VNAA
Visiting Nurse Associations of America

September 8, 2015

Andrew Slavitt
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS- 5516-P, Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services

Dear Administrator Slavitt:

The Visiting Nurse Associations of America (VNAA) submits the following comments on the Comprehensive Care for Joint Replacement Payment Model proposed rule.

VNAA is a national association that supports, promotes and advocates for nonprofit home health, hospice and palliative care and health promotion services to ensure quality care within all communities. VNAA members embody Lillian Wald's founding principle of providing cost-effective and compassionate home health and hospice care to the nation's most vulnerable individuals, particularly the elderly and individuals with disabilities. VNAA represents more than 140 agencies in over 40 states. Member agencies are diverse and include traditional independent, free-standing visiting nurse services and agencies, home health and hospices that are affiliated with or owned by integrated health care systems, and free-standing hospices. In today's health care environment, nonprofit VNAA members are an essential component of health care delivery systems in communities across the country.

This rule proposes to implement a mandatory 90-day bundled payment model for joint replacements in 75 regions. These bundles would be triggered by an acute care event related to DRGs 469 and 470. While other providers would treat the patient and the patient would retain full choice of provider, the hospital would ultimately be responsible for ensuring that cost and quality targets are met.

The VNAA supports the move to value-based payment arrangements. VNAA members are participating in a number of initiatives with alternative payment models, including accountable care organizations (ACOs), bundled payments, and the Medicare Care Choices demonstration, among others. Several VNAA members are leading Bundled Payment for Care Improvement (BPCI) models and have assumed risk for meeting cost and quality targets. Given our experience managing care for individuals after hospitalizations, we question CMS' decision to have hospitals manage these bundles. While a patient may spend several days in an inpatient facility, there are 90 additional days in the bundle, many of which will be spent in a post-acute or community-based setting. Our experience is that most hospitals have little experience managing care for individuals once they have left the hospital. We therefore urge

CMS to reconsider the hospital-centric approach and allow post-acute care providers to compete with hospitals for the responsibility to manage the bundle.

Should CMS continue to move forward with a mandatory model that holds hospitals accountable, we urge CMS to continue to work with hospitals and their representatives to impress upon them the importance of this initiative and the need to engage other community providers in order to be successful. Despite many VNAA members' success in participating in various value-based purchasing initiatives, others have encountered barriers to engaging community partners in these models. If the hospitals and physicians do not initiate one of the new models or excessively restrict provider partners, there is little opportunity for home-based care providers to participate. Some of our members have found that hospitals in their community remain uneducated about the importance of preparing for this initiative. Several of our members in the selected 75 geographic areas report that they immediately reached out to their local hospitals who responded with ambivalence about the program. Home health agencies are eager to support this effort but will need willing partners within the community in order to be successful.

Based on our experiences in the BPCI and other models, we offer comments on how to improve the proposed Comprehensive Care for Joint Replacement program.

VNAA Comments

1. Quality Measures

CMS proposes three performance measures as part of the CCJR model:

- Hospital-level risk-standardized complication rate following elective primary total hip arthroplasty and/or total knee arthroplasty (NQF #1550)
- Hospital-level 30-day, all cause risk-standardized readmission rate following elective primary total hip arthroplasty and/or total knee arthroplasty (NQF #1551)
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey (NQF #0166)

VNAA Comment: VNAA appreciates CMS' attempt to focus performance improvement efforts by proposing to use only three measures. However, we are very concerned that the measures are disproportionately hospital-focused. Performance measures must measure quality and patient experience for the duration of the bundle. For example, we encourage CMS to develop a blended CAHPS score based on surveys conducted across providers treating beneficiaries throughout the 90-day bundle.

We also recommend that CMS add a functional measure to assess patient outcomes. CMS could evaluate functional status scores across all post-acute care providers to better understand patient outcomes in different sites of care, risk adjusted to appropriately account for higher need patients. We emphasize that if used, functional measures should not exclusively measure *improvement.* The measure should account for stabilization or slowing of decline if those outcomes are consistent with expectations for a particular patient.

We recognize that hospitals may be concerned with their ability to influence or control performance in non-hospital settings. However, without measures that span the duration of the episode, hospitals have little incentive to work collaboratively with other providers to ensure that the highest

quality care is provided to the beneficiary. The only measure that may be impacted by other providers treating the beneficiary during the bundle is the readmission measure. However, this measure has to main flaws: (1) it is too short in duration for a 90-day bundle, and (2) it is already captured in the hospital value-based purchasing program and is therefore unlikely to motivate hospitals to improve performance any more than they are already doing.

2. Beneficiary Protection

Consistent with BPCI, ACOs, and other models, CMS does not limit beneficiary choice of provider or the range of services available to the beneficiary. However, the rule would allow hospitals to partner with other providers in the community, including in "Sharing Arrangements" in which other providers may assume part of the financial risk. In order to account for potential bias (or steering of patients), CMS maintains the requirement that hospitals provide patients with a complete list of all available post-acute care options in the service area as a part of discharge planning.

VNAA Comment: VNAA strongly supports CMS' proposal to retain beneficiary choice of provider. However, our experience has been that simply agreeing to reimburse claims for any provider the beneficiary chooses does not fully support beneficiary choice. In practice, beneficiary choice is largely defined by the beneficiary's referring physician and the hospital discharge planner. Most beneficiaries and their families follow recommendations made by their physician or the hospital staff. Requiring discharge planners to provide a complete list of post-acute care providers in the service area has little if any impact on beneficiary choice.

Given the influence referring providers have on the selection of post-acute care providers, we believe it is necessary to consider the development of "preferred" provider relationships or "collaborators" as creating a provider network for the bundle. Hospitals should be required to ensure that they have an adequate network within their collaborator or preferred partnerships to provide meaningful choice to beneficiaries. All hospitals should be required to have partnerships with the full range of providers who may serve the patient as part of the bundle. This includes home health agencies, skilled nursing facilities, rehab facilities, and hospices, among others.

CMS recently announced that there are 360 organizations participating in the BPCI initiative with the vast majority testing Model 2 (acute/post-acute) and Model 3 (post-acute only) bundles. 423 hospitals, 441 physicians, 1071 skilled nursing facilities, and 101 home health agencies, among other providers, are participating. This means that either many home health agencies are participating in multiple models or, more likely, that less than a third of participating organizations have partnered with a home health agency. This low rate of home health participation is unexpected, given strong and growing evidence that the home is a safe, efficient, and beneficiary-preferred site of care. Analysis conducted by Avalere Health, LLC shows that the percentage of Medicare beneficiaries rehospitalized within 30 days of major joint replacement or reattachment of lower extremity without major complications is 3.84 percent for individuals who were discharged to home health versus 7.53 percent for individuals discharged to skilled nursing.[1] This begs the questions: why are so few of these organizations working with home health agencies, and how can these organizations truly offer patient choice if they are not working with all post-acute care provider types?

[1] *Home Health Chartbook,* Avalere Health, November 2014. Accessed at: http://ahhqi.org/images/uploads/FINAL_2014_AHHQI_Chartbook.pdf

In establishing partnerships, bundled payment conveners, such as hospitals as part of the CCJR model, should be required to establish criteria for partnership/network development. The following elements should serve as minimum criteria: quality of care, health outcomes, price, accessibility, willingness to work together on evidence-based protocols, and patient experience of care. Partnerships should not be based solely on existing financial, governance, or technical (e.g., health information technology) relationships between the providers and the hospital/convener. By setting minimum baseline criteria, CMS can better ensure a level playing field for all community providers. Failure to support a broad range of community providers will result in increased vertical and horizontal consolidation among healthcare providers. While robust systems of care *may* lead to more coordinated care, consolidation may also lead to price increases and diminished quality as competition is reduced. This phenomena is playing out in other care delivery and payment models. A recent study by The Commonwealth Fund found that 97 percent of markets for purposes of Medicare Advantage are highly concentrated. Highly concentrated markets are "less likely to exhibit the positive effects of competition," such as better control over costs and focus on quality improvement.[2]

3. Proposed Waivers

CMS proposes to allow several waivers for payment for services not traditionally covered by the fee-for-service Medicare program. These include waivers of:

- Post-Discharge Home Visits
- Billing and Payment for Telehealth Services
- Skilled Nursing Facility 3-Day Rule
- Waivers of Medicare Program Rules to Allow Reconciliation Payment or Repayment Actions Resulting from the Net Payment Reconciliation Amount

VNAA Comment: VNAA strongly supports CMS' proposal to waive certain provisions of Medicare payment policy to test innovative ways of delivering services to beneficiaries. However, we urge CMS to reconsider its position with respect to waiver of the homebound requirement for home health services.

Post-Discharge Home Visit

VNAA strongly supports CMS' proposal to allow beneficiaries participating in the CCJR model who do not qualify for the home health benefit to receive up to nine post-discharge in-home visits. As CMS states, this would allow an average of just less than one visit per week for the duration of the episode. Clinicians may use these visits to conduct beneficiary and caregiver education, conduct care coordination/management activities, conduct medication reconciliation, among other services. We concur that nine visits per 90-day episode gives providers latitude to test different configurations of visits to see what approach may provide the best outcomes.

[2] B. Biles, G. Casillas, and S. Guterman, *Competition Among Medicare's Private Health Plans: Does It Really Exist?* The Commonwealth Fund, August 2015.

We are concerned, however, about CMS' proposal to only allow hospitals, physicians, and certain non-physician practitioners to bill for these visits. Hospitals and physicians, while critical to the development of a beneficiary's plan of care, do not have expertise of providing services in the home. In order to conduct these visits, we anticipate that the billing providers will turn to their home health colleagues to provide these services. This process will create an unnecessary administrative layer that will direct resources away from patient care. Instead, CMS should permit home health agencies to bill directly for these services on a fee-for-service basis (e.g., not on an episodic basis) using the per-visit LUPA rate. Physicians, in coordination with the beneficiary, hospital and other care providers, would continue to direct the plan of care, identify the services to be provided in the home, and make the referral to home health.

While these nine visits may provide the right level of in-home support for many beneficiaries, we anticipate that there are others who would benefit from the full scope of home health services as traditionally provided through a home health episode of care. This is true for homebound and non-homebound beneficiaries alike. There is reason to encourage the delivery of post-acute care services in the home for even those individuals who are not homebound. In many instances, the line between homebound and not-homebound is gray. Many individuals' capacity to leave their home on a given day or over the course of the 90-day bundle may vary based on how they feel physically and emotionally, the availability of caregiver support, and external conditions (e.g., heat, snow/ice, etc.), among other factors. Providing services in the home is cost effective, safe, and patient-preferred. Patients who are treated in their homes are likely to experience reduced physical and emotional stress and exposure to communicable disease. They are less likely to miss appointments and have high rates of satisfaction with their care.

CMS argues as part of its defense for declining to waiver homebound status that, "…in other CMS episode payment models, such as BPCI, we have not waived the homebound requirement for home health services." We question why CMS has multiple models if not to test different benefit constructs. If all models test the same waivers, how will CMS know which models work and which do not?

We strongly encourage CMS to finalize the proposal to waive Medicare rules for post-discharge home visits and to waive the homebound requirement for individuals who would benefit from the full scope of home health services.

Billing and Payment for Telehealth Services.
VNAA supports the waiver to allow providers participating in the CCJR model to bill for services provided via telehealth that are provided in the home and in non-rural areas. We are concerned, however, by the limitations CMS has placed on who may provide services via telehealth. CMS proposes to exclude services provided by home health agencies from reimbursement when provided via telehealth. Specifically, we disagree with the following elements of the proposal:

> "With respect to home health services paid under the home health prospective payment system (HH PPS), we emphasize that telehealth visits under this model cannot substitute for in-person home health visits per section 1895(e)(1)(A) of the Act. Furthermore, telehealth services by social workers cannot be furnished for CCJR beneficiaries who are in a home health episode of care because medical social services are included as home health services per section 1861(m) of the Act and paid for under

the Medicare HH PPS. However, telehealth services permitted under section 1834 of the Act and furnished by physicians or other practitioners, specifically physician assistants, nurse practitioners, clinical nurse specialists, certified nurse midwives, nurse anesthetists, psychologists, and dieticians, can be furnished for CCJR beneficiaries who are in a home health episode of care."

Telehealth plays an important role in supporting the delivery of needed health care services in the home while also improving patient care and reducing costs. Home health agencies are uniquely able to provide telehealth services. They are a trusted part of a patients' care team with first-hand knowledge of the patient. Frequent, face-to-face contact is the corner stone of the relationship of the skilled care the patient receives; telehealth furthers the relationship and does not replace it. Instead, telehealth assists home health providers in maximizing the effectiveness and efficiency of limited healthcare resources. For example, home health providers often use telehealth to monitor patients remotely and intervene at the most appropriate time, which may be different than the initially prescribed schedule. Some examples of the innovative ways VNAA members incorporate technology include:

- Consult with a patient's primary care provider while in the home using secure live video.
- Provide rehabilitation sessions and other consults via live video conferencing.
- Use telehealth for "comfort checks" to assess the patient (and/or caregiver) on a daily basis on a number of areas such as pain control, mental status, emotional support, bowels, and skin condition. This data is used to drive when home visits are made.
- Provide wound care management.

VNAA strongly urges CMS to reconsider allowing home health agencies to serve patients in the CCJR model via telehealth when appropriate.

4. Evaluation Plan

CMS identified several key evaluation areas, including payment, utilization, outcomes/quality, referral patterns and market impact, unintended consequences, potential for extrapolation of results, and explanations for variations in impact.

VNAA Comment: We recommend that CMS incorporate several additional research questions as part of the evaluation plan, including:

Utilization: CMS should examine whether utilization shifts between sites of care. For instance, do participating hospitals refer more patients to home health in place of skilled nursing? If so, which types of patients are more likely to be referred to a specific setting and what is the impact of different sites of care on quality, health outcomes, and total spending?

Outcomes & Quality: CMS should examine the impact of the model on certain vulnerable sub-populations, including, including low income individuals, individuals residing in low-access areas, and racial and ethnic minorities.

Referral Patterns: CMS should evaluate the criteria hospitals use to identify preferred partner relationships and how hospitals define and measure value.

Unintended Consequences: CMS should consider the extent to which beneficiary choice is preserved and whether or not hospitals steer patients towards certain providers.

Thank you again for the opportunity to provide our comments. VNAA encourages CMS to finalize this program with consideration for our comments above. We commit to assisting our members as they partner with hospitals in their community to improve the quality and efficiency of the care provided to individuals receiving joint replacements. Please contact me at VNAA should you have any questions on these comments. I may be reached at msmith1@vnaa.org or 571-527-1529.

Sincerely,

/s/

Molly Smith
Vice President, Policy and Innovation