June 10, 2024

The Honorable Chiquita Brooks-LaSure
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1808-P
P.O. 8013
Baltimore, MD 21244-8013

Submitted electronically to http://www.regulations.gov

Re: Medicare and Medicaid Programs and the Children's Health Insurance Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2025 Rates; Quality Programs Requirements; and Other Policy Changes [Docket Number: CMS-1808-P]

Dear Administrator Brooks-LaSure:

On behalf of the American Medical Rehabilitation Providers Association (AMRPA), we appreciate the opportunity to comment on the Fiscal Year (FY) 2025 Inpatient Prospective Payment System (IPPS) proposed rule, published in the Federal Register on May 2, 2024. Our comments are focused solely on the proposed Transforming Episode Accountability Model (TEAM), through which the Centers for Medicare and Medicaid Services (CMS) will require selected acute care hospitals to participate in a five-year mandatory episodic payment model starting in CY 2026. While inpatient rehabilitation hospitals and units will not qualify as "initiators," the current model structure stands to have a significant and immediate impact on post-acute care utilization and care delivery – particularly for patients in need of inpatient rehabilitation. We therefore urge CMS to adopt AMRPA's recommended refinements to the model, which will help preserve patient access to medically necessary inpatient rehabilitation care and promote longer-term functional recovery and outcomes.

AMRPA is the national trade association representing more than 700 inpatient rehabilitation hospitals and units (referred to by CMS as Inpatient Rehabilitation Facilities, or IRFs). Our members focus on the care and functional recovery of some of the most vulnerable Medicare beneficiaries, such as traumatic brain injury, stroke, and spinal cord injury patients. Given the complexity and long-term trajectory of medical rehabilitation patients' care and recovery, IRF admission determinations and referrals for post-discharge services (e.g., outpatient therapy, home health services) are determined by patients' treating physicians and their multi-disciplinary care teams. This in turn drives IRF patients' strong rates of return to home and community compared to other PAC settings and helps prevent avoidable post-stay complications and readmissions.

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AMRPA is seriously concerned, therefore, by numerous TEAM components that would force care delivery decisions to be made primarily in consideration of a short-term target price. Without refinement, this model may significantly limit or eliminate acute-care hospitals' ability to utilize post-acute care (PAC) services following the covered surgical procedures, which will consequently impact patients' long-term recovery, likelihood of rehospitalizations, and other adverse consequences following the short episode window. These concerns are compounded by the mandatory nature of the demonstration, proposed episode length, and inadequate quality measures, all of which will create significant access and patient choice-related issues for beneficiaries following their underlying procedure.

Furthermore, AMRPA notes that the current TEAM proposal shares characteristics with other Center for Medicare and Medicaid Innovation (CMMI) models, such as the various Accountable Care Organization programs and Comprehensive Care for Joint Replacement (CJR), among others. These types of models often use financial incentives that complicate referrals to higher-cost PAC settings (such as inpatient rehabilitation) despite the long-term value proposition of the care furnished by such providers. As an initial matter, we question what new data or insight CMS stands to gain from TEAM, given the fact that it has already tested the five TEAM clinical episodes across other CMMI models with essentially the same program design (requiring that care delivery decisions be made based on a target price with relatively few or meaningful quality measures that require long-term accountability for patient care). These types of programs are particularly ill-suited for the Medicare population and often result in higher spending outside of the specified episode length. This may be a contributing factor to CMS' challenges in achieving savings across its models, with a Center for Medicare and Medicaid Innovation (CMMI) white paper recently noting that only six out of the 50+ CMMI models have "generated statistically significant savings to Medicare and to taxpayers." While AMRPA appreciates CMS' efforts to modernize the Medicare program and achieve savings, we encourage CMS to consider a markedly different approach to TEAM with the goal of improving outcomes and spending in a way that similarly structured models have been unable to achieve.

For all these reasons, AMRPA urges CMS to implement the following key reforms to TEAM:

- **Episode Length:** In order to promote longer-term and more sustainable improvements in care delivery, outcomes, and spending, AMRPA recommends that CMS adopt an episode length of at least 60- or 90-days, with corresponding changes to the target price.

- **Voluntary Participation:** Given that TEAM will directly impact patients' post-surgical treatment options, it is imperative that early initiators have the requisite experience, competencies, and robust post-acute care referral partners to ensure patients receive high-quality and appropriate levels of care throughout the episode. AMRPA therefore recommends that the demonstration include a period of voluntary participation and evaluation before moving to mandatory participation.

- **Fewer Conditions Subject to Testing:** AMRPA recommends that CMS commence the demonstration with fewer covered conditions to reduce the burden and potential care disruptions within TEAM. We particularly urge CMS to reconsider the mandatory inclusion of spinal fusion and coronary artery bypass grafting (CABG), given the risk that the target price could be largely eroded by the underlying procedure and therefore limit patients' ability to receive medically necessary post-discharge items and services.

- **Longer Leadtime to Upside Risk:** In order to ensure that hospitals do not limit or eliminate post-acute care referrals based on target price-related pressures, CMS should provide a longer period of upside-only risk. This would allow hospitals and their PAC partners to determine whether target prices for certain conditions need to be refined (prior to a move to downside risk) such that they do not impede access to medically necessary care. Furthermore, a longer upside-only risk period better positions TEAM hospitals and their PAC partners with opportunities to adopt innovative care models (consist with TEAM objectives) rather than simply push patients into lower-cost PAC settings due to the model's pricing structure.

- **Meaningful Quality Measurements that Limit Administrative Burden and Incentivize Patients' Full Functional Recovery:** While CMS asserts its intent to reduce the administrative burden for initiating hospitals through the selection and use of the three proposed measures, AMRPA is strongly concerned that these measures will make it particularly challenging for IRFs to produce reliable and valid information for their TEAM quality reporting requirements. Furthermore, AMRPA encourages CMS to look for opportunities to utilize quality measure information collected as part of the IRF QRP (as well as other PAC settings that may be part of TEAM episodes) to bolster the TEAM quality measurement requirements. Lastly, and consistent with AMRPA's past comments on similar CMMI models, we recommend that CMS include one or more functional status measures as part of the quality measures included in this proposal.

- **Accounting for Patient Choice and Treatment Preference:** AMRPA urges CMS to ensure that beneficiaries are fully informed about their inclusion in the model and the potential impact on their care. Further, in addition to providing patients with a list of all available post-acute care providers, patients' preferences for post-acute services must be meaningfully considered as part of the care furnished under TEAM.

- **More Equitable Risk Adjustment Methodology:** AMRPA urges numerous refinements to the current risk adjustment methodology proposal to ensure that patient complexity is appropriately accounted for in target prices and that patient access to IRF care is not impeded as a result of the risk adjustment calculations.

- **CMS Must Allow for Further Public Comment on Key Components of the Model:** While TEAM stands to impact a significant number of hospitals (hospitals in 25% of the nation's core-based statistical areas (CBSAs)), CMS has not specified

which areas will be subject to the demonstration. CMS must therefore provide a final rule *with comment period* or other type of additional avenue for public input when it identifies the model's impacted CBSAs. It is critical that the affected hospitals have the opportunity to offer geographic and hospital-specific feedback on TEAM prior to the model's start date. Similarly, if CMS changes the TEAM model episode length (i.e., from 30-days to 60-days), this will correspondingly impact the number and type of quality measures that would be appropriate for the demonstration and warrant a dedicated comment period.

Our full comments follow:

I. CMS Should Adopt Longer Episodes with Refined Target Prices to Protect Access to Medically Necessary Post-Discharge Care and Promote Improved Longer-Term Outcomes

In the FY 2025 IPPS proposed rule, CMS proposes a 30-day window for TEAM episodes. This 30-day episode length would consist of all Part A and Part B services (with limited exceptions) that the patient receives in the 30-day window following the inpatient discharge or outpatient procedure. While CMS encourages feedback on the proposed episode length, the primary rationales cited for the current 30-day window include the greater likelihood of potential savings and the fact that such episode length is seen as the appropriate timeframe for the risk borne by the initiating hospitals.

AMRPA has significant concerns with both the proposed episode length and CMS' cited rationales for using a 30-day window. First, we believe that a 30-day window will significantly impact referrals and PAC utilization. Based on AMRPA and other stakeholders' assessment of the proposed TEAM episodes and target price calculations, the vast majority of the target price (80%+) for a 30-day episode will be accounted for in the acute-care hospitals' MS-DRG payment. This will create a stark and immediate limitation on how acute-care hospitals can leverage their PAC partners to facilitate patients' full recovery. For patients deemed to need inpatient rehabilitation (as recommended by a rehabilitation physician) following a procedure such as spinal fusion, joint replacement, or CABG, the initiating hospital will be forced to weigh medically necessary care against the risk created by the target price. AMRPA therefore believes that a longer window (i.e., 60 or 90 days) will be much more aligned with CMS' goal of delivering value-based care and achieving sustainable spending reductions moving forward.

Second, AMRPA understands that TEAM must be structured in a way such that acute-care hospitals are not held accountable for additional care or services that are unrelated to the underlying episode. To that end, we encourage CMS to closely review hospital stakeholders' comments on the adequacy of exclusion criteria (identifying which items or services are deemed clinically unrelated to the episode). However, if demonstration programs such as TEAM are truly intended to "support health care transformation and increase access to high-quality care,"[1], participants must be held accountable for the longer-term trajectory of patients' recovery. We

[1] CMMI Models Home Page; https://www.cms.gov/priorities/innovation/models

therefore urge CMS to utilize a 60- or 90-day window, as this type of extended episode length will incentivize initiating hospitals to develop a care plan with the patients' full functional recovery in mind. This will help ensure that initiating hospitals and their TEAM partners deliver the highest-value care within TEAM episodes and better position CMS to achieve its savings goals across the 5-year demonstration. In comparison, the current truncated episode window and corresponding target price will likely result in providers leveraging market dynamics to reduce costs in the short-term rather than moving to any sort of sustainable savings model or meaningful care transformations.

In sum, AMRPA urges CMS to adopt at least a 60-day window for TEAM and restructure the target prices accordingly to ensure that patients are able to access IRF and/or other PAC services as part of their longer-term recovery. We believe that an extended episode length will better position CMS to reduce overall spending, and that the extended period of risk for initiating hospitals will foster more coordinated and effective care delivery.

II. CMS Should Initiate the Model on a Voluntary Basis to Ensure that Initiators have the Capacity, Competencies and Established PAC Partnerships Necessary for Success

CMS currently proposes to mandate TEAM participation for all IPPS hospitals in certain CBSAs without consideration for hospitals' size or ability to oversee an episode-based payment model with the potential to span multiple care settings and service lines. Based on AMRPA members' experiences with other similar models, we believe it is critical that the model first be tested among those hospitals with the requisite experience, competencies, and strong post-acute care referral partners to ensure patients receive high-quality and appropriate levels of care. These hospitals' experiences will help CMS and providers determine the appropriate target price methodology and other key model metrics such that refinements can be made prior to the broader implementation. AMRPA reiterates our longstanding support for this type of voluntary testing as a precursor to expansion and mandatory participation, as our members believe that this is among the most critical patient safeguards in any model impacting Medicare payment and care delivery.

III. CMS Should Allow Hospitals to Choose Among Covered Conditions & Eliminate the Higher-Cost Procedures from TEAM

In addition to launching the model on a voluntary-only basis, AMRPA urges CMS to further consider giving the participants the ability to select which of the five proposed conditions they would like to voluntarily test. This would allow providers to focus on those episodes for which they are particularly well-equipped to coordinate the patient's care throughout their recovery trajectory and undertake the requisite financial risk. For example, hospitals that have relatively low volume for one of the conditions currently included on the list could face significant variability in performance and large losses due to only a handful of patients – an issue that was reported during the CJR as well.

AMRPA therefore recommends that CMS commence the demonstration with fewer covered conditions to reduce the burden and potential care disruptions within TEAM. We also

urge CMS to particularly reconsider the mandatory inclusion of spinal fusion and CABG, as the target prices for these procedures are more likely to be eroded by the underlying procedure costs and therefore limit the patients' ability to receive medically necessary post-discharge items and services.

IV. Hospitals Should Be Granted at Least 2 Years of Upside-Only Risk in Order to Ensure that Target Prices Do Not Adversely Impact Referrals or Service Utilization

Currently, CMS is proposing that TEAM participants would have the option of incurring upside risk in the first performance year (PY), and would then be subject to increasing levels of risk in subsequent PYs. CMS asserts that this structure will provide hospitals with the "opportunity to deliver value-based care and would avoid the financial pressures of a two-sided financial risk model that could make their participation in TEAM untenable." CMS further asserts that introducing mandatory downside risk in PY 2 and beyond will "help drive care improvement and establish care efficiencies that could lead to better outcomes on cost and quality of care." While AMRPA applauds CMS for only exposing hospitals to upside risk in PY 1, we believe a longer period of upside-only financial risk is needed in order for TEAM participants to improve outcomes drive quality of care, and eliminate barriers to medically necessary IRF services.

Adopting TEAM in a way that does not reduce access to appropriate PAC care and effectively improves care coordination will require an investment of both time and resources for the initiating hospitals and their PAC partners. Hospitals will need an appropriate timeframe to gain experience with TEAM episodes and identify how to improve care coordination without impeding quality (and, most importantly, stinting on necessary care). CMS cited similar rationales in providing a considerably longer period of upside-only risk (up to 5 years) in the Medicare Shared Savings Program, and these same factors warrant consideration under TEAM. CMS should therefore provide a longer period of upside-only risk of at least two years and utilize this timeframe to make any necessary modifications to the target price or episode length for the covered procedures. This is especially important given that CMS is intentionally oversampling from markets with limited experience with past bundled programs.

Furthermore, a longer upside-only risk period better positions TEAM hospitals and their PAC partners with opportunities to adopt innovative care models (consist with TEAM objectives) rather than simply push patients into lower-cost PAC settings due to the model's pricing structure. This refinement is critical to ensuring that patients are able to sustain access to medically necessary IRF care during the duration of TEAM and that IRFs are able to play a meaningful (and essential) role in promoting longer-term functional recovery for patients impacted by this program.

Lastly, AMRPA echoes other hospital association recommendations that certain hospitals – such as safety-net and rural hospitals – should only face upside-risk for the duration of the model.

V. CMS Should Take Action to Alleviate the Administrative Burdens of the Proposed TEAM Measures on IRF Providers and Include Functional Measures as Part of the Model's Accountability Framework

CMS currently proposes three measures for TEAM:

1. Hybrid Hospital-Wide All-Cause Readmission Measure with Claims and Electronic Health Record Data (CMS Measure Inventory [CMIT] ID #356);
2. CMS Patient Safety and Adverse Events Composite (CMS PSI 90) (CMIT ID #135); and
3. Hospital-Level Total Hip and/or Total Knee Arthroplasty (THA/TKA) Patient-Reported Outcome-Based Performance Measure (PRO-PM) (CMIT ID #1618)

The first two measures would be applicable to all episodes, while the third measure (THA/TKA PRO-PM) would only be applicable to LEJR episodes. CMS asserts that these measures are designed to promote care coordination and patient safety while reducing administrative burden. With respect to quality measurement, hospitals would use existing Hospital Inpatient Quality Reporting Program processes to track and report the required data.

While CMS asserts its intent to reduce the administrative burden for initiating hospitals through the selection and use of these measures, AMRPA is strongly concerned that these measures will make it particularly challenging for IRFs to produce reliable and valid information for their TEAM quality reporting requirements. Furthermore, AMRPA encourages CMS to look for opportunities to utilize quality measure information collected as part of the IRF QRP (as well as other PAC settings that may be part of TEAM episodes) to bolster the TEAM quality measurement requirements. Lastly, and consistent with AMRPA's past comments on similar CMMI models, we recommend that CMS include one or more functional status measures as part of the quality measures included in this proposal.

First, AMRPA asks CMS to consider the administrative burden that IRFs will incur in order to support the proposed TEAM quality measures. While the proposed measures have already been incorporated into the quality measure reporting process for acute care hospitals, IRFs and any other post-acute care providers would need to change their existing reporting requirements to produce reliable and valid information for use in the quality reporting for TEAM. For example, the proposed inclusion of the CMS Patient Safety and Adverse Events Composite (CMS PSI 90) measure may require IRFs to collect additional data outside of current IRF quality reporting requirements. One of the measures included in the CMS PSI 90 composite measure is the Pressure Ulcer Rate measure, which utilizes ICD-10 codes identified as secondary diagnoses on the claim at admission and discharge rather than the Pressure Ulcer/Injury assessment items included in the IRF-PAI as Standardized Patient Assessment Data Elements (SPADEs) for the IRF QRP. Should this measure require that information be provided on the claims data instead of on the IRF-PAI, IRFs will need to make sure that the necessary ICD-10 codes appear on the claim among the codes IRFs currently included for payment (Comorbidity Tier) and 60% Rule compliance purposes. This will require training and education as well as significant upgrades to existing technology (EMRs) to make sure that the correct information is

identified and placed on the claim. Similarly, while AMRPA supports the use of certain patient-reported outcomes, the proposed Hospital-Level, Risk-Standardized Patient-Reported Outcomes Following Elective Primary THA/TKA measure will require significant resources to integrate into existing quality payment and quality reporting requirements. AMRPA encourages CMS to consider the potential increase in administrative burden should they proceed with the proposed measures. AMRPA also suggests that CMS look for opportunities to utilize quality measure information collected as part of the IRF QRP to fulfill some of the quality measure requirements proposed for TEAM.

In addition to our concern over increases administrative burden, AMRPA is disappointed that functional status is not included among the quality measures proposed for TEAM. As AMRPA has indicated in comments provided to CMS for the Bundled Payment for Care Improvement (BPCI) Advanced model, 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 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[2,3,4]. Research has also shown functional status to significantly outperform comorbidities as a predictor of a patient's likelihood for readmissions following hospital discharge.

Noting the importance of functional status, AMRPA believes that it would be short-sighted for CMS to focus solely on achieving Medicare savings in the short term when unnecessary disability and lack of functional improvement could lead to far greater expenditures in the longer 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. To avoid any unintended consequences brought about by the TEAM proposal, we recommend that CMS include one or more functional status measures as part of the quality measures included in this proposal.

VI. CMS Must Implement Safeguards to Ensure that TEAM Accounts for Patient Choice and Treatment Preference

[2] 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
[3] 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.
[4] 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

As part of its TEAM oversight, AMRPA asks CMS to ensure that beneficiaries are fully informed about their inclusion in the model and the potential impact on their care. Further, in addition to providing patients with a list of all available post-acute care providers, the patients' preferences for post-acute services should be formally factored into the episode. This is especially critical given the findings of previous CMMI episode-based payment model reports that patient PAC preferences were inadequately considered and/or that patients had an inadequate understanding of where and how to care for themselves post-discharge.[5]

VII. CMS Must Modify the TEAM Risk Adjustment Factors to Account for Patient Complexity

AMRPA is seriously concerned that the current TEAM risk adjustment factors are insufficient to adequately account for differences in patient complexity, and could directly impact the access to medically necessary IRF care for certain patients impacted by the model. At a minimum, the risk adjustment factor must be recalibrated to fully account for patients' functional status and disability. We echo other stakeholders' recommendations that the risk adjustment factor should capture complication or comorbidity flags from the anchor hospitalization, hierarchical condition codes (HCC) flags prior to the hospitalization as well as hierarchical condition codes flags for 24-36 months prior to the hospitalization (compared to the 90-day period currently proposed). We believe these types of adjustments would help ensure a more appropriate target price for patients in need of IRF services as part of their longer recovery trajectory and ensure that the model's methodology would not place such patients (and the hospitals treating them) at a systematic disadvantage.

VIII. CMS Must Allow for Meaningful Hospital Input and Potential Further Public Comment on Key Components of the Model

Should CMS finalize TEAM as proposed, TEAM would impact a significant number of hospitals (hospitals in 25% of the nation's core-based statistical areas (CBSAs)). Once the CBSAs are selected, CMS must directly engage hospitals in those areas to help them understand the model's implications on their finances, interactions with other providers, and continued ability to provide high quality care to patients. CMS' proposal to use regional data to establish benchmarks for the episodes inherently means that a hospital's success in the model could be dependent on its location, as there is significant variation in costs for the five proposed episodes across the country (with some high-cost regions and some low-cost regions). Therefore, CMS must provide technical assistance to hospitals and stand ready to make adjustments to the model based on the input and experience of participants and patients.

Furthermore, we understand that AMRPA is one of numerous organizations asking for large-scale changes to the current TEAM structure. If CMS finalizes meaningful changes to the initial TEAM proposal, further dialogue may be needed as to how those program refinements impact other components of the model. For example, if CMS changes the TEAM model episode

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

length (e.g., from 30-days to 60-days), this will correspondingly impact the number and type of quality measures that would be appropriate for the demonstration and warrant a dedicated comment period. If these additional comment periods complicate CMS' stated goal of finalizing the program a year prior to the start date (i.e., finalizing TEAM by January 1, 2025 for a January 1, 2026 start date), CMS should consider delaying the model's start date in the interest of stakeholder collaboration and transparency.

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AMRPA stands ready to work with CMS to ensure that the proposed TEAM – and any other episode-based payment models – are structured in a way that effectively promotes improved care delivery and longer-term outcomes, which will in turn put downward pressure on Medicare spending. We hope that our aforementioned recommendations help promote patient access to IRF services and the long-term value of the care provided by our hospitals, which is well-evidenced in our quality reporting performance and comparative long-term outcomes. Should you have any questions or wish to discuss our comments further, please contact Kate Beller, AMRPA President, at KBeller@amrpa.org and Troy Hillman, AMRPA Director of Health Policy and Quality, at THillman@amrpa.org.

Sincerely,

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Vice President and Chief Operations Officer – Madonna Rehabilitation Hospitals