Via online submission to http://www.regulations.gov

February 6, 2015

Sylvia M. Burwell
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1461–P
P.O. Box 8013
Baltimore, MD 21244-1850

Re: Proposed Rule: Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations (CMS-1461-P)

Dear Dr. Burwell:

The American Occupational Therapy Association (AOTA) is the national professional association representing the interests of more than 185,000 occupational therapists, students of occupational therapy, and occupational therapy assistants. The practice of occupational therapy is science-driven, evidence-based, and enables people of all ages to live life to its fullest by promoting health and minimizing the functional effects of illness, injury, and disability. Many occupational therapy practitioners are reimbursed under the Medicare fee-for-service system and invested in the Medicare Shared Savings Program (MSSP). Occupational therapy practitioners also work in all of the settings in which Medicare services are provided including home health, skilled nursing facilities (SNF), Long term acute care hospitals, inpatient rehabilitation facilities (IRF) and acute hospitals, all of which will be encompassed under the ACO umbrella. AOTA appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule for the Medicare Shared Savings Program and Accountable Care Organizations (ACOs), which was published in the Federal Register on December 8, 2014 at 79 Fed. Reg. 72760.

AOTA continues to support CMS’ triple aim of achieving better health, better care and reduced growth of health care expenditures, and our members look forward to working with CMS to accomplish these important goals. AOTA appreciate that CMS seeks to implement revisions in the proposed rule to improve the operations of ACOs and benefit from the last several years of experience to reduce administrate burdens on ACOs while facilitating their efforts to improve care outcomes and reduced costs. We also endorse the specific MSSP goals as a benefit to Medicare beneficiaries, including the intent to: (1) Encourage providers and suppliers to join together to form ACOs that will be accountable for the care provided to an assigned population of Medicare beneficiaries; (2) Improve the coordination of fee-for-service items and services; and (3) Encourage investment in infrastructure and redesigned care processes for high quality and efficient service delivery that demonstrates a dedication to, and focus on, patient-centered care that results in higher quality care. The profession of occupational therapy provides services that
improve outcomes for patients as a direct result of its distinct cost-effective, clinical focus on patient-centered care that enables healthy behaviors and independence. Occupational therapists in private practice, as suppliers in the Medicare program, are eligible to participate in ACOs as are the provider entities for which occupational therapy practitioners work as noted above. When integrated appropriately into care delivery models, occupational therapy can play a valuable role in helping both ACOs and CMS achieve the objectives of the MSSP especially in areas that affect self-management, reduced reliance on supports, and improved healthy habits.

We offer the following comments in response to the MSSP proposed rule:

I. Definition of “Primary Care Services”

The proposed rule continues to define “primary care services” for purposes of assignment to an ACO to encompass a narrow set of HCPCS codes and eligible provider types. While we appreciate the difficulty involved in defining primary care services to meet the programmatic mission of ACOs, the narrow use of the term in this and previous MSSP rules is contrary to CMS’s objectives for primary care. Primary care, if the healthcare delivery system is to be effective and efficient, must be defined broadly, as in the Innovation Center’s Comprehensive Primary Care Initiative (CPCI). Under CPCI—as well as in the transforming clinical practices initiative (TCPI), patient centered medical homes (PCMH) and advanced primary care (APC) programs—primary care includes care coordination across a medical neighborhood, patient and caregiver engagement, population health initiatives, advanced access and integrated treatment planning. Across a broad range of initiatives (including the MSSP ACO), CMS is pushing to broaden the definition of primary care.

This proposed rule, however, because it relies on a definition of “primary care services” to determine beneficiary assignment, pulls the construct of “primary care” in precisely the opposite direction. The proposed use of the term “primary care” and its concept of “plurality of services” is inadvertently being conflated with the “beneficiary assignment” calculation used to determine inclusion in an ACO. In doing so, the MSSP ACO program presents a limited view of comprehensive primary care services under Medicare, which could result in a limitation on the view of a broad, continuous, team-based approach to meeting primary and chronic care needs. Indeed, in an ACO—as in other CMS initiatives—a more expansive definition of primary care is central to the envisioned system reform.

AOTA therefore encourages CMS to redefine the narrow set of HCPCS codes and provider types used to assign beneficiaries to ACOs under § I.I.E.3 of the proposed rule and § 425.20 of the November 2011 final rule as “beneficiary assignment services.” In this way, CMS can satisfy the need to narrowly define ACO assignment while continuing to broaden the definition of “primary care” in a manner consistent with a wide range of CMS’s health reform efforts.

II. Required Process to Coordinate Care

AOTA understands that Section 1899(b)(2)(G) of the Act requires an ACO to define processes to coordinate care, such as through the use of telehealth, remote patient monitoring, and other such
enabling technologies. In the November 2011 final rule, CMS established requirements under § 425.112(b)(4) that ACOs define their care coordination processes across and among primary care physicians, specialists, and acute and post-acute providers. As part of this requirement, an ACO must define its methods and processes to coordinate care throughout an episode of care and during its transitions.

AOTA strongly supports the ongoing applicability of this provision and supports the process requiring an ACO to demonstrate in its application to participate in the MSSP how the ACO implements coordinated care through an individualized care process, along with a sample care plan—this is vital to the success of the MSSP. Indeed such care planning is consistent with our reference to a broad, comprehensive definition of primary care. Any care planning must encompass the total acute, preventive, rehabilitative, and chronic needs of beneficiaries; it must address services including occupational therapy.

AOTA also supports the requirements that an ACO explain in its application how this program is used to promote improved outcomes for its high-risk and multiple chronic condition patients. Since occupational therapists are significantly involved in the provision of services to Medicare patients in a variety of post-acute care settings, including skilled nursing facilities, inpatient rehabilitation facilities, long term care hospitals and home health care agencies, occupational therapists routinely treat patients who are high-risk with multiple chronic conditions. These patients are often frail, at risk for falls and re-hospitalizations if not carefully treated and monitored over the entire episode of care. Furthermore, beneficiaries need services delivered in a variety of ways and settings, including in homes and the community. Planning and attention to all these services is particularly important for those with chronic conditions.

AOTA strongly supports the proposal for a new provision requiring that an ACO describe how it intends to partner with long-term and post-acute care providers to improve care coordination. Implementation of this proposal, if done appropriately, will help assure the ongoing success of the ACO in collaborating with providers across the continuum of care as “essential partners to physicians in the management of patient care.” The terms “patient-centeredness” and “patient engagement” are mentioned within this section of the proposed rule. AOTA asserts that one way to carefully implement the proposal is for MSSP ACOs to give meaningful consideration to what the patient (and often also the patient’s family/caregivers) wishes to achieve in their care, recovery and life; these considerations are central to the occupational therapy practice model. Thus, ACOs should be required to coordinate care in a manner that clearly considers the patient’s needs and objectives as part of the overall health delivery model, not only in permitting the use of telehealth and related enabling technologies to communicate patient functional status, but in implementing procedures to bring the patient’s care objectives into the decision-making process and to engage patients in their own care. In this spirit, AOTA respectfully requests that CMS give close review to whether the proposed intent of the ACO to partner with long-term and post-acute care providers is sufficiently patient-centered and engages the patient in the care process as much as feasible.

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III. Ways to Encourage ACO Participation in Performance Based Risk Arrangements

1. Waiver of the SNF 3-Day Rule

AOTA supports the CMS proposal to waive the SNF 3-day rule for ACOs in a two-sided performance-based risk track in a manner consistent with the innovation Center’s Pioneer ACO Model. AOTA agree with CMS that the SNF 3-day rule is a vestige of the Medicare Program that may no longer have utility in new payment structures. Further, it may be more medically appropriate for certain patients to receive skilled nursing and/or skilled rehabilitative services provided at SNFs without a prior inpatient hospitalization or with a hospitalization of less than 3 days. Various sources indicate that hospital lengths of stay are much shorter than they were decades ago due to enhancements in medical practice and technology.

Given these facts, AOTA supports CMS waiving the SNF 3-day rule under certain circumstances and with protections inherent in shared risk to assure stays are only reduced if they will positively benefit the patient and outcomes, and permit ACOs in the MSSP to pursue coordinated, quality, patient-centered care that is cost-effective. AOTA recommends that the circumstances for waiver should align with those implemented under the Pioneer ACO model in which the patient must be medically stable, not require an inpatient evaluation or treatment and have a skilled nursing or rehabilitation need that could not be provided as an outpatient. In addition, the SNFs must have the appropriate staff capacity and infrastructure to carry out the medically necessary care and activities described in the proposal. For the purposes of clinical coordination and aligning the ACO incentives on the side of quality care, AOTA further recommends that waivers be granted only for those SNFs that are ACO participants or ACO provider/suppliers at this time.

2. Billing and Payment for Telehealth Services

Currently CMS places many restrictions on the use of telehealth (including tele-rehabilitation or tele-occupational therapy) services. More exploration is warranted and necessary to determine whether quality care outcomes and cost-savings can be achieved by permitting telehealth services across the continuum of care and settings, including rehabilitation care. In addition to the waiver proposed under § II.F.4.a(2) permitting telehealth services outside of rural and within Metropolitan Statistical Areas, AOTA recommends that CMS implement a waiver of current CMS telehealth requirements to permit ACO demonstrations that define occupational therapists as eligible practitioners and occupational therapy as an eligible service to be conducted via telehealth. There is a growing base of evidence demonstrating the efficacy of technologically mediated occupational therapy. M SSP ACOs, especially those in two-sided performance-based risk tracks, should be permitted to leverage this growing knowledge base to achieve the triple aim. AOTA also agrees with the intent of the agency to add requirements to ensure transparency

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and reduce the likelihood of abuse as appropriate and consistent with the intent of the MSSP as it pertains to patient outcomes.

3. Waiver of the Homebound Requirement Under the Home Health Benefit

AOTA supports the CMS proposal to appropriately and carefully waive the “homebound” requirement for MSSP ACOs using the authority granted under Section 1899(f). Occupational therapists contract with home health agencies to provide rehabilitation services to Medicare patients under the home health benefit and many of these patients are medically complex with multiple chronic conditions. The homebound requirement is a vestige of the Medicare program that defined services as home health based on the patient being confined to the home and should be more loosely defined as systems of care change. Patient need, however, must always be preeminent so that cost is not balanced too heavily against appropriate services provided in the most appropriate manner to achieve outcomes. Beneficiaries who may benefit from home health services should be able to access the benefit and AOTA believes that enhancing access in appropriate cases will result in direct cost savings through the avoidance of hospital admissions and re-admissions, serious falls, and skin integrity issues to name a few areas.

In terms of CMS’ request for additional comments regarding the waiver of other relevant home health benefit rules that will support the intent of the MSSP to achieve quality, patient-centered care at lower costs, AOTA recommends that occupational therapy be recognized as a “qualifying service” under the Medicare home health care benefit and occupational therapists be permitted to open ‘therapy only’ cases if occupational therapy is in the physician’s order. This is a position that AOTA has been advocating with CMS for almost 3 decades. Indeed, occupational therapy as a qualifying service was put into law in 1980 but was rescinded in a larger cut back of Medicare changes. Occupational therapy has been included in Medicare as a free standing benefit since 1987 but is not eligible as a qualifying service for home health benefits. This means that occupational therapists cannot conduct the initial assessments for Medicare home health cases even when occupational therapy is included in the physician’s orders along with a qualifying service such as physical therapy or speech-language pathology services. Occupational therapy can only be provided when there is a “continuing need” for therapy. This creates situations in which care is not provided in the manner or order which is best for the patient (e.g., if occupational therapy is medically indicated as the first needed service of a home health episode). This can contribute to an agency providing services just to get to other services, creates confusion about the important roles of all therapies, and impedes the flexibility of home health agencies from using the most appropriate skilled therapists to open cases.

Including occupational therapy as an initiating service for Medicare home health services would meet the clearly stated objectives of the MSSP to provide Medicare beneficiaries with patient-centered coordinated quality care and improved access to the most appropriate services, while at the same time allowing ACO home health agencies to more efficiently use their occupational therapists to provide medically necessary services.

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Thank you for the opportunity to comment on the proposed rule. Should you have any questions, or need additional information, please contact us at (301) 652-6611 ext. 2023 or
ssandhu@aota.org. AOTA looks forward to a continuing dialogue with CMS on coverage and payment policies that affect the ability of occupational therapists to provide quality care to Medicare beneficiaries.

Sincerely,

Sharmila Sandhu, JD
Director of Regulatory Affairs