



June 22, 2015

SUBMITTED VIA REGULATIONS.GOV

Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: (CMS-1624-P) Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2016

Dear Acting Administrator Slavitt:

The undersigned members of the Coalition to Preserve Rehabilitation (CPR) appreciate the opportunity to comment on the proposed [rule](#) entitled, *Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2016*. 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.

Overview

The proposed rule adopted an IRF-specific market basket update, and updated quality measures and reporting requirements under the IRF quality reporting program (QRP), among other things. CPR supports that the proposed rule provides a respectable increase in overall funding without including many problematic provisions that Centers for Medicare and Medicaid Services (CMS) could have pursued in this rule. Due in part to the Improving Medicare Post-Acute Care Transformation (“IMPACT”) Act of 2014, signed by the President into law last October, the rule focuses heavily on implementation of quality reporting and payment.

Notably, the rule does not include any pilots, demonstration projects, or more significant implementation of bundling of post-acute care, site-neutral payment between IRFs and other settings of care, or other post-acute care proposals contained in the President’s most recent budget, recent MedPAC recommendations, or Congressional bills and hearings. CPR is grateful to CMS for choosing not to include these types of provisions in this rule, considering the serious reservations CPR members have with many of these proposals.

Medicare PAC Payment Reform Requires Serious Deliberation and Reliable Data

All Medicare post-acute care reforms that CMS considers should, first and foremost, preserve access to quality rehabilitation services provided at the appropriate level of intensity, in the right setting, and at the right time to meet the individual needs of Medicare beneficiaries. This is, of course, much easier said than done. Meeting this challenge, while making Medicare post-acute care payment policy more efficient, requires serious deliberation and should be based on reliable data that is comparable from one post-acute care (PAC) setting to another. Uniform and current data need to be collected across a variety of PAC settings with a major emphasis on appropriate quality standards and risk adjustment to protect patients against underservice. Implementation of the IMPACT Act now serves this data collection purpose.

CPR favors payment and delivery models that are based on sound evidence with fully developed quality measures and risk-adjusters so that any savings are achieved through genuine efficiencies, not achieved by stinting on patient care. Unfortunately, a “bundled” PAC payment system that includes these critical beneficiary protections does not currently exist and, we expect, will take several years to develop, adequately test, and validate. This is why we support refraining from either regulating or legislating “site-neutral” PAC payments or taking other PAC reform actions until data is collected and analyzed under the authorities enacted in the IMPACT Act.

This data can be used to develop a uniform quality assessment instrument to measure outcomes across PAC settings. Such a tool would be invaluable to developing and enacting PAC reforms that do not compromise patient care. This is a critical step in both adopting appropriate—and sufficiently granular—quality metrics to ensure PAC patients under a bundled Medicare payment system achieve good patient outcomes and risk adjusters accurately capture the unique needs of individual patients.

Until these and other patient protections are in place, we do not support regulating or legislating PAC reforms that bundle episodes of care, impose financial incentives to treat patients in the least intensive setting, or otherwise limit rehabilitation benefits under the Medicare program. It is simply too risky to Medicare beneficiaries to implement PAC bundling or related reforms prematurely.

Therefore, we thank CMS for refraining from proposing PAC policies through regulation that are simply not well developed at this stage. We request that CMS take sufficient time to collect data under the IMPACT Act’s provisions, and this proposed rule and future rules, before adopting a short-term, underdeveloped, approach to PAC reform that may negatively impact the recovery and rehabilitation of some of Medicare’s most vulnerable beneficiaries.

Meaningful Quality Measures Needed

CPR favors quality measures in PAC environments that accurately assess patients’ improvement and function. As PAC reform proceeds, CPR requests that CMS ensures that new PAC delivery models do not save Medicare dollars by stinting on patient care. The quality measures as discussed in this proposed rule are fairly rudimentary and do not address key concerns of beneficiaries with disabilities and chronic conditions, including, where appropriate: the ability to live as independently as possible; to function at the maximum extent possible; to return to employment; to engage in recreational and athletic pursuits; to engage in community activities; and to maintain the highest quality of life possible.

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 Steven Postal, CPR staff, by emailing Steven.Postal@ppsv.com, or by calling 202-466-6550.

Sincerely,

CPR Steering Committee

Judith Stein (Center for Medicare Advocacy)
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Endorsing Organizations

ACCSES
The American Academy of Physical Medicine and Rehabilitation
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American Congress of Rehabilitation Medicine
American Music Therapy Association
American Occupational Therapy Association
American Therapeutic Recreation Association
Amputee Coalition
Association of Academic Physiatrists
Association of Rehabilitation Nurses
Brain Injury Association of America
Center for Medicare Advocacy
Christopher and Dana Reeve Foundation
Lakeshore Foundation
National Association for the Advancement of Orthotics & Prosthetics
National Association of State Head Injury Administrators
National Multiple Sclerosis Society
United Spinal Association