NARA
The National Association of Rehabilitation Providers and Agencies

June 10, 2024

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Baltimore, MD 21244
Attention: CMS–1808–P, Mail Stop C4–26–05,
7500 Security Boulevard, Baltimore, MD 21244–1850

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

Re: ***CMS–1808–P: 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 - Proposed rule.***

Dear Administrator Brooks-LaSure:

The National Association of Rehabilitation Providers and Agencies (NARA) represents over 90,000 physical therapy, occupational therapy and speech-language pathology practitioners through our member organizations who provide therapy across the United States to Medicare beneficiaries. They provide therapy in all settings across the continuum such as outpatient clinics, skilled nursing facilities, assisted living facilities, hospital outpatient, hospital inpatient, in the beneficiary's home, and in retirement communities. As a member-driven organization, NARA promotes the growth and business success of physical therapy, occupational therapy, and speech-language pathology providers through education, support, and advocacy. NARA's membership demographics give us a unique insight into payment, policy and quality programs impacting the hospital inpatient setting. We appreciate the opportunity to provide the following comments on the proposed rule:

Transforming Episode Accountability Model (TEAM)

The Transforming Episode Accountability Model (TEAM) proposes the creation and testing of a new mandatory alternative payment model. The Center for Medicare and Medicaid Services' (CMS) intention for this model would be to improve beneficiary care through financial accountability for episode categories that begin with any of the following procedures: coronary artery bypass graft, lower extremity joint replacement, major bowel procedure, surgical hip/femur fracture treatment or spinal fusion. TEAM would evaluate whether financial

accountability for these episode categories reduces Medicare expenditures while preserving or enhancing the quality of care for Medicare beneficiaries. CMS anticipates TEAM would benefit Medicare beneficiaries through improving the coordination of items and services paid for through Medicare fee-for-service (FFS) payments, encouraging provider investment in health care infrastructure and redesigned care processes, and incentivizing higher value care across the inpatient and post-acute care settings for the episode.

NARA believes under the TEAM proposal it would be possible for a "TEAM participant" hospital to inappropriately divert the beneficiary away from necessary post-acute SNF care during the entire 30-day post-hospital transfer window. Therefore, we request before finalizing any 'TEAM' bundle proposal, that appropriate and necessary beneficiary protections are included in the model, such as expanding the *"Medical Appropriateness Exceptions"* to protect the beneficiary's access to their SNF benefit, and to prevent an avoidable and costly hospital readmission. According to Section 1812(a)(2) of Title XVIII of the Social Security Act (the Act) provides for a beneficiary to receive access to *"post hospital extended care services for up to 100 days during any spell of illness"* in a SNF under Medicare Part A benefits. However, under SNF date of admission regulatory requirements at 42 CFR 409.30(b), *"…the beneficiary must be in need of posthospital SNF care, be admitted to the facility, and receive the needed care within 30 calendar days after the date of discharge from a hospital or CAH."* Furthermore, CMS provides additional sub regulatory guidance regarding the *"Thirty-Day Transfer"* policy in The Medicare Benefit Policy Manual, Chapter 8, Section 20.2 emphasizing that the beneficiary's SNF benefit eligibility window following a qualifying hospital stay is 30 days, unless there is a specified *"Medical Appropriateness Exception."* Without such an exception, a beneficiary that did not receive SNF care within 30 days of a qualifying hospital stay would not be eligible for SNF benefits unless they were readmitted to a hospital for another qualifying hospital stay. Since the "Team participant" hospital remains responsible for the scope of services furnished during the first 30-days after the hospital discharge, NARA recommends starting the 30-day period for the Medical Appropriateness Exception the day after the last day of the hospital's accountability for the TEAM bundle.

TEAM – Initiation of Episode

TEAM allows only a single entity, the acute care hospital, to initiate episodes and be the leading participant and "downstream participants" to participate as "TEAM activities". CMS is proposing that episodes in TEAM begin with an acute care hospital stay or hospital outpatient department procedure visit, an emergency room visit, or possible transfer from another hospital's emergency room, or followed by PAC. NARA recommends that CMS give SNFs, and other providers identified as "downstream participants" the opportunity to initiate or co-lead the TEAM with the identified acute care hospital.

SNFs and other PAC providers take leading roles in the management and success of these types of stays. The current TEAM construct proposed by CMS relegates SNFs and other PAC providers to be selected by the hospital, rather than giving the beneficiary the choice of location for services in the 30-day window after hospital discharge. This could lead to beneficiaries being diverted to

lower levels of care rather than to the appropriate setting. At a minimum, the TEAM participant hospital should be required to include identified/contracted "downstream participants" in hospital TEAM strategies and pre-discharge placement decisions and that beneficiaries are adequately informed about appropriate post-discharge care options and not inappropriately 'steered' to an inappropriate care environment due to financial incentives.

TEAM Remedial Action

CMS proposes to impose any of multiple remedial actions set forth in the proposed rule if it is determined that the TEAM participant or a "downstream participant" did not comply with the mandatory program requirements. As written, "downstream participants" who may not even be involved in a negative outcome or program integrity issue involving another provider in the "TEAM participant's" network could be penalized, even though they are not permitted to participate in the "TEAM participant's" beneficiary hospital program strategy or pre-discharge decision-making. We believe requiring hospitals to gainshare incentives with "downstream participants" in the network and to require participation of "downstream participants" in hospital TEAM strategy and pre-discharge placement decisions would significantly mitigate this imbalance. NARA supports the intent of the proposed remedial actions; however, if the "downstream participants" such as SNFs and other PAC providers are not involved in the care strategies or decision-making process then they should not be subject to this action. We urge CMS to ensure "TEAM participants" and "downstream participants" have a reasonable appeal process that includes review options by an outside agency or through arbitration. These have proven effective in providing a balanced and independent process in other settings.

TEAM Limitations on Review

CMS proposes to codify the preclusion of administrative and judicial review under the Act, as it states that there is no administrative or judicial review for any of the following:

- The selection of models for testing or expansion under section 1115A of the Act.
- The selection of organizations, sites, or participants to test models selected.
- The elements, parameters, scope, and duration of such models for testing or dissemination.
- Determinations regarding budget neutrality under section 1115A(b)(3) of the Act.
- The termination or modification of the design and implementation of a model under section 1115A(b)(3)(B) of the Act.
- Determinations about expansion of the duration and scope of a model under section 1115A(c) of the Act, including the determination that a model is not expected to meet criteria described in paragraph (1) or (2) of such section.

NARA does not support CMS' proposal to preclude administrative and judicial review the selection of a "TEAM participant", or by extension the "downstream participants" in the program. We are concerned that in the case of a geographically established mandatory bundle, beneficiary choice of provider protection could be seriously eroded as in many areas as the number of hospitals they could receive care at are limited. These Medicare beneficiaries' options for access

to appropriate "downstream participants" following an acute care hospital stay may be further compromised depending on how limited the "TEAM participant's" network is. A beneficiary or "downstream participant" should have the opportunity to challenge an exclusion of a "downstream participant" from participating in the model in a mandatory bundle model to protect beneficiary choice rights.

Proposed Quality Measures

CMS proposes that TEAM incorporate quality measures that focus on care coordination, patient safety, and patient reported outcomes (PROs) which represent areas of quality that are particularly important to patients undergoing acute procedures. CMS will align TEAM quality measures with those used in ongoing models and programs to minimize hospital participant burden. CMS states their goal is to focus on improving beneficiary quality of care and capture meaningful quality data for use in the TEAM pay-for-performance methodologies.

We are concerned that the "outcomes" measures proposed are unbalanced, inadequate, and represent a significant deviation from the Congressional intent of the IMPACT Act of 2024 in addressing standardized assessment and measurement of quality outcomes for integrated post-acute care. We recommend CMS collaborate with both surgical providers and post-acute providers to identify appropriate post-surgical functional outcomes measures, particularly those related to mobility and self-care, which are aligned with PAC measures established under the IMPACT Act.

Additionally, we recommend CMS include a transfer of health information measure that positively adjusts a "TEAM participant" incentive payment if they invest resources from the incentive payment to increase the rate of health information exchange with the "downstream participants."

While we appreciate CMS is interested in assuring a beneficiary receiving hospital surgical services receives safe and effective coordinated care through their acute and post-acute care journey, the intent of the post-acute care is to assure the beneficiaries' successful return to prior or optimal living environment. Therefore, the focus for post-acute providers is not on stabilization of the condition, but on continuing the healing process as well as facilitate the restoration of function such as mobility and self-care or the identification and implementation of interventions and adaptive equipment to best assure the beneficiary is safe in their home environment.

Under the proposal, two of the outcomes measures only measure negative events – all-cause hospital readmissions and a composite adverse events measure, while three other negative events measures are being considered for future years (falls with injury, standardized death rate, and postoperative respiratory failure. Only one positive outcomes measure related to a persons' functional abilities and the effectiveness of functional recover interventions (the THA/TKA PRO-PM measure) is proposed – and only for one of the four proposed post-surgical bundles. This indicates the measures are unbalanced since the incentive program is focusing most heavily on cost savings and the prevention of medical complications with little or no focus on the primary

purpose of the post-acute care provider – to help assure the beneficiary can live safely in their home environment with the optimal function. Ignoring the importance of mobility and self-care functional restoration as part of the measures to determine the value of the post-acute care furnished (or denied) after any post-surgical hospital discharge can incentivize hospitals to inappropriately direct beneficiaries away from appropriate and necessary post-acute providers as they would not be held accountable for the functional outcomes of such individuals. A great deal of research has demonstrated that post-surgical rehabilitation delivered early after surgery can be safer and more effective than delayed or denied post-surgical rehabilitation.

NARA believes that cognitive function is also a key component of this post-acute care that does not appear to be accounted for in this proposal as beneficiaries may have chronic or progressive cognitive deficits that need to be considered. Many cognitively intact individuals may present with temporary post-operative delirium during the post-acute period that can impact recovery time and safety. For these reasons, NARA strongly recommends CMS collaborate with both surgical providers and post-acute providers to identify appropriate post-surgical functional outcomes measures, particularly those related to mobility, self-care, and cognition that are aligned with PAC measures established under the IMPACT Act.

Additionally, how information is exchanged is critical to improving care outcomes for beneficiaries. Improving Medicare Post-Acute Care Transformation Act of 2024 (IMPACT Act) (P.L.113-185) was enacted specifically to provide CMS with the standardized functional assessment items and quality measures necessary to permit more effective communication between hospitals and PAC providers and to permit comparison of post-acute outcomes as part of accountable care payment models. CMS has the following web page dedicated to the IMPACT Act that links to other quality initiative pages including the Hospital Quality Initiative: https://www.cms.gov/medicare/quality/initiatives/pac-quality-initiatives/impact-act-2014-data-standardization-cross-setting-measures#:~:text=The%20IMPACT%20Act%20mandates%20the,Inpatient%20Rehabilitation%20Facilities%20(IRFs).

While most of the IMPACT Act activities have focused on PAC providers, the **bold text in the below excerpt** from section (c) of the IMPACT Act clearly identifies the intent of the PAC standardized assessment items and measures were to improve communications between hospitals and PAC providers.

> ‘‘(c) QUALITY MEASURES.—
> ‘‘(1) REQUIREMENT FOR REPORTING QUALITY MEASURES.—
> Not later than the specified application date, as applicable to measures and PAC providers, the Secretary shall specify quality measures on which PAC providers are required under the applicable reporting provisions to submit standardized patient assessment data described in subsection (b)(1) and other necessary data specified by the Secretary. Such measures shall

be with respect to at least the following domains:

‘‘(A) Functional status, cognitive function, and changes in function and cognitive function.

‘‘(B) Skin integrity and changes in skin integrity.

‘‘(C) Medication reconciliation.

‘‘(D) Incidence of major falls.

‘‘(E) Accurately communicating the existence of and providing for the transfer of health information and care preferences of an individual to the individual, family caregiver of the individual, and providers of services furnishing items and services to the individual, when the individual transitions—

‘‘(i) from a hospital or critical access hospital to another applicable setting, including a PAC provider or the home of the individual; or

‘‘(ii) from a PAC provider to another applicable setting, including a different PAC provider, a hospital, a critical access hospital, or the home of the individual.

NARA is concerned that CMS has not proposed a TEAM measure holding the “TEAM participant” hospital accountable for optimizing health information exchange with the post-acute “downstream participants”. There is precedent from the implementation of the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act) and the establishment of physician and hospital-led accountable care organizations (ACOs), that while these upstream providers were funded and incentivized to adopt and implement interoperable health information exchange to improve the efficiency, safety, and outcomes of care, there has been no similar funding for post-acute providers or incentives for hospitals or physicians to support such advancements by trickling down some of the incentive payments they have been receiving.

The proposed TEAM model again places all the proposed incentive payments in the hands of the surgical hospital episode initiator and only encourages the hospital to facilitate better information exchange with “downstream participants”. NARA believes that unless a surgical hospital receiving incentive payments is held accountable for facilitating information exchange with “downstream participants”, they will not dedicate resources towards improving the status quo. In May 2024, the Department of Health and Hunan Services (HHS) Office of the National Coordinator for Health Information Technology published a Data Brief[1] highlighting this problem. This report indicates that most hospitals have high rates of interoperable data exchange within their systems, yet few exchange information with external post-acute providers. Specifically, the report states, *“Only*

[1] Office of the National Coordinator for Health Information Technology. Interoperable Exchange of Patient Health Information Among U.S. Hospitals: 2023. May 2024. https://www.healthit.gov/sites/default/files/2024-05/Interoperable-Exchange-of-Patient-Health-Information-Among-U.S.-Hospitals-2023.pdf

16% of hospitals reported sending summary of care records to most or all long-term/post-acute care providers and 17% reported sending summary of care records to most or all behavioral health providers." Given these concerns, we recommend that CMS include a transfer of health information measure that positively adjusts a "TEAM participant" incentive payment if they invest resources from the incentive payment to increase the rate of health information exchange with the "downstream participants".

We thank you for the opportunity to provide comments related to this proposed rule. Should you have any questions concerning these comments, please contact Christie Sheets, NARA Executive Director at christie.sheets@naranet.org.

Respectfully submitted,

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