AMRPA
AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

May 1, 2018

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Adam Boehler
Deputy Administrator for Innovation and Quality and Director
Center for Medicare and Medicaid Innovation
7500 Security Boulevard
Baltimore, MD 21244

Amy Bassano
Deputy Director
Center for Medicare and Medicaid Innovation
7500 Security Boulevard
Baltimore, MD 21244

Re: Bundled Payment for Care Improvement (BPCI) Advanced

Dear Administrator Verma, Director Boehler, and Deputy Director Administrator Bassano:

On behalf of the American Medical Rehabilitation Providers Association (AMRPA), we write in response to the Center for Medicare and Medicaid Innovation's (Innovation Center) announcement of the Bundled Payment for Care Improvement (BPCI) Advanced model. Like many health care providers, AMRPA members have been anticipating BPCI Advanced since the model was first referenced in the Episode Payment Models (EPM) final rule last year. However, we and our members were disappointed by the scope and nature of BPCI Advanced, most specifically by the discontinuation of the post-acute care-initiated bundle episodes and by the lack of functional status quality measures. Our comments delineate concerns with BPCI Advanced and offer our recommendations for enhancing the model in future program years. We believe adoption of our proposals will allow BPCI Advanced to properly balance enhancing economic efficiency and coordination of care while concurrently maximizing beneficiaries' health outcomes and preserving their freedom of choice.

AMRPA is the national trade association representing more than 600 freestanding inpatient rehabilitation hospitals and rehabilitation units of general hospitals (collectively referred to as inpatient rehabilitation facilities (IRFs) by Medicare), outpatient rehabilitation service providers, long-term care hospitals (LTCHs), and several skilled nursing facilities (SNFs). Inpatient rehabilitation hospitals and units (IRH/Us) provide hospital-level care, which is significantly different in intensity, capacity, and outcomes from post-acute care (PAC) provided in non-hospital settings. AMRPA members help their patients maximize their health, functional ability, independence, and participation in society so they are able to return to home, work, or an active retirement.

RICHARD KATHRINS, PhD · CHAIR, AMRPA BOARD OF DIRECTORS
President and Chief Executive Officer, Bacharach Institute for Rehabilitation
1710 N Street NW, Washington, DC 20036 · Phone: 202-591-2469 · Toll-Free: 888-346-4624 · Fax: 202-591-2445

The majority of our members are Medicare participating providers and, on average, Medicare Part A payments represent more than 60 percent of IRH/U revenues.[1] In 2016, IRH/Us served approximately 350,000 Medicare beneficiaries, representing more than 391,000 stays.[2] Further, several AMRPA members served as Episode Initiators in BPCI Model 3 and many others participated as care partners under Model 2 (the same model that forms the basis of BPCI Advanced).

We commend the Innovation Center for continuing voluntary participation in BPCI Advanced. In order for pilot models to be able to evince best practices in a sustainable and scalable manner, it is critical that these lessons first be demonstrated within health care organizations that have the desire, adequate resources and bandwidth to do so, particularly in a capitated payment environment. AMRPA has a demonstrated track record of supporting CMS in its pursuit of innovations that align incentives to improve the quality and outcomes of beneficiaries' care. We have engaged with the agency's various initiatives for care and payment model innovations, providing comments on the EPMs and Comprehensive Care for Joint Replacement (CJR) rules, Health Care Payment Learning and Action Network (HCP LAN) white papers on bundled payments and, most recently, in response to the Innovation Center's "New Directions" request for information. In 2013, an AMRPA subsidiary submitted a proposal to the Health Care Innovation Awards Round 2 to develop a PAC delivery and payment model under which payments are based on patient characteristics, not site of care, and tied to quality outcomes. Delivering efficient care in a patient-centric and quality-driven manner is core to IRH/Us' mission and AMRPA is committed to exploring ways to achieve that mission.

I. Need for Functional Status Quality Measures

The pursuit of value-based care, in which "value" is defined as outcomes divided by cost, can only be as robust as the data in the numerator and the denominator of this ratio. By that token, we think the current BPCI Advanced quality measure set is completely inadequate to address outcomes and should be improved and expanded to mandate inclusion of functional outcome measures that are critically important and meaningful to patients. Any model seeking to deliver patient-centered care needs to include in its quality framework measures that evaluate patient functional status, functional improvement, and the patient's ability to sustain these improvements over longer periods of time.

In rehabilitation, no quality domain is more important than functional outcomes. It entails measuring patients' gains in cognitive and physical function and is a fundamental metric of the total impact and value of rehabilitative care. Individuals with higher function are more capable of caring for themselves, more likely to remain in the community, and better equipped to return to work or an active retirement. Patients' achievement of meaningful gains in activities of daily living (ADLs) and instrumental activities of daily living (IADLs) is highly indicative of their

[1] Medicare Payment Advisory Commission, Report to Congress, Medicare Payment Policy, 267 (Mar. 2018).

[2] *Id*.

long-term health and well-being, in addition to their future resource use and level of independent living and community integration post injury or illness.[3,4,5] Functional status is clearly a driver of resource utilization. The Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS), for instance, is predicated upon the causal relationship between a patient's level of function and their resource use, and sets a precedence for CMS' recognition of this relationship. Research has also shown functional status to significantly outperform comorbidities as a predictor of a patient's likelihood for readmissions following hospital discharge.[6]

Although CMS states it "may look favorably" on BPCI Advanced applications with measures addressing "patient functionality," we find the noncommittal sentiment of this statement extremely problematic.[7] It certainly understates the extraordinary value of functional outcomes measures. A bundled payment model without adequate quality safeguards carries the risk of incentivizing providers to limit costs and stint on care, instead of prioritizing patient well-being, return to function, and quality of life. Several Clinical Episodes in BPCI Advanced involve patients in need of significant hospital-level rehabilitative care, such as stroke, cervical spinal fusion, and back and neck issues. Many stroke and spinal injury patients require intensive rehabilitation services to recover and improve function. Recent clinical guidelines published by the American Heart Association/American Stroke Association recommend acute hospital-level care for post-stroke rehabilitation.[8] Consistent with this guideline, CMS found that BPCI Model 2 stroke patients experienced functional improvements when treated in IRH/Us compared with relative declines in other PAC settings.[9]

The human cost and impact of denied medically necessary care is devastating. Unfortunately, it is relatively easy for bundle holders to reduce Medicare Spending Per Beneficiary (MSPB) by denying patient access to timely and intensive rehabilitation services and diverting beneficiaries

---

[3] Arling, G.,Williams, A. R. Cognitive impairment and resource use of nursing home residents a structural equation model. Medical Care , 41 (7), 802–812. 2003

[4] Millán-Calenti, J. C., Tubío. Prevalence of functional disability in activities of daily living (ADL), instrumental activities of daily living (IADL) and associated factors, as predictors of morbidity and mortality. Archives of Gerontology and Geriatrics, 50 (3), 306–310. 2010.

[5] Ramos, L. R., Simoes, E. J., & Albert, M. S. Dependence in activities of daily living and cognitive impairment strongly predicted mortality in older urban residents in Brazil: A 2-year follow-up. Journal of the American Geriatrics Society, 49 (9), 1168–1175. 2001

[6] Shih, S., Gerrard, P. Functional Status Outperforms Comorbidities in Predicting Acute Care Readmissions in Medically Complex Patients. Journal of General Internal Medicine. (30)11, 1688-95. 2015

[7] CMS, Bundled Payments for Care Improvement Advanced Request for Applications (RFA). January 8, 2018.

[8] American Heart Association/American Stroke Association, Guidelines for Adult Stroke Rehabilitation and Recovery. May 4, 2016.

[9] The Lewin Group, CMS Bundled Payments for Care Improvement Initiative Models 2-4: Year 3 Evaluation & Monitoring Annual Report (Oct. 2017). 260. Lewin states: "Seven of eight measures using assessment data pointed to a relative decline in functional improvement for BPCI [Model 2 stroke] patients who received post-acute care (PAC) in home health agencies (HHAs) and skilled nursing facilities (SNFs) long enough to have two patient assessments, although only two of the changes from the baseline to intervention period were statistically significant. In contrast, both measures assessing functional limitations for patients treated by inpatient rehabilitation facilities (IRFs) pointed to relative improvements for BPCI patients."

with the above-cited conditions to less intense levels of post-acute care. It is also relatively easy to reduce PAC costs by limiting or restricting the amount, duration, and scope of rehabilitation services and devices. It would be short-sighted for CMS to focus solely on achieving Medicare savings in the short term when unnecessary disability and lack of function would lead to far greater expenditures in the long term. Less independent living, greater levels of sedentary living, greater dependence on home care, and greater reliance on mobility aids and equipment contribute to high, long-term costs that could be averted through timely, intensive and appropriate rehabilitation services and devices. Medicare reforms should be built upon a solid base that prioritizes patients' health and functional outcomes above all and certainly values these factors over pure cost-containment.

We recommend the Innovation Center recognize the importance of functional outcomes measures by making them mandatory in the BPCI Advanced quality reporting framework starting in Program Year 2. In the interim, CMS should offer financial incentives to providers that elect to report these measures, as done in CJR, in the first Program Year.

II. Inclusion of Post-acute Care Providers as Episode Initiators

We are disappointed that PAC providers are excluded from being Episode Initiators in BPCI Advanced and that the BPCI Model 3 will effectively be discontinued with the advent of BPCI Advanced. As observed in the current BPCI program, there is significant opportunity for more hospital-level PAC providers such as IRH/Us to be Episode Initiators in voluntary bundled payment models. AMRPA supports PAC delivery and payment reform; it is demonstration pilots like BPCI Advanced that will enable providers to explore more efficient ways to deliver care while maintaining or ideally improving patient outcomes.

We believe there is far greater evidentiary basis for expanding PAC-initiated episodes than physician-group practice-initiated (PGP) episodes. Although PGP-initiated episodes account for over half (53 percent) of BPCI Model 2 and Model 3 episodes, CMS has yet to evaluate and assess their impact in the three BPCI Evaluation Reports to date.[10] AMRPA appreciates that BPCI Advanced was designed as a vehicle to enable physicians and other eligible clinicians to meet the requirements of the Quality Payment Program (QPP). Nonetheless, it is critical that CMS builds innovation models on a solid base of evidence and understanding of the potential impact to cost savings and, most importantly, patient well-being.

CMS cites observed changes in patient mix under BPCI, or "cherry-picking," as one reason why there is not a PAC-initiated bundle in BPCI Advanced.[11] It appears, however, that CMS has already addressed patient selection issues by using a Final Target Price in BPCI Advanced which

[10] *Id* at 435. Lewin writes that "One of the most important advances in this evaluation over the next year will be analyzing the impact of BPCI among the BPCI-participating PGPs. As of Q3 2015, PGPs accounted for approximately 40% of Model 2 EIs and 13% of Model 3 EIs. The final annual report will include the experience of PGPs and the impact of BPCI on PGP-initiated episode costs and quality. This will help complete the picture of BPCI on multiple outcomes across all types of EIs."

[11] CMS, BPCI Advanced General Frequently Asked Questions (FAQs), January 2018.

would be adjusted for the actual mix of patients admitted under the model. Any perceived challenges associated with PAC-initiated episodes, whether related to development or implementation, cannot be resolved by wholly excluding the sector from participating in bundling initiatives as Episode Initiators. A commitment to aligning provider and patient incentives entails a commitment to engage the full continuum of providers involved in patient care, especially those providers that are most familiar with the post-acute care needs of patients.

We urge CMS to include PAC providers as eligible Episode Initiators in BPCI Advanced at least beginning in Program Year 2.

Furthermore, the criterion to use Certified Electronic Health Record Technology (CEHRT) poses a restrictive barrier for post-acute care providers to participate in BPCI Advanced, even as care partners. PAC settings were excluded from the Electronic Health Record Incentive "Meaningful Use" Program and they lag behind hospitals and physician offices in both EHR and health information exchange (HIE) adoption.[12,13] Again, AMRPA appreciates that the BPCI Advanced model was designed to satisfy the definition of an Advanced APM under the QPP. While many IRH/Us have transitioned or are in the process of transitioning to electronic medical records, they may lag behind their acute care hospital counterparts in being able to meet the specified CEHRT criteria established for Advanced APMs.

We recommend CMS revise and adapt the CEHRT requirements to allow more PAC providers to be able to participate in BPCI Advanced.

III. Patient Choice

Unfortunately, there is limited literature to date on the impact of bundled payment models from the patient or caregiver perspective or on their experience of care. What is available however suggests that hospitals may not be satisfactorily transparent or timely in their patient interactions, including communicating to patients that their care will be provided under a bundled environment and what that means, the financial implications therein, and providing a thorough list of the post-discharge care options with meaningful information on the quality of care available.[14] The BPCI Evaluation report makes similar observations regarding patient experience of care, finding that patients in several BPCI Model 2 clinical episodes reported significantly worse experiences than their non-BPCI counterparts. These results include:

- Patients with major joint replacement of the lower extremity were less likely to agree that they were discharged at the right time, and less likely to agree that medical staff clearly explained what follow-up care is needed prior to discharge.

[12] Dougherty, M. Long-Term And Post-Acute Care Providers Engaged In Health Information Exchange: Final Report to the HHS Office of the Assistant Secretary for Planning and Evaluation. October 29, 2013

[13] Wolf, L., Harvell, J., & Jha, A. K. Hospitals ineligible for federal meaningful-use incentives have dismally low rates of adoption of electronic health records. Health Affairs, 31(3), 505-513. March 2012.

[14] Joff, T. The Battle Of The Bundle: Lessons From My Mother's Partial Hip Replacement. Health Affairs, 36(8), 1511-1514. August 2017.

- Patients with pneumonia were less likely to agree that their care preferences for post-discharge services were considered, or that they understood how to take care of themselves after discharge.
- Sepsis patients reported significantly worse outcomes on multiple experience of care measures, including:
    - Having always received the appropriate level of care;
    - Patient preferences being taken into account in deciding post-discharge care;
    - Receiving conflicting information from medical staff; and
    - Medical staff always speaking to them in their preferred language.[15]

For BPCI Advanced to succeed for all parties involved, but especially for patients and their families/caregivers, patients must have full confidence that the decisions being made about their care are indeed in their best interests. It is imperative for CMS to ensure that Medicare beneficiaries retain their freedom of choice when they are placed in a model in which one entity bears financial risk for the total cost of care across multiple provider settings.

To address these concerns, we recommend that:

- **CMS require BPCI Advanced participants to notify BPCI Advanced-eligible beneficiaries of their inclusion in the model as early as possible and in each step of the care continuum to the extent possible** (though we recognize this may be more administratively challenging for certain urgent/emergent clinical episodes).
- **Episode Initiators should provide BPCI Advanced beneficiaries with a list of all available post-acute care providers (IRH/Us, SNFs, LTCHs, HHAs) in their service area as part of the discharge planning process**. **The list should distinguish between those providers who are included or not included within any narrow or "preferred provider" networks used by the Episode Initiator for BPCI Advanced purposes.**
- **BPCI Advanced beneficiaries should also be informed as to the differences in the quality and intensity of care, capacity, and out-of-pocket costs among their various post-acute care options**.

IV. IRH/Us Need Alternative Reimbursement/Pricing and Regulatory Flexibility

CMS has encouraged IRH/Us to participate in 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 "units" of utilization in either a per diem payment system (nursing homes) or a fixed-length episodic payment system (home health). Although IRH/Us are encouraged to participate in models in which their services are part

[15] The Lewin Group, CMS Bundled Payments for Care Improvement Initiative Models 2-4: Year 3 Evaluation & Monitoring Annual Report (Oct. 2017). 97-98.

of a broader bundle, they are not given sufficient flexibility to control the resources that are utilized under the bundle.

To facilitate innovation of care delivery, CMS should grant 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 bundled payment programs.

In addition to pricing flexibility, CMS and the Innovation Center clearly retain the regulatory authority to waive some or all of the restrictive requirements in the context of these models, and have made similar concessions for other providers. For example, in the context of APMs such as the Medicare Shared Saving Program (MSSP), Next Generation Accountable Care Organizations, BPCI, and CJR, CMS waived significant regulations such as the well-established rule necessitating a minimum three-day inpatient stay prior to covered SNF services.[16] Nevertheless, the agency has been unwilling to waive certain regulatory requirements that must be relaxed to facilitate IRH/U participation in these programs. Accordingly, various regulatory requirements should be waived in the context of specific APMs to allow IRH/Us to participate.

A. ***Alternative Reimbursement/Pricing***: Because BPCI Advanced holds short-stay acute care hospitals (STACHs) and PGPs responsible for PAC spending, it encourages IRH/Us, and other PAC providers, to produce high-quality outcomes at a reduced cost. Unlike some other PAC providers, however, rehabilitation hospitals are paid on a per-discharge basis for patients. Medicare rules do not allow IRH/Us to "charge less" in this context. Existing bundling programs therefore incentivize bundle-holders to steer patients away from receiving hospital-level rehabilitation, even when it is imperative to patients' recovery. CMS' latest BPCI Evaluation report revealed this very pattern in BPCI Model 2, finding that "numerous" BPCI participants "attempted to reduce episode payments by reducing institutional PAC use."[17] This has resulted in a dramatic drop in the number of beneficiaries being discharged to institutional PAC settings, with institutional PAC use declining in almost two out of three (61 percent) Model 2 episodes.[18]

For IRH/Us to be able to remain a competitive and viable PAC setting within APMs, we recommend that CMS permit IRH/Us to receive reduced reimbursement, a per diem payment, or otherwise offer a discount from the IRF PPS amount if they so choose. Although this likely means that IRH/Us will be 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

[16] 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).

[17] The Lewin Group, CMS Bundled Payments for Care Improvement Initiative Models 2-4: Year 3 Evaluation & Monitoring Annual Report (Oct. 2017). ES-6, 82.

[18] *Id.* at ES-5. Per Lewin, institutional PAC settings include IRH/Us, LTCHs, and SNFs.

who serve them. Since margins are very small or negative for the majority of IRH/Us,[19] pricing flexibility must be voluntary, as should all alternative payment and care delivery concepts being tested.

Regulatory Flexibility: It is critical for IRH/Us to have sufficient regulatory flexibility to ensure they are able to deliver appropriate care in the bundled payment context. **AMRPA recommends that CMS relax the IRH/U intensity of therapy standard for those APM cases for which the provider has elected to receive reduced reimbursement.** Specifically, the so-called 3-Hour Rule (which CMS has traditionally interpreted to rigidly require three hours of intensive individualized therapy each day for five days per week that a patient is in an IRH/U) should not apply to cases for which the IRH/U has elected to receive reduced reimbursement under an APM framework.

In addition, CMS should afford IRH/Us the option of including patients admitted under an APM as counting towards the IRH/U's compliance with the 60 Percent Rule. 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. These 13 conditions are extremely outdated, having been expanded only once since their inception in 1975 (from 10 to 13 conditions), and limit 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 the option of counting patients admitted under APMs towards their satisfaction of the 60 Percent Rule; this would afford IRH/Us the much-needed regulatory flexibility to more fully participate in alternative care and payment delivery models.

These approaches are consistent with CMS' recent emphasis on expanding provider access to APMs, and has been favorably discussed by MedPAC in the context of reforming and advancing Medicare's post-acute care payment systems. CMS has the authority to permit such flexibility, and to waive these bureaucratic requirements without Congressional approval; the agency should do so when promulgating any future models or changes to the current programs.

B. ***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

[19] 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.

receiving IRF PPS rates or reduced reimbursement, should be presumed to be covered in the rehabilitation hospital setting. **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.** Episode Initiators 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 a BPCI Advanced STACH or PGP chooses to discharge patients to an IRH/U, they should have full discretion to do so without Medicare contractor interference. CMS should instruct its contractors to respect PAC referrals and admission determinations under APMs such as BPCI Advanced.

AMRPA urges CMS to introduce more regulatory flexibility, such as allowing alternative pricing, relaxing siloed regulatory requirements, and presuming IRH/U coverage to allow for IRH/Us to fully participate in CMS efforts to create a more efficient Medicare system.

* * *

AMRPA members are committed to Medicare innovations that truly place patients back at the center of their care and achieve high-quality and meaningful long-term outcomes for beneficiaries. We welcome the opportunity to meet with the Innovation Center to further discuss our ideas in this area. Thank you for your consideration of these comments as the Innovation Center continues implementation of BPCI Advanced. If you have any questions, do not hesitate to contact Carolyn Zollar, JD, Executive Vice President for Policy Development and Government Relations of AMRPA (202-223-1920, czollar@amrpa.org) or Mimi Zhang, Senior Policy and Research Analyst (202-223-1920, mzhang@amrpa.org).

Sincerely,

Richard Kathrins, PhD
Chair, AMRPA Board of Directors
President and CEO, Bacharach Institute for Rehabilitation