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**House Committee on Energy and Commerce
Subcommittee on Health**

Hearing on “Medicare Post Acute Care Delivery and Options to Improve It”

**Written Statement
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The American Medical Rehabilitation Providers Association (AMRPA) appreciates this opportunity to submit a statement for the House Energy and Commerce Health Subcommittee on “Medicare Post Acute Care Delivery and Options to Improve It.” AMRPA is the national trade association representing more than 500 freestanding inpatient rehabilitation hospitals and units (IRH/Us), outpatient rehabilitation service providers, and skilled nursing facilities (SNFs), as well as a number of long-term care hospitals (LTCHs). Like acute care hospitals, federal regulations require IRH/Us to provide hospital-level care and to be staffed around the clock by specialized physicians and nurses who provide intensive rehabilitation care through interdisciplinary teams made up of therapists and other professionals. IRH/Us seek to maximize patients’ health, functional skills, and independence so they can return to their homes, work, or an active retirement.

AMRPA encourages the Subcommittee to carefully examine whether H.R. 1458, the Bundling and Coordinating Post-Acute Care (BACPAC) Act, or other proposals that seek to equalize payments among different providers generate Medicare savings and do so without compromising the quality of care delivered to patients. And as part of its examination of these potential reforms, the Committee should assure that any post-acute care changes preserve Medicare beneficiaries’ access to the appropriate level and intensity of medical rehabilitation. AMRPA appreciates that in passing the Improving Medicare Post-Acute Care Transformation (IMPACT) Act (P.L. 113-185), Congress recognized the need to collect and standardize data across post-acute care settings to understand the value of care provided in each setting and serve as a foundation for any future post-acute care reforms.

The Value of Inpatient Medical Rehabilitation

IRH/Us provide intensive medical management by specialty-trained physicians, extensive rehabilitation nursing care by registered nurses, and rigorous and varied therapy services. Medicare requirements for IRH/Us are stringent and different from those required of other post-acute care providers. For example, to be classified as an IRH/U, the hospital must have medical directors and nurses who specialize in physical medicine and rehabilitation, have 60 percent of admissions come from 13 specific diagnoses, and can only admit patients who can sustain 3 hours of therapy a day and have the potential to meet predetermined goals. IRH/Us treat medically complex patients recovering from strokes, brain injuries,

spinal cord injuries, neurological diseases, major musculoskeletal disorders, and transplantation. However, unlike acute care hospitals, which focus on a patient's diagnosis in developing a care plan, IRH/Us consider an individual's function, other patient characteristics, and environmental factors in determining the appropriate care for that individual.

The Medicare Payment Advisory Commission's (MedPAC's) March 2015 Report to Congress paints a picture of a sector that is constrained. MedPAC notes that the volume of Medicare fee-for-service (FFS) beneficiaries treated in IRH/Us remained relatively stable since 2011, but has declined considerably since 2004. Although the supply of IRH/Us has been declining since 2005, the Commission found that the aggregate supply of IRH/Us declined only slightly between 2012 and 2013 to 1,161 providers with approximately 38,000 beds. In January 2010, CMS adopted new, more restrictive medical necessity coverage criteria, which has further limited the growth of IRH/Us admissions. Unlike other post-acute care providers that have experienced explosive growth, spending on IRH/Us accounts for less than 1.2 percent of total Medicare expenditures and has remained flat.¹

Dobson DaVanzo & Associates, LLC completed a study in 2014 comparing clinically similar Medicare FFS beneficiaries over a two-year period following discharge from IRH/Us or nursing homes. The study, *Assessment of Patient Outcomes of Rehabilitative Care Provided in Inpatient Rehabilitation Facilities (IRFs) and After Discharge*, found that:

- Patients treated in rehabilitation hospitals or units return home 14 days sooner than patients treated in a nursing home;
- Rehabilitation hospital patients also remain at home 51 days longer than similar patients in nursing homes;
- Inpatient rehabilitation hospital and unit patients had fewer hospital readmissions and emergency room visits than nursing home patients;
- Individuals who receive care in an inpatient rehabilitation hospital or unit live 52 days longer on average than patients in nursing homes; and
- IRH/U patients experienced an 8 percent lower mortality rate during the two-year study period than SNF patients.

This study provides evidence of the differences in care provided by IRH/Us compared to nursing homes. These results confirm the existing understanding of the stark differences between the two settings; moreover, the results are not surprising given that Medicare requirements for IRH/Us are more rigorous than other post-acute care providers. When exploring payment and delivery reforms, policymakers should consider patients' health outcomes over the longer term (*i.e.*, two years) not simply over a 30-day or 90-day timeframe to avert any real harm to Medicare beneficiaries. Because of the implications and evidence for longer term results, the Dobson DaVanzo study should be part of the research that Members of Congress use as they consider Medicare post-acute care reforms.

AMRPA cautions policymakers that there are already too many payment policies and practices as well as proposals restricting access to inpatient rehabilitation services, including the following:

- Arbitrary quotas or categorization systems, such as the 60 percent compliance threshold for IRH/Us, that constrain admission of medically appropriate patients;
- An arbitrary cap on outpatient therapy for Medicare beneficiaries;
- Limitation on the number of days for the rehabilitation hospital benefit by various payers;
- Denials of coverage for inpatient rehabilitation hospital care by managed care companies that are financially motivated to steer patients into a seemingly less expensive setting;

¹ Medicare Payment Advisory Commission, Report to Congress: Medicare Payment Policy (March 2015).

- Coverage denials on the basis of medical necessity that are made by clinicians who do not have sufficient knowledge, experience, or expertise about rehabilitation to make such determinations;
- Non-coverage of durable medical equipment (DME) including expensive, but necessary, equipment like powered wheelchairs;
- Use of patient screening tools that do not consider the long-term consequences of site of service decisions;
- Policies that allow denial of coverage of rehabilitation services that do not meet “improvement” standards as opposed to a goal of maintenance of function;
- Retroactive coverage denials that presume (without evidence) that care “could have been delivered in a less intensive setting;”
- Policies that make the assumption that care provided in a SNF is equivalent to the care delivered in an IRH/U; and
- Failure to consider compelling evidence from studies that show life-threatening consequences to steering patients into inappropriate clinical settings.

These policies, practices, and proposals harm individuals living with disabling conditions, especially individuals who need rehabilitation services over a longer period of time. A major civil rights movement, resulting in the enactment of the Americans with Disabilities Act (ADA), was prompted because of these and other abuses experienced by individuals with disabling conditions.

In considering post-acute care payment reforms, any new payment system should:

1. Include protections to guard against stinting of care and diversion to less effective care settings and meet the needs of individuals with disabling conditions;
2. Include quality measures that are evidence-based, sensitive and meaningful, and have been proven effective in the long-term (at least two years);
3. Be transparent to individuals with disabling conditions in delineating the clinical differences among care settings so that patients are empowered to make informed decisions about their care;
4. Make quality data accessible to individuals with disabling conditions and caregivers and provide key information about a provider’s level of clinical care and patient outcomes;
5. Provide some level of standardization for rehabilitation programs among the various post-acute care settings in order to protect individuals with disabling conditions against receiving inadequate rehabilitation care; and
6. Refrain from relying on “big data” or statistical analytics to guide care decisions because the low incidence of many conditions for individuals with disabling conditions is not large enough to allow for meaningful use of predictive tools.

An Overview of Bundled Payments

The primary goal of any payment reforms in the post-acute care sector should be to improve patient access to services, choice, and health outcomes. Any payment reforms should avoid financial incentives that jeopardize patient choice and access or lead to inappropriate underutilization of medically necessary rehabilitation services. The intent of bundled payments is to increase efficiency in care provided to patients through both improving health outcomes and reducing costs. Coordinating care for individuals with disabling conditions holds great promise. However, if payment reforms intended to better coordinate care do not consider the longer-term health outcomes and resource use of patients, policymakers put vulnerable Medicare populations and individuals with disabling conditions at risk.

AMRPA believes that an approach to bundling payment could be developed that has the potential to meet the twin aims of improving quality and reducing cost in the post-acute care sector. Bundling typically

involves payment to one accountable entity for a predefined grouping of items and services, which may be supplied by various providers and settings for an episode of care. Whether bundling acute care services with post-acute care services or bundling multiple forms of post-acute services together, it is critical that any bundled payment program include incentives to provide high quality care in the most appropriate setting to improve patient outcomes.

AMRPA believes that reforms with the greatest chance of long-term success do not use reimbursement to try to override clinical decision-making, but instead seek to align payment changes with efficiencies in the delivery of care. The Continuing Care Hospital (CCH) model, which is described in detail below, has the potential to be another success story, moving from a provider-oriented to a patient-centered payment system and improving care coordination. However, the primary medical diagnosis or procedure code is not a predictor of post-acute care needs or resource use and should not be used as such in any program. After all, it is function and health care needs that are the biggest determinants of resource consumption and readmissions in post-acute care settings.

In the 1990s, the Health Care Financing Administration (HCFA, now CMS) funded several studies to assist in the conceptual development of a bundling demonstration, but decided not to pursue such a concept or demonstration further because of, among other things, serious design and accountability problems. These studies included *Issues in Bundling Hospital and Post-Acute Care* by Robert Kane, University of Minnesota, and *Postacute Care in Health Maintenance Organizations: Implications for Bundling* by at the RAND Corporation. Kane concluded that “any bundling approach is subject to temptations for underuse of post-acute care and will need offsetting accountability,” that a demonstration is needed prior to considering the proposal, and that demonstration must include extensive work on how to calculate the rate and enhance accountability. The RAND study raised similar issues and urged that a demonstration be done first. These concerns are also acknowledged in the MedPAC June 2008 discussion of the concept.

AMRPA supports careful consideration of alternative payment models, but not as a façade for cutting costs and shifting spending to other parts of the Medicare program, or Medicaid or other payers, at the expense of patients’ full recoveries from serious illness and injuries.

The Bundling and Coordinating Post-Acute Care (BACPAC) Act

The BACPAC Act (H.R. 1458), introduced by Representatives David McKinley, Jerry McNerney, and Tom Price, recognizes important limitations in the current payment system, but attempts to superimpose a complex new payment model on a tenuous foundation. Although AMRPA agrees that the health care system should explore ways to transition toward patient-centric, episode-based models of care, doing so should not create financial disincentives for patients to receive medically appropriate inpatient rehabilitation care.

Current Medicare payment policies in the post-acute care sector are defined by “silos” of post-acute services and have substantial room for improvement with regard to efficiency and patient-centricity. AMRPA could only support a well-developed bundling proposal that is built upon an adequate foundation of data integration and based on sound evidence with fully developed quality measures and risk-adjusted payment systems. At this time, a bundled payment system that includes critical beneficiary protections does not exist, and it would likely take several years to develop, adequately test, and validate.

AMRPA hopes to work with policymakers to include sufficient safeguards for patient access and choice in the BACPAC Act. We are unable to support the legislation in its current form. The potential savings to the Medicare program from prematurely implementing a bundling payment system on the current

foundation are dubious and far outweighed by the unjustifiable risk to Medicare beneficiaries. AMRPA applauds the sponsors for making changes to the legislation since it was originally introduced in the 113th Congress. At a minimum, we propose the following important revisions to the most recently introduced version of the BACPAC Act:

- **PAC Physician:** AMRPA supports the BACPAC’s designation of a physician as the primary person responsible for delivering post-acute care services. The legislation should include a requirement that this physician have experience in post-acute care/rehabilitation service delivery, including the implementation of post-acute care plans.
- **Holder of the Bundle:** AMRPA opposes the proposal to permit acute care hospitals and insurance companies to serve as the “holder” of the bundled payment for the 90-day bundling period. Regardless of their ability to bear risk, this approach imposes formidable incentives to divert patients to the least costly setting, regardless of patients’ specific clinical needs. Regardless of the structure, the bundle holder should be accountable for performance across a series of quality and outcome measures to protect against underservice and stinting on medically necessary care. There should also be a method to measure these outcomes within a short timeframe as opposed to looking at them retrospectively annually.
- **Risk-Bearing Entities:** The holder of the bundle must be able to assume fully the risk of holding this bundled payment while providing services to a beneficiary over a 90-day episode of care. The legislation should require financial solvency and related standards to ensure that bundle holders have the capacity to provide consistent and reliable care, even to outlier patients. These standards should be specifically adapted to the post-acute care setting.
- **Exemption of Certain Vulnerable Patients from First Phase of Bundling:** Bundling is a concept that has not been sufficiently tested and, while AMRPA does not oppose the concept, we strongly believe that adequate safeguards must be included in any legislation to protect vulnerable Medicare beneficiaries. Among these beneficiaries are people with traumatic brain injuries, spinal cord injuries, moderate to severe strokes, multiple-limb trauma, amputations, and severe neuromuscular and musculoskeletal conditions. While these subgroups constitute a minority of Medicare beneficiaries served on an annual basis, they constitute particularly vulnerable subgroups that ought to be exempt from the initial phases of any bundled payment system, until new payment systems can demonstrate sufficient quality outcomes, risk adjustment, adequate payment levels and patient safeguards to ensure quality care. Meanwhile, other subgroups have a clearer care and cost trajectory and may be more readily adaptable to post-acute care bundling such as lower extremity amputations. Several participants in the Bundled Payment Care Improvement (BCPI) initiative are testing bundling such cases. The demonstration projects should be completed, however, before any further steps are taken.
- **Prosthetics, Orthotics and Custom DME Should Be Exempt from the Bundle:** AMRPA believes that certain devices and related services should be exempt from the bundled payment system. For example, customized devices that are relatively expensive and intended to be used by only one person should be separately billable to Medicare Part B during the 90-day bundled period, as well as prosthetic limbs and orthotic braces, custom mobility devices and Speech Generating Devices (“SGDs”). Under a bundled payment system, there are strong financial incentives to delay or deny access to these devices and related services until the bundle period lapses. Once this

occurs, Medicare Part B would be available to cover the cost of these devices, but this delay has potentially significant negative consequences for patient outcomes, and opportunities are lost for rehabilitation and training on the use of the device or technology during the post-acute care stay.

- **Inclusion of Quality and Outcome Measures:** Quality measures must be mandated in any post-acute care bundled payment system to assess whether patients have proper access to necessary care. Today this is one of the most critically important methods to determine whether savings are being achieved through better coordination and efficiency, or through denials and delays in services. However, uniform quality and outcome measures that cross the various post-acute care settings do not currently exist – and sometimes identical measures in settings are not appropriate. The existing LTCH CARE instrument for LTCHs, the IRF-PAI for rehabilitation hospitals and units, the MDS 3.0 for SNFs, and the OASIS instrument for home health agencies are all appropriate measurement tools for each of these settings. But the reality is they measure different factors, are not compatible across settings, and do not take into consideration to a sufficient extent a whole series of factors that truly assess the relative success of a post-acute episode of care in ameliorating complex medical conditions and functional limitations of this patient population. Therefore, AMRPA recommends that the following measures be incorporated into the post-acute care system:
 - **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;
 - **Function:** Incorporate and require the use of measures and measurement tools focused on functional outcomes that include measurement of maintenance and the prevention of deterioration of function, not just improvement of function;
 - **Individual Performance:** Measurement tools should be linked to quality outcomes that maximize individual performance, not recovery/rehabilitation geared toward the “average” patient;
 - **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.);² and
 - **Patient Satisfaction:** Measures should not be confined to provider-administered measures but should directly assess patient satisfaction and self-assessment of outcomes. CMS or MedPAC should be required to contract with a non-profit entity to conduct studies in this area and factor the results into any final post-acute care bundled payment system in the future.³

² These extended functional assessment and quality of life measures are consistent with the World Health Organization’s International Classification of Functioning, Disability and Health and the measurement tool designed around the WHO-ICF known as the Activity Measure for Post-Acute Care™ (“AM-PAC”™).

³ “uSPEQ” (pronounced “You Speak”) is an example of a patient satisfaction assessment tool that measures the end user’s experience with his or her post-acute care experience. The survey can be answered by the patient, family, or caregiver.

- **Grouping of Condition-Related Groups:** The legislation should provide more clarity regarding how the Secretary of HHS must rank and group condition-related groups (CRGs) for purposes of payments.
- **HHS Post-Acute Care Advisory Committee:** The legislation should direct the Secretary to establish an Advisory Committee of post-acute care providers and health professionals to review and provide input to CMS regarding policy and regulations that affect individuals with disabling conditions.
- **Evaluation Process:** Post-acute care reforms must include vigorous evaluation methodologies to stop flawed payment or delivery systems and accelerate adoption of any successful pilots.
- **Avoid Financial Incentives to Divert Patients to Less Intensive Settings:** In order to protect against diversion of patients to less intensive, inappropriate post-acute care settings, we recommend that any PAC bundling legislation include instructions to the Secretary that payment penalties should be established to dissuade post-acute care bundle-holders from underserving patients or stinting on care.

AMRPA reiterates its concurrence with proponents of the IMPACT Act that introducing bundled payments in the absence of a complete quality picture, infrastructure to seamlessly coordinate services, and contemporaneous data that transcends individual sites of care would be premature.

AMRPA's Principles for Post-Acute Care Reform

As the Committee considers bundled payments and other post-acute care reforms, AMRPA developed a set of principles for reform that will help ensure that a reformed payment and delivery system is feasible for providers and beneficial for patients. Specifically, we urge Congress to be guided by the following principles in any reforms to the post-acute care sector:

- While reforming post-acute care, Congress should take steps to reduce the need for post-acute care in the first instance. As a nation, we have a vast amount of knowledge in treating the predominant reasons that patients need post-acute care, including stroke, traumatic brain injury, spinal cord injury, congestive heart failure, chronic obstructive pulmonary disease, and serious wounds. At the same time, we know of ways to prevent them or mitigate their effects. Congress should establish policies that prevent the need for acute and post-acute care as a fundamental step to reducing costs and improving outcomes.
- Qualified clinicians should determine patient care—both with respect to the type and site of care. Clinicians should be empowered to make post-acute care utilization decisions with reasonable criteria that are evidence- and consensus-based. Periodic audits could be utilized to hold physicians accountable to exercising that authority.
- Post-acute care reform should include an accurate definition of post-acute care. The current definition excludes outpatient services and is being driven by how Medicare Parts A and B are defined, not by how care is actually delivered. Post-acute care reform and reinvention will only be ultimately successful by eliminating this arbitrary divide.

- A reformed system should ensure electronic interoperability between and among different providers of care. Post-acute care providers are at the crossroads of information flowing out of the acute care hospitals, yet post-acute care providers were not included in recent health information technology (HIT) incentive programs. The absence of such funding for post-acute care providers has arguably made information sharing worse than before the incentives were provided. Post-acute care providers should be included in HIT incentives to enhance patient care safety and efficiency, and reduce costs.
- A reformed system should create a mechanism to promote frank and open discussion between acute care hospitals and post-acute care providers to identify and rectify adverse health outcomes that occur because of care transitions.
- The current post-acute care system, including provider fee schedules and coverage criteria, is long-standing. Therefore, any changes to this system will require extensive provider, professional, and patient outreach and education. As a result, implementation of a reformed system should include a sufficient transition period and resources for such education. All stakeholders, including health care professionals and patients, should be consulted in the development of any new Medicare payment systems.
- A reformed system should include a quality measurement and reporting system for post-acute care providers that should be based on the principles of:
 - Avoiding adverse events;
 - Achieving positive health outcomes;
 - Achieving positive functional gains;
 - Providing a positive patient experience;
 - Achieving durable health and functional gains; and
 - Demonstrating efficient and cost effective use of resources.
- Payments must reflect the true cost of care and resources utilized based on the patient’s conditions. Systems that allow for a fixed number of visits or an average cost limit disproportionately penalize patients with complex disabilities such as spinal cord injuries, brain injuries, and some neurological conditions that require extended rehabilitation.
- Provider administrative burden should be minimized whenever possible. Current regulations that inhibit the use of the most cost effective setting—such as the three-hour rule for IRH/Us and the “25 Percent Rule” for LTCHs—should be eliminated and replaced with incentives to use post-acute care settings prudently.
- The payment eligibility criteria for post-acute care providers should be reformed based on structure, process, and outcomes for each setting, and these criteria should not be confused with defining appropriateness for a specific patient.

The Continuing Care Hospital Model

The Continuing Care Hospital (CCH) Pilot Test was enacted in Section 3023 of the Patient Protection and Affordable Care Act of 2010 (ACA), P.L. 111-148, but to date the legislative directive has not been implemented by the Center for Medicare and Medicaid Innovation (CMMI).

AMRPA strongly supported its inclusion in the health care reform legislation. The model is a delivery system reform, not just a payment reform. The CCH concept provides an opportunity to develop a patient-centered care model in which the “silos” established by the variety of Medicare payment systems based on care setting are eliminated. Care under the CCH model is delivered based on need rather than setting, and there is an opportunity to realize cost savings due to efficiencies the CCH model would allow. Payment may also be more reflective of actual cost and resource use and not include the multiple costs associated with meeting the requirements of the current payment systems and transfers among care settings as is currently required.

The CCH represents both a new approach to the delivery of post-acute care and financing reform for the medical rehabilitation and complex medical services delivered by today’s IRH/Us, hospital-based skilled nursing facilities (HSNFs) and LTCHs. The model would also provide or coordinate home health and outpatient rehabilitation services for patients who need them after discharge. The CCH model would organize care around the patient instead of the provider by consolidating all three levels of inpatient post-acute care into a single enterprise with a single payment system and single method for measuring quality. The CCH could be either real (all care levels in a common building) or virtual (all levels operated as a single entity, but in two or more physically distinct locations). The CCH is intended to enhance the quality of care patients experience by eliminating the physical and invented boundaries of the current hospital-based post-acute care system. It would result in reduced administrative costs to deliver complex medical and rehabilitation post-acute care, improve the cost-effectiveness of post-acute services, and enhance the quality of care received by patients.

The medical rehabilitation field was developed in the first third of the 20th Century by physicians who believed that there was more to health care than simply diagnosing and medically treating patients with serious permanent impairments. Over the years, physician-directed, hospital-based multidisciplinary teams devoted to the principles of rehabilitation evolved into the field of medical rehabilitation and, as we know it today, the IRH/U. The LTCH field evolved from treating TB and other chronic, medically complex diseases during a similar period. HSNFs also expanded starting with the onset of the DRGs in 1982. The post-acute sector grew with the advent of the inpatient PPS in 1983. With this growth has come confusion about how best to distinguish among the various post-acute facilities and the services they provide.

In 2015, there are about 1,172 IRH/Us organized specifically to provide medical rehabilitation. In addition, MedPAC reports that in 2013 approximately 15,000 SNFs and 408 LTCHs existed to provide medically complex care and some level of medical rehabilitation services to patients. Currently, each of these entities must meet specific conditions of participation, and, in some cases, specific additional criteria, under the Medicare program in order to be reimbursed. The plethora of coverage criteria and definitional standards regarding either the types of patients or processes of care in each of these post-acute care venues has raised concerns in policy circles that there are few objective standards or criteria by which to assign individual patients to specific settings. These factors point to a need to improve the post-acute care delivery system by focusing on patient-centered care. AMRPA proposed the creation of a Continuing Care Hospital to strengthen the delivery system with a focus on patients’ clinical needs.

Payment would be determined by the patient’s clinical and functional characteristics and the program resources needed to provide that care. Pilot test participants would be allowed to care for certain types of patients if they demonstrate the ability to provide care, as defined by law and regulation, meet specific patient care and patient safety standards, and demonstrate certain outcomes.

Congress should direct CMMI to promptly implement the CCH pilot, as required by statute. Defining the episode of care as a CCH stay plus the 30 days following discharge allows CMS to begin testing a viable post-acute care bundled payment model before having to report to Congress on prospective payment and other post-acute care payment reforms. The CCH pilot requires the use of performance and outcome measures consistent with the IMPACT Act. Although CMMI does not require additional legislation to launch the CCH pilot, which it is already statutorily mandated to do, Congress should ensure that implementation occurs swiftly as an important step in evaluating viable post-acute care payment reforms.

Conclusion

AMRPA shares legislators' and policymakers' interest in addressing variation in spending, quality and margins across different sites of service and supports careful consideration of new payment models. We remain concerned that prematurely implementing a bundled payment system presents risks to Medicare beneficiaries that outweigh the potential for Medicare program savings. Bundled payments must not act as a façade for reducing costs and shifting spending to other parts of the Medicare program at the expense of patients' full recoveries from serious illness and injuries. Medicare policies must ensure that individuals with disabilities, serious injuries, life-threatening illness, and other beneficiaries continue to have access to medically necessary inpatient rehabilitation care. Although AMRPA cannot support the BACPAC Act in its current iteration, we look forward to working with the House Energy and Commerce Health Subcommittee in thoroughly vetting proposals that would establish bundled payments for IRH/Us. We thank you once again for the opportunity to provide testimony to the Committee.