June 23, 2015

**SUBMITTED VIA E-MAIL**

Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

**RE: (CMS–1632–P)** ***Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2016 Rates; Revisions of Quality Reporting Requirements for Specific Providers, Including Changes Related to the Electronic Health Record Incentive Program (Federal Register;*** **April 30, 2015)**

Dear Acting Administrator Slavitt:

The Coalition to Preserve Rehabilitation (CPR) appreciates the opportunity to comment on the above-referenced proposed rule. Our comments are limited to the *Solicitation of Public Comments on Expanding the Bundled Payment for Care Improvement (BPCI) Initiative* section of the proposed rule.[1] CPR is a coalition of national consumer, clinician, and membership organizations that advocate for policies to ensure access to rehabilitative care so that individuals with injuries, illnesses, disabilities and chronic conditions may regain and/or maintain their maximum level of health and independent function. CPR appreciates CMS' consideration of this letter as timely, given that the published comment due date in the Federal Register was June 29, and the Coalition did not receive proper notice that the due date was moved ahead to June 16.

**Considerations and Criteria for Expansion**

In the proposed rule, the Centers for Medicare and Medicaid (CMS) notes that since 2011 and pursuant to the Affordable Care Act (ACA) it has been developing and testing models of bundling Medicare payments to determine if bundled payments result in higher quality and more coordinated care at a lower cost to Medicare. Under the BPCI initiative, provider organizations enter into payment agreements with CMS that include financial and performance accountability for BPCI participants. The program includes four models and various episodes of care based on MS-DRGs.

[1] See page 24414 of the proposed rule.

Additionally, CMS states that evaluation of any BPCI expansion is expected to include analyses based on a combination of qualitative and quantitative sources including: Medicare claims, patient surveys, awardee reports, interviews, and site visits.

While CMS acknowledges that additional evaluation is necessary, it does not discuss in the proposed rule what evaluation has occurred to date as evidence that expansion is appropriate. CMS does not disclose information that demonstrates that quality of care has improved or that cost savings have been achieved, yet it seeks to expand the program. We have seen only one report of the first year of the program entitled *CMS Bundled Payments for Care Improvement (BPCI) Initiative Models 2-4: Year 1 Evaluation & Monitoring Annual Report.* We question whether data are available that would demonstrate that beneficiary access to care has or has not been denied or limited in any way. Without such publicly available information, we are concerned that the statutory requirements that allow for expansion of the BPCI have not been satisfied.

Additionally, CPR believes that CMS should consider additional criteria beyond those required by the ACA to judge the success of the BPCI program.[2] At this time, BPCI participants are able to select their own quality metrics which makes standardization and analysis of the results difficult. This lack of standardization risks that the sole criterion for "success" is cost savings achieved, which neglects other aspects of the program, namely, improvements in care coordination and quality. Policymakers should work with stakeholders to further define the metrics of success of bundled payment programs.

**Breadth and Scope of Expansion**

Not having sufficient data to assess whether existing BPCI programs are maintaining access to critical post-acute care services, we are reluctant to recommend expansion of bundling programs. However, if this program is expanded, we recommend that CMS exercise great caution in expanding the PAC models (Models 2 and 3). It is critical to continue a specific focus on PAC and the needs of these complex Medicare patients. A separate PAC model will also better identify and find ways to prevent any stinting on care that may occur when an acute hospital holds the bundle and pays downstream rehabilitation providers. CPR believes that a PAC-only bundle is critically important to ensure that the importance of these services is recognized and provided to Medicare beneficiaries. Model 2 should also include required quality and outcome metrics measured quarterly to assure there is not any stinting on post-acute care services for medically and functionally complex patients.

One challenge CPR has identified is that with so many models moving forward at once, it is hard to evaluate the overall impact of any single model to determine if the desired outcomes—improved quality, care coordination and cost savings—were impacted by a single model or by a combination of payment reform demonstrations. Therefore, CMS should conduct a thorough evaluation of the existing programs to help ensure these models deliver the desired outcomes and are scalable on a regional or nationwide basis before proceeding with expansion. CPR also recommends that as part of any expansion, CMS add several mandatory outcome measures rather than simply allowing participating providers to select their own quality and outcome metrics.

[2] See Page 24417 of the Proposed Rule. The ACA authorized development and testing of alternative payment models and authorized CMS to expand such programs if it makes the following findings: the Secretary determines that the expansion is expected to either reduce Medicare spending without reducing the quality of care or improve the quality of patient care without increasing spending; the CMS Chief Actuary certifies that the expansion would reduce (or would not result in any increase in) net Medicare program spending; and the Secretary determines that the expansion would not deny or limit the coverage or provision of Medicare benefits.

CPR also recommends that any expansion of the BPCI Initiative be strictly voluntary. Again, without a thorough evaluation it would be premature to move to a mandatory program. Without such an evaluation, it will be difficult to determine which innovations led to positive changes. The program should be expanded to include a greater number and type of participants and then be fully evaluated at two and three years before considering a mandatory approach.

**Definition of "Episode of Care"**

CPR recommends that CMS allow for flexibility in defining the length of the episode covered by the bundle. CPR is concerned that an episode of care defined as the acute hospital stay plus 30 days post discharge is not adequate to address the entire period of care needed for certain types of patients needing post-acute care (PAC). Specifically, these patients include individuals with brain injuries, some spinal cord injury patients, those with multiple trauma, medically complex and ventilator patients currently in inpatient rehabilitation hospitals/units (IRH/Us) and long-term care hospitals (LTCHs), and others.

For example, an RTI study entitled "Examining Post-Acute Care Relationships in an Integrated Hospital System" shows that the mean episode length of stay for many PAC patients well exceeds 30 days, even when the acute care hospital stay (average 6.8 days in 2006) is deducted. Hence, the definition of the episode of care, particularly for post-acute care episodes, should be flexible and perhaps even condition-specific. Either way, it should be long enough to incentivize providers to provide timely care and not simply "run out the clock" until providers can bill separately for services covered under Medicare Part B.

CPR also recommends that PAC episodes be based on standardized assessment data across PAC settings as well as discharge diagnostic and clinical information, which is not the case at this time. The Improving Post-Acute Care Transformation (IMPACT) Act of 2014 (Pub. L. 113-185) would provide at least some of the standardized data necessary to help develop clear episode recognition and definition. Until such time as patients with brain injuries, spinal cord injuries, multiple amputations and similarly serious conditions can be assured appropriate care post injury or illness, CMS should exempt these subpopulations of patients from bundled payment systems.

**Qualifications of the Bundle Holder**

CPR recommends that the bundle holder have the appropriate knowledge of the clinical needs of Medicare beneficiaries who require rehabilitation and post-acute care services, as this is a heterogeneous population, particularly with regard to PAC services. Bundle holders should also have an adequate understanding of the differences among settings of care, particularly the differences between inpatient hospital rehabilitation and skilled nursing. Without proper quality metrics to ensure beneficiaries are protected and criteria to ensure the bundle holder is capable of administering the bundle and its associated services, access to services for beneficiaries could be jeopardized. CPR generally supports the position that bundle holders should be limited to those with extensive PAC experience, most likely, PAC providers themselves.

CPR believes any entity qualified to serve as the bundle holder must meet specific criteria, including:

- The requisite clinical staff and expertise overall and for each condition included in the program;
- Systems in place to include rehabilitation physicians and extenders early in the discharge planning process to help in identifying the proper trajectory of care for patients;

- The ability to deliver, or contract for, the entire bundle of services to be rendered, including clear statements of the capacity to provide all levels of rehabilitation services, including IRH/U services.
- Clinical pathways and effective discharge planning capacities;
- The ability to manage transitions or handoffs from one setting to another when necessary (e.g. entry, transitions, and discharge);
- Interoperable health information technology and decision support systems that seek to meet or meet HHS/CMS EHR standards and which communicates between acute and post-acute care providers;
- The ability to monitor patient clinical status and coordinate medication; management as patient's progress across the acute and post-acute settings;
- The ability to track quality indicators and patient outcomes across an array of services and settings;
- The ability to manage medical complications and assume risk for readmissions;
- The ability to coordinate with other community services to foster the patient's independence, including coordination with providers of durable medical equipment, prosthetics, orthotics, and supplies; and,
- The ability to care for all types of patients including intense medical rehabilitation patients and medically complex patients.

**Mitigating Risk of "Soft-Steering"**

"Steering" of Medicare patients to certain providers may improve efficiency but this occurs at the expense of one of the paragons of Medicare policy: patient choice. "Soft steering" is a term often used to describe ways that hospitals and other providers can arrange systems of care that attempt to preserve patient choice to the maximum extent possible. CPR recommends that CMS exercise great caution if it permits "soft steering" by providers in bundled programs. CPR believes there can be negative consequences from this practice.

For example, in its most recent meeting (April 2015), the Medicare Payment Advisory Commission (MedPAC) discussed the use of "soft steering" that would allow hospitals, under specified guidelines, to encourage the use of certain providers, such as high quality, efficient providers. One concern is that the bundle holder may not have an adequate understanding of the difference between providers or provider types (such as the difference between inpatient hospital rehabilitation and skilled nursing). Additionally, the bundle holder may drive patients to "low cost" providers in order to retain a greater share of the savings, but putting beneficiaries at clinical risk in the process and potentially stinting on care. Alternatively, the bundle holder could "steer" patients to providers with which it has a financial relationship regardless of clinical need. In any event, the bundle holder should be required to continue to inform the beneficiary of his or her freedom of choice rights.

Therefore, CMS should carefully consider how BPCI providers can be given the flexibility to develop innovative relationships and require beneficiary protections, such as quality metrics, that ensure patients receive clinically appropriate care.

**Quality Measurement and Payment for Value**

Accurate measure of quality and outcomes is absolutely critical to ensuring that Medicare patients in bundled payment models receive the high quality care they deserve. CPR recommends that CMS use metrics that have a track record and are already collected, such as those from the Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP), whenever possible to reduce the burden

of actually collecting the measurement data. CPR also recommends the use of certain commonly used measures including medication reconciliation, the number of falls, pressure ulcers, and the rate of readmissions.

**High-Cost Outliers**

There are multiple approaches to addressing the concerns surrounding high cost patients that may merit higher payment to providers. Without such payments, providers will have financial incentives to refuse to accept certain patients: those who need health care services the most. CPR suggests, at least in the initial phases of bundling projects, that CMS exclude certain high cost cases such as certain strokes, brain injuries, spinal cord injuries, and complex trauma patients. Additionally, CPR recommends that CMS provide bonus payments to encourage providers to accept certain complex cases and avoid stinting on care. High cost outlier payments address some of the concerns regarding medically and functionally complex cases but CMS must be vigilant to ensure these patients receive the appropriate level of intensity, amount, duration, and scope of coverage they are entitled to and deserve.

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We greatly appreciate your attention to our concerns and your interest in our participation in this process. Should you have further questions regarding this information, please contact Steven Postal, CPR staff, by emailing Steven.Postal@ppsv.com, or by calling 202-466-6550.

Sincerely,

CPR Steering Committee


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