September 8, 2015 via Electronic Submission

The Honorable Andrew Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore M.D. 21244-8016

Re: CMS-5516-CN: Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services

Dear Acting Administrator Slavitt:

On behalf of Almost Family, Inc. (AFAM), we appreciate the opportunity to provide comment to the Centers for Medicare and Medicaid Services (CMS) on the proposed rule that would implement the Comprehensive Care for Joint Replacement (CCJR) model.

We compliment the Agency on proposing to test this new payment model and strongly support it conceptually, as it addresses one of the most common and expensive procedures in Medicare: lower extremity joint replacement (LEJR). AFAM has a particular interest in the CCJR model because we operate and will be affected by the program in 21 of the 75 metropolitan statistical areas (MSAs) proposed for the model. These communities vary geographically to include operations in the South, Mid-West and Northeast regions of the nation.

Introductory Comments – Due to Relatively Unique Characteristics of Patient Population:

- **Cost savings likely to come from increased home health use –** In our view, the Project, as may be amended following the comment period, is likely to work well with this specific patient population which is relatively narrowly designed and medically-stable. Current medical protocols generally preclude elective procedures on unstable patients. Thus, to the extent unstable patients are included they would likely be after a fall or other trauma. As suggested in the CMS-sponsored 2015 Lewin Report, and by our own patient experiences, joint replacement patients generally have comparatively lower re-hospitalization risk (Lewin Report: 8.6%).[i] Accordingly, we believe most LEJR cost savings will come from lowering the costs of care post-discharge from the acute care facility. This in turn will come from using more low-cost home health and out-patient rehabilitation care and less high-cost inpatient settings such as IRF's and SNF's.

- **Project design cannot be applied to chronic populations –** In the case of the LEJR subject population, the initiation of health care generally ***does*** begin when the patient is admitted to the hospital. However, with the chronically unstable population an event of hospitalization is more often the result of a failure to treat the disease and maintain the patient in their own residence. With the chronic patient population we must think of health care beginning ***in the home*** rather than upon admission to an inpatient facility. Accordingly, **we strongly caution against**

extrapolating this Project design to more complicated chronic disease states, in particular those with comorbidities and unstable conditions. With the chronic population the focus of the Program should be more pre-acute and on avoiding hospitalizations to begin with, rather than on how to lower costs after the hospital discharge.

Section I – Executive Summary of Comments

The following is a summary of our comments which are more fully developed in the pages that follow:

1. With regard to **the good policy proposed and suggestions for its improvement (Section II):**
   a. The CCJR model reflects good policy and is well-designed. However, it should be restructured to place homecare and physicians on equal footing with hospitals to better reflect their essential role as clinically appropriate and cost-effective post-acute providers (see "Lewin Report").
   b. Homecare should be a full participant in the patient's choice of post-acute options to avoid undesired outcomes from potential inappropriate patient steerage by hospitals to select post-acute providers. This population targeted under the rule has relatively low re-hospitalization rates, so most of the benefit will accrue from driving post-acute costs down through the use of more home health care as a substitute for higher cost inpatient settings.
   c. Patients should receive information about their full range of post-acute options, including homecare, according to the Medical needs of their condition, preferably as part of a discharge plan from the hospital.
   d. We express concern regarding the availability of beneficiary protections and how they can be secured under the rule, while also giving providers the ability to manage changing costs.

2. With regard to **suggested structural changes in the current rule (Section III):**
   a. Subject to appropriate clinical criteria and with appropriate program integrity considerations, CMS should consider waiving the homebound requirements in certain circumstances during the 90-day post-discharge period so patients and the Program can take advantage of continued and uninterrupted homecare services, which can deliver better outcomes and avoid costly hospital admissions/readmissions.
   b. The model should allow homecare providers to render covered services during the 3-day period prior to admission, including specifically pre-operative in-home visits for purposes of preparing the beneficiary for post-operative rehabilitation. This practice has historically been questioned by HHS-OIG.

3. With regard to **data transparency, process, telehealth and collaboration (Section IV):**
   a. CMS should grant post-acute providers access to available patient-level information on the same basis as hospitals under the model.
   b. We express concern regarding the combined effect of implementing multiple competing risk models.
   c. We applaud the provision facilitating enhanced use of telehealth services under the rule.
   d. CMS should consider interviewing stakeholders and soliciting their written comments before issuing proposed rules, as the Senate Finance Committee recently did in anticipation of developing chronic care management legislation.

Section II – Suggestions for Improvement of Good Policy Reflected in CCJR Model

The CCJR model reflects good policy and is well-designed. However, we make the following recommendations on ways to improve the program:

- **Hospitals should not be the only driver of the CCJR model: Homecare and physicians should be equal participants and episode initiators under the rule —** Homecare is both a clinically appropriate and proven cost-effect post-acute provider for beneficiaries and, as such, is well positioned to be a participant in the CCJR model. This is recognized in the Lewin Report, which states in part: "Lowering the cost of care may involve substituting more intensive with less intensive services (for example, using home health care rather than skilled nursing care)".[ii] Further, the rapid growth of ACO's and BPCI programs is designed to and is driving higher acuity patients into homecare. Physicians also play an essential role and are on the frontlines of making clinical determinations regarding post-acute care for patients. We urge the agency to consider whether a more patient-centric physician-led model would not be a better way improve outcomes and lead to lower cost.

  We are concerned the CCJR model cedes control almost entirely to hospital systems for payment, risk sharing, patient referrals and outcomes—all counterintuitive to recent studies. We note as well CMS has already underway its BCPI initiative with 4 different models being tested. One model in particular, Model 3, structures an episode to begin in post-acute settings such as homecare. Careful consideration of the results of this initiative prior to deployment of the proposed CCJR rule might better inform changes or delay of the rule pending further refinements. Lastly, we note the population targeted under the rule has relatively low re-hospitalization rates, meaning that most of the benefit will accrue from driving post-acute costs down through the use of more home health care as a substitute for higher cost inpatient settings.

- **Hospital Control of Post-Acute Care Options May Limit Patient Choice and Defeat Desired Goals** — While conceptually supportive of the rule, we are concerned the model positions hospitals inappropriately and cedes excessive control to hospital systems in a way that limits patient choice. Under the model, eligible beneficiaries receiving services from participating hospitals would be forbidden from opting out. This can have grave consequences for post-acute providers and could negatively affect a patient's ability to choose post-acute providers. One possible negative consequence is inappropriate patient steerage by hospitals. By allowing them to fully control payment throughout the 90-day episode, hospitals would be permitted to steer patients to their preferred post-acute providers. Not only could patients be steered inappropriately, but hospitals could "cherry-pick" post-acute providers for financial reasons other than betterment of patient conditions. Lastly, we express concern regarding the availability of beneficiary protections and how they can be secured under the rule, while also giving providers the ability to manage changing costs.

- **Recommendation:** The model proposed should be restructured to align homecare and physicians as equal partners with hospitals to better reflect their essential role as a clinically appropriate and cost effective post-acute providers. This can avoid undesired results from the potential of hospital patient steerage to select post-acute providers.

- **Recommendation:** Patients should receive information about their full range of post-acute options, including homecare, according to the medical needs of their condition, preferably as part of discharge planning from the hospital.

Section III — Proposed Structural Changes: The CCJR Proposal Can be Refined to Maximize Efficiency of Homecare

While recognizing the value of homecare as a "collaborator," if not a "participant," in the model, the Project runs the risk of failing to achieve the desired patient outcomes and lower costs. We believe the rule can be refined to achieve better patient outcomes and lower costs. One way to achieve desired outcomes would be to waive the homebound requirement for beneficiaries receiving homecare. Otherwise, the very patients targeted for success may not qualify for homecare at all upon discharge for failure to meet Medicare's homebound requirement. In which case, participating hospitals would be unable to access the very homecare services that can improve their chances of success. This result can compound the contrary outcomes should they transition or porpoise in and out of homecare eligibility.

Further, the 3-day period before hospital admission is an opportunity for qualified homecare professionals to determine in the home of patients the help they may need upon hospital discharge. Homecare professionals are trained to determine the in-home physical barriers, clinical, technological and other supports the patient may need upon discharge and can render invaluable assessment services that can speed patient recovery. This practice has historically been questioned by HHS-OIG.

- **Recommendation:** Subject to appropriate clinical criteria and with appropriate program integrity considerations, CMS should consider waiving the homebound requirements in certain circumstances during the 90-day post-discharge period, so patients and the Program can take advantage of continued and uninterrupted homecare services which can deliver better outcomes and avoid costly hospital admissions/readmissions.

- **Recommendation:** The model should recognize the option or availability of homecare providers to render covered services in the period prior to admission.

Section IV — Data Transparency, Process, Telehealth and Collaboration

- **CMS should expand data sharing to give post-acute providers the same information as hospitals receive —** We note the proposed rule indicates hospitals may limit discharges to certain post-acute providers in cases where data they will access demonstrates higher readmission rates among such providers. While we support transparency of data we strongly urge CMS to provide the same or similar data to post-acute providers so as to better inform patient choice, avoid hospital steerage as mentioned above and improve the performance of post-acute providers. We believe better access to data through electronic information interchange would serve to drive better care coordination, better outcomes and lower costs for all providers.

- **Recommendation:** CMS should grant participating homecare providers with the same historical claims data hospitals receive about patients upon admission. As homecare agencies are held increasingly accountable for outcomes under the proposed model, they should also be allowed to see the Medicare claims history on patients for use in framing the best care plan to produce high value service. This is particularly important in a new system where quality is paramount.

- **We Support the use of a Shadow Check** — AFAM compliments the use a "shadow check" to give providers ample time to prepare for the program and ensure readiness for the risks and adjustments involved in implementation. In addition to giving providers more time, deploying a shadow check period gives CMS more time to study results and provider behavioral changes. Lastly, a shadow check period may also have the effect of improving overall quality and patient outcomes by taking advantage of a well-established phenomenon known as the "Sentinel Effect." The Sentinel Effect suggests that human performance tends to improve when a person becomes aware that his or her behavior is being monitored. In the context of CCJR, this means that through the use of a shadow check CMS' model could benefit from the savings and positive behavioral changes associated with increased monitoring of providers without immediately exposing them to significant downside risk.

- **We Support the Enhanced Use of Telehealth and Telemonitoring** — We support efforts to expand the use and availability of telemedicine in caring for Medicare beneficiaries within the home and have established an entity within our company to further such technological innovations. Our HealthCare Innovations business segment is supporting efforts within our company and in legislatures around the country to deploy as a paid benefit in-home tele-monitoring devices to prevent hospitalizations in the first place and improve patient outcomes in their own home. We are therefore pleased that the CCJR proposal would allow such services to be furnished to eligible individuals when they are located at one of the eight original sites at the time the service is furnished via a telecommunications system without regard to the site meeting one of the geographic site requirements. We believe this is an important enhancement for beneficiaries and agree that this waiver will allow the greatest degree of efficiency and communication between providers, suppliers, and beneficiaries by allowing them to receive tele-health services in their home.

- **Combination Effect of Multiple Programs Seems Under-Contemplated** — CMS is currently implementing demonstrations and innovations at an incredibly fast rate. The combination effect of these multiple initiatives must be considered just like clinicians must contemplate drug interactions in a patient's care plan. Poor coordination and reconciliation of medications is well documented as a cause of poor patient outcomes because one prescriber did not know what the other prescriber was doing. The same risk applies here. Simultaneously implementing a 75-MSA mandate for the CCJR model and a 9-state mandate for the recently proposed home health value-based purchasing model, for example, must be considered in overlay. Each will have some effect on the other. Throwing on top of that numerous bundles for other disease states implemented at the hospital PAC level, and the rapid growth of ACO's in most market places sets up competition among a variety of CMS plans rather than providing for comprehensive coordination in patient care and outcomes. Dealing with many different programs all at once could serve to actually increase rather than decrease providers' costs and decrease rather than increase their success rates.

Table 1. HHVBP-CCJR Overlapping MSAs		
MSA	**State**	**MSA Title**
32820	TN	Memphis, TN-MS-AR
34980	TN	Nashville-Davidson--Murfreesboro--Franklin, TN
23540	FL	Gainesville, FL
33100	FL	Miami-Fort Lauderdale-West Palm Beach, FL

34940	FL	Naples-Immokalee-Marco Island, FL
36740	FL	Orlando-Kissimmee-Sanford, FL
37860	FL	Pensacola-Ferry Pass-Brent, FL
38940	FL	Port St. Lucie, FL
42680	FL	Sebastian-Vero Beach, FL
45300	FL	Tampa-St. Petersburg-Clearwater, FL
11700	NC	Asheville, NC
16740	NC	Charlotte-Concord-Gastonia, NC-SC
20500	NC	Durham-Chapel Hill, NC
24780	NC	Greenville, NC
47260	NC	Virginia Beach-Norfolk-Newport News, VA-NC
38900	WA	Portland-Vancouver-Hillsboro, OR-WA
42660	WA	Seattle-Tacoma-Bellevue, WA
30700	NE	Lincoln, NE
HHVBP-CCJR Overlapping MSAs:	**18**	
Total CCJR MSAs:	**75 (24%)**	

As shown in Table 1 above, 18 out of 75 (24%) Joint program MSA's overlap with the HHVBP states. Also, 5 out of 9 (56%) of HHVBP states overlap with Joint program MSA's.

- **Allow Provider Input in Advance of Release of Proposed Rule —** We appreciate this opportunity to comment, but would urge the Agency to consider adopting an additional step in the rulemaking process to improve the design and implementation of this very significant rule. Recently, the Senate Finance Committee solicited stakeholder responses on innovative ways to care for patients with chronic conditions. As part of the process, the Committee invited stakeholders to come in and discuss their proposals with staff. We encourage the Agency to adopt a similar process in the promulgation of the current rule because we believe it would result in a better program and rule.

We appreciate this opportunity to share our comments and look forward to continuing to work with you and your staff. We would welcome the opportunity to participate in further stakeholder discussions to improve the proposed CCJR model. If you have any questions, please do not hesitate to contact us by phone at 502-891-1000 or email at WBY@AlmostFamily.com or SteveGuenthner@AlmostFamily.com.

Sincerely,

William B. Yarmuth
Chairman and CEO
Almost Family, Inc.

C. Steven Guenthner
President
Almost Family, Inc.

[i] The Lewin Group, "CMS Bundled Payments for Care Improvement (BPCI) Initiative Models 2-4: Year 1 Evaluation & Monitoring Annual Report." Prepared for CMS. February 2015, pg. 19.
[ii] The Lewin Group, "CMS Bundled Payments for Care Improvement (BPCI) Initiative Models 2-4: Year 1 Evaluation & Monitoring Annual Report." Prepared for CMS. February 2015, pg. 21.