



October 3, 2016

**DELIVERED ELECTRONICALLY**

Andy Slavitt  
Acting Administrator  
Centers for Medicare and Medicaid Services  
U.S. Department of Health and Human Services  
Attention: CMS-5519-P  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

***Ref: CMS-5519-P Medicare Program; 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)***

Dear Acting Administrator Slavitt:

The Steering Committee of the Coalition to Preserve Rehabilitation (CPR) appreciates the opportunity to comment on the above-referenced proposed rule.<sup>1</sup> 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 puts forth bundled payment models for Medicare fee-for-service beneficiaries receiving services during acute myocardial infarction and coronary artery bypass graft, two very common cardiac procedures. In addition, this Proposed Rule modifies the Comprehensive Care for Joint Replacement (CJR) bundled payment program by including surgical hip/femur fracture treatment episodes, and is based on the CJR model. Our comments will focus on the cardiac rehabilitation incentive payments, the definition of “episode of care” under the rule, the qualifications of the bundle holder, financial relationships between the acute care hospitals and post-acute care providers, quality measures, and scope of implementation. We also argue 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.

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<sup>1</sup> *Medicare Program; 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)*; Proposed Rule, 81 Fed. Reg. 50,794 (August 2, 2016). Available at: <https://www.gpo.gov/fdsys/pkg/FR-2016-08-02/pdf/2016-17733.pdf>.

### **Cardiac Rehabilitation Incentive Payments**

According to CMS, the Proposed Rule provides newly created cardiac rehabilitation incentive payments to hospitals where beneficiaries are hospitalized for a heart attack or bypass surgery. The payments would be based on beneficiary utilization of cardiac rehabilitation and intensive cardiac rehabilitation services in the 90-day care period following hospital discharge. Hospitals would use these payments to coordinate cardiac rehabilitation. These incentive payments are not tied directly to the bundled incentive payment program. Beneficiaries in 45 geographic areas that CMS selects for cardiac care bundled payments would have access to expanded rehabilitative services, and 45 geographic areas that CMS did not select, would have access to these incentive payments as well. 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.

CPR supports the concept of cardiac rehabilitation incentive payments in this Proposed Rule. We believe that this new incentive model has merit in and of itself, and should not necessarily be coupled with a bundled payment model. CPR therefore supports the cardiac rehabilitation incentive payments, whether or not these payments are tied to bundling. CPR has the greatest concern for cardiac patients who would experience bundled care under this Proposed Rule, yet would not have access to additional cardiac rehabilitation. Instead, we encourage CMS to expand access to rehabilitative services for beneficiaries under the CJR model as well. Providing appropriate access to early intensive rehabilitation can have a major impact in, functional improvement, return to community living and lower re-hospitalization rates.

### **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. In addition to this Proposed Rule, CMS had previously issued its CJR final rule in November 2015, with implementation beginning April 1, 2016. As of July 2016, 836 participants were enrolled in Phase 2 of Model 3 (Retrospective Post Acute Care Only) of the Bundled Payments for Care Improvement program (BPCI), while 1,448 participants were enrolled in Phase 2 of Model 2 (Retrospective Acute & PAC Episode) of the BPCI.<sup>2</sup>

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, 13 participating Comprehensive ESRD Care Initiatives, 18 participating Next Generation ACOs, and 9 participating Pioneer ACOs.<sup>3</sup> CMS' stated goal is to have 30% of patients in APMs by year's end, and 50% by the end of 2018.<sup>4</sup>

CPR believes that there are 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

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<sup>2</sup> <https://innovation.cms.gov/initiatives/Bundled-Payments/index.html>.

<sup>3</sup> <https://innovation.cms.gov/initiatives/ACO>.

<sup>4</sup> <https://innovation.cms.gov/initiatives/Health-Care-Payment-Learning-and-Action-Network/>.

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.

Lastly, 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 rehabilitation beneficiaries.

### **Relationships between Hospitals and Post-Acute Care Providers**

“Steering” of Medicare patients to certain providers may improve efficiency but this still often occurs at the expense of one of the paragons of Medicare policy: patient choice. “Soft steering” is a term often used to describe ways that hospitals and other providers can arrange systems of care that attempt to preserve patient choice to the maximum extent possible. CPR recommends that CMS exercise great caution if it permits “soft steering” by providers in bundled programs. CPR believes there can be negative consequences from this practice. For example, the bundle holder may drive patients to “low cost” providers in order to retain a greater share of the savings, but put beneficiaries at clinical risk in the process by potentially stinting on care.

Alternatively, bundle holders could “steer” patients to providers with which they have financial relationships regardless of clinical need. In any event, bundle holders should be required to continue to inform beneficiaries of their freedom of choice rights. We believe that any financial relationship between hospitals and post-acute care providers should be disclosed to patients, so that beneficiaries are aware of various incentives of care as that care is prescribed and provided.

### **Appropriate PAC Quality and Outcome Measures**

CPR recommends that quality measures be particularly strong in the CJR and cardiac 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. The cardiac bundling program includes new benefits that incentivize rehabilitation as part of the patients’ cardiac care. 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.);<sup>5</sup>
- **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.

### **Reduction in Scope**

Due to the concerns expressed above, CPR advocates that instead of a mandatory bundling model, CMS should implement the cardiac bundling model as a voluntary bundling demonstration project incorporating no more than 5-10 Metropolitan Statistical Areas (MSAs). Until CMS fully understands the impact on patient care that mandatory bundled payment models have on beneficiaries, it should refrain from widespread implementation. Having said this, we recognize and appreciate CMS’ inclusion in the Proposed Rule of new rehabilitation benefits and incentives to provide them to Medicare beneficiaries with applicable cardiac conditions.

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<sup>5</sup> 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.

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We greatly appreciate your attention to our concerns and your interest in our participation in this process. Should you have further questions regarding this information, please contact Peter Thomas or Steve Postal, CPR Coordinators, by emailing [Peter.Thomas@ppsv.com](mailto:Peter.Thomas@ppsv.com) or [Steve.Postal@ppsv.com](mailto:Steve.Postal@ppsv.com), or by calling 202-466-6550.

Sincerely,

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