July 6, 2018

The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Washington, D.C. 20201

Re: Request for Information (RFI) on the Facilitation of Public-Private Dialogue to Increase Innovation and Investment in the Healthcare Sector

Dear Secretary Azar and Administrator Verma:

On behalf of the American Medical Rehabilitation Providers Association (AMRPA), we write in response to the Department of Health and Human Services' (HHS) Request for Information (RFI) seeking feedback regarding a workgroup to facilitate dialogue between HHS and those focused on innovating and investing in the health care industry.

AMRPA is the national voluntary trade association representing more than 625 freestanding rehabilitation hospitals and rehabilitation units of general hospitals (IRH/Us, or collectively referred to by Medicare as inpatient rehabilitation facilities (IRFs)), outpatient rehabilitation service providers, long-term care hospitals (LTCHs), and several skilled nursing facilities (SNFs). IRH/Us provide hospital-level care, which is significantly different in intensity, capacity, and outcomes from post-acute care provided in non-hospital settings. AMRPA members help patients maximize their health, functional ability, independence, and participation in society so they are able to return to home, work, or an active retirement. The majority of our members are Medicare participating providers and in 2016, IRH/Us served 350,000 Medicare beneficiaries with more than 391,000 stays.[1]

AMRPA appreciates the Department's solicitation of comments and we believe that proactive stakeholder engagement of this nature will pay dividends in developing truly innovative solutions to tackle the complicated challenges facing the health care industry. Our comments offer recommendations regarding the composition of the innovation workgroup and recommendations for optimizing the delivery of post-acute and medical rehabilitation care.

I. Need for Medical Rehabilitation and Post-Acute Care Representation

[1] Medicare Payment Advisory Commission, *Executive Summary*, in Report to the Congress: Medicare Payment Policy xx (Mar. 2018)

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Across all payers, approximately one in five patients are discharged to post-acute care (PAC) following an acute care hospitalization,[2] and 43 percent of Medicare beneficiaries are discharged to PAC.[3] PAC is a critically important part of the care continuum and any federal workgroup tasked with discussing health care innovation would be incomplete and misguided without substantive representation from PAC stakeholders. The rate of private sector innovation and investment in PAC has grown in recent years as both payers and providers increasingly recognize the critical role of post-discharge care in successful patient outcomes. Creating high-value PAC networks is a key priority for many stakeholders today as they prepare for innovative payment and care delivery reforms, such as value-based payments and population health management. It would behoove HHS to recognize where industry players are investing their resources and the Department could follow suit by ensuring that there is adequate PAC representation on its innovation workgroup.

The IRH/U sector has long been at the forefront of innovating and improving PAC delivery. Among the sites of care in the PAC continuum, which include LTCHs, SNFs, and home health agencies (HHAs), IRH/Us have the unique distinction of being the site of care that delivers both intensive rehabilitation services and hospital-level medical care.[4] In addition, IRH/Us provide care through a unique interdisciplinary team approach, which includes physical therapists, occupational therapists, speech-language pathologists, rehabilitation nurses, rehabilitation physicians, and other clinicians who work in a highly coordinated manner in order for a patient with a serious debility to regain function and quality of life.[5] Being the lone site of hospital-level care proficient at intensive therapy delivery for highly complex patients, IRH/Us have led the PAC industry in innovative approaches to recovery from complex injuries and conditions. **We strongly urge HHS to include IRH/U representatives on the workgroup. AMRPA would be pleased to serve as the representative for IRH/Us and other medical rehabilitation services.**

Due to Medicare's setting-specific and idiosyncratic PAC regulations, **AMRPA recommends that HHS also seek representatives from other PAC settings**. Representatives with experience specific to their care setting would be able to offer optimal relevant insights regarding perceived barriers to innovation in the industry and how the Department's programs or regulatory requirements affect them.

II. Increasing Transparency between CMS and IRH/U Stakeholders

The RFI also seeks comment more broadly on opportunities for increased engagement and dialogue between HHS and stakeholders, including alternatives to the workgroup structure discussed in the RFI.

AMRPA has previously recommended that the Centers for Medicare and Medicaid Services (CMS) develop a Post-Acute Care Advisory Council. This council would be

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[2] Tian, W. An All-Payer View of Hospital Discharge to Postacute Care, 2013. Healthcare Cost and Utilization Project 1-17 (May 2016).

[3] Medicare Payment Advisory Commission. A Data Book: Health Care Spending and the Medicare Program 76 (June 2017).

[4] *See* 42 C.F.R. § 412.622 (CMS Regulations Require IRH/Us to deliver at least 3 hours of therapy per day, in addition to providing close physician supervision of all patients and treatments, a feature unique among all sites of care).

[5] *See* Medicare Benefit Policy Manual § 110.2.5 - Interdisciplinary Team Approach to the Delivery of Care.

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dedicated to post-acute rehabilitation care, should be formed within CMS, and given a broad mandate to provide recommendations and ongoing advice to the Secretary and to the Congress on issues relating to Medicare coverage for post-acute rehabilitation services. The Advisory Council would have authority to review and comment on any CMS regulatory changes or activities impacting post-acute care providers, including: all rulemakings that impact medical rehabilitation providers and patient access to medical rehabilitation care; criteria for documenting medical necessity for post-acute admissions; and the proper use of available research funds and authorities focused on medical rehabilitation, among other topics. Given CMS' and other policy makers' interest in improving the disparate payment systems for different PAC sites of care, the Agency would benefit tremendously from a standing body with relevant expertise.

In response to previous RFIs, **AMRPA has also called on CMS to establish periodic Open Door Forum (ODF) conference calls with inpatient hospital rehabilitation providers** as a way to provide important updates on relevant CMS activities and to solicit stakeholder feedback. We believe that regular ODF calls—such as those that exist for other Medicare providers, including other PAC providers—would facilitate greater transparency and alignment in medical rehabilitation policy.

III. Recommendations for Innovating Post-Acute Payment and Care Delivery

A. Continuing Care Hospital (CCH)

AMRPA knows of no more promising way to revolutionize post-acute payment and care delivery than through testing and adoption of the Continuing Care Hospital (CCH) model. Congress statutorily directed the Center for Medicare and Medicaid Innovation (Innovation Center) to test the CCH model,[6] but the prior Administration declined to move forward to test and implement this Congressionally directed model. The model is not only a compelling alternative payment model (APM) but a promising care delivery system reform that would foster better, more coordinated, patient-centric care and disincentivize costly, disruptive and needless transfers. **The CCH should be implemented, as it would create important efficiencies, reduce administrative costs, and ultimately improve patient outcomes.**

The CCH model provides an opportunity to develop a patient-centered care model in which the "silos" established by the various site-specific PAC Medicare payment systems are eliminated. Care under the CCH model is delivered based on individual patient needs and characteristics rather than by conforming to the regulatory requirements of a particular setting. Specifically, the CCH model would organize care around the patient instead of the setting by consolidating different levels of post-acute rehabilitative care into a single enterprise with a single payment system and single method for measuring quality. The CCH could either be real (all care levels in a common physical space) or virtual (all levels operated as a single entity, but in two or more physically distinct locations). In either instance, the payment ramifications and corresponding bureaucratic processes, documentation requirements, and placement imbroglios of moving patients among PAC settings are circumvented, allowing clinicians to let these decisions to be driven by patients' clinical indicators.

[6] 42 U.S.C. § 1395cc-4(g).

In addition to the patient-centric orientation of care, the CCH has real potential to realize cost savings due to efficiencies and reduced administrative burden. Payments would be more reflective of actual cost and resource use, and would not include the considerable costs associated with transferring patients among PAC settings or with meeting the extensive and often redundant regulations of the current PAC payment systems.

CMS does not require any additional authorizing legislation or appropriations to launch the CCH model. Congress has also given CMS explicit authority to test the CCH model within the context of Innovation Center.[7] Accordingly, CMS should expeditiously test the CCH model as an important step in evaluating innovative PAC payment reforms.

B. The Continuing Care Network

In the absence of administrative action to test the CCH model or other promising PAC delivery system reforms, AMRPA is in the early stages of working with commercial payers to explore opportunities to streamline the delivery of PAC services in the private sector. AMRPA is leading a collaborative initiative to develop and test an integrated post-acute network, known as the Continuing Care Network (CCNet). The objective of the CCNet is to coordinate care across the PAC continuum and ensure patients are treated in the right setting at the right time. Notably, the IRH/U community is pioneering novel delivery and payment models for managed care and engaging private partners to test and ultimately adopt these approaches.

Like the CCH, the goal of the CCNet model is to break down the current PAC regulatory silos and create a full-spectrum continuing care collaborative that encompasses post-acute and continuing care with a patient-focused approach and novel incentives for improved outcomes. This approach aligns with the broader evolution in health care: moving toward unified payments that assess value based on both quality outcomes and total costs of care.

We are confident that the model presents an opportunity to integrate continuing care providers through partnerships with one another and with managed care organizations that could subsequently be tested through pilot projects—and ultimately expanded nationally—in the Medicare Advantage (MA) program. AMRPA intends to share what is learned from the CCNet with HHS and other policymakers so that we can ensure this evidence base is factored into future innovations in the Medicare program.

IV. Recommendations to Overcome Barriers to Innovation: Inpatient Rehabilitation Hospital and Units Need Regulatory and Pricing Flexibility

A. Regulatory Flexibility

It is critical for IRH/Us to have sufficient regulatory flexibility to optimally deliver care in an evolving health care environment. To facilitate care innovation, **CMS should provide IRH/Us with greater flexibility by waiving siloed regulatory requirements such as the 60 Percent Rule and the intensity of therapy requirement.**
CMS and the Innovation Center clearly retain the regulatory authority to waive these requirements, and the Agency has made similar concessions for other providers,

[7] *Id*. § 1315a(b)(2)(B)(xiii).

particularly in the context of APMs. For example, in the Medicare Shared Saving Program (MSSP), Next Generation Accountable Care Organizations, Bundled Payment for Care Improvement (BPCI) initiative, and Comprehensive Care for Joint Replacement (CJR) program, CMS waived significant regulations such as the well-established rule necessitating a minimum three-day inpatient stay prior to covered SNF services.[8] Furthermore, these regulatory changes have been favorably discussed by MedPAC in the context of reforming and advancing Medicare's PAC payment systems.[9]

Unlike other hospitals participating in Medicare, in order for IRH/Us to receive payment under their prospective payment system, they must have a patient mix that fits a very specific criterion. Known as the "60 Percent Rule," the regulation mandates that 60 percent of all IRH/U patients (across all payers) must have diagnoses derived from 13 medical conditions. This list of 13 conditions is extremely outdated, having been revised only once since its inception in 1983, and limits IRH/Us' ability to evolve with the ever-changing medical treatment landscape. Innovations and advances in medicine over the past four decades have enabled patients with other serious diagnoses to not only survive acute care hospitalizations, but to also benefit tremendously from the intensive and multidisciplinary rehabilitation program provided in IRH/Us. However, these patients are often denied admission because they do not meet 60 Percent Rule compliance. **Hence we ask that CMS grant IRH/Us relief from the 60 Percent Rule to afford IRH/Us the much-needed flexibility to expand and make care accessible to all patients who need intensive rehabilitation services.**

Similarly, CMS should relax the intensity of therapy requirement, also known as the "3-Hour Rule." This rule dictates that an IRH/U must provide three hours of therapy per day, at least five days a week, and only certain types of therapy services satisfy the requirement. To keep pace with the advances in medical rehabilitation, the requirement should, at a minimum, be changed to include additional types of therapy services and modalities. AMRPA has previously provided comments to CMS on ways to increase efficiencies and reduce redundancies for IRH/Us.[10] We suggest the Department refer to those comments for our detailed recommendations regarding the 60 Percent Rule and 3-Hour Rule.

B. Alternative Pricing/Reimbursement

CMS encourages IRH/Us to participate in payment and care delivery innovations such as bundled payment models and other APMs. However, Medicare reimbursement for rehabilitation hospital services is very rigid, with a fixed per-patient discharge prospective payment system based largely on factors outside of the IRH/U's control (*e.g.*, principal diagnosis in the preceding hospitalization). In contrast, other PAC providers have a greater degree of control over their Medicare costs, namely through reducing their

[8] *E.g.*, Centers for Medicare and Medicaid Services, Medicare Shared Savings Program: Skilled Nursing Facility 3-Day Rule Waiver, Guidance Document v. 3 (June 2017).

[9] Medicare Payment Advisory Commission, *Mandated report: Developing a unified payment system for post-acute care*, in Report to Congress: Medicare and the Health Care Delivery System 93 (June 2016).

[10] See AMRPA comments regarding CMS' Request for Information within Medicare Program: Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2018 (CMS-1671-P), available at https://www.regulations.gov/document?D=CMS-2017-0059-0063.

"units" of utilization in either a per diem payment system (nursing homes) or a fixed-length episodic payment system (home health). **CMS should provide IRH/Us the flexibility to be responsive to market-based dynamics and not be constrained by an inelastic Medicare fee structure that effectively prices them out of APMs.**

APMs encourage providers to produce high-quality outcomes at a reduced cost. Unlike some other PAC providers, however, IRH/Us are paid on a per-discharge basis for patients and do not have the flexibility to reduce their costs, or charges to the Medicare program, in this sense. Many innovation care models therefore incentivize the risk-bearing entities to steer patients away from receiving hospital-level rehabilitation, even when it is imperative to patients' recovery. CMS observed this very pattern in BPCI, finding that "numerous" BPCI participants "attempted to reduce episode payments by reducing institutional PAC use."[11] This has resulted in a dramatic 61 percent drop in utilization of institutional PAC services.[12]

For IRH/Us to be able to remain a competitive and viable PAC setting within APMs, **we recommend that CMS allow IRH/Us to receive reduced reimbursements, and/or a per diem payment, or otherwise offer a discount from payments received under the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) if they so choose.** Although this would likely result in IRH/Us being paid below cost for treating some patients in these programs, the alternative—that patients are denied access to inpatient rehabilitation altogether—is far worse for Medicare patients and the IRH/U providers who serve them. Since margins are very small or negative for the majority of IRH/Us,[13] pricing flexibility must be voluntary, as should all alternative payment and care delivery concepts being tested.

C. Administrative Presumption of Medicare Coverage under APMs

All patients admitted to IRH/Us from upstream hospitals in an APM, regardless of whether the IRH/U is receiving IRF PPS rates or reduced reimbursement, should be presumed to be covered in the rehabilitation hospital setting. IRH/Us often are denied payment by Medicare contractors due to differing and evolving interpretations of medical necessity or technical requirements for patient stays. Appealing these decisions is resource-intensive and costly for providers. When providers bear downside financial risk for patients' through the APM, contractors should not be permitted to deny cases on these grounds. **Specifically, CMS' contractors should not be permitted to deny payment for cases treated under APMs based on pre-payment review or post-payment reopening, unless there is evidence of fraud.** APM participants are responsible for the cost and quality of care for the patients under their bundle and thus are already held accountable for their post-acute care placement decisions by virtue of the performance metrics and outcomes used in the APM. Hence if an upstream hospital chooses to

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[11] The Lewin Group, CMS Bundled Payments for Care Improvement Initiative Models 2-4: Year 3 Evaluation & Monitoring Annual Report ES-6, 82. (Oct. 2017).
[12] *Id.* at ES-5. Per Lewin, for BPCI Model 2 episodes where institutional PAC settings include IRH/Us, LTCHs, and SNFs.
[13] For FY 2018, 43 percent of IRH/Us with available data had negative Medicare margins (below 0 percent) and 52 percent of IRH/Us had margins below 5.0 percent, based on AMRPA analysis of CMS Final Rule FY 2018 Inpatient Rehabilitation Facility Prospective Payment System rate setting files.

discharge patients to an IRH/U, they should have full discretion to do so without Medicare contractor interference.

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AMRPA again thanks HHS for its focus on innovation while mitigating burdensome regulations that hinder health care stakeholders' ability to realize the full potential of emerging best practices. If you have any questions about our comments, please contact Carolyn Zollar, JD, Executive Vice President for Policy Development and Government Relations of AMRPA (202-860-1002, czollar@amrpa.org) or Mimi Zhang, Senior Policy and Research Analyst (202-860-1003, mzhang@amrpa.org).

Sincerely,

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