates that comorbidities reported within 12 months prior to the index hospitalization are utilized in the risk-adjustment methodology based upon clinical relevance and statistical significance.

In addition, the measure developers indicate that *the measure does not adjust for the patient's admission source or discharge disposition (for example, a skilled nursing facility) because these factors are associated with the structure of the health care system and the different care patterns the measure seeks to illuminate.* In addition, patient demographic data is excluded from risk-adjustment as *variations in payments associated with these characteristics may indicate differences in the care provided to vulnerable populations, and adjusting for these factors would obscure these disparities.*

However, AHCA contends that when the outcome measure is cost, and not clinical outcome, then factors including prior use of health services admissions source, and available administrative data on support systems are clinically relevant and have a strong relationship with the <u>cost</u> outcome. These factors can and should be utilized as proxies for clinical complexity that cannot otherwise be identified in available administrative data. The following provides examples:

- Elective THA/TKA patients that required acute and/or post-acute services in the 12 months prior to the index hospitalization may have significant predictable cost differences from patients with similar comorbidities that only received ambulatory care services in the prior 12 months.
- Admission source may also be significant predictable cost variables for elective THA/TKA patients. The post-acute rehabilitation potential and goals, and therefore associated costs can vary significantly for patients with similar comorbidities if they were admitted from a SNF versus from a community-based environment. For example, a THA/TKA patient admitted to a SNF for post-acute

care that was previously residing in the SNF may have limited functional rehabilitation goals and limited costs, while a similar patient admitted to a SNF for post-acute services but expecting to return home to a two-story walkup home may have more extensive rehabilitation goals which would result in higher costs.

- Support systems may also be significant predictable cost variables. The post-acute rehabilitation potential and goals, and therefore associated costs can vary significantly for patients with similar comorbidities but different available support systems. For example, a THA/TKA patient admitted to a SNF for post-acute care but expecting to return home without support systems may have more extensive rehabilitation goals which would result in higher costs than a similar patient that had support systems at home. While administrative data only contains limited information related to support systems (e.g. lives with spouse), such information should be considered within the measure.

AHCA is concerned that if the hospital-level, risk-standardized payment measure associated with a 90-day episode of care for elective THA/TKA does not address these cost-predictive variables, and if the measure is adopted for quality or payment policy purposes in the future, then patient access to such services may be compromised. Hospitals may become dis-incentivized to perform necessary elective THA/TKA procedures on patients with these factors that have not been adequately risk-adjusted.

On behalf of our members, AHCA thanks you for the opportunity to submit these comments regarding the Development of Measures of Payment for Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA). Please do not hesitate to reach out to me directly at 302-740-7888 or dciolek@ahca.org should you have any questions.

Sincerely,

Daniel E. Ciolek
AHCA, Senior Director, Therapy Advocacy