October 16, 2017

DELIVERED ELECTRONICALLY

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS–5524–P
Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

Ref: CMS–5524–P *Medicare Program; Cancellation of Advancing Care Coordination Through Episode Payment and Cardiac Rehabilitation Incentive Payment Models; Changes to Comprehensive Care for Joint Replacement Payment Model*

Dear Administrator Verma:

The undersigned organizations write as members of the Coalition to Preserve Rehabilitation (CPR) to comment on the above-referenced 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.

This proposed rule calls for the cancellation of the Episode Payment Models (EPMs) and Cardiac Rehabilitation (CR) incentive payment model as well as the rescission of the regulations governing these models. It would also revise certain aspects of the Comprehensive Care for Joint Replacement (CJR) model, including:

- Giving certain hospitals selected for participation in the CJR model a one-time option to choose whether to continue their participation in the model;
- Adding technical refinements and clarifications for certain payment;
- Revising reconciliation and quality provisions; and,
- Enacting a change to increase the pool of eligible clinicians that qualify as affiliated practitioners under the Advanced Alternative Payment Model (APM) track.

[1] *Medicare Program; Cancellation of Advancing Care Coordination Through Episode Payment and Cardiac Rehabilitation Incentive Payment Models; Changes to Comprehensive Care for Joint Replacement Payment Model*; Proposed Rule, 82 Fed. Reg. 39,310 (August 17, 2017). Available at: https://www.gpo.gov/fdsys/pkg/FR-2017-08-17/pdf/2017-17446.pdf.

Our comments will focus on the cancellation of the cardiac rehabilitation incentive payment model, and the revisions to the CJR model. We also recommend that CMS should take time to thoroughly assess the multiple bundled payment models it is currently implementing before implementing additional bundling programs, in order to assess the impact on beneficiary access to quality healthcare, including rehabilitative services and devices.

One of the primary reasons CPR has commented on mandatory bundling payment models in the past is the concern that patients may be underserved if sufficient quality indicators are not granular enough to truly assess whether bundled payment programs achieve savings through efficiencies or by stinting on patient care. Individuals with significant health care needs, such as people with disabilities and chronic conditions, are at particular risk for being underserved. For this reason, CPR believes certain conditions such as stroke, brain injury, spinal cord injury, complex neurological disorders, and other conditions should be exempt from mandatory bundled payment programs until such time that these mechanisms ensure patient access to quality care, particularly rehabilitation services and devices.

If Reinstated, Cardiac Rehabilitation Incentive Payments Should Not Be Coupled With A Bundled Payment Model

CMS' January 2017 Final Rule *Medicare Program; Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model (CJR)* provided newly created cardiac rehabilitation incentive payments to hospitals where beneficiaries are hospitalized for a heart attack or bypass surgery. The payments were based on beneficiary use of cardiac rehabilitation services in the 90-day care period following hospital discharge. Hospitals would use these payments to coordinate cardiac rehabilitation. These incentive payments were not tied directly to the bundled incentive payment program. Meanwhile, these providers would continue to receive standard Medicare payments for cardiac rehabilitation services for the affected beneficiaries. All beneficiaries under these models would have access to the same rehabilitation benefits currently available to them.

However, CMS noted that some commenters expressed concerns about the design of the CR incentive payment model waivers. Commenters stated that current direct supervision requirements would continue to contribute to a lack of access to cardiac rehabilitation services and would inhibit providers' ability to redesign care for the CR incentive payment model. Based on CMS' additional review and consideration of this and other stakeholder feedback, it concluded that the CR incentive payment model should be improved and more fully developed prior to the start of the model, and that moving forward with the implementation of the CR incentive payment model as put forth in the January 3, 2017 EPM final rule would not be in the best interest of beneficiaries or providers at this time. Based on our acknowledgment of the many concerns about the design of these models articulated by stakeholders, CMS proposed to cancel the CR incentive payment model before it began.

CPR supported the concept of cardiac rehabilitation incentive payments in the January 2017 final rule, but appreciates the above concerns. CPR believes that in the event this new incentive model is reinstated, it should not be coupled with a bundled payment model.

CMS Should Strengthen the CJR Model with More Robust Quality Metrics

The Comprehensive Care for Joint Replacement (CJR) model originally became effective on April 1, 2016 and mandated that hospitals in 67 specified metropolitan statistical areas (MSAs) must participate in an episode-based payment program for hip and knee joint replacement patients. The proposed rule, which would be effective February 1, 2018, reduces the mandatory participation in the CJR essentially

by one half to 34 MSAs. Hospitals in the other 33 MSAs would no longer be required to participate in the CJR model, but may elect voluntarily to participate in that program by notifying CMS by January 31, 2018. In addition, within the 34 MSAs for which participation is mandatory, identified low volume or rural hospitals also would no longer be required to participate but may elect to do so voluntarily.

CPR notes that CMS does not propose any changes to the CJR quality framework in this proposed rule. CPR recommends that CMS strengthens CJR quality reporting requirements so that providers are encouraged to focus on quality of care to a greater extent than focusing on reducing over-utilization (often at the expense of quality of care). CPR also recommends quality reporting requirements that discourage providers from stinting on care.

CPR recommends that CMS evaluate the CJR model based on measures such as patient experience of care, outcomes and quality, and access. CPR recommends that CMS make these findings readily available to the public online.

CJR Model Should Comply with *Jimmo* Decision

With all patients receiving care under the CJR model, it is imperative that patients receiving skilled maintenance care under the *Jimmo* settlement, which establishes coverage for skilled services to maintain or prevent deterioration of an individual's function not only to improve it, are not inadvertently or unfairly targeted or impacted.

CMS Should Refrain from Implementing Bundling Programs without Sufficient Data

CMS has been issuing mandatory bundling programs without fully assessing their true impact on patient outcomes or their care experience. As of July 2017, 713 participants (down from 836 in July 2016) were enrolled in Phase 2 of Model 3 (Retrospective Post Acute Care Only) of the Bundled Payments for Care Improvement program (BPCI),[2] while 529 participants (down from 601 in July 2016) were enrolled in Phase 2 of Model 2 (Retrospective Acute & PAC Episode) of the BPCI.[3]

In addition to bundling, there are also currently several other existing alternative payment models (APMs). Among Accountable Care Organizations (ACOs), there are 45 participating ACO Investment Models, 35 participating Advance Payment ACOs, 37 ESRD Seamless Care Organizations (ESCOs) participating in the Comprehensive ESRD Care Model, 44 participating Next Generation ACOs (up from 18 last year), and 8 participating Pioneer ACOs.[4] CMS' stated goal is to have 50% of patients in APMs by the end of 2018.[5]

CPR believes that there is presently insufficient data to accurately measure and appropriately assess the efficacy of bundling, in terms of patient outcomes, quality of care, quality of life, and from a cost perspective. While many of the members of CPR have constituents who are not directly affected by these APMs, the members of CPR are concerned about the potentially precedent-setting nature of these developments for other patient populations, including people with disabilities and chronic conditions. For example, we are concerned about the very concept of defining appropriate care based on a particular diagnosis or treatment. This sort of "rule of thumb" has long been found to conflict with Medicare law and policy, which requires an individualized assessment of each beneficiary's need.

[2] https://innovation.cms.gov/initiatives/BPCI-Model-3/index.html.
[3] https://innovation.cms.gov/initiatives/BPCI-Model-2/index.html.
[4] https://innovation.cms.gov/initiatives/ACO.
[5] https://innovation.cms.gov/initiatives/Health-Care-Payment-Learning-and-Action-Network/.

As stated earlier, all rehabilitation patients are vulnerable to bundling due to the risk of stinting on patient care. All bundled payment systems must contain sufficient risk adjustment factors and quality measures, so that savings do not occur at the expense of patient access and quality.

For these reasons, we encourage CMS to refrain from further expansion of current bundling/APM initiatives such as the CJR, and from implementing new bundling/APM initiatives such as bundling cardiac services or other bundling programs, until sufficient data has been gathered to determine that these payment models are, in fact, in the best interest of Medicare beneficiaries in need of rehabilitation. CPR also recommends that any future bundling program be voluntary in nature.

Appropriate PAC Quality and Outcome Measures

CPR recommends that quality measures be particularly strong in the CJR and any future bundling models, especially with regard to patient experience and pain measures. Quality measures must be mandated in any bundling regulation to assess whether patients have proper access to necessary care and are achieving maximum levels of recovery, health and function. This is one of the most important methods of determining whether savings are being achieved through better coordination and efficiency, or through denials and delays in services. It is important that the outcomes of these services be measured to assess their efficacy across PAC settings. Before widespread bundling that incorporates PAC services is adopted, measures must be incorporated into the PAC system as follows:

- Function: Incorporate and require the use of measures and measurement tools focused on functional outcomes, and include measurement of maintenance and the prevention of deterioration of function, not just improvement of function;
- Quality of Life: Require the use of quality of life outcomes (measures that assess a return to life roles and activities, return to work if appropriate, reintegration in community living, level of independence, social interaction, etc.);[6]
- Individual Performance: Measurement tools should be linked to quality outcomes that maximize individual performance, not recovery/rehabilitation geared toward the "average" patient;
- Access and Choice: Measures should include assessment of whether the patient has appropriate access to the right setting of care at the right time and whether the patient is able to exercise meaningful choice; and
- Patient Satisfaction: Measures should not be confined to provider-administered measures but should directly assess patient satisfaction and self-assessment of outcomes.

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We greatly appreciate your attention to our concerns. Should you have further questions regarding this information, please contact Peter Thomas, CPR Coordinator, by emailing Peter.Thomas@ppsv.com or by calling 202-466-6550.

[6] These extended functional assessment and quality of life measures are consistent with the World Health Organization's International Classification of Function, Disability and Health (ICF) and the measurement tool designed around the WHO-ICF known as the AM-PAC.

Sincerely,

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CPR Members

American Congress of Rehabilitation Medicine
American Occupational Therapy Association
American Physical Therapy Association
American Spinal Injury Association
American Therapeutic Recreation Association
Amputee Coalition
Association of Academic Physiatrists
Association of Rehabilitation Nurses
Association of University Centers on Disabilities
ACCSES
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Uniform Data System for Medical Rehabilitation
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