ASHT
AMERICAN SOCIETY OF HAND THERAPISTS

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June 24, 2016

The Honorable Andy Slavitt
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5517-P
PO Box 8013
Baltimore, MD 21244-8013

Dear Acting Administrator Slavitt:

Thank you for the opportunity to comment on the Quality Payment Procedure proposed rule. We look forward to collaborating with CMS in their efforts to accomplish the proposed goals.

We represent the American Society of Hand Therapists, an organization focused on the delivery of quality, evidence-guided rehabilitation services for diseases, injuries and conditions affecting upper extremity function. We have over 3000 members who are physical or occupational therapists, assistants or students who all share the goal of providing the best care to optimize patient function.

Although the new Quality Payment Program does not include our members at this time, we anticipate inclusion in the future and welcome this opportunity to reflect on the impact the rule may have on the delivery and reimbursement of our services. The Merit Incentive Based System is the track that would include the majority of our members and our comments are focused on that part of the proposed rule.

One of our primary concerns is the shift in health responsibility from the beneficiary to the provider, reinforcing a paternalistic system that could discourage beneficiaries from assuming autonomy and responsibility for their health and wellness. This in turn, negatively affects the overall population health in the US. In order to reach the goal of reducing cost and utilization of health care services, *all stakeholders* should bear financial responsibility with beneficiaries subject to the same behavioral and economic benchmarks as payers and providers.

Social determinants of health including access to safe housing, social support, and economic status have a profound impact on health outcomes. Differences in patient population including educational, religious and cultural factors often interfere with optimal treatment adherence. Communities, payers and patients must partner to identify and reduce disparities in order to improve health and reduce overall costs.

Holding providers responsible for suboptimal outcomes in underserved areas could lead to the unintended consequence of fewer available providers or discriminatory patient selection practices such as "cherry-picking" the lowest risk patients. The addition of some form of scoring adjustment for providers serving socio-economically challenged or complex patients could help mitigate provider risk.

Competition is clearly a tool in this proposal with the goal of reducing costs and improving quality. As currently designed, providers are competing with their peers. While we do not disagree with being compared to our peers, we want to make sure that this is a comparison within our upper extremity specialty practice and not to all occupational or physical therapists. As an example, custom-fabricated orthoses are an integral part of our services. Comparing our rates of billing of these items to all outpatient therapists would unnecessarily target Hand Therapists as over-utilizing orthoses. Benchmarks should be established acknowledging the unique service utilization between specialties rather than viewing all rehabilitation services as homogenous.

We agree that improving efficiency is an important goal. The collection of *irrelevant* quality measures paradoxically reduces the efficient delivery of specialized services. Rather than measuring quality the effort becomes a measure of provider compliance. In order to successfully report all of the proposed standards in MACRA, providers must spend an excessive amount of time directly capturing and entering patient data in the medical record that is not essential to the diagnosis and treatment of upper extremity musculoskeletal conditions or injuries. Patients are better served when providers concentrate their time and efforts in recording data that are *pertinent* to the specific issues for which the patient seeks care.

To that end, we believe the quality measures reported should reflect our specialty and the needs of our patients. Measures such as body-mass index are not typical priorities for our focused care delivery. The current requirement to report PQRS measure 182: Functional Outcome Assessment **and** separate Functional Limitation codes is redundant. We recommend eliminating the free standing Functional Limitation Reporting and retaining measure 182 in order to align with CMS' goal of improving reporting efficiency.

Optimizing patient function is our priority and functional reporting is at the heart of our services, however for the data to be valid, standardized tools must be used appropriately. As our services are focused and specialized, diagnosis-specific tools such as the Boston Carpal Tunnel Questionnaire or region-specific tools such as the DASH or Quick DASH could be identified and incorporated in order to accurately capture changes in function rather than using global outcome measures that are often not sensitive enough to register patient progress. The data from validated, diagnosis or region-specific tools have greater clinical utility than data collected from a variety of unspecified, unvalidated instruments, thus improving the quality of the reported information.

We are willing to work with CMS and other organizations to identify these reliable diagnosis/region specific validated outcome tools and measures appropriate to our services.

We are very concerned about the projected impact of the rule on small and solo providers. Small practices provide economical, convenient and personalized care for the beneficiaries they serve, yet according to the Proposed Rule, 87% of solo practitioners will be penalized while 81% of clinicians in large groups are projected to earn bonuses. This encourages the expansion of large medical corporations and hospital systems and decreases competition. Published reports have shown these mergers increase the cost of care. Recent examples include Carolinas HealthCare[1] and the University of Southern California study on Hospital Mergers[2].

Each additional reporting initiative increases the non-reimbursable administrative burden for small practices with thin profit margins. This is occurring in a climate of decreasing provider reimbursement and increasing practice costs. Reporting requirements require time-consuming documentation and training of providers and staff. Reporting measures specific to the upper extremity are presently only available to therapists through registries that require an annual fee, yet another expense in order to meet the reporting requirements of this proposal. We recommend these measures be available through all reporting options and not limited to registry reporting. Practices located in rural areas are often small practices providing the only available services for populations with limited access to care. The increasing costs associated with increasing regulations threaten their survival.

Hand Therapists changing jobs may find their prospects affected by their Composite Performance Scores under their former employer, through no fault of their own. The rule is unclear regarding whether reimbursement penalties will follow the therapist or remain with the reporting organization. Reporting success or failure is unknown until the following year, potentially delaying or discouraging hiring by a new employer pending these reporting results.

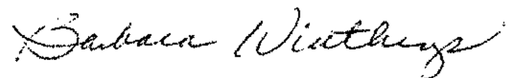
The shift in incentives for payment from volume to value relies on demonstrating value through documentation and data collection. The *art* of medicine is being sacrificed to data analytics. The existing therapy reporting measures do not reflect individual patient learning abilities, emotional states or the environmental impact of injury; in short all the characteristics that contribute to outcome and cost variations are those characteristics that make our patients human. Human nature will never be standardized, yet providers are being evaluated and reimbursed based on that very assumption. Individual patient characteristics contribute to our inability to consistently predict or define uniform optimal outcomes. The right care for the right patient at the right time is just that: it is a partnership between the patient and the provider and must take into consideration personal goals, motivation and cultural differences.

Providers must have the opportunity to identify the individual barriers to successful outcomes and focus on strategies to overcome these barriers. The development of a relationship with a patient takes time and allows us to establish trust, identify adherence barriers, impact patient motivation and develop meaningful individual functional goals. Fee-for-service payment more accurately reflects these differences and equitably compensates Hand Therapists for their service delivery.

Our members require appropriate advance notice prior to inclusion in the program. A minimum of one year and an ideal of two years' notice provides the lead-time necessary to inform and educate our members regarding the specifics of this complex program and allows time to acquire the necessary training and make adjustments to billing procedures, software and staff. Should the rule be applied to our members as currently proposed, we would like the opportunity to collaborate on the categories used in our evaluation and their individual weights. Occupational and Physical therapists were not included in the Meaningful Use program. Substantial training and additional expense will be required if inclusion in the Advancing Care category is forthcoming.

The ASHT is eager to work with CMS to establish specialty-specific standards and performance measures appropriate to the services we deliver and we welcome partnering with other specialty stakeholders as well as CMS to ensure that provider payment reform ultimately improves the care of patients with upper extremity impairments.

Sincerely,



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1. Alexander A and Garloch K: State and feds say Carolinas HealthCare drove up costs by curbing competition. In the Charlotte Observer, June 9, 2016. http://www.charlotteobserver.com/news/local/article82726402.html accessed online 6/14/16

2. Melnick GA and Fonkych K: Hospital prices increase in California especially among hospitals in the largest multi-hospital systems. IN: Inquiry: The journal of Health Care organization, Provision and Financing 53: 1-7, 2016. http://inq.sagepub.com/content/53/0046958016651555.full accessed online 6/14/16