May 24, 2019

The Honorable Seema Verma  
Administrator  
Centers for Medicare and Medicaid Services  
U.S. Department of Health and Human Services  
Hubert H. Humphrey Building  
200 Independence Avenue, Southwest  
Washington, DC 20201

Delivered Electronically via Regulations.Gov

RE: AMRPA Initial Comment Letter on Fiscal Year 2020 IRF PPS Proposed Rule [CMS-1710-P]

Dear Administrator Verma:

This early comment letter is submitted on behalf of the American Medical Rehabilitation Providers Association (AMRPA) regarding the Centers for Medicare and Medicaid Services’ (CMS) Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) and Quality Reporting Program Federal Fiscal Year (FY) 2020 Proposed Rule (hereinafter referred to as the “Proposed Rule”), published in the Federal Register on April 24, 2019. AMRPA will submit a more detailed and comprehensive response later in the comment period that addresses all aspects of the FY 2020 Proposed Rule. We are submitting this initial comment letter, however, to request that CMS furnish additional data related to certain provisions in the proposed rule (outlined fully below), as AMRPA believes that this data is critical to stakeholders’ analysis and response. As always, AMRPA appreciates your consideration of our comments on the proposed rule.

As a preliminary matter, AMRPA commends CMS for its responsiveness to the concerns we raised in our FY 2019 proposed rule comments about the use of an unweighted motor score applied to the Quality Indicator (QI) assessment items in the IRF patient assessment instrument (IRF PAI). At that time, we noted that, “void of any explanation or data from CMS to justify otherwise, we cannot perceive how reverting to an unweighted motor score for the proposed FY 2020 CMGs would improve or further refine the IRF PPS.” While we continue to believe that a weighted motor score is more likely than an unweighted motor score to improve/further refine the IRF PPS, we note that stakeholders’ understanding of the rule’s proposed impacts would significantly benefit from additional technical information pertaining to the proposed weighted score and other issues.

We greatly value CMS’ collaboration with AMRPA as major changes are implemented to the IRF PPS, as well as other post-acute care payment systems. To this end, we respectfully ask
that CMS and (and the Research Triangle Institute (RTI), as required) timely provide the following data to allow AMRPA to comment meaningfully on the proposed IRF PPS changes for both FY 2020 and future payment years:

- **Additional Explanation of Changes to Motor Sub-Weight Items:** AMRPA notes that there are significant changes between the current motor subscore weights (used under the FIM™) and the proposed weights (used for the related Quality Indicator items (SPADEs)) under IRF PAI Sections GG and H. While we understand that the weight of motor items will not be identically distributed under Section GG/H reporting as it was with FIM™, we ask that more information be provided on some notable changes – for example, why the Eating sub-item weight would change from 0.6 (current) to 2.7 (proposed). As a broader issue, AMRPA also notes that self-care items were generally assigned lower weights under the FIM™, with mobility items receiving higher weights. Under the proposed weights applied to Section GG/H items, it appears that CMS is taking the inverse approach – assigning higher weights to self-care items and lower weights to mobility items. AMRPA requests additional justification for this change and data, such as Sections GG/H patient assessment data, as we consider our response to this section of the rule.

- **Additional Data on CMG Compression:** We ask CMS to provide any modeling that was performed to examine how the proposed CMG changes will impact certain patient conditions and payment rates. The rule proposes to remove CMGs in four Rehabilitation Impairment Categories (RICs): Stroke (RIC 01), Traumatic brain injury (RIC 02), Non-traumatic spinal cord injury (RIC 05), and Replacement of lower extremity joint (RIC 08). These conditions represent more than a third of all IRF patients. We seek information regarding how patients in the removed CMGs will be reclassified under the proposed CMGs, and the resulting impact/changes to reimbursement rates as a result of these changes. To that end, we request data such as a frequency/distribution table showing how the subset of FYs 2017 and 2018 stays used in RTI’s analysis (N=551,503) were classified under the current CMG system, and how those same stays would be classified under the proposed CMG system. AMRPA would similarly appreciate any additional data CMS and/or RTI can share about the compression observed in the proposed CMGs.

- **Provider-Specific Impact Analysis File:** AMRPA requests certain additional data – such as a methodology or “data dictionary” – to help understand how the provider-specific impact analysis file was calculated. For example, AMRPA did not find any clarification in the rule as to whether/which facility-level adjusters were used and the year from which the case-mix was derived. Without this data, our members cannot fully assess how the proposed rule would impact their hospital in FY 2020.

AMRPA looks forward to continuing to review the rule and, as noted, will be providing CMS with substantive comments on behalf of our member hospitals later in the comment period.

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We appreciate the opportunity, however, to provide these initial comments and we thank CMS in advance for its responsiveness to these articulated concerns, and for its efforts to ensure stakeholders can provide meaningful and timely comments on the FY 2020 proposed rule.

If you have any questions do not hesitate to reach out to Kate Beller, Executive Vice President for Policy Development and Government Relations of AMRPA (202-207-1132, kbeller@amrpa.org); Carolyn Zollar, AMRPA Senior Policy Counsel (202-860-1002, czollar@amrpa.org); or Mimi Zhang, AMRPA Director of Payment Innovation, Quality and Research (202-860-1003, mzhang@amrpa.org).

Sincerely,

Richard Kathrins, Ph.D.
Chair, AMRPA Board of Directors
President and CEO, Bacharach Institute for Rehabilitation