June 23, 2017

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1671-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Delivered Electronically


Dear Administrator Verma:

This letter is submitted on behalf of the American Medical Rehabilitation Providers Association (AMRPA) regarding the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) Federal Fiscal Year (FY) 2018 Proposed Rule, published in the Federal Register on May 3, 2017. AMRPA is the national voluntary trade association representing more than 525 freestanding rehabilitation hospitals, rehabilitation units of general hospitals, outpatient rehabilitation service providers and several skilled nursing facilities (SNFs). The vast majority of our members are Medicare participating providers.

In 2015, inpatient rehabilitation hospitals and units, or inpatient rehabilitation facilities (IRFs) as referred to by the Centers for Medicare and Medicaid Services (CMS), served 344,000 Medicare beneficiaries with more than 381,000 IRF stays. On average, Medicare Part A payments represent more than 60 percent of IRFs’ revenues. Hence, any alterations to the Medicare payment system have substantial implications for these medical providers. IRFs provide hospital-level care, which is significantly different in intensity, capacity, and outcomes from post-acute care (PAC) provided in non-hospital facilities. AMRPA members help their patients maximize their health, functional ability, independence, and participation in society so they are able to return to home, work, or an active retirement. Our comments follow.

The comments contained in this letter and attachments reflect extensive feedback from the medical rehabilitation industry, including professionals involved in every aspect of the treatment of IRF patients. Over the past two months, AMRPA has convened multiple committees and workgroups with experts from the field to closely analyze and comment on every aspect of the proposed rule. The diverse range of perspectives and robust discussion and debate involved in crafting these comments

1 Medicare Payment Advisory Commission, Executive Summary, in REPORT TO THE CONGRESS, MEDICARE PAYMENT POLICY xviii (March 2017).
2 Id. (In 2014, Medicare paid for 60 percent of IRFs’ discharges.)
ensure that these recommendations reflect the most knowledgeable and thorough understanding of the proposed rule and its impact on IRFs and their patients.

Summary of Recommendations
AMRPA appreciates the opportunity to comment on this proposed rule and CMS’s careful consideration of the issues raised in this letter. We welcome the opportunity to provide input on the IRF classification criteria, including the 60 Percent Rule, and also appreciate the Administration’s solicitation of recommendations for CMS flexibilities and improvements vis-à-vis the IRF benefit. With regard to the proposed rule, we are primarily concerned about proposals pertaining to the ICD-10 diagnosis codes used for presumptive compliance methodology and the implementation timeline, the expansion of the IRF Quality Reporting Program (QRP) to encompass standardized patient assessment data, and issues related to publicly reported quality data.

Our complete recommendations, comments, and analysis are included in Attachment A; a summary of our recommendations follow.

I. IRF Classification Criteria
1. AMRPA recommends the complete elimination of the 60 Percent Rule due to its inconsistencies with the statutory and stated regulatory intent, and because of the detrimental consequences on Medicare beneficiary and non-Medicare patients’ access to intensive rehabilitation services.

2. AMRPA recommends the continued inclusion of the other IRF classification criteria that relate to the services and program structure provided, including multi-disciplinary medical teams, pre-admission screening requirements, intensive rehabilitation programs, and intensity of medical supervision. To do so will ensure a physician’s judgment on the need for admission based on the services provided at an IRF does not continue to be usurped by the 60 Percent Rule.

3. In the alternative, should CMS not choose to eliminate the 60 Percent Rule, AMRPA recommends the inclusion of several new diagnoses under the 60 Percent Rule – including cardiac, pulmonary, cancer, and organ transplant – and a significant lowering of the current threshold. The new diagnoses should include diagnoses which have seen an increased need for intensive rehabilitation services due to changes in treatment norms and expected outcomes. Further, the new compliance threshold should be reduced to a maximum of 50 percent to facilitate enhanced access to medically necessary rehabilitative care for patients with complex conditions who are not currently included.

II. Proposed Refinements to the Presumptive Compliance Methodology ICD-10-CM Diagnosis Codes
   A. Removal of Unspecified Codes
      AMRPA remains extremely concerned that CMS has targeted unspecified codes for elimination from the list of presumptively compliant codes. We urge CMS to provide detailed clinical rationale as to why it believes a diagnosis code no longer meets the presumptive compliance standard and not remove codes simply because the codes is “unspecified.”
B. Treatment of Specific Codes

1. **Traumatic Brain Injury under IGC 2.21 and IGC 2.22**
   AMRPA recommends that CMS retain codes S06.9X9A, S02.101B + A, S02.102B + A, S02.101A + A, S02.102A + A on the presumptive compliance list as they indicate brain injury condition that fall squarely within 60 Percent Rule requirements.

2. **Hip Fractures under IGC 8.11 and IGC 8.12**
   AMRPA supports CMS’ proposal to remove certain unspecified hip fracture codes from the presumptive compliance list, since IRFs should be able to indicate the involved femur.

3. **Other Specified Myopathies, G72.89**
   1. AMRPA strongly urges CMS not to adopt its proposal to remove G72.89 – Other Specified Myopathies from the presumptive compliance list.
   2. AMRPA disagrees with CMS that “disproportionate” code use is appropriate rationale for removing a code from the presumptive compliance list. Instead, we recommend the Agency directly address these types of concerns through the appropriate oversight mechanisms.
   3. AMRPA recommends that CMS clarify its expectations for and educate providers on the proper use of G72.89, including the specific conditions for which it intended G72.89 to be used, and the appropriate medical documentation thereof.

C. **Effective Date**
   AMRPA strongly recommends that any changes to presumptive compliance codes only apply to an IRF at the beginning of its next compliance review period subsequent to the effective date, and not apply to an IRF’s compliance review period that has already commenced. AMRPA recommends that CMS implement bifurcated effective dates for these changes, as follows:
   1. For ICD-10-CM codes **restored** to the list Presumptive Compliance (ICD-10-CM) OR **removed** as an excluded etiologic diagnosis on the list “Impairment Group Codes That Meet Presumptive Compliance Criteria (ICD-10-CM): These proposed changes should be made effective retroactively for compliance review periods beginning on or after October 1, 2015.
      a. At a minimum, these codes should be made effective for discharges on or after October 1, 2017.

   2. For ICD-10-CM codes **removed** from the list Presumptive Compliance ICD-10-CM OR **added** as an excluded etiologic diagnosis on the list of Impairment Group Codes That Meet Presumptive Compliance Criteria ICD-10-CM: Implementation of these proposals should be delayed by at least one year, becoming effective for compliance review periods beginning on or after October 1, 2018 at the earliest. AMRPA strongly opposes any implementation of these particular codes prior to October 1, 2018.

D. **Subregulatory Process for Future Updates to ICD-10-CM Codes on Presumptive Compliance List**
   AMRPA does not support this policy as proposed and recommend that CMS delay
finalization until more detailed and appropriate guidelines can be promulgated through notice and comment rulemaking.

E. Suggested Changes to the Presumptive Compliance Methodology

AMRPA would like to offer several suggested changes to the presumptive compliance methodology, including ways to ensure that future updates are made in a more constructive and collaborative manner.

1. AMRPA recommends CMS eliminate the 50 percent Medicare patient threshold for eligibility to use the presumptive compliance methodology.
2. AMRPA recommends that CMS establish a TEP comprised persons with clinical, operational, and policy expertise which should meet at least once annually with CMS staff to discuss the 60 Percent Rule.
3. AMRPA recommends that CMS publish a list of only the codes proposed for revision in each year’s NPRM, designating whether each code has been added to or removed from a particular list.
4. AMRPA requests that CMS provide IRFs with access to the pertinent information (software specifications, patient-level data, etc.) that would allow providers to review and compare internally generated presumptive compliance percentages with those generated by CMS’ contractor.

III. Revisions and Updates to the IRF Quality Reporting Program (IRF QRP)

A. Standardized Patient Assessment Data and Collection

1. Collection Burden
   Recognizing that the FY 2018 IRF PPS payment adjustment is statutorily set at 1.0 percent, AMRPA urges CMS to account for the resource intensity of the new IRF QRP reporting requirements in the FY 2019 IRF PPS payment update.

2. Data Completion Threshold and QRP Penalty
   1. AMRPA strongly opposes CMS’ proposal to extend the current IRF QRP 95 percent data completion requirement to include standardized patient assessment data. We recommend CMS adopt an 80 percent threshold for standardized patient assessment data in the IRF QRP, consistent with the requirements for other PAC QRPs.
   2. At a minimum, the completion threshold should be lower than 95 percent in the first reporting year these items are required, and we suggest that CMS work with IRF stakeholders to develop a more appropriate completion threshold.
   3. We also strongly urge CMS to conduct provider education and training well in advance of the items’ October 1, 2018 implementation date.

3. Proposed Application of Other IRF QRP Policies
   1. AMRPA does not recommend CMS adopt a subregulatory process for non-substantive changes until it can propose and vet with stakeholders illustrative examples of non-substantive and substantive changes as they pertain to standardized patient assessment data.
2. We support CMS’ proposals to adopt the IRF QRP exceptions policy, extensions policies, and the retention policy to the reporting of standardized patient assessment data.

4. Proposed IRF PAI Assessment Items
   1. AMRPA urges CMS to conduct provider training on the proposed patient assessment items well in advance of their October 1, 2018 effective date.
   2. AMRPA supports the proposal to use data reported under Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631) to satisfy the IMPACT Act’s functional data reporting requirement. However, we recommend that CMS propose in future rulemaking a more patient-centric functional status data item for adoption across PAC settings to meet the Act’s requirement.
   3. Given our concerns with the Short Confusion Assessment Method (CAM), we recommend that CMS provide detailed assessment specifications as soon as possible.
   4. AMRPA supports the use of the PHQ-2.
   5. AMRPA recommends that CMS add “Regular Food: solids and liquids swallowed safely without supervision or modified food consistency” as a response option for Item K0520--Nutritional Approaches at admission and discharge.
   6. We recommend that CMS investigate how it may be able to glean information on special services, treatments and interventions by utilizing Medicare claims data already at its disposal rather than doing so by imposing additional provider reporting requirements.

B. Proposed Changes to IRF QRP Measures

1. Proposed Changes to Pressure Ulcer Measure (NQF #0678)
   1. We support adoption of the modified pressure ulcer measure. We also recommend that the Agency conduct training regarding the modified assessment practices well in advance of October 1, 2018.
   2. AMRPA does not support removing Item M0900 wholly from the IRF PAI. We recommend that CMS retain it for voluntary reporting.
   3. We recommend that CMS also include morbid obesity (BMI > 40) as a risk adjustor.

2. Removal of All-Cause Unplanned Readmission Measure
   AMRPA supports CMS’ proposal to remove All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge (NQF #2502) from the IRF QRP.

3. Potential Future Changes and Measures

a. IRF Experience of Care Survey
   1. AMRPA recommends that CMS include questions on an IRF experience of care survey that better address therapy services.
   2. We recommend that CMS account for the rate of return of completed surveys in evaluating the survey’s fitness for the IRF QRP.
3. We strongly recommend that CMS make a draft survey/questions and survey implementation processes publicly available and allow an opportunity for stakeholder input well in advance of implementing it in the IRF QRP.

b. Application of Percent of Residents Who Self-Report Moderate to Severe Pain (Short Stay) (NQF #0676)
   AMRPA does not think this is an apt measure for the IRF QRP and does not recommend or support CMS’ adoption of the measure in the future.

c. Modifications to the Discharge to Community Measure
   1. AMRPA supports modifying this measure to exclude baseline nursing facility residents, having consistently recommended this approach in prior rulemaking and other public comment opportunities.
   2. We also suggest that CMS look for ways to address these beneficiaries’ needs in quality reporting programs via other strategies and not wholly exclude them from nursing facilities’ accountability.

d. Risk Adjustment for Social Risk Factors
   1. AMRPA strongly supports a methodologically sound approach to risk-adjustment for socioeconomic and sociodemographic status factors.
   2. AMRPA recommends that CMS compare quality performance rates and resource use spending for providers that have comparable proportions of similar patients, such as low-income beneficiaries.
   3. We also recommend that CMS develop a way to account for family/caregiver status and/or community supports.

e. Input Sought for Data Related to Assessment-Based Measures
   1. AMRPA supports expanding assessment-based measures to non-Medicare populations so that more patients are encompassed in quality improvement initiatives.
   2. AMRPA also recommends that CMS continue to align the beneficiary populations which are assessed by patient assessment instruments across PAC settings. We believe that quality measures and data collection implemented under the Act should apply to a uniform Medicare patient population (inclusive of at least Medicare Part A and Part C beneficiaries).
   3. Should CMS in the future propose to publicly report quality data for non-Medicare beneficiaries, the data should be stratified by payer status and CMS should work with stakeholders to develop what would be appropriate reporting methods in advance of public display.

C. Public Reporting

1. General Recommendations
   1. AMRPA urges CMS to adhere to the following principles in publicly reporting IRF quality measures and data:
      a. IRF Compare measures should have robust comparative value.
      b. IRF Compare should use measures and data that produce statistically meaningful information.
c. IRF Compare measures and performance ratings should report clinically meaningful information.
2. We recommend that CMS remove the performance categories (“Better/Worse than”) from IRF Compare data as soon as possible.
3. We also request that CMS be more transparent with regard to the statistical methodologies it uses to calculate provider performance. The Agency should publicize the methodology and calculations used so these can be analyzed and replicated by stakeholders, similar to how other IRF QRP data is made available for provider validation.

2. Proposed Changes to Publicly Reported Measures
1. AMRPA does not support publicly reporting the potentially preventable readmission (PPR) post-discharge measure or the PPR within stay measure at this time. We urge CMS to work with stakeholders to develop a methodological approach to publically report readmissions quality data in a practical and meaningful way. Should CMS proceed with public reporting for PPR measures without first developing this framework, it should not use performance categories or ratings in public reporting.
2. AMRPA strongly recommends that CMS’ not finalize its proposal to publicly report MSPB data.
3. AMRPA supports CMS’ proposals to remove from public reporting the All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge (NQF #2502) and to replace it with the modified measure proposed in this rule, Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury.

3. Low Volume Threshold
We recommend that CMS use a low volume threshold of 30 cases for all measures.

IV. Request for Information on CMS Flexibilities and Efficiencies

A. Revise IRF Classification Criteria
1. Reduce the Threshold of the 60 Percent Rule: To facilitate enhanced access to medically necessary rehabilitative care for patients with complex conditions such as organ transplantation and cancer, CMS should reduce the compliance threshold to a maximum of 50 percent.

2. Expand the Conditions Covered by the 60 Percent Rule: CMS should expand the list of 13 qualifying conditions that satisfy the compliance threshold to include other impairment group codes, including patients with cardiac conditions, COPD, organ transplant, and femur fracture, among others.

B. Clarify Coverage Criteria
1. Simplify the Intensity of Therapy Requirement and Ensure that Contractors Correctly Apply It: CMS should simplify the intensity of therapy requirement to require that the aggregate amount of therapy over the course of the IRF stay aggregates
to at least 15 hours per week, as is currently permitted under the benefit manual when
certain circumstances allow.

2. **Clarify Policies Regarding Delivery of Non-Individual Therapy**: CMS should clarify in subregulatory guidance documents that group and concurrent therapy count toward the intensity of therapy requirement (i.e., 3-Hour Rule) when determined to be medically appropriate by the rehabilitation physician and therapy teams and documented accordingly.

3. **Clarify the Intensity of Therapy Requirements**: CMS should expand the coverage criteria to include other types of skilled therapy services (such as recreational therapy), when it is: (1) prescribed by the treating physician and the rehabilitation team as part of the patient’s plan of care; (2) considered active treatment; and (3) provided by a qualified therapist.

C. **Implement the Continuing Care Hospital**: CMMI should test the CCH model, which is not only an APM but a promising delivery system reform that would foster better care coordination and disincentivize disruptive and needless transfers.

D. **Ensure New Unit Parity**: Hospital-based rehabilitation units should be paid a CMG from the outset, the same as freestanding rehabilitation hospitals, regardless of whether the unit opens on or after the first day of the cost reporting period.

E. **Protect Medicare Advantage Beneficiaries’ Access to Inpatient Rehabilitation Care**: CMS should issue directives to MA plans about the preeminence of Medicare coverage regulations over proprietary guidelines through a formal pronouncement of policy.

F. **Reduce Redundancies in Patient Assessment Documentation**: CMS should direct contractors to deem documentation for a single claim to satisfy each of the levels of assessment for that patient. Alternatively, the agency could eliminate redundancies in patient assessment documentation criteria.

G. **Provide Regulatory Flexibility in Alternative Payment Models**

1. **Allow IRFs to Implement Alternative Pricing**: CMS should waive certain Medicare payment rules to allow IRFs participating in APMs to implement alternative pricing models, such as per diem payments or discounts from the IRF PPS amount.

2. **Administrative Presumption of Coverage under APMs**: All patients admitted to IRFs from acute care hospitals participating in an APM, regardless of whether the facility is receiving IRF PPS or reduced reimbursement, should be presumed to be covered in the IRF setting.

H. **Establish a Post-Acute Care Advisory Council**: CMS should form an Advisory Council dedicated to post-acute rehabilitation care and give it a broad mandate to provide recommendations and ongoing advice to the Secretary and Congress on issues relating to Medicare coverage for post-acute rehabilitation services.
I. Implement Proposals Addressing Audits, Denials and Appeals

1. **Eliminate Technical Denials**: CMS should include a statement in the regulations governing either IRF coverage or contractor audits clarifying that isolated technical deficiencies in documentation shall not constitute the sole basis for denial of a claim. Alternatively, the agency could establish a “totality of the circumstances” test for determining whether coverage criteria are met.

2. **Streamline the Appeals Process**: CMS should consolidate the redetermination and reconsideration stages of the appeals process or, at a minimum, allow providers to opt out of reconsideration before proceeding to ALJ review.

3. **Halt Recoupment of Claims Denied Post-Payment through the Issuance of an ALJ Decision**: CMS should expand the current limitation on recoupment related to post-payment denials through the date an ALJ decision is issued.

4. **Create an Audit “Circuit Breaker”**: Medicare contractors should be barred from conducting payment reviews based solely on statistical analyses when a provider demonstrates why its caseload is at variance with the applicable regional or national analyses.

5. **Require Recalculation of Error Rates for Providers Under Pre-Payment Review**: MACs that institute ongoing pre-payment reviews against providers should be required to recalculate error rates on a quarterly basis (and include the results of any favorable appeals in the calculation) for purposes of determining whether it is appropriate to continue pre-payment review or revise the percentage of claims to be reviewed.

6. **Deem Appealed Claims as Payable if they Remain Pending for Five Years or More After the Initial Determination**: For any appeal still pending five years after the date of the initial determination on the claim, the claim should be deemed payable provided the claim denial does not involve allegations of fraud or similar fault.

V. Proposed Changes to the IRF PPS

A. **Facility Level Adjustment Factors for FY 2018**
AMRPA urges CMS to include more detailed information in the final rule explaining the Agency’s rationale for continuing the freeze of the facility level adjustments. Lastly, we continue to support a minimum interval for any change in the IRF provider-level adjustment factors, such as once every three years, as well as the establishment of a percentage change threshold for each factor requiring an update.

B. **Proposed Wage Index Update and Labor Related Share for FY 2018**
As stated in our comment letter on the FY 2017 IRF PPS proposed rule, AMRPA recommends that CMS utilize the most current wage data (which is already used for acute care hospitals and other PAC providers) to determine the IRF wage index and level the recruitment playing field across all post-acute sites of care.
C. Proposed IRF Standard Payment Conversion Factor and CMS Payment Rates for FY 2018
AMRPA respectfully requests that CMS carefully monitor the impact these productivity adjustments have on the rehabilitation hospital sector, provide feedback to Congress as appropriate, and utilize any authority the Agency has to reduce the productivity adjustment.

D. Proposed Update to the High Cost Outliers and Cost to Charge Ratio Ceiling and Urban/ Rural Averages for FY 2018
AMRPA supports the policy of setting outlier payments at 3 percent of total estimated aggregate payments. We request that CMS update the final rule outlier threshold amount using the latest available data to ensure that the entire 3 percent outlier pool will be paid to IRF providers. AMRPA also recommends that CMS modify its methodology for determining outlier payments so the full 3 percent is paid out every fiscal year.

VI. Proposed Update to the Case-Mix Group (CMG) Relative Weights and Average Length of Stay Values for FY 2018

A. Data Used to Update the CMG Relative Weights
We agree with use of the FY 2016 IRF claims data and the FY 2015 cost report data. However, as described more thoroughly below, it is difficult for stakeholders to provide feedback on the application of that data to the updated methodologies. We request that CMS make available each year the report or analyses it uses to apply the updated data in its calculation of the proposed adjusted relative weights, including cost data related to comorbidities.

B. Process for Calculating the CMG Relative Weights
AMRPA supports the stated process for calculating the CMG relative weights. However, as stated before, CMS should make available the report or analyses it performs to determine the updated relative weights for comorbidities and tiers.

C. Average Length of Stay (ALOS)
1. As stated in prior comment letters, AMRPA recommends that CMS publish its methodology for calculating the annual ALOS for each CMG and tier, just as it does for the CMG weights and other components of the payment system. The ALOS has a substantial impact on the payment policy for IRFs. Therefore it should be subject to the same notice and comment rulemaking as other methodologies used to determine IRF payments.

2. As stated previously in this section, AMRPA urges CMS to provide the underlying analyses and report it uses to update the ALOS for CMGs, including any cost data on comorbidities. Without this information, stakeholders cannot properly understand the way the data is applied to the CMGs and tiers, and respond to the proposed rule.
VII. Proposed Revisions to the IRF PAI

A. Removal of Voluntary Item 27–Swallowing Status
   AMRPA recommends that CMS retain Item 27–Swallowing Status as a voluntary item until Item K0520–Nutritional Approaches is added to the IRF PAI for admission and discharge assessments.

B. Using IRF PAI information to determine patient BMI greater than 50 for cases of lower extremity single joint replacement and count qualifying patients in the presumptive methodology for the 60 Percent Rule
   AMRPA recommends CMS not implement this proposal as it is inconsistent with the current methodology of determining presumptive compliance, i.e. using ICD-10 diagnosis codes.

C. Removal of the 25 Percent Payment Penalty for Late IRF PAI Submissions of the IRF Patient Assessment Instrument (IRF PAI) beginning October 1, 2017
   AMRPA recommends that CMS finalize its proposal to remove the 25 percent penalty for all discharges beginning on or after October 1, 2017.

AMRPA welcomes continued opportunities to collaborate with the Department of Health and Human Services (HHS) and CMS to refine and improve the IRF PPS. If you have any questions about AMRPA’s recommendations, please contact us or AMRPA’s Executive Vice President for Government Relations and Policy Development, Carolyn Zollar, M.A., J.D. (czollar@amrpa.org / 202-223-1920).

Sincerely,

Bruce M. Gans, M.D.
Chair, AMRPA Board of Directors
Executive Vice President and Chief Medical Officer, Kessler Institute for Rehabilitation
National Medical Director for Rehabilitation, Select Medical

Mark J. Tarr
Chair, AMRPA Regulatory and Legislative Policy Committee
President and Chief Operating Officer, HealthSouth Corporation

Cc:
Laurence Wilson
Jeanette Kranacs
Todd Smith
Susanne Seagrave
Gwendolyn Johnson
Mary Pratt
Attachment A
American Medical Rehabilitation Providers Association’s Analysis, Comments and
Recommendations on the Medicare Program; Inpatient Rehabilitation Facility Prospective Payment
Attachment A


I. IRF Classification Criteria

A. General Discussion

There are several fundamental reasons why the IRF 60 Percent Rule should be eliminated. As explained below, the Rule is not patient-centered and limits access to care, does not truly describe an IRF as a distinct type of medical provider, and its utility has been obviated by the changes in payment systems and medical advances in the decades since its inception.

Four years ago, senior officials from CMS and the Medicare Payment Advisory Commission (MedPAC) testified before the House Ways and Means Health Subcommittee at a hearing examining Medicare’s post-acute care payment systems and policies. During the hearing, these witnesses characterized the 60 Percent Rule as “arbitrary,” “clunky,” “crude,” and “not having a lot of science” behind it.⁵ In the ensuing four years, essentially nothing has changed to alter these characterizations of the 60 Percent Rule — it remains arbitrary, clunky, crude, and devoid of science.

1. The 60 Percent Rule is Not Patient-Centered and Limits Access to Needed Care

The 60 Percent Rule mandates that 60 percent of IRF patients must have “required intensive rehabilitation services” with diagnoses derived from 13 outdated and archaic diagnostic categories and medical conditions.⁴ The list of 13 conditions forces IRFs to meticulously monitor the diagnoses of admitted patients and screen those being considered for admission in order to comply with the Rule’s provisions, disproportionately emphasizing diagnosis rather than the patient’s rehabilitative and medical needs. In presupposing that patients with particular diagnoses require IRF services, the 60 Percent Rule creates an impression that patients whose diagnoses fall outside of its diagnostic categories and medical conditions do not require IRF services. These arbitrary assumptions supplant the medical judgment of physicians discharging their patients from general acute care hospitals to IRFs. The same holds true for rehabilitation physicians in IRFs when deciding whether to admit patients into their hospital or hospital-based unit. The Rule assumes that physician judgment regarding a patient’s rehabilitation placement is only secondary to Medicare regulations and is best

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³ Proposals to Reform Medicare Post-Acute Care (“PAC”) Payments before the Subcomm. on Health of the H. Comm. on Ways and Means, 113th Cong. (2013)
⁴ 42 C.F.R. § 412.29 (2017)
characterized as top-down decision-making. It cannot be described as a patient-centered approach.

The 60 Percent Rule also limits access to needed treatment for both Medicare and non-Medicare patients. Patients suffering with diagnoses derived from medical conditions outside the Rule receive IRF care on what amounts to a rationed approach. IRF treatment is allocated via this lottery system because each IRF can only accommodate non-60 Percent Rule patients by virtue of its stance relative to the 60 Percent compliance threshold. This backwards result of distorted admission patterns and access barriers demonstrates that the 60 Percent Rule is outdated and an inappropriate criterion to classify IRFs and distinguish them from acute care hospitals as required by the statute.

2. **The 60 Percent Rule Does Not Describe an IRF as a Distinct Type of Medical Facility**

   When the 60 Percent Rule was implemented in 1984 (then as a 75 Percent Rule), a prospective payment system was just being implemented in general acute care hospitals and cost-based reimbursement was still in effect for rehabilitation hospitals.\(^5\) Under these very different dynamics, the 60 Percent Rule was used to classify IRFs and served the purpose of distinguishing the uniquely intensive medical rehabilitation services and program attributes an IRF provides from general acute care hospitals.

   Since then, CMS has created a separate prospective payment system for IRFs, and instated the classification criteria, including licensure requirements, pre-admission screenings to determine suitability for intensive rehabilitation, multi-disciplinary medical teams, and close medical supervision such as full-time physician coverage and 24-hour nursing. CMS has also implemented ongoing review of IRF medical necessity and patient admission/coverage criteria, which more than ensures that IRFs are treating patients who need their services. The 60 Percent Rule therefore serves little purpose in classifying IRFs but has remained a blunt instrument denying large swaths of patients access to their services.

3. **Advances in Healthcare Expenditure Dynamics and in Medical Treatment Have Obviated The Need for The 60 Percent Rule**

   Since the 60 Percent Rule’s incorporation into the IRF PPS classification criteria, payment and care delivery systems have developed ample incentives to use IRF services only as appropriate. Alternative payment models (APMs) such as accountable care organizations (ACOs), the Bundled Payment for Care Improvement (BPCI) initiative, the Comprehensive Care for Joint Replacement (CJR), and the overall impact of managed care, including Medicare Advantage (MA), are affecting the utilization of post-acute care services to a level and degree that was not occurring even five years ago. These programs incentivize utilization of high-quality care in the most efficient manner. Similarly, the Medicare Spending Per Beneficiary (MSPB) measure under the hospital value-based purchasing (HVBP) program is also affecting IRF utilization and acute hospitals/physicians decision-making as they contemplate patient referrals for rehabilitative care. The MSPB measure incentivizes acute care hospitals to pay close attention to their discharge planning practices and post-acute care utilization, because

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\(^5\) Medicare Program; Prospective Payment for Medicare Inpatient Hospital Services, 49 Fed. Reg. 239 (Jan. 3, 1984)
doing so yields financial rewards for a hospital while failing to do so can result in financial penalties.

The Rule’s original ten conditions, which still serve as the core of today’s 13 conditions, were developed based on a technical review of treatments in IRFs in 1975. In the 42 years since, medical treatment and outcomes have seen major changes. Many diagnoses that could benefit from IRF treatment remain excluded, such as cardiac, pulmonary, oncology, and transplantation, among others. The majority of these excluded diagnoses have seen major advances in medical treatments, technology, patient outcomes and mortality rates in more recent years, leading to more patients in these categories becoming suitable for intensive rehabilitation. As an example, due to treatment advances and improving outcomes, the American College of Surgeon’s Commission on Cancer now requires that rehabilitation services be included in order to certify a program. Yet despite rehabilitation services becoming the standard of care, oncology remains excluded from the list of 13 conditions.

Further, patients with medical conditions derived from the Rule’s 13 diagnoses who were once often in need of intensive rehabilitation, such as some orthopedic procedures, no longer require an IRF stay with as much frequency as was previously the case due to advancements in surgical techniques.

The table below shows the trends in IRF patient mix from 2005 and 2015 and illustrates the growing proportions of cardiac and pulmonary patients whom IRFs treat.

<table>
<thead>
<tr>
<th>RIC or RIC Group</th>
<th>Change in Medicare Discharge Volume, 2005-2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthopedic RIC Group (RICs 7, 8, 9, 10, 11, 12, 13, 17)</td>
<td>32.2% decrease</td>
</tr>
<tr>
<td>RIC 14 – Cardiac</td>
<td>33.2% increase</td>
</tr>
<tr>
<td>RIC 15 – Pulmonary</td>
<td>25.3% increase</td>
</tr>
</tbody>
</table>

Source: eRehabData®

In such an environment, where the totality of care delivery and payment models have shifted to incentivize efficiencies, and medical advances have altered the types of patients who require intensive rehabilitation, the need for the 60 Percent Rule is obviated and, as a result, it only functions as a barrier to access to care.

B. Implementation of the 60 Percent Rule
This comment letter often reference the descriptions associated with the 60 Percent Rule’s presumptive methodology. While CMS frequently states that medical record review is available to facilities, AMRPA and its members disagree with its decision to use that methodology as a justification for imperfections in the presumptive methodology. As we have consistently and repeatedly highlighted, the medical record review process is overly burdensome and, in some cases, completely cost prohibitive. The presumptive methodology is without question the predominant basis through which the Rule is administered by CMS

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6 Id.
and its contractors and also through which it is satisfied by IRFs. The codes and impairment group categories (IGCs) that count toward the 60 Percent Rule are determined almost exclusively by “extensive clinical and coding expertise available within CMS’s staff,” though IRF stakeholders are permitted to provide comments on these determinations through the notice/comment process.

The FY 2018 IRF PPS Proposed Rule marks the third instance since FY 2014 during which CMS has proposed major modifications to the 60 Percent Rule via presumptive compliance code changes. All of these proposals have resulted in the Rule becoming more restrictive and difficult for IRFs to satisfy. In addition, the switch to the ICD-10-CM codes has further complicated and made nonsensical the use of a list of codes to determine compliance under the 60 Percent Rule. Under ICD-9-CM, codes were not regularly revised or changed. As CMS notes in another part of this year’s proposed rule, the ICD-10-CM code set will be subject to routine updates. Incorporating ICD-10-CM revisions into the IRF PPS presumptive compliance codes via annual rulemaking or subregulatory processes will pose an ongoing and significant burden to CMS and to providers, who must continually update their admission screening procedures. This constant game of catch-up will serve only to further restrict patient access to IRFs as providers become more protective of their compliance standing. As standard medical coding has evolved and modernized, so too should the IRF Classification Criteria and its implementation.

C. Recommendations

AMRPA recommends that CMS focus on the other existing IRF classification criteria that define providers based upon the medical, rehabilitative, and nursing services and programs within the hospital/unit and the manner in which they are provided, rather than the specific and narrow set of diagnoses of patients treated within the facility. The concept of classifying IRFs based on services and other attributes, rather than narrow diagnostic codes, is consistent with the original statutory intent as well as CMS’ policy goals for the IRF PPS. In the first rulemaking to establish the payment system, CMS cited the fact that IRFs were to be excluded from the IPPS because the acute care payment system was “not designed to account for these types of treatments.” Further, the rule stated that its overarching policy objective of the IRF PPS was to “be able to recognize legitimate cost differences among various settings.” This statement clarifies that IRFs should be differentiated based upon the rehabilitation programs and other medical and nursing services they provide, not the diagnostic codes that are used to reflect providers’ patient mix.

Should CMS choose not to eliminate the 60 Percent Rule, it should significantly lower the threshold to blunt the harmful effects of the rule. AMRPA recommends that the compliance threshold should be reduced to a maximum of 50 percent to facilitate enhanced access to medically necessary rehabilitative care for patients with complex conditions such as organ transplantation, cancer, cardiac, and pulmonary conditions that are not currently included in the 60 Percent Rule. Although this would not fully alleviate the barriers to access created by this type of rule, the lower threshold would result in considerably fewer patients arbitrarily

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10 Id.
being denied access to medically necessary inpatient rehabilitation care. Under the Medicare, Medicaid, and SCHIP Extension Act of 2007, CMS was directed to “require a compliance rate that is no greater than the 60 percent compliance rate that became effective for cost reporting periods beginning on or after July 1, 2006,” meaning that CMS has full authority to lower the threshold below 60 percent.

As a companion to lowering the threshold, CMS should significantly expand the list of 13 conditions currently included under the rule. As discussed above, advances in medicine have resulted in a number of types of patients for which intensive rehabilitation programs are medically necessary. The specific list of additional conditions should flow from data and clinical expertise to ensure that the most appropriate conditions are included in the rule. Further, there should be a mechanism to ensure that the list is able to keep pace with advancements in clinical practice, such as through the establishment of an advisory committee.

In short, the 60 Percent Rule usurps physicians’ medical judgment and makes it more difficult for patients with medical conditions not included in one of the Rule’s 13 outdated categories to access IRF services. As evidenced over the last several decades, medical treatments and expectations are constantly evolving, and any attempt to pre-determine which patients are best served by an IRF is futile and will overly-restrict patients’ access to needed IRF treatment. Our recommendations would ensure that, consistent with other PPSs administered by CMS, a provider’s definition is designed around the attributes involved in delivering medically necessary services and qualified physician judgment, rather than the particular diagnostic code associated with the patient being treated, which is more appropriately addressed in coverage criteria.

Therefore, AMRPA recommends the following changes to the IRF classification criteria:

1. AMRPA recommends the complete elimination of the 60 Percent Rule due to its inconsistencies with the statutory and stated regulatory intent, and because of the detrimental consequences on Medicare beneficiary and non-Medicare patients’ access to intensive rehabilitation services.
2. AMRPA recommends the continued inclusion of the other IRF classification criteria that relate to the services and program structure provided, including multi-disciplinary medical teams, pre-admission screening requirements, intensive rehabilitation programs, and intensity of medical supervision. To do so will ensure a physician’s judgment on the need for admission based on the services provided at an IRF does not continue to be usurped by the 60 Percent Rule.
3. In the alternative, should CMS not choose to eliminate the 60 Percent Rule, AMRPA recommends the inclusion of several new diagnoses under the 60 Percent Rule – including cardiac, pulmonary, cancer, and organ transplant – and a significant lowering of the current threshold. The new diagnoses should include diagnoses which, as discussed above, have seen an increased need for intensive rehabilitation services due to changes in treatment norms and expected outcomes. Further, the new compliance threshold should be reduced to a maximum of 50 percent to facilitate

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enhanced access to medically necessary rehabilitative care for patients with complex conditions who are not currently included.

II. Proposed Refinements to the Presumptive Compliance Methodology ICD-10-CM Diagnosis Codes

A. General Comments on Removal and Addition of Codes

The FY 2015 IRF PPS final rule published a list of ICD-10-CM codes to be included in the presumptive compliance methodology for the 60 Percent Rule.\textsuperscript{12} Shortly thereafter, AMRPA members reported that many critical codes previously covered under presumptive compliance in the ICD-9-CMs were not included in this list. AMRPA described this issue at length in comments submitted on the FY 2016 and FY 2017 IRF PPS proposed rules, but CMS made only minimal changes in response. AMRPA therefore is pleased that CMS has included many of its previously recommended changes in the proposed rule.

However, AMRPA remains extremely concerned that CMS has targeted unspecified codes for elimination from the list of presumptively compliant codes. There are many clinical or medical reasons why an unspecified code could be used that has no bearing on or indication of a particular patient’s suitability for IRF services. First, many such codes are unspecified only as to the cause of the original injury, as discussed below regarding the code specifying “Unspecified intracranial injury with loss of consciousness of unspecified duration.” As a post-acute provider, an IRF must rely on the acute care hospital or other referring provider for information on the original injury. The information necessary to assign a more specific code to a particular patient may be missing from the acute care hospital’s medical record or not ascertainable (such as, for example, in the case of a patient with memory loss). When these types of factors exist, the unspecified nature of the original injury has no bearing on or indication of the patient’s current functional status or need to receive IRF services, and should not be considered for purposes of determining whether an “unspecified” code should “count” under the 60 Percent Rule’s presumptive compliance framework.

eRehabData\textregistered analysis shows that on average, IRFs would sustain an 8.81 percent decrease in presumptively compliant patients in RIC 14-Cardiac and an 11.0 percent decrease in RIC 15-Pulmonary due to the FY 2018 proposed removal of unspecified codes. These are not trivial impacts, indicating that a sizable proportion of patients with these diagnoses need IRF level care and thereby should not be excluded from the 60 Percent Rule’s presumptive compliance framework. We urge CMS to provide detailed clinical rationale as to why it believes a diagnosis code no longer meets the presumptive compliance standard and not remove codes simply because the codes is “unspecified.”

B. Treatment of Specific Codes

1. Traumatic Brain Injury under IGC 2.21 and IGC 2.22

CMS proposes removing some of the traumatic brain injury codes listed as exclusions on the IGC list, thereby allowing them to count toward the presumptive compliance criteria. AMRPA supports these proposals and also has recommendations below

\textsuperscript{12}Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2015, Final Rule, 79 Fed. Reg. 45,871, 45,896 (Aug. 6, 2014)
regarding the implementation of these codes’ reinstatement (see Section C: Effective Date).

However, AMRPA would like to address a number of brain injury codes that will remain on, or are being added to, the exclusion list.

a. *S06.9X9A, Unspecified intracranial injury with loss of consciousness of unspecified duration, initial encounter*

   This code, similar to other intracranial injury codes with loss of consciousness, indicates a significant brain injury just as serious as other codes that were included. CMS did not provide a specific reason for excluding this code from presumptive compliance, but AMRPA suspects it is because the term “unspecified” is used in the code name. As noted above, CMS should remain cognizant that IRFs, as post-acute care providers, are not patients’ first site of care. As such, IRFs must rely on medical records beyond their control to code the injury as anything other than unspecified. Determinations of clinical appropriateness for IRF care for traumatic brain injury patients should not differ simply because the cause of their original injury cannot be specified, especially for cases including loss of consciousness (which indicate a severe injury). AMRPA recommends that CMS retain this code on the presumptive compliance list as it indicates a condition that falls squarely within 60 Percent Rule requirements.

b. *S02.101B + A, S02.102B + A, S02.101A + A, S02.102A + A, Fracture of base of skull, right/left side, initial encounter for open/closed fracture*

   CMS provides no explanation for the removal of these codes from the presumptive compliance code list. These codes indicate serious injuries, for which IRF care is often medically necessary. AMRPA therefore recommends that they be retained on the presumptive compliance list as they indicate conditions that fall under the 60 Percent Rule.

**Recommendation:**

AMRPA recommends that CMS retain the above codes on the presumptive compliance list as they indicate a condition that falls squarely within 60 Percent Rule requirements.

2. **Hip Fractures under IGC 8.11 and IGC 8.12**

   Despite AMRPA’s general objection to the removal of unspecified codes, we agree with CMS’ decision to remove the code pertaining to “fracture of unspecified part of neck of femur of unspecified femur,” since an IRF should be able to indicate the involved femur. Where basic information should be readily available to a post-acute provider without unnecessary testing (such as the afflicted side of the patient’s body), it is reasonable for CMS to request specificity in coding. However, this does not diminish AMRPA’s objection to removing unspecified codes when a more specific alternative presumptively compliant code is unavailable, or where information that would permit the use of a more specific code is not available to the IRF.
Recommendation:
AMRPA supports CMS’ proposal to remove these unspecified fracture codes from the presumptive compliance list.

3. Other Specified Myopathies, G72.89
AMRPA strongly disagrees with CMS’ proposal to remove code G72.89 – Other Specified Myopathies from the presumptive compliance list. G72.89 is the sole code for a long list of patient types for whom IRF services are medically necessary, including congestive heart failure (CHF) myopathy, myopathy associated with cardiac disease, COPD myopathy, uremic myopathy, and disuse myopathy. Removing this code would have a significant impact on presumptive compliance since there is no more specific code in the presumptive compliance list under which these patients can be coded. We request that CMS release any and all information and data it used to justify the proposal to remove G72.89 from the presumptive methodology framework.

AMRPA has serious concerns with CMS’ statement on page 20711 that it is removing some specified codes, particularly G72.89 – Other Specified Myopathies, from presumptive compliance because the Agency suspects that “some IRFs” are using this code disproportionately compared to other IRFs. It is wholly inappropriate for CMS to respond to concerns arising from “disproportionate” utilization of a particular code by completely removing that code from the 60 Percent Rule’s presumptive testing framework. CMS’ rationale for this proposal is to address coding utilization concerns and turn the 60 Percent Rule into a program integrity tool. While the 60 Percent Rule certainly limits the number of patients who can access IRF services based on their medical conditions and diagnoses, it should not be used as a tool to address issues arising from particularized patterns of utilization trends observed by CMS. The Agency’s proposal makes a determination that will impact access to IRF services for many patients suffering from specific myopathies and their effects. Further, the policy does not align with medical literature which supports an early and intensive rehabilitation regimen to improve functional recovery and independence for patients with myopathy.\textsuperscript{13,14,15} We have conducted an impact analysis of FY 2018 proposed code changes and found that 27.8 percent of patients with neuromuscular disorders would no longer satisfy the 60 Percent Rule under the presumptive framework. This drop is almost entirely attributable to the removal of G72.89 as a qualifying comorbidity and as a qualifying etiologic diagnosis under IGC 3.8.\textsuperscript{16} Therefore rather than using this overly broad approach, AMRPA recommends that CMS not consider disproportionate use of the G72.89 code as inappropriate for purposes of removing the code from the list of presumptive compliance codes. Instead, we recommend that CMS address these types of concerns through the appropriate oversight mechanisms.

\textsuperscript{14} N. Latronico and CF Bolton, “Critical illness polyneuropathy and myopathy: a major cause of muscle weakness and paralysis,” Lancet Neurology, 10(10):931-41, October 2011
\textsuperscript{16} eRehabData® variance analysis using Q4 2016 Medicare patients in IGC 3.8 Neuromuscular Disorders as the baseline.
It is also concerning that CMS perceives this code is being utilized “to represent patients with generalized weakness.” Myopathy is a medical condition that can be diagnosed clinically in the IRF, and weakness is a symptom of it. It would be shortsighted for CMS to say that patients suffering from the debilitating effects of a stroke, or a spinal cord or brain injury, or a hip fracture, or a major multiple trauma, are “generally weak” and thus should not be treated in an IRF. In short, myopathies represented through G72.89 are medical and musculoskeletal conditions that cause muscle and other weaknesses – these conditions do not represent the weaknesses themselves and CMS has provided no evidence or rationale, other than “disproportionate” utilization trends, to the contrary.

Additionally, CMS states that G72.89 should only be used for a “relatively narrow set of specified myopathies” to be confirmed through the results of “specific medical testing.” AMRPA is perplexed by this description of CMS’ general expectations associated with this code’s utilization for purposes of the 60 Percent Rule, for a couple of reasons. First, we are not aware that G72.89’s use has ever been limited to any particular myopathies or subsets thereof, whether CHF myopathy, myopathy associated with cardiac disease, COPD myopathy, or uremic myopathy. Second, we are not aware that CMS has ever previously stated that only the specific myopathies it believes should be represented through G72.89 for purposes of the 60 Percent Rule can be so represented only when they are “confirmed by the results of specific medical testing.” In this regard, it is worth noting that the contemporary literature does not agree that medical testing is necessary for all patients suffering from the effects of a myopathy. While biopsies or electrophysiologic investigations may have previously been the diagnostic tests of choice, recent studies indicate that a standardized bedside neuromuscular examination can effectively identify patients with myopathy. AMRPA’s members report that many of their rehabilitation physicians and medical doctors routinely diagnose patients suffering from myopathies, utilizing both the information contained in the patient’s medical records forwarded from the acute care hospital and based on their medical judgment, without needing to perform biopsies or other invasive medical testing.

**Recommendation:**
1. AMRPA strongly urges CMS not to adopt its proposal to remove G72.89 – Other Specified Myopathies from the presumptive compliance list.
2. AMRPA disagrees with CMS that “disproportionate” code use is appropriate rationale for removing a code from the presumptive compliance list. Instead, we recommend the Agency directly address these types of concerns through the appropriate oversight mechanisms.
3. AMRPA recommends that CMS clarify its expectations for and educate providers on the proper use of G72.89, including the specific conditions for which it intended G72.89 to be used, and the appropriate medical documentation thereof.

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C. Effective Date

AMRPA is extremely concerned that CMS’ proposed effective date of October 1, 2017 for these changes would create a confusing and burdensome process for determining IRF compliance under the presumptive methodology. Further, CMS’ proposed timeline does not sufficiently resolve consequences attributable to the transition from ICD-9-CM to ICD-10-CM, which have negatively affected IRFs’ presumptive compliance percentages since October 1, 2015.

AMRPA strongly recommends that any changes to presumptive compliance codes only apply to an IRF at the beginning of its next compliance review period and not apply to part of an IRF’s compliance review period that has already commenced. Previous IRF PPS rules with changes to presumptive compliance codes have specified that policies are effective for compliance review periods beginning on a fiscal year, and CMS maintained that “changes to the presumptive compliance methodology are being applied effective for full 12-month compliance review periods, and will not be applied to only part of an IRF’s compliance review period.” It is critical that implementation dates for presumptive compliance coding changes adhere to compliance review periods, as our recommendations outline below.

IRFs currently are subject to presumptive compliance review under two different standards – one for compliance review periods prior to October 1, 2015 (referred to here as “pre-FY 2016 codes”), and one for those after that date (“FY 2016 codes”). Should CMS decide to implement these changes on October 1, 2017 (“FY 2018 codes”), IRFs would be subject to three different standards for presumptive compliance review over a four-year period. Furthermore, some IRFs with compliance review periods that straddle October 1, 2017 would have two sets of presumptive compliance standards apply to a single compliance review year. This would clearly impose a tremendous administrative burden on providers and their software vendors – who must adjust their practices yet again to ensure regulatory compliance – as well as on CMS and its contractors.

At a point when the Administration seeks regulatory simplification, these proposed changes also would create an administrative burden for CMS contractors, requiring them to institute stringent evaluation procedures to ensure that the correct standards (pre-FY 2016 codes, FY 2016 codes, or FY 2018 codes) are applied to the correct months of each IRF’s compliance review period. Even now, in applying two existing review standards, some contractors have confused the presumptive compliance methodology and algorithms and applied erroneous interpretations. AMRPA is concerned that adding a third method would further compound contractor confusion and increase regulatory burdens on IRFs at a time when CMS has been tasked with doing exactly the opposite.

18 Medicare Program; Prospective Payment System for Inpatient Rehabilitation Facilities; Final Rule, 78 Fed. Reg. 47860 (Aug. 6, 2013)
19 Medicare Program; Prospective Payment System for Inpatient Rehabilitation Facilities; Final Rule, 79 Fed. Reg. 45872 (Aug. 6, 2014)
20 Id.
1. **Resolving ICD-10-CM Transition Issues**

CMS proposes to: (1) remove certain etiologic diagnoses from being excluded under brain injury IGCs 2.21 and 2.22, and hip fracture IGCs 8.11 and 8.12, and (2) add codes to the Presumptive Compliance (ICD-10-CM) list effective October 1, 2017. AMRPA is pleased to see that, following CMS’ comprehensive review of ICD-10-CM codes, the Agency agrees that these diagnoses continue to be clinically appropriate for IRF services and thereby proposes their “reinstatement” under the presumptive compliance methodology. However, AMRPA believes CMS should make these proposals retroactively effective for compliance review periods beginning on or after October 1, 2015. These codes are currently excluded from presumptive compliance – and have been since October 2015 – only due to a technical error in the transition from ICD-9-CM to ICD-10-CM, not because CMS deemed them clinically inappropriate. Accordingly, they should be included under the presumptive compliance methodology retroactively to the time when they were inadvertently excluded, i.e., for compliance review periods beginning on or after October 1, 2015. This would constitute a non-substantive change that corrects a technical glitch which consequentially (and needlessly) made it much harder for IRFs to meet presumptive compliance.

2. **Delaying Implementation of Certain Codes**

CMS also proposes to remove codes from the Presumptive Compliance ICD-10-CM list and add excluded etiologic diagnoses to the list of Impairment Group Codes That Meet Presumptive Compliance Criteria ICD-10-CM effective October 1, 2017. AMRPA adamantly opposes this timeline and urges CMS to delay these proposals by one year, to become effective October 1, 2018. These are substantive policy changes that would make it significantly more challenging for IRFs to meet the 60 Percent Rule under the presumptive methodology. Providers need time to adjust and adapt their processes to any changes in the presumptive compliance methodology. Many of the codes CMS proposes to remove are “non-specific” and providers will require more time than the two months between final rule publication in August and the proposed October 1, 2017 effective date to update their coding practices.

Every IRF must have a full opportunity (i.e., a complete compliance review period) to adjust its documentation practices to account for revisions in the presumptive compliance codes. CMS recognized this point in prior rulemakings by delaying the effective date of presumptive compliance coding changes in the FY 2014 and FY 2015 IRF PPS to FY 2016.23 A one-year delay to the FY 2018 proposals thus would be consistent with the implementation timelines of previous rules that also substantively changed the presumptive compliance codes.

**Recommendation:**
AMRPA recommends that CMS implement bifurcated effective dates for these changes, as follows:

1. For ICD-10-CM codes restored to the list Presumptive Compliance (ICD-10-CM) OR removed as an excluded etiologic diagnosis on the list “Impairment Group Codes That Meet Presumptive Compliance Criteria (ICD-10-CM): These proposed

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changes should be made effective retroactively for compliance review periods beginning on or after October 1, 2015.

a. At a minimum, these codes should be made effective for discharges on or after October 1, 2017.

2. For ICD-10-CM codes removed from the list Presumptive Compliance ICD-10-CM OR added as an excluded etiologic diagnosis on the list of Impairment Group Codes That Meet Presumptive Compliance Criteria ICD-10-CM: Implementation of these proposals should be delayed by at least one year, becoming effective for compliance review periods beginning on or after October 1, 2018 at the earliest. AMRPA strongly opposes any implementation of these particular codes prior to October 1, 2018, and respectfully reminds CMS of the previous approaches it took in the FYs 2014 and 2015 Final Rules that enabled IRFs to adjust to the effects of the changes to the presumptive compliance framework implemented in those rules, which included the ability for IRFs to have their presumptive compliance data reviewed on a full 12 months of data reflecting those changes. By contrast, removing any code from the list Presumptive Compliance ICD-10-CM or adding any code as an excluded etiologic diagnosis on Impairment Group Codes That Meet Presumptive Compliance Criteria ICD-10-CM, prior to October 1, 2018, would be tantamount to retroactive rulemaking. CMS cannot go back into earlier portions of any IRF’s currently effective compliance review period and declare that codes it utilized multiple numbers of months ago as presumptively compliant based on CMS’s most recent rulemakings and policies, are no longer presumptively compliant effective October 1, 2017. All codes currently proposed for removal are still valid presumptive codes, and IRFs that are currently utilizing them as such must be afforded a full compliance review period, i.e., at least 12 months, to make necessary adjustments to their patient admission, documentation, or coding practices, in response to the effects of such removal(s), should such removal(s) be implemented in the pending Final Rule.

The immediate approach in #1 above is an equitable solution, since many of the codes CMS proposes to add were inadvertently excluded from presumptive compliance during the transition to ICD-10-CM and should have been included all along. The delay in removing not-presumptively compliant codes specified in #2 is also equitable, since IRFs would otherwise be subject to their third major change in compliance standards in as many years, as well as retroactive rulemaking with adverse consequences for noncompliance. This approach would ensure that IRFs are given time to evaluate their practices to comply with the revised regulations, thereby affording them a reasonable opportunity to be found in presumptive compliance at their next compliance review period.

D. Subregulatory Process for Future Updates to ICD-10-CM Codes on Presumptive Compliance List
CMS proposes to establish a subregulatory process for making non-substantive changes to the list of ICD-10-CM codes used in the presumptive compliance methodology for the 60 Percent Rule. AMRPA has serious concerns about the lack of specificity in this proposal, including the meaning of “substantive,” especially in light of our experience that just a single addition or removal of a code from the list can significantly impact beneficiaries’
access to care. Given this reality, AMRPA does not think there should be a presumption that removal of a code is non-substantive. Any change to the 60 Percent Rule framework, regardless of how insignificant it may seem, that when implemented would or could potentially make the rule more difficult to satisfy on a presumptive basis, should be considered “substantive” and not adopted outside the traditional notice/comment process. In past rules, CMS has proposed changes to the presumptive compliance list that would have resulted in serious unforeseen impacts and opted not to finalize them based on stakeholder feedback through the notice and comment process. Even in this proposed rule, CMS issued a correction on May 26, 2017 because there were “technical omissions” contained within its proposed IGC exclusion list as originally published with the rule. Had it not been for stakeholder feedback, the error may not have been corrected, which would have had a substantial negative impact on IRFs ability to satisfy the 60 Percent rule under the presumptive methodology. Therefore we urge the Agency, at a minimum, to continue to engage in the notice and comment process for any code changes. We further recommend that CMS involve stakeholders more in the process of developing these code sets, as described in the Section E below.

Additionally, since changes to the ICD-10-CM code set are proposed and finalized by the ICD-10 Maintenance and Coordination Committee more than a year before their implementation date, AMRPA believes there is sufficient time for CMS to incorporate corresponding changes in the yearly NPRM. We totally disagree with CMS’ assumption that changes to the presumptive compliance list, even those reflecting revisions to the underlying ICD-10-CM code set, should automatically be considered non-substantive. AMRPA therefore recommends that CMS not finalize this proposal.

Nonetheless, should CMS decide to proceed with this proposal, the Agency should provide a significantly more detailed delineation and description of when a change to the presumptive compliance list will be considered substantive and subject to notice and comment rulemaking and non-substantive and therefore not subject to notice and comment rulemaking. Failure to disclose central aspects or critical assumptions of a rule deprive members of the public a meaningful opportunity to comment on a proposed rule.24 The FY 2018 IRF PPS proposed rule cites the “substantive versus non-substantive” standard finalized in the CY 2013 OPPS/ASC final rule. However, that rule discusses changes within the context of the IRF QRP and wholly inadequately illustrates how it relates or could be applied to the presumptive compliance codes. Stakeholders must be given the opportunity to comment on a specific, detailed set of guidelines CMS intends to use when proceeding with changes outside of the notice and comment process.

Modifying a prior agency position by moving part of a regulation to a sub-regulatory process also raises serious Administrative Procedure Act (APA) concerns. While an agency may issue interpretive rules outside of a notice-and-comment process, those rules do not have the force and effect of law.25 Substantive (or “legislative”) rules, which create rights or obligations of general applicability must be afforded proper notice and comment

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through the *Federal Register*.\(^{26}\) Further, agencies must “use the same procedures when they amend or repeal a rule as they used to issue the rule in the first instance.”\(^{27}\)

**Recommendation:**
AMRPA does not recommend that CMS adopt this proposal. We recommend the Agency to delay finalization until more detailed and appropriate guidelines can be promulgated through notice and comment rulemaking.

**E. Suggested Changes to the Presumptive Compliance Methodology**
AMRPA would like to offer several suggested changes to the presumptive compliance methodology, including ways to ensure that future updates are made in a more constructive and collaborative manner. These include: removal of the 50 percent Medicare patient threshold to qualify an IRF under the presumptive compliance methodology; creation of a Technical Expert Panel (“TEP”) to provide input before making proposed changes to the ICD-10-CM codes; publication of a discrete list of proposed changes to the presumptive compliance code sets; and provision of data that would allow IRFs to review the data associated with their presumptive compliance calculations.

1. **Removal of the 50 Percent Threshold**
   A provider seeking eligibility for 60 Percent Rule-compliance determination through the presumptive methodology must demonstrate that 50 percent or more of its patients are Medicare beneficiaries. This rule is outdated and imposes an undue burden on IRFs with a smaller mix of Medicare patients. As CMS often notes, providers retain the ability to demonstrate compliance with the 60 Percent Rule through medical review. However, this review is a burdensome and resource-intensive process that places considerable strain on IRFs, especially smaller providers with limited resources, as well as the Agency and its contractors. AMRPA believes that a statistically valid extrapolation for compliance could be determined for providers serving fewer than 50 percent Medicare patients. CMS should therefore eliminate the 50 percent Medicare patient threshold for eligibility to use the presumptive compliance methodology.

2. **Technical Expert Panel**
   Because an IRF must comply with the 60 Percent Rule in order to operate, AMRPA believes stakeholders should be permitted to provide feedback on potential changes to the presumptive compliance methodology and the 60 Percent Rule as early as possible. AMRPA therefore recommends that CMS establish a TEP comprised of at least 15 persons with clinical, operational, and policy expertise and experience in dealing with the 60 Percent Rule and its effects. Panel members should be selected from the IRF provider community, representing both freestanding and hospital-based units in proprietary and non-profit business forms, as well as trade associations representing IRFs.

   The TEP should meet at least once annually with the staff of the Chronic Care Policy Group, as well as CMS medical and clinical personnel charged with overseeing and maintaining the 60 Percent Rule. This meeting should be scheduled to allow sufficient meeting time to permit in-depth discussion and review of the 60 Percent Rule’s list of

\(^{26}\) 5 U.S. Code § 552(a)(1) (See also Chrysler Corp. v. Brown, 441 U.S. 281, 302 (1979)).

\(^{27}\) Perez, 135 S. Ct. at 1206.
codes and IGCs, with such input taken under advisement by CMS for purposes of future refinements to the Rule.

AMRPA members are increasingly concerned that the 60 Percent Rule is being narrowed and made more difficult to satisfy through a vague, essentially “black-box” process that determines which codes and IGCs “require” IRF services and which do not. IRF clinicians and practitioners have had little opportunity to gain insight into CMS’ thinking and objectives in this area or to provide feedback and reaction to such thoughts, beyond submitting annual comment letters. AMRPA strongly believes that the 60 Percent Rule is outdated and should be dispensed with; however, if it is not, CMS should be more transparent and interactive with IRFs and clinicians as it considers and implements changes to the policy.

3. Publication of Code Changes

In this rulemaking, CMS publishes a proposed new, complete list of codes to be included under the presumptive methodology. However, there is no explanatory crosswalk to currently implemented codes, and to decipher the precise changes CMS is proposing, stakeholders must perform an intensive comparison to the previous list to determine the exact changes. AMRPA recommends that CMS publish a list of only the codes proposed for revision, designating whether each code has been added to or removed from a particular list. The Agency previously has done so, including in the FY 2014 IRF PPS proposed rule a list of “Proposed ICD-9-CM Codes To Be Removed From Appendix C: ICD-9-CM Codes That Meet Presumptive Compliance Criteria.” Such transparency would provide a better reference point for stakeholders and allow them to provide meaningful comments on CMS’ proposed changes.

4. Provider Review of Data

AMRPA has previously requested that CMS make available to IRFs the software specifications and data used by CMS’ independent contractor to determine providers’ 60 Percent Rule compliance under the presumptive methodology. Presumptive testing is based on assessment data submitted by IRFs (IRF PAI), and CMS affords providers the opportunity to review and validate assessment-based data on a patient-level basis for other programmatic requirements such as the IRF QRP. In the interest of transparency and consistency, we request that CMS provide IRFs with access to the pertinent information (software specifications, patient-level data, etc.) that would allow providers to review and compare internally generated presumptive compliance percentages with those generated by CMS’ contractor. We believe this process would educate providers, streamline and enhance the precision of the presumptive methodology and reduce the administrative burden – to providers and to Medicare – of a medical record review.

Recommendation:

1. AMRPA recommends CMS eliminate the 50 percent Medicare patient threshold for eligibility to use the presumptive compliance methodology.
2. AMRPA recommends that CMS establish a TEP comprised persons with clinical, operational, and policy expertise which should meet at least once annually with CMS staff to discuss the 60 Percent Rule.
3. AMRPA recommends that CMS publish a list of only the codes proposed for revision in each year’s NPRM, designating whether each code has been added to or removed from a particular list.

4. AMRPA requests that CMS provide IRFs with access to the pertinent information (software specifications, patient-level data, etc.) that would allow providers to review and compare internally generated presumptive compliance percentages with those generated by CMS’ contractor.

III. Revisions and Updates to the IRF Quality Reporting Program (IRF QRP)

A. Standardized Patient Assessment Data and Collection

1. Collection Burden

CMS estimates that the additional IRF PAI items proposed in this rule will add 14.4 minutes to the patient assessment (7.2 minutes each at admission and discharge). We believe these estimates are based on incorrect assumptions and misrepresent the actual time burdens associated with the IRF QRP’s extensive reporting requirements. AMRPA’s Quality Committee and members have independently evaluated the time, expense, and burden of collecting this information in an actual IRF setting. Based on our review, we conclude that 14.4 minutes significantly underestimates the time needed to complete the new items, since most of the required information can be obtained only through a detailed chart review.

While some of the proposed items have been time-tested in PAC settings, these tests were conducted by assessment staff specifically trained on the items in a study environment designed for data collection. We therefore do not think these results accurately represent the actual time burden associated with completing the additional assessment items in the field.

AMRPA acknowledges that the FY 2018 IRF PPS payment update is statutorily set at 1.0 percent and cannot be increased to address the additional resource intensity attributable to the new assessment items. However, we recommend that CMS not minimize the resource intensity associated with these items and account for it in the FY 2019 IRF PPS proposed payment update.

Recommendation:
AMRPA urges CMS to account for the resource intensity of the new IRF QRP reporting requirements in the FY 2019 IRF PPS payment update.

2. Data Completion Threshold and QRP Penalty

AMRPA strongly opposes CMS’ proposal to extend the current IRF QRP 95 percent data completion requirement to include standardized patient assessment data. For the SNF QRP and LTCH QRP, CMS proposes an 80 percent completion threshold for the
We think the Agency should not perpetuate discrepant standards in QRP reporting requirements across PAC settings. As such, we recommend CMS also adopt an 80 percent threshold for standardized patient assessment data in the IRF QRP. At a minimum, the completion threshold should be lower than 95 percent in the first reporting year these items are required, and we suggest that CMS work with IRF stakeholders to develop a more appropriate completion threshold. The proposed standardized patient assessment data elements adds six pages to the IRF PAI and significant staff time and resources will be necessary to correctly complete the new items. CMS should afford providers the flexibility needed to adjust their assessment practices to adapt to this increase in reporting burden. We also strongly urge CMS to conduct provider education and training well in advance of the items’ October 1, 2018 implementation date.

Recommendation:

1. AMRPA strongly opposes CMS’ proposal to extend the current IRF QRP 95 percent data completion requirement to include standardized patient assessment data. We recommend CMS adopt an 80 percent threshold for standardized patient assessment data in the IRF QRP, consistent with the requirements for other PAC QRPs.
2. At a minimum, the completion threshold should be lower than 95 percent in the first reporting year these items are required, and we suggest that CMS work with IRF stakeholders to develop a more appropriate completion threshold.
3. We also strongly urge CMS to conduct provider education and training well in advance of the items’ October 1, 2018 implementation date.

3. Proposed Application of Other IRF QRP Policies
CMS proposes to utilize the IRF QRP’s subregulatory process for non-substantive changes to make future changes to the standardized patient assessment data. In describing the proposed policy, CMS states that changes it may generally consider to be substantive include, but are not limited to, circumstances in which the changes are so significant that the measure is effectively no longer the same measure, or when a standard of performance assessed by a measure becomes more stringent (for example, changes in acceptable timing of medication, NQF expansion of endorsement of a previously-endorsed measure to a new setting, procedure/process, or test administration). CMS also proposes to evaluate modifications on a case-by-case basis to determine whether or not a change is, in fact, substantive.

AMRPA supports the core concept that non-substantive changes would not include any modification that renders a standard of performance more difficult to satisfy. However, CMS does not provide comparable examples in the proposed rule, as it did in the CY

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30 In CY 2013 Outpatient Prospective Payment System/Ambulatory Surgical Center (OPPS/ASC) Payment Systems final rule, CMS adopted a subregulatory process to incorporate updates to IRF quality measures that do not substantively change the nature of the measure.
2013 OPPS/ASC final rule, of substantive changes vis-à-vis the reporting of standardized patient assessment data. Without this information, stakeholders cannot evaluate the potential impact of adopting this policy for the reporting of patient assessment data. We recommend that CMS not finalize this proposal until it can propose and vet with stakeholders illustrative examples of non-substantive and substantive changes as they pertain to standardized patient assessment data. Furthermore, in addition to continuing to evaluate modifications on a case-by-case basis, the Agency should be transparent and engage stakeholders in making these determinations. IRFs are best positioned to aptly determine if a proposed change would, in fact, make reporting standardized assessment data more stringent or unduly increase provider burden.

CMS also proposes to apply the IRF QRP exceptions policy, extensions policies, and the retention policy to the reporting of standardized assessment data. AMRPA supports these proposals.

**Recommendation:**
1. We do not recommend CMS adopt this proposal until the Agency can propose and vet with stakeholders illustrative examples of non-substantive and substantive changes as they pertain to standardized patient assessment data.
2. We support CMS’ proposals to adopt the IRF QRP exceptions policy, extensions policies, and the retention policy to the reporting of standardized patient assessment data.

**4. Proposed IRF PAI Assessment Items**

a. Functional Status Data
CMS proposes that data reported under Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631) would satisfy the IMPACT Act’s functional data reporting requirement. AMRPA supports this proposal, in recognition of the Agency’s statutory mandate to standardize cross-setting PAC data collection by October 1, 2018. However, NQF #2631 is only a process measure and does not assess patients’ functional status or outcomes. AMRPA recommends that CMS propose in future rulemaking an outcomes-based functional status data item for adoption across PAC settings.

b. Cognitive Function and Mental Status Data
   i. *Brief Interview for Mental Status (BIMS)*
      AMRPA supports using the BIMS to meet the IMPACT Act domain of cognitive and mental status data.
   
   ii. *Confusion Assessment Method (Short CAM)*
      This item is essentially a screen for delirium and assesses the presence of certain behavioral symptoms (disorganized thinking, inattention, altered state of consciousness). However, it fails to identify whether these symptoms are due to an underlying neurological disorder or injury, which affects many IRF patients.
It may also produce false positives for delirium in instances where patients have cognitive or communication issues but may not be delirious. The item also asks if there is evidence of an acute change in mental status from the patient’s “baseline,” but does not specify to what “baseline” refers. We recommend that CMS provide assessment specifications as soon as possible. In addition, the Agency should conduct ample provider training in advance of implementation.

iii. Behavioral Signs and Symptoms
We are concerned that this element could wrongly indicate dementia and other mental health issues without consideration of the patient’s underlying neurological or cognitive disorders. Some IRF patients with neurological or cognitive deficits could become more aggressive as they heal. This behavior is not a hallmark of dementia or other impairments, but of the patient’s progression and recovery. In an earlier report on standardized patient assessment data, CMS noted that Behavioral Signs and Symptoms was not assessed for interrater reliability in the PAC PRD “because of the low incidence.” We do not think it is appropriate for CMS to use mandatory provider reporting à la the IRF QRP to, in essence, conduct field testing. We recommend CMS not incorporate this item in the IRF QRP until it has been tested for clinical relevance to PAC assessments.

iv. Patient Health Questionnaire (PHQ-2)
AMRPA supports the use of the PHQ-2. CMS has also previously suggested that the PHQ-2 be used as a gateway data element for the longer PHQ-9. We remind CMS that neither the PHQ-2 nor PHQ-9 address issues related to how the presence of anxiety, trauma, or fear may interfere with a patient’s ability to improve. While the assessment item includes depression as a “treatable” condition interfering with behavior, anxiety can be as much of an interference and also (perhaps more so) “treatable.”

c. Special Services, Treatments, and Impairments

i. Item K0520--Nutritional Approaches
We recommend that CMS add “Regular Food: solids and liquids swallowed safely without supervision or modified food consistency” as a response option to this item at admission and discharge. In the proposed item, patients who are on a regular food diet would be coded as “Z. None of the above.” The current IRF PAI Item 27—Swallowing Status has an option for Regular Food, and we think the proposed Item K0520 should also recognize this distinction in order to be sufficiently sensitive to changes in patients’ feeding modalities. Any data item collected under the IMPACT Act should at least be as granular as current PAC assessments.

ii. Other items
CMS proposes to add more than 25 new reporting items to the IRF PAI to cover the Special Services, Treatments, and Interventions identified for cross-setting PAC reporting. We appreciate that CMS revised some of these items per our recommendations in response to Development and Maintenance of Post-Acute
Care Cross Setting Standardized Patient Assessment Data: Data Element Specifications for Public Comment.31 These include:

- Addressing data items for peritoneal dialysis, peripherally inserted central catheters (PICCs), midline IVs, and ventilator use; and
- Distinguishing BiPAP and CPAP as separate response elements.

In our view, most of the information CMS seeks through these items could be obtained through Medicare claims data and ICD-10 documentation since many of the data elements focus on resource use and the intensity of care available in various PAC settings. It seems redundant and wholly unnecessary to require providers to additionally assess or comb through medical records at admission and discharge for clinical information solely to populate PAC assessment forms. Needless to say, any additional reporting requirements will be administratively burdensome and divert time and resources away from patient care. The IMPACT Act requires the Secretary to match claims data with assessment data by October 1, 2018, which is the same date that providers must begin reporting standardized patient assessment data.32 We recommend that CMS investigate how it may be able to glean information on special services, treatments and interventions by utilizing Medicare claims data already at its disposal rather than by imposing additional provider reporting requirements.

Recommendation:
1. AMRPA urges CMS to conduct provider training on the proposed patient assessment items well in advance of their October 1, 2018 effective date.
2. AMRPA supports the proposal to use data reported under Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631) to satisfy the IMPACT Act’s functional data reporting requirement. However, we recommend that CMS propose in future rulemaking a more patient-centric functional status data item for adoption across PAC settings to meet the Act’s requirement.
3. Given our concerns with the Short Confusion Assessment Method (CAM), we recommend that CMS provide detailed assessment specifications as soon as possible.
4. AMRPA supports the use of the PHQ-2.
5. AMRPA recommends that CMS add “Regular Food: solids and liquids swallowed safely without supervision or modified food consistency” as a

32 Alignment Of Claims Data With Standardized Patient Assessment Data.—To the extent practicable, not later than October 1, 2018, for PAC providers described in clauses (ii), (iii), and (iv) of subsection (a)(2)(A), and January 1, 2019, for PAC providers described in clause (i) of such subsection, the Secretary shall match claims data with assessment data pursuant to this section for purposes of assessing prior service use and concurrent service use, such as antecedent hospital or PAC provider use, and may use such matched data for such other uses as the Secretary determines appropriate. 42 U.S.C. § 1395lll(b)(2).
response option for Item K0520--Nutritional Approaches at admission and discharge.

6. We recommend that CMS investigate how it may be able to glean information on special services, treatments and interventions by utilizing Medicare claims data already at its disposal rather than doing so by imposing additional provider reporting requirements.

B. Proposed Changes to IRF QRP Measures

1. Proposed Changes to Pressure Ulcer Measure (NQF #0678)

CMS proposes to replace the current pressure ulcer measure, “Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short Stay) (NQF #0678)” with a modified pressure ulcer measure titled “Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury” beginning October 2018. This modified measure was released for public comment in November 2016 at which time AMRPA commented in support of the changes.\[33\] We recommend CMS finalize the modified measure and appreciate CMS’ move to streamline assessment items and reduce provider burden.

Under the modified measure, the frequency of pressure ulcers reported via the IRF PAI will increase more than two-fold. Thus the new measure would significantly change the way that pressure ulcers are evaluated and considered “worsened.” It is paramount that CMS conduct provider training and education, and we recommend the Agency begins this well in advance of the measure’s implementation date. Accurately assessing those pressure ulcers which are “present on admission” will be a key aspect of valid reporting and CMS must ensure that this is being done consistently across PAC settings.

CMS also proposes to remove item M0900: Healed Pressure Ulcers from the IRF PAI effective October 1, 2018, ostensibly to reduce provider burden. This proposal was not among the proposed revisions from November 2016. AMRPA does not support removing Item M0900 wholly from the IRF PAI. We recommend that CMS retain it for voluntary reporting. It is clinically valuable to monitor positive outcomes such as healed pressure ulcers in addition to tracking adverse outcomes. Furthermore, the number of pressure ulcers that have healed during an IRF stay far exceeds the number of those worsened, indicating that M0900 has greater applicability and utility for IRFs’ internal quality improvement processes.

CMS proposes to risk adjust the modified measure for the following patient characteristics:

- Functional Mobility Admission Performance;
- Bowel Continence;
- Peripheral Vascular Disease / Peripheral Arterial Disease or Diabetes Mellitus; and
- Low Body Mass Index.

\[33\] CMS Public Comment Posting for Project Title: “Refinement of Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short-Stay) (NQF #0678) and Language Modifications Being Explored with the Term “Pressure Injury.” The comment period was open from 10/17/2016-11/15/2016.
We recommend that CMS also include morbid obesity (BMI > 40) as a risk adjustor.

Although CMS does not propose an IRF QRP data validation policy in this rule, it has stated previously that it is still considering a validation policy considered for future implementation. AMRPA recommends the pressure ulcer measure be excluded from any future IRF QRP data validation policy. The measure has undergone multiple iterations since it was adopted for the IRF QRP in FY 2012, having been modified or revised in some manner nearly every year since. Data collected under the measure would not be consistent or reliable longitudinally and would make a poor indicator for data validation.

**Recommendation:**
1. We support adoption of the modified pressure ulcer measure. We also recommend that the Agency conduct training regarding the modified assessment practices well in advance of October 1, 2018.
2. AMRPA does not support removing Item M0900 wholly from the IRF PAI. We recommend that CMS retain it for voluntary reporting.
3. We recommend that CMS also include morbid obesity (BMI > 40) as a risk adjustor.

### 2. Removal of All-Cause Unplanned Readmission Measure

AMRPA supports CMS’ proposal to remove All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge (NQF #2502) from the IRF QRP. We appreciate CMS recognizing that having three readmissions measures is duplicative and unnecessarily burdensome for IRFs. Since the measure will still be reported on IRF Compare until its proposed removal in October 2018, our members are concerned with the way performance is being publicly reported on IRF Compare. We discuss this issue further in our comments on public reporting.

**Recommendation:**
AMRPA supports CMS’ proposal to remove All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge (NQF #2502) from the IRF QRP.

### 3. Potential Future Changes and Measures

#### a. IRF Experience of Care Survey

With regard to the IRF Experience of Care survey, several AMRPA members that served as test sites for the survey report that the survey’s “experience during the IRF stay” portion does not adequately address the therapy the patient received during their stay. The provision of therapy is a foundational aspect of IRF care. We recommend that CMS include questions that better address therapy services in an IRF experience of care survey.

We also recommend that CMS account for the “rate of return” of completed surveys in evaluating the survey’s fitness for the IRF QRP. For instance, if only 10 or 15 percent of a provider’s discharged patients successfully complete the survey, how would that impact a provider’s measure performance? What methods will CMS and its contractors employ to ensure that patient-reported information translates to psychometrically robust and meaningful quality data?
Beyond these points however, we are limited in our ability to provide CMS the feedback it seeks regarding logistical implementation. While CMS has provided some updates regarding the survey’s development timeline, it has not, to our knowledge, released a draft survey or implementation details for public comment. We strongly recommend that CMS make a draft survey/questions and survey implementation processes publicly available and allow an opportunity for stakeholder input well in advance of implementing it in the IRF QRP. This survey has been under development since 2015 with the issuance of the Request for Information in the Federal Register, but there have been few opportunities for wide stakeholder involvement since then. It is critical that CMS thoroughly engage IRF stakeholders in order to develop a clinically meaningful and operationally feasible survey.

**Recommendation:**
1. AMRPA recommends that CMS include questions on an IRF experience of care survey that better address therapy services.
2. We recommend that CMS account for the rate of return of completed surveys in evaluating the survey’s fitness for the IRF QRP.
3. We strongly recommend that CMS make a draft survey/questions and survey implementation processes publicly available and allow an opportunity for stakeholder input well in advance of implementing it in the IRF QRP.

**b. Application of Percent of Residents Who Self-Report Moderate to Severe Pain (Short Stay) (NQF #0676)**

CMS is considering for future implementation in the IRF QRP the Application of Percent of Residents Who Self-Report Moderate to Severe Pain (Short Stay) (NQF #0676). This measure is currently specified for nursing homes and captures the percent of short stay residents with at least one episode of moderate/severe pain or horrible/excruciating pain of any frequency in the last five days. AMRPA does not think this is an apt measure for the IRF QRP and does not recommend or support CMS’ adoption of the measure in the future. Due to the highly intensive nature of therapy services delivered in IRFs, it is not uncommon for IRF patients to experience some degree of pain. As required under Medicare regulations, patients treated in IRFs must receive an intensive level of therapy services typically demonstrated by participation in a minimum of 15 hours of therapy a week. Given the intensity of IRF therapy, we do not think that the presence of pain, on face value, has merit as a quality measure for the IRF QRP.

Furthermore, #NQF 0676 does not assess outcomes that matter most to patients and providers, such as how effectively providers addressed or met the patient’s pain needs or how many patients improved throughout the duration of their stay, etc. Taken in context with the Agency’s Request for Information specific to the nation’s opioid

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34 Presentation by CMS CCSQ staff at AMRPA Executive Forum and Congressional Fly-In, March 2017. CMS reported that phases include information gathering (Sep. 2015-Aug. 2016), Field Testing (Aug. 2016-April 2017), and Mode Experiment Testing (Summer 2017).

35 Federal Register Volume 80, Number 224, Medicare Program; Request for Information To Aid in the Design and Development of a Survey Regarding Patient and Family Member Experiences With Care Received in Inpatient Rehabilitation Facilities. November 20, 2015.

crisis, we question how such a measure fits into or contributes to an Administrative framework meant to combat opioid/painkiller overutilization? It is crucial, perhaps now more than ever, to evaluate not simply the incidence of pain but whether the pain was addressed in a clinically appropriate manner, whether the right treatments were administered safely and judiciously, and if treatment sought to counter non-clinical factors that may lead a patient to self-reported pain. CMS must be cognizant of the potential consequences of its quality strategies and not enact policies that would adversely incentivize health care providers to prioritize medicating pain above treating the patient.

**Recommendation:**
AMRPA does not think this is an apt measure for the IRF QRP and does not recommend or support CMS’ adoption of the measure in the future.

c. **Modifications to the Discharge to Community Measure**
CMS seeks comment on “possible modifications” to exclude baseline nursing facility residents from the Discharge to Community-Post Acute Care for PAC measure. AMRPA supports such modifications and has consistently recommended this approach in prior rulemaking and other public comment opportunities. For accurate comparability across post-acute settings and to avoid distortion, CMS should link Medicare claims data to longitudinal Minimum Data Set to identify baseline nursing facility residents who are discharged to a long-term care/residential portion within the same facility, and then exclude them from counting in the discharge to community measure numerator. Though this patient population should not be included in the discharge to community measure to enable cross-setting standardization, CMS should look for ways to address these beneficiaries’ needs in quality reporting programs and not wholly exclude them from nursing facilities’ accountability.

**Recommendation:**
1. AMRPA supports modifying this measure to exclude baseline nursing facility residents, having consistently recommended this approach in prior rulemaking and other public comment opportunities.
2. We also suggest that CMS look for ways to address these beneficiaries’ needs in quality reporting programs via other strategies and not wholly exclude them from nursing facilities’ accountability.

d. **Risk Adjustment for Social Risk Factors**
AMRPA strongly supports a methodologically sound approach to risk-adjustment for socioeconomic and sociodemographic status (SES/SDS) factors. Our members perceive dual-eligible status, low-income subsidy status, and geographic area of residence as important factors that are also more readily accessible in currently available data sources. AMRPA recommends that CMS compare quality performance rates and resource use spending for providers that have comparable proportions of similar patients, such as low-income beneficiaries. MedPAC also recommend this to CMS.37

We also recommend that CMS develop a way to account for family/caregiver status and/or community supports. IRFs that serve patients with fewer community support systems can expect to have higher readmission rates because an outcome such as a readmission may be influenced by factors independent of the provider’s control. Many PAC patients who live alone without the oversight or assistance of a family or other community caregiver have a higher risk of readmission, as well as poorer outcomes regarding quality and resource use metrics. The presence and willingness of family or community supports are critical drivers for IRFs when deciding upon a patient’s appropriate discharge destination. For example, even though a patient has met the goals of a rehabilitation hospital admission (e.g., regained household level ambulatory function and is able to walk on level surfaces at discharge), if he or she lives alone in a third floor walkup without handicap access, a discharge home may not be safe.

**Recommendation:**
1. AMRPA strongly supports a methodologically sound approach to risk-adjustment for socioeconomic and sociodemographic status factors.
2. AMRPA recommends that CMS compare quality performance rates and resource use spending for providers that have comparable proportions of similar patients, such as low-income beneficiaries.
3. We also recommend that CMS develop a way to account for family/caregiver status and/or community supports.

**e. Input Sought for Data Related to Assessment-Based Measures**

CMS seeks input on whether it should require quality data reporting on all IRF patients regardless of payer. In our view, expanding the assessment-based measures of the IRF QRP to all patients would not be too burdensome from a data collection perspective. The vast majority of AMRPA members complete IRF PAIs for all patients regardless of payer status. AMRPA supports expanding the QRP so that more patients are encompassed in quality improvement initiatives.

AMRPA firmly agrees with CMS that quality improvement is an appropriate goal for all patients, regardless of payer source. Therefore we recommend that CMS continue its efforts to align the beneficiary populations assessed by patient assessment instruments across PAC settings. For instance, the IRF PAI is currently required for Medicare Parts A and Part C patients, but the MDS 3.0 is required only for Medicare Part A residents. This lack of uniformity in quality data across settings unnecessarily confounds the IMPACT Act’s efforts to standardize quality measures and patient assessment data. Rather than contributing to comprehensive and commensurate PAC quality reporting programs, continuing this practice will instead exacerbate the problem and result in selective sampling of the patient population that would skew the collected data and distort or otherwise invalidate meaningful comparisons across measures and across settings. This falls short of the PAC standardization goals of the IMPACT Act. AMRPA believes that quality measures and data collection implemented under the Act should apply to a uniform Medicare patient population (inclusive of at least Medicare Part A and Part C beneficiaries).
Although CMS does not address public reporting of non-Medicare quality data in the proposed rule, we believe that additional adjustments are necessary to ensure that payer status is properly accounted for in publicly reporting. Different SES/SDS patient populations disproportionally utilize private versus public payers and, as such, payer status is akin to a risk adjustment factor. We encourage CMS to develop methods that stratify non-Medicare quality data by payer status. CMS should work with stakeholders in future rulemaking opportunities to develop appropriate methods before it proposes to publicly report non-Medicare quality data.

**Recommendation:**

1. AMRPA supports expanding assessment-based measures to non-Medicare populations so that more patients are encompassed in quality improvement initiatives.
2. AMRPA also recommends that CMS continue to align the beneficiary populations which are assessed by patient assessment instruments across PAC settings. We believe that quality measures and data collection implemented under the Act should apply to a uniform Medicare patient population (inclusive of at least Medicare Part A and Part C beneficiaries).
3. Should CMS in the future propose to publicly report quality data for non-Medicare beneficiaries, the data should be stratified by payer status and CMS should work with stakeholders to develop what would be appropriate reporting methods in advance of public display.

**C. Public Reporting**

As of May 2017, the following IRF QRP measures are publicly reported on IRF Compare:

- NHSN Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138);
- All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge (NQF #2502); and
- Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short Stay) (NQF #0678).

AMRPA has analyzed the available IRF Compare data and believes there are key principles to which CMS should adhere in order to improve public reporting before any expansion. Our analysis and rationale are outlined below.

**1. General Comments**

a. **IRF Compare measures should have robust comparative value.**

Currently, an overwhelming majority of IRFs, 63 percent, do not have any data for the CAUTI measure (see table below). This is primarily due to facilities having such a low CAUTI incidence rate that the CDC/NHSN cannot calculate their performance. As a result, there is a “null” result for more than half of the field. The CAUTI measure offers limited comparative value and this dilutes the utility of IRF Compare. We urge CMS to use public reporting quality measures that are relevant to IRFs and generate robust, discriminating data.
b. IRF Compare should use measures and data that produce statistically meaningful information.

Thirty-three (33) percent of IRFs are rated as “Worse than the National Rate” based on their performance on the All-Cause Readmissions measure (see table below). It is illogical for one third of a sample set to be categorized singularly as “below average;” this does not follow a normal distribution. We raise this issue not to question CMS’ statistical or risk adjustment methodologies, the latter being especially critical for equitable comparisons among IRFs, but to question 1) whether any measure that produces such tight clustering is a relevant and useful quality indicator, and 2) if it is even appropriate to assign performance categories in this scenario.

As CMS evaluates IRF QRP for public reporting, we urge it to use measures that produce statistically meaningful information and not simply those for which it has data. CMS should prioritize purpose and utility in the realm of consumer education, not convenience. Even though the All-Cause Readmissions measure would be removed in 2018, we believe CMS should also remove the performance categories for all publicly reported data as soon as possible. This aspect of public reporting is not statutorily mandated by the IMPACT Act and the categories are, at this time, charged statements which lack any practical meaning.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Performance Category</th>
<th>Number of IRFs</th>
<th>Percent of all publicly reported IRFs</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAUTI</td>
<td>Better than the National Benchmark</td>
<td>14</td>
<td>1%</td>
</tr>
<tr>
<td></td>
<td>No Different than the National Benchmark</td>
<td>409</td>
<td>34%</td>
</tr>
<tr>
<td></td>
<td>Worse than the National Benchmark</td>
<td>23</td>
<td>2%</td>
</tr>
<tr>
<td></td>
<td>Not Available</td>
<td>747</td>
<td>63%</td>
</tr>
</tbody>
</table>

c. IRF Compare measures and performance ratings should report clinically meaningful information.

The table below shows a sample of three IRFs and their performance on the All-Cause Readmission measure. The three performance categories are separated by deviations of only 0.21 percent or 0.35 percent. These hairline variations, though they may derive from statistically significant confidence intervals, are in reality not significant in any meaningful way. Patients and other public users cannot discern a
practical difference between an IRF with a 13.39 percent readmission rate versus one with a 12.84 percent readmission rate. There must be clinically meaningful differences in the gradations between a high-quality/well-performing provider and others. Furthermore, this data does not provide actionable information for an IRF seeking to operationalize quality improvement strategies – how does an IRF improve its readmission rate by 0.35 percent?

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>All-Cause Readmissions Risk-Standardized Readmission Rate (RSRR)</th>
<th>Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample IRF 1</td>
<td>Better than the National Rate</td>
<td>13.39</td>
</tr>
<tr>
<td>Sample IRF 2</td>
<td>No Different than the National Rate</td>
<td>13.18</td>
</tr>
<tr>
<td>Sample IRF 3</td>
<td>Worse than the National Rate</td>
<td>12.84</td>
</tr>
</tbody>
</table>

Finally, we recommend that CMS be transparent with regard to the statistical methodologies it uses to calculate provider performance. The Agency should publicize the methodology and calculations used so these can be analyzed and replicated by stakeholders, similar to how other IRF QRP data are made available for provider validation.

**Recommendation:**
1. AMRPA urges CMS to adhere to the following principles in publicly reporting IRF quality measures and data:
   a. IRF Compare measures should have robust comparative value.
   b. IRF Compare should use measures and data that produce statistically meaningful information.
   c. IRF Compare measures and performance ratings should report clinically meaningful information.
2. We recommend that CMS remove the performance categories (“Better/Worse than”) from IRF Compare data as soon as possible.
3. We also request that CMS be more transparent with regard to the statistical methodologies it uses to calculate provider performance. The Agency should publicize the methodology and calculations used so these can be analyzed and replicated by stakeholders, similar to how other IRF QRP data is made available for provider validation.

**2. Proposed Changes to Publicly Reported Measures**
CMS proposes to add four claims-based measures and two assessment-based measures to IRF’s public reporting in CY 2018:
- Application of Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631) (assessment-based);
• Application of Percent of Residents Experiencing One or More Falls with Major Injury (NQF #0674) (assessment-based);
• Medicare Spending Per Beneficiary-PAC IRF QRP (claims-based);
• Discharge to Community-PAC IRF QRP (claims-based);
• Potentially Preventable 30-Day Post-Disposition Readmission Measure for IRF QRP (claims-based); and
• Potentially Preventable Within Stay Readmission Measure for IRFs (claims-based).

a. Potentially Preventable Readmission Measures
AMRPA does not support publicly reporting the PPR post-discharge readmission measure or the PPR within stay measure at this time. The proposed rule does not detail how provider data would be displayed and, as described above, we have serious concerns regarding the current approach CMS uses in publicly reporting readmission data. Hence, we do not support the policy as proposed. We urge CMS to work with stakeholders to develop a methodological approach to publically report readmissions quality data in a practical and meaningful way. Should CMS proceed with public reporting for PPR measures without first developing this framework, we recommend that CMS not use performance categories or ratings.

b. Medicare Spending Per Beneficiary
AMRPA does not support CMS’ proposal to publicly report MSPB data on IRF Compare in CY 2018. MSPB is solely a resource use metric that does not correlate with the quality of care a patient receives and should not be publicly displayed under the auspices of quality reporting. Additionally, MPSB is not a readily intuitive measure for consumers to understand and instead may contribute to consumer misinformation and confusion rather than education. For instance, the public may liken MSPB to the Medical Loss Ratio (MLR) reported by private insurance plans. The MLR is the percent of premiums an insurer spends on claims and expenses that improve health care quality. Consumers may conclude that “more money spent” positively correlates with the quality of care received. However, it would be inaccurate to draw a parallel so succinctly. MSPB data should still be made publicly available to researchers and interested parties who have an understanding of the metric’s nuances, but it is not ready for prime time via public display.

c. Pressure Ulcer Measure Proposed for Replacement
AMRPA supports CMS’ proposal to remove from public reporting the All-Cause Unplanned Readmission Measure for 30 Days Post-Disposition (NQF #2502). We also support the proposal to replace it in public reporting with the modified measure proposed in this rule, Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury.

Recommendation:
1. AMRPA does not support publicly reporting the PPR post-discharge readmission measure or the PPR within stay measure at this time. We urge CMS

38 https://www.cigna.com/health-care-reform/medical-loss-ratio
to work with stakeholders to develop a methodological approach to publically report readmissions quality data in a practical and meaningful way. Should CMS proceed with public reporting for PPR measures without first developing this framework, it should not use performance categories or ratings in public reporting.

2. AMRPA strongly recommends that CMS’ not finalize its proposal to publicly report MSPB data.

3. AMRPA supports CMS’ proposals to remove from public reporting the All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge (NQF #2502) and to replace it with the modified measure proposed in this rule, Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury.

3. Low Volume Threshold
   CMS proposes the following volume thresholds for IRFs before their data are publicly reported:
   - 20 cases for the assessment-based measures;
   - 20 cases for the MSPB measure; and
   - 25 cases for all other claims-based measures.

   CMS does not detail its rationale or methodology for the proposed limits. We recommend that CMS use a low volume threshold of 30 cases for all measures.

   **Recommendation:**
   We recommend that CMS use a low volume threshold of 30 cases for all measures.

IV. Request for Information on CMS Flexibilities and Efficiencies
   AMRPA commends CMS for including this request for information (RFI) to better understand the complexity of delivering inpatient rehabilitation care and discern opportunities to enhance programmatic flexibilities and foster provider efficiencies. We believe proactive stakeholder engagement will pay dividends in making the program more flexible, accountable, transparent, and ultimately more responsive to beneficiaries’ needs and taxpayers’ concerns.

   AMRPA shares the Administration’s goal of transforming the health care delivery system to streamline administrative processes to put patients back at the center of their own care. To that end, our response to this RFI illuminates a number of longstanding and emerging obstacles that providers of inpatient rehabilitation care must overcome to deliver high-quality, efficient, and patient-centric care. In confronting these obstacles, we offer specific proposals to reduce burdens on providers, improve quality of care, decrease costs, and ensure that patient and provider decisions are informed by clinical judgment, best practices, and the patient’s best interest, rather than arcane bureaucratic policies. In some cases, the best solutions require enactment of authorizing legislation. In most cases, however, CMS has the existing legal authority to substantially resolve the problem. In all cases, we have offered suggestions for how the agency could improve upon the current situation through rulemaking, subregulatory guidance, and/or other procedural and practice changes.

   A. Revise IRF Classification Criteria
      The current compliance threshold—commonly referred to as the “60 Percent Rule”—which requires providers to qualify as IRFs by having at least 60% of patient
discharges each year fall within one of 13 diagnoses, is a relic of Medicare history. The initial list of qualifying conditions was based on an informal assessment of types of patients served in rehabilitation hospitals during the 1970s and has not been meaningfully updated since it was first formally promulgated 33 years ago. The list of conditions was not developed to identify which patients should receive IRF care, but is widely misunderstood as serving that purpose. Instead, it is one of multiple criteria used to define an IRF and distinguish it from an acute care hospital.

Advances in medicine over the past four decades have allowed individuals with other serious diagnoses, such as cancer and organ failure, to survive acute care episodes. As a result, patients requiring IRF care in categories such as cardiac, pulmonary, oncology, and transplantation, among others, do not count toward 60 Percent Rule compliance and therefore are often denied admission. In addition to the enormous administrative burden it imposes both on IRFs and the agency, the rule impedes access to critical medically necessary and life-altering rehabilitation care without providing any benefit to patients or providers.

The 60 Percent Rule narrowly defines IRFs by the patients they treat and categorizes patients by the primary diagnosis for which they were hospitalized. The rule fails to look at patients holistically or to understand the vital role IRFs play in the continuum of care. The impact of the rule could hardly be more draconian—an IRF with 60.1% of cases from the 13 conditions is reimbursed for 100% of its claims according to the CMGs, but an IRF with 59.9% of cases from these conditions gets 0%. The arbitrary nature of the rule confuses patients, physicians, and hospitals, thereby forcing providers to essentially operate a lottery system of admissions depending on the other patients that have already been cared for in the reporting year. This outcome means the same patient could be admitted one day, but denied the next simply because of who else received care in that IRF. As virtually all experts have observed, there are far more logical, evidence-based approaches to ensuring that the IRF payment system is reserved for truly dedicated rehabilitation hospitals and units, such as looking at the infrastructure or type of care delivered.

To blunt the harmful effects of the 60 Percent Rule, AMRPA recommends the following actions, which indisputably fall within the agency’s existing authority.

1. Reduce the threshold of the 60 Percent Rule
   To facilitate enhanced access to medically necessary rehabilitative care for patients with complex conditions such as organ transplantation and cancer, the compliance threshold should be reduced to a maximum of 50%. Although this change does not fully address the underlying problems with the rule itself, the lower threshold would result in considerably fewer Medicare and non-Medicare patients arbitrarily being denied access to medically necessary inpatient rehabilitation care. There is no question that CMS has the existing authority to reduce the compliance threshold. In 2007, Congress passed the Medicare, Medicaid, and SCHIP Extension Act of 2007, which directed CMS to “require a compliance rate that is no greater than the 60 percent compliance rate that became effective for cost reporting periods beginning
on or after July 1, 2006.” Therefore, while CMS may not increase the compliance threshold above 60%, the agency may reduce the threshold percentage through notice and comment rulemaking.

2. **Expand the Conditions Covered by the 60 Percent Rule**

Based on an examination of the types of patients currently deemed appropriate for admission to an IRF, the list of 13 qualifying conditions that satisfy the compliance threshold should be expanded to include other impairment group codes, including patients with cardiac or pulmonary conditions, COPD, organ transplantation, among others. The specific list of additional conditions should flow from the data to ensure that the most prevalent and homogeneous conditions outside of the CMS-13 are included in the rule. Further, there should be a mechanism to ensure that the list is able to keep pace with advancements in clinical practice, such as through the establishment of an advisory committee (as discussed below).

**B. Coverage Criteria Proposals**

CMS should thoroughly review and streamline the ever-growing body of subregulatory policies governing IRF coverage criteria to better align with advances in medical rehabilitation and generally cut down on the many hundreds of hours IRFs devote to paperwork to satisfy these rigid requirements. Later in our response to this RFI, we propose recommendations to improve the audit and appeals processes, but simplifying the bureaucratic coverage criteria—and thus what is auditable—would go a long way toward addressing the daunting challenges CMS faces relating to Medicare claims adjudication.

In particular, the so-called 3-Hour Rule interpreting the “intensity of therapy” requirement has resulted in a labyrinth of subregulatory requirements, “clarification” documents, and “regulation by conference call.” The expectations for daily therapy delivered in individual, group, and concurrent settings, as well as the permissible modalities of therapy—when they can be gleaned—have become so rigid and technical that clinical judgment about individual patients’ needs has been relegated to a secondary consideration. To address the proliferating pronouncements of IRF coverage policy, and disparate standards being employed to deny valid claims, AMRPA recommends CMS take the following actions, which would require only that the agency reaffirm its prior statements.

1. **Simplify the Intensity of Therapy Requirement and Ensure that Contractors Correctly Apply It**

At present, the intensity of therapy requirement is improperly interpreted to mandate that all IRF patients receive a minimum of three hours of physical, occupational or speech language therapy services five days a week for the duration of their stay, unless exceptional circumstances apply. However, this strict “requirement” does not flow from codified regulations. The Medicare Benefit Policy Manual is also quite flexible; in pertinent part, it states:

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Although the intensity of rehabilitation services can be reflected in various ways, the generally-accepted standard by which the intensity of these services is typically demonstrated in IRFs is by the provision of intensive therapies at least 3 hours per day at least 5 days per week. However, this is not the only way that such intensity of services can be demonstrated (that is, CMS does not intend for this measure to be used as a “rule of thumb” for determining whether a particular IRF claim is reasonable and necessary).  

Through various subregulatory statements, CMS and the Medicare contractors themselves have made this “standard” increasingly rigid such that even the slightest deviation for a single day results in a claim for the entire IRF stay being denied. The rule should be simplified to instead require that the aggregate amount of therapy over the course of the IRF stay aggregates to at least 15 hours per week, as is currently allowed under the benefit manual when certain circumstances allow. CMS could execute this change by simply withdrawing various subregulatory guidance documents and issue new guidance instructing contractors to interpret the requirement in this manner. This resolution would actually be stricter than the requirements articulated in regulations and the benefit manual, and yet considerably more manageable for rehabilitation providers than the current jumble of policies and interpretations that do not allow for any variation for individual patient need. Making the 3-Hour Rule more flexible would not reduce the aggregate amount of therapy patients currently receive, but would allow therapy to be tailored to patients’ unique circumstances and individualized care plans. Moreover, this simplification would allow IRFs to forgo copious amounts of documentation or risk losing payment for the entire stay, simply because the therapy on a given day was less than three hours for clinically valid reasons.

2. Clarify Policies Regarding Delivery of Non-Individual Therapy

CMS has stated in rulemaking and policy manuals that the standard of care for IRF patients is individualized therapy and that the “preponderance” of therapy provided must be individualized. Yet Medicare contractors routinely deny claims that exceed this standard, even when the vast majority of therapy is individualized, if it amounts to less than 3 hours on a given day. The benefit manual currently specifies that for “those instances in which group therapy better meets the patient’s needs,” such therapy meets the standard if it is appropriately documented in the patient’s medical record. The benefits of group and concurrent therapy, which are every bit as intensive as one-on-one therapy, are also apparent from a patient’s standpoint, as they often facilitate group learning/modeling, coaching/peer motivation, and camaraderie, among other benefits. For example, a patient with speech deficits will

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40 CMS, Medicare Benefit Policy Manual, Ch. 1 § 110.2.2 (Jan. 1, 2010) (emphasis added). See also 42 C.F.R. § 412.622(a)(3) (“[T]here must be a reasonable expectation that the patient meets all of the following requirements at the time of the patient's admission to the IRF . . . [that the patient] can reasonably be expected to actively participate in, and benefit from, an intensive rehabilitation therapy program . . . [which] generally consists of at least 3 hours of therapy (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy) per day at least 5 days per week.”) (emphasis added).
41 Id. § 110.2 (Jan. 7, 2014).
42 Id. § 110.2.2.
experience greater intensity of speech therapy by conducting conversation with more than a single person, which better approximates the world to which they are returning. Therefore, subregulatory guidance documents \((e.g., \text{Q&As})\) and contractor transmittals that decline to follow this approach should clarify that group and concurrent therapy count toward the intensity of therapy requirement \((i.e., 3\)-Hour Rule\) when they are determined to be medically appropriate by the rehabilitation physician and therapy teams, and are documented accordingly. As revised, the policy would allow group and concurrent therapy to be counted, provided that individual therapy constitutes the predominant mode \((i.e., \text{more than half})\). Because CMS has articulated this “preponderance” standard repeatedly, this “change” need only be executed through clear communication to contractors to apply the existing requirements properly. Alternatively, CMS could amend the regulations to crystallize this standard and prevent future deviation from it.

3. **Clarify the Intensity of Therapy Requirements**

Currently, the coverage criteria are interpreted to limit qualifying therapy modalities to physical, occupational or speech language pathology services. To keep pace with advances in medical rehabilitation, the rule should be expanded to include additional types of therapy services. For example, other types of skilled therapy, such as recreational therapy, should be counted as a qualifying modality when it is: (1) prescribed by the treating physician and the rehabilitation team as part of the patient’s plan of care; (2) considered active treatment; and (3) provided by a qualified therapist. Other services that may be considered include psychological and neuropsychological services. This approach would be wholly consistent with bipartisan legislation in Congress supported by the relevant professional and disability rights organizations. Nonetheless, it is uncontroversed that CMS has the authority to reinterpret the “intensity of therapy” requirement as it has previously done in rulemaking and subregulatory guidance.\(^ {43}\)

C. **Implement the Continuing Care Hospital**

The Continuing Care Hospital (CCH) is authorized by statute for a national demonstration program. More specifically, CMMI is directed to test the CCH,\(^ {44}\) but has so far refused to do so. The model is not only an alternative payment model (APM) but a promising delivery system reform that would foster better care coordination and would disincentivize disruptive and needless transfers. The CCH concept provides an opportunity to develop a patient-centered care model in which the “silos” established by the site-specific Medicare payment systems are eliminated. Care under the CCH model is delivered based on individual patient need rather than the regulatory policies of the applicable setting. Specifically, 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 either be 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). In addition to the patient-centric orientation of care, the CCH has real potential to realize cost savings due to efficiencies and reduced administrative costs.

\(^{43}\) See, \(e.g., 74\) Fed. Reg. 39762 (Aug. 7, 2009); CMS Transmittal 119 (Change Request 6699) (Jan. 15, 2010).

\(^{44}\) 42 U.S.C. § 1395cc-4(g).
Payment would also be more reflective of actual cost and resource use and would not include the multiple costs associated with meeting the requirements of the current payment systems and transfers among care settings as is currently required.

As noted, CMS does not require any additional authorizing legislation or appropriations to promptly launch the CCH, which the agency is already statutorily mandated to do. CMS should ensure that implementation occurs swiftly as an important step in evaluating viable post-acute care payment reforms.

D. New Unit Parity
As CMS well appreciates, the IRF prospective payment system (PPS) is designed to treat freestanding rehabilitation hospitals and inpatient rehabilitation units alike. However, the agency’s policy for paying new IRF units creates a glaring disparity in their treatment. If a unit opens before the first day of a cost report period, the unit is paid on the basis of an acute hospital’s diagnosis related group (DRG) instead of the corresponding IRF case-mix group (CMG) for the remainder of the cost-reporting period. Thus, new hospital-based rehabilitation units are all but required to open on, or a day or two prior to, the hospital’s cost report year. If the hospital encounters an unanticipated construction or approval delay (for which some states are notorious), it could miss the deadline by a few days to a few weeks and thus be stuck with the DRG rate for nearly a full year. The payment differential can be significant, imposing what is in essence a multi-million dollar penalty. More broadly, it does not make sense for an arbitrary Medicare policy to essentially force rehabilitation units to open on one specific day of the year. Freestanding rehabilitation hospitals do not face this problem because they have no existing cost report year. The hospital can thus open whenever ready and will be paid according to the appropriate CMG rate beginning on day one.

When confronted with these concerns in the past, CMS personnel have indicated that there is nothing that can be done to address the problem because a hospital unit is actually paid an outlier payment upon opening based on the division of cost (as evidenced by its filed cost report) and the number of patients it treats. In addition to confusing providers, this convoluted approach to new units results in outlier payments that exceed the annual cap, and thus by the start of the next cost report year, CMS recoups approximately 90 percent of the outlier payment. Hospital-based rehabilitation units should be paid a CMG from the outset, the same as a freestanding rehabilitation hospital. This is a simple fix that harmonizes the payments across all new IRFs, prevents an arbitrary policy from restricting when a hospital can open, or worse, imposing an arbitrary multi-million dollar penalty on hospital-based rehabilitation units.

E. Medicare Advantage Access
As AMRPA explained in recent letters to CMS, Medicare Advantage (MA) plan enrollees’ severely limited access to inpatient rehabilitation care remains a top concern.

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of our members. Many MA plans have erected challenging or insurmountable administrative barriers to getting patients the post-acute care they need. Instead of following Medicare IRF coverage criteria, many MA plans improperly apply private, proprietary decision tools, such as Milliman and InterQual guidelines, to make coverage decisions that override shared patient and clinician decision-making, both prospectively and retrospectively. The cumulative effect of using these guidelines is reflected in CMS’ own data detailed in MedPAC’s March 2016 and 2017 Reports to Congress, which reveal a marked disparity between the traditional fee-for-service and MA enrollees’ utilization of IRF-level care. The individual impact of this practice is to divert patients who qualify for inpatient hospital rehabilitation to clinically inappropriate lower-acuity settings, such as nursing homes and homecare, inevitably decreasing these patients’ prospects for full recovery.

Although CMS could address this lack of access in different ways, we believe the most appropriate course of action would be to issue directives to MA plans about the preeminence of Medicare coverage regulations over proprietary guidelines. While this could be accomplished through a change in regulations, the simplest approach would be a clear pronouncement in the next MA call letter.

Ultimately, clarifying Medicare rules for access to post-acute care is in everyone’s interest, including the government, providers, plans, and patients. All participants would benefit from regulatory simplification necessitating fewer medical reviews, especially pre-authorization and the disagreements that invariably ensue. Although the law is clear, the lack of explicit direction from CMS has created an environment designed around conflict where all sides have built up infrastructure to dispute referral and placement decisions ranging from line staff to medical reviewers to appeals specialists. Regulatory clarity in this instance would alleviate tremendous burden and ever-growing costs on the part of plans, but especially, on providers. More importantly, allowing medical decision-making to be guided by patients, their caregivers and physicians puts patients back at the center of their care and ensures that it is dictated by sound decision-making directed by clinical parameters and other individualized factors, rather than blanket bureaucratic policies, whether the government’s or managed care organizations’.

F. Reduce Redundancies in Patient Assessment Documentation

Medicare contractor review now necessitates three separate sets of documentation for every patient admitted to an IRF. These documentation requirements relate to the Pre-Admission Screen (PAS), the Post-Admission Physician’s Evaluation (PAPE), and the Individual Overall Plan of Care (IPOC). The PAS must be documented within 48 hours of admission; the PAPE must be documented within 24 hours of admission; and the IPOC must be documented within 4 days of admission. As discussed below, contractors will deny claims for missing any of these deadlines by one hour or submitting documentation without ironclad proof the deadlines were met. We separately recommend that CMS restrict the abusive practice of denying entire claims for the most technical documentation deficiencies.

Much of the information that must be documented for the PAS, PAPE, or IPOC is redundant insofar as the exact same information must be documented for one of the
other two assessments. Contractors categorically deny claims that omit any documentation required for any one of the three assessments, even if the exact same information is supplied in the documentation for one of the other two assessments. For example:

- Both the PAS and the PAPE require an IRF to document the patient’s level of function *prior to the onset* of the current illness. Under no circumstances, will the level of function have changed between the documentation for the PAS and PAPE.
- The PAPE requires an IRF to document the patient’s *current* function when it is the same as documented in the PAS. While it is reasonable that the PAPE include notation that there has not been any change in function, if there is no change, providing documentation to this effect is entirely redundant of the PAS.
- The IPOC requires a rehabilitation physician to support the patient’s IRF plan of care using a synthesis of information obtained through various evaluations. Specifically, the IPOC must include sufficient information to justify the plan of care, including documentation of the needed therapy interventions, intensity, frequency and duration, the medical prognosis at the time of admission, the expected functional outcomes, discharge destination, length of stay, and other information submitted in the PAS and/or PAPE.

The time and administrative burden associated with documenting these duplicative requirements for the purpose of contractor claim review is substantial, as they require not just administrative staff, but extensive participation and certification by medical professionals. CMS should cut down on this duplication (and triplication) in one of two ways. First, the agency could simply direct contractors to deem documentation for a single claim to satisfy each of the levels of assessment for that patient. Thus, if an IRF submitted documentation that satisfied identical requirements of the PAPE and IPOC for only one and not the other, the contractor would be required to accept the documentation for both assessments. CMS could issue a simple directive to its contractors requiring this administrative simplification. Alternatively, the agency could go a step further and actually eliminate the redundancies in the patient assessment documentation criteria. Although the patient would still be assessed on each of these domains at each level, secondary documentation would only be required for a single assessment level. This would be a more meaningful deregulatory action that would not just avoid technical claims denials, but would actually reduce the time and cost burden associated with submitting each claim. AMRPA welcomes the opportunity to work with CMS and its contractors to itemize the redundant documentation requirements and to recommend streamlining redundancies.

G. Regulatory Flexibility in Alternative Payment Models
CMS has been encouraging IRFs to participate in APMs. IRFs are eligible participants of several models within the Bundled Payment for Care Initiative (BPCI), are encouraged to be collaborators in the mandatory Comprehensive Care for Joint Replacement (CJR) model, and play an active role in other demonstrations and pilots. CMS and CMMI clearly have the regulatory authority to waive all of the offending requirements in the context of these programs, and have made similar concessions for other providers. For example, in the context of other APMs such as accountable care
organizations (ACOs) as well as the CJR, CMS has waived significant regulations such as the well-established rule necessitating a minimum three-day inpatient stay prior to covered skilled nursing facility services. Nevertheless, the agency has been unwilling to waive certain regulatory requirements that must be relaxed to facilitate IRF participation in these programs. Accordingly, various regulatory requirements should be waived in the context of specific APMs.

1. **Alternative Pricing**
   An increasing number of APMs hold provider entities, such as acute care hospitals or broader networks of providers, responsible for post-acute spending. Like other post-acute care providers, these models encourage IRFs to produce high-quality outcomes at a reduced cost. However, unlike other post-acute providers such as nursing homes, IRFs are paid on a flat per-discharge basis for patients. Because default Medicare rules do not allow IRFs to “charge less” in this context, these bundling programs merely incentivize bundle-holders to keep patients from receiving inpatient medical rehabilitation, even when it is imperative to their recovery. This phenomenon is exacerbated by these programs’ failure to penalize for stinting on medically necessary care or otherwise measure long-term functional outcomes. For IRFs to be able to compete alongside other providers in these models, willing participants must be permitted to receive reduced reimbursement, a per diem payment, or offer a discount from the IRF PPS amount, if they so choose. Although this likely means that IRFs will be paid below cost for treating patients in these programs, the alternative—that patients are denied access to inpatient rehabilitation altogether—is far worse for IRFs, but especially for patients. Since margins are very small or negative for the majority of IRFs, pricing flexibility must be voluntary, as should all alternative payment and delivery models being tested.

In addition, it is critical for IRFs to have sufficient flexibility to ensure they are able to deliver the appropriate care in this context. Providers opting for reduced reimbursement for patients associated with non-CMS 13 (i.e., non-60 Percent Rule compliant) cases should be allowed to exclude those cases from the calculation used to determine the threshold compliance. For example, if an IRF treats a patient who satisfies the 60 Percent Rule at lower pricing under an APM, the patient should “count” toward satisfaction of the rule. Additionally, the intensity of therapy standard should be relaxed for these cases as well. Specifically, the 3-Hour Rule should not apply to APM cases for which the IRF has elected to receive reduced reimbursement. This approach is consistent with CMS’ recent emphasis on expanding the reach of APMs, and has been favorably discussed by MedPAC in the context of the uniform post-acute payment system. CMS has the authority to permit such flexibility, and to waive these bureaucratic requirements without Congressional approval; the agency should do so when promulgating any future models or changes to the current programs.

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2. Administrative Presumption of Coverage under APMs

All patients admitted to IRFs from acute care hospitals participating in an APM, regardless of whether the facility is receiving IRF PPS or reduced reimbursement, should be presumed to be covered in the IRF setting. Acute hospital “bundle holders” are responsible for the cost and quality of care for their bundled patients. If they choose to discharge patients to an IRF, they should have full discretion to do so without Medicare contractor interference as their performance metrics and outcomes in the APM will be irrespectively impacted by the placement decision. CMS should instruct Medicare and its contractors to respect post-acute care referrals and admission determinations under APMs and not be permitted to deny payment based on pre-payment review or post-payment reopening, unless there is evidence of fraud.

H. Establish a Post-Acute Care Advisory Council

An Advisory Council dedicated to post-acute rehabilitation care should be formed within CMS and given a broad mandate to provide recommendations and ongoing advice to the Secretary and to the Congress on issues relating to Medicare coverage for post-acute rehabilitation services. The Advisory Council would have authority to review and comment on any CMS regulatory changes or activities impacting post-acute care providers, including: all rulemakings that impact medical rehabilitation providers and patient access to medical rehabilitation care; criteria for documenting medical necessity for post-acute admissions; and the proper use of available research funds and authorities focused on medical rehabilitation, among other topics. In prior Congresses, bipartisan, bicameral legislation would have created a 17-member council comprised of experts appointed by the Secretary in consultation with the medical rehabilitation community, and by Congress on a bipartisan basis. Given CMS’ and other policy makers’ interest in improving the disparate payment systems for different post-acute care sites of service, the agency would benefit tremendously from a standing body with relevant expertise.

I. Proposals Addressing Audits, Denials and Appeals

As CMS, the Department of Health and Human Services (HHS), and this Administration are well aware, the challenges stemming from Medicare’s broken claim review and audit system, and the years-long appellate backlog that has resulted, are daunting. AMRPA applauds the Administration for taking a hard look at the shortcomings of the current audit programs and proposing additional resources to addressing the magnitude of backlogged appeals. Simply put, the aggregate burdens of the Medicare’s various audit programs have become intolerable for health care providers, including IRFs. According to CMS’ own data, appeals filed in 2017 will take well in excess of 1,000 days to process,48 years beyond the 90-day deadline that a federal court recently affirmed is mandatory and non-waivable.49 Many of AMRPA’s members have been waiting three to four years for a hearing before an administrative law judge (ALJ), without access to the funds in controversy. All the while, AMRPA

members report that a single appeal can cost a provider more than $7,000 in administrative and other costs.50 Notably, however, at the ALJ stage, IRFs are successful in getting the substantial majority of denials overturned.

As we noted at the outset, part of the problem in the context of IRF claims is not just the audit processes themselves, but the ever-proliferating compendium of items that have become “auditable” in the first place. While AMRPA shares CMS’ goal of combatting fraud, waste and abuse in the Medicare program, the vast majority of claims denials our members experience relate to technical violations of subregulatory coverage policies. For example, one of our members recently experienced claim denials for each of the following reasons during a recent SMRC review:

- Pre-admission physician examination did not indicate the prior level of function – even though the prior level of function is documented elsewhere in the medical record;
- The IPOC did not indicate a medical prognosis – again, even if documented elsewhere;
- The IPOC was not completed within four days;
- Interdisciplinary team conference missing documentation of team member (e.g., case manager, SLP, OT, etc.); and
- No physician signature on pre-admission review or outside of the 48-hour window, or done with an EMR that somehow does not meet CMS’ requirements.

Reining in some of the most arbitrary documentation requirements on which auditors rely to deny claims would, over time, substantially reduce the strain that Medicare claims appeals are placing on our administrative law system, judicial system, and taxpayers. In addition to reducing layers of rigid policies designed to second-guess clinical judgment, many improvements could be made to the audit processes themselves to ease burdens on providers and patients. The Audit & Appeal Fairness, Integrity, and Reforms in Medicare (AFIRM) Act represents a crucial step forward, but there are many more audit policy changes that CMS could and should institute on its own accord. AMRPA recommends CMS take the following actions, at a minimum, and would welcome the opportunity to work with the agency to developing even bigger-picture solutions to a worsening problem.

1. **Eliminate Technical Denials**
   
   To lessen the draconian penalties imposed on IRFs for highly technical paperwork errors, and to reduce the overall burden on the administrative appeals system, CMS should eliminate technical errors as a basis for Medicare contractors to deny claims. This change would prevent claims from being denied for many of the more perfunctory reasons described above, such as failing to check a box on a form or documenting the post-admission one hour late, unless they are systematic or can otherwise be shown to impact patient care. A prohibition on technical denials would reduce the total number of claims that are appealed, as well as the rate at which such denials are overturned. It would also alleviate one of the most frustrating aspects of providing services to Medicare beneficiaries—delivering high-quality

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50 AMRPA Audit Tracking membership survey, 2013.
care that restores a patient’s physical and cognitive function only to be denied payment for an insignificant paperwork error.

The simplest way to institute this policy would be for CMS to include an affirmative statement in the regulations governing either IRF coverage or contractor audits clarifying that isolated technical deficiencies in documentation shall not constitute the sole basis for denial of a claim. Alternatively, CMS could establish a “totality of the circumstances” test for determining whether the coverage criteria are met, based on a complete review of the entire medical record rather than a piecemeal examination of individual elements of documentation in the medical record. Either approach would be consistent with verbal assurances made by CMS officials before the 2010 IRF regulations were implemented and would create a much more equitable standard of review as applied by Medicare contractors. Moreover, either approach represents a vast improvement over the status quo.

2. **Streamline the Appeals Process**

In order to shorten the lengthy Medicare appeals process, reduce the costs associated with pursuing appeals, and hasten the time to final resolution, CMS should consolidate the redetermination and reconsideration stages of the appeals process. At a minimum, providers should be allowed to opt out of the reconsideration before proceeding to ALJ review. Notably, Qualified Independent Contractor (QIC) reconsiderations rarely result in a different outcome than the original redetermination and are rightfully perceived as a “rubber stamp” of the initial denial. A 2012 HHS Office of the Inspector General (OIG) Report found that ALJs reversed QIC decisions and decided fully in favor of Part A hospital providers in 72 percent of appeals.51 This posture is likely based on the information and circumstances that QICs are empowered to take into consideration, as well as their general orientation to the bases for denials, including technical denials and contractor errors. CMS likely has authority to modify the procedure by consolidating the first two levels of appeal at the provider-appellant’s request. Although the Medicare statute entitles claimants to the reconsideration stage,52 CMS could nonetheless issue policies to allow providers to opt out. Should CMS conclude that any modifications to the stages of Medicare appeals process require legislation, we believe a legislative fix would be well warranted to address the unacceptably long and costly process to obtain payment for medically necessary care. This proposal is designed to reduce the amount of time and resources a provider is forced to expend on the obligatory lower levels of appeal, which do not offer a meaningful opportunity to overturn the initial denial, and thus simply add expense and time—which is of course itself a cost—to the appeals process.

3. **Halt Recoupment of Claims Denied Post-Payment through the Issuance of an ALJ Decision**

In order to lessen the financial strain imparted by the current appeals process, and to spare CMS compounding interests costs, CMS should expand the current limitation

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on recoupment related to post-payment denials through the date an ALJ decision is issued. Under current policy, claims that are denied and reaffirmed on redetermination must be paid back pending appeal. As noted above, however, it is not until the ALJ phase that there is a meaningful opportunity to review the medical necessity of care. Therefore, this proposal would alleviate some of the financial burden borne by providers stuck in the years-long appeals backlog by allowing them continued access to reimbursement for care already furnished. This proposal would also benefit CMS by taking some of the pressure off the ALJ backlog and reducing the amount of interest that must be paid back to providers at the conclusion of the appeals process in the case of overturned denials. Although this policy admittedly does not address the concerns raised by the extended appeals backlog for those providers pursuing pre-payment denied claim, it is nevertheless an improvement on the status quo.

4. **Create an Audit “Circuit Breaker”**
Medicare contractors should be barred from conducting payment reviews based solely on statistical analyses when a provider demonstrates why its caseload is at variance with the applicable regional or national analyses. In recent years, Medicare contractors have increasingly audited cases citing statistical analysis as their rationale. For example, the contractor’s letter may state that documents are requested because the provider exceeds the regional average for the particular types of cases audited, such as stroke. In reality, the multitude of factors that influence individualized post-acute care placement decisions are not conducive to an oversimplified audit-by-number approach. Providers may exceed the averages stated in the letters for any number of valid reasons, which may not be apparent in simple statistical analyses. For instance, the IRF may be the only teaching program in the state or region; other nearby IRFs may have closed and it has assumed all of the closed providers patients; or the IRF may be renowned for a specific rehabilitation subspecialty or may be attached to a trauma center, cancer center, or cardiac center. In the end, such statistical analyses simply demonstrate variation from a mean, not improper practices. Audits on this basis alone are therefore harassing, unwarranted, and add to the overall burden of a flawed recovery audit program. The data will show that they are often fruitless, to boot.\(^{53}\) CMS should direct contractors not to launch reviews on the basis of statistical analyses alone.

AMRPA supports other stakeholder proposals to revamp Medicare audit and appeals processes in ways that eliminate needless burdens on providers, reduce the strain on scarce administrative and judicial resources, and put patient care back at the center of the health care system. To advance these objectives, we advocate:

5. **Require Recalculation of Error Rates for Providers Under Pre-Payment Review**
Medicare Administrative Contractors (MACs) that institute ongoing pre-payment

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\(^{53}\) Per the Appendix G4 to CMS’ FY 2015 RAC Report to Congress, 77 percent of claims reviewed were identified through automated review but yielded just 18 percent of the total amount collected through RAC audits. By contrast, the 20 percent of cases identified through complex review (which involves a review of the supporting medical records) yielded 79 percent of the total amount collected. Moreover, Appendix G1 shows that the average amount collected per claim through automated review in FY 2015 was $142.76, versus $2405.17 through complex review.
reviews against a provider should be required to recalculate providers’ error rates on a quarterly basis (and include the results of any favorable appeals in the calculation) for purposes of determining whether it is appropriate to continue pre-payment review or revise the percentage of claims to be reviewed. Since prior regulations limiting the use of recalculation were rescinded, there has been a noticeable increase in its use by the MACs with virtually no rules restricting these contractors. While pre-payment review furthers can help identify improper payments before they are made, it also creates significant administrative inefficiencies if it fails to account for appeal outcomes, continuously shuttling new denials into the appeals system.

6. **Deem Appealed Claims as Payable if they Remain Pending for Five Years or More After the Initial Determination**

   For any appeal still pending five years after the date of the initial determination on the claim, the claim should be deemed payable. By presuming that after a certain period of time a claim should be considered finally decided, this proposal is consistent with reopening regulations treatment for claims not involving allegations of fraud or similar fault. A five-year period accounts for the typical year it should ordinarily take an appeal to work through the ALJ level of appeal (at most), plus the four years permitted for reopening. But for the extensive appeal backlog, this five-year period would typically account for the maximum amount of time reimbursement for a claim could be at issue.

AMRPA believes that these proposed changes advance the objectives set forth in the RFI of reducing burdens on providers and patients and ensuring medical decision-making is driven by clinical judgment of individualized patient need. These proposals also advance the core objectives of Executive Order 13777, which instructs regulatory reform task forces to identify regulations that: inhibit job creation; are outdated, unnecessary, or ineffective; impose costs that exceed benefits; and create inconsistencies; and are insufficiently transparent, among other shortcomings.\(^{54}\) Each of the regulations, and especially subregulatory policies, discussed above contravenes multiple of these criteria. Eliminating or simplifying any of these regulations would be a tremendous benefit to providers, patients, and the Medicare program; rectifying many of these flawed policies could begin to revolutionize post-acute care delivery.

We identify these ineffective and often harmful policies as the “lowest hanging fruit” of regulatory reform. However, AMRPA members are committed to big-picture reforms that redefine the value proposition of medical rehabilitation and truly place patients back at the center of care. We are working on some very exciting initiatives with the private sector and welcome the opportunity to present our work to the agency when appropriate.

**V. Proposed Changes to the IRF PPS**

**A. Facility Level Adjustment Factors for FY 2018**

CMS does not propose any change to the IRF facility level adjustment factors for FY 2018. AMRPA reiterates the recommendation submitted in its comments on the FY 2016 and 2017 IRF PPS proposed rules that CMS increase transparency regarding the methodology and

factors utilized in calculating facility adjustment payments to IRFs. In the FY 2017 Final Rule, CMS stated that comments on these factors were beyond the scope of the proposed rule since no changes were proposed. We urge the Agency to reconsider its position and increase transparency in this area.

In adopting OMB Bulletin No. 13-01 in FY 2016 and OMB Bulletin No. 15-01 in the FY 2018 proposed rule, CMS will have caused a total of twenty IRFs (almost 14 percent of rural IRFs based on the FY 2018 rate setting file\(^{55}\)) to lose their rural designation since it began freezing the Facility Adjustment Factors. Given this significant shift, it seems implausible that there has not been a corresponding material shift in the data and results of the rural factor add-on amount. It is incumbent on CMS to consider this data; the Agency cannot avoid it simply by stating that it has not proposed any changes to the facility adjustment factors. See District Hosp. Partners v. Burwell, 786 F.3d 46, 57 (D.C. Cir. 2015) (“If an agency fails to examine the relevant data – which examination could reveal, \textit{inter alia}, that the figures being used are erroneous – it has failed to comply with the APA.”).

Moreover, without knowing the data and methodology CMS relied on to conclude that no changes were needed to these payment adjustment factors, the IRF field cannot understand or evaluate CMS’ conclusions. Cf. Shands Jacksonville Med. Ctr. v. Burwell, 139 F. Supp. 3d 240, (D.D.C. 2015) (holding that the Secretary failed to “provide sufficient notice of the actuarial assumptions and methodology she employed and that disclosure of this information was essential to communicate the basis for the proposed adjustments”).

\textbf{Recommendation:}
AMRPA urges CMS to include more detailed information in the final rule explaining the Agency’s rationale for continuing the freeze of the facility level adjustments. Lastly, we continue to support a minimum interval for any change in the IRF provider-level adjustment factors, such as once every three years, as well as the establishment of a percentage change threshold for each factor requiring an update.

\textbf{B. Proposed Wage Index Update and Labor Related Share for FY 2018}

CMS proposes using a labor-related share of 70.7 percent for the IRF PPS in FY 2018. Wages and salaries are estimated to be 47.7 percent, and CMS will continue to use the same methodology for wage index updates that has been used in previous years. AMRPA has no specific recommendation on the labor-related share, but we remain concerned that IRFs are disadvantaged in recruiting staff by the current wage index policies. The wage index utilized for IRFs is the prior year, pre-reclassified acute care hospital wage index, while the other PAC providers (\textit{e.g.}, LTCH, SNF and Home Health providers) utilize the current fiscal year IPPS pre-reclassified acute care hospital wage index. As Medicare payment policy continues trending away from paying for site-specific care and toward ACOs and/or bundled payment arrangements, it will be important for all post-acute care provider settings to use the same wage index variables. CMS will eventually need to harmonize the wage index discrepancy, and we believe that doing so sooner would level the playing field for recruiting clinical personnel and ensure a uniform payment policy across all provider settings.

\(^{55}\) The FY 2018 IRF CMS Rate setting file has 147 IRFs designated as rural; 20 facilities out of 147 equals approximately 14 percent.
Recommendation:  
As stated in our comment letter on the FY 2017 IRF PPS proposed rule, AMRPA recommends that CMS utilize the most current wage data (which is already used for acute care hospitals and other PAC providers) to determine the IRF wage index and level the recruitment playing field across all post-acute sites of care.

C. Proposed IRF Standard Payment Conversion Factor and CMS Payment Rates for FY 2018
CMS proposes a standard rate conversion factor for FY 2018 of $15,835, an increase from the FY 2017 factor, which is $15,708. CMS explains that this amount results from: a one-percent rehabilitation-specific market basket as required by section 411(b) of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015; budget neutrality factors for the wage index and labor related share of 1.0007 percent; and a budget neutrality factor for the revised CMG relative weights of 0.9974 percent.

AMRPA supports the market basket update for FY 2018. However, we remain concerned about the manner in which productivity adjustments will apply in future periods. The theory underlying the productivity adjustment is that Medicare providers should be able to achieve the same level of productivity improvement as workers across the U.S. economy. However, several factors specific to rehabilitation providers render it difficult, if not impossible, to do so. First, rehabilitation services are very labor-intensive. Successful rehabilitation outcomes require a comprehensive labor component that includes the interaction of a multidisciplinary team comprised of physicians, nurses, physical and occupational therapists, speech language pathologists, social workers, psychologists and others.

Second, IRFs are subject to intensity of therapy requirements (often referred to as the three-hour rule), pre-admission screening requirements, and medical director coverage requirements. While other medical fields may benefit from improved technology that yields increased productivity, rehabilitation, by its nature and by virtue of the requirements placed on it by CMS, cannot advance productivity through technology or other means in the same way other medical fields can. As the Administration seeks to spur economic growth, this will in turn lead to larger productivity adjustments that have no correlation to actual gains in the IRF sector.

In addition, the proposed rule continues the trend of implementing significant new costs related to the IRF QRP that may not be captured in the reduced market basket rate update. Lastly, the House of Representatives recently passed the American Health Care Act which, if enacted, would significantly reduce Medicaid enrollment. The Affordable Care Act (ACA) enacted these productivity adjustments as an offset for the reduction in uncompensated care costs, even though IRFs did not benefit from these coverage expansions. IRFs thus could be permanently shackled to this payment reduction even if the purported offset for the reduction is removed.

Recommendation:  
AMRPA respectfully requests that CMS carefully monitor the impact these productivity adjustments have on the rehabilitation hospital sector, provide feedback to Congress as appropriate, and utilize any authority the Agency has to reduce the productivity adjustment.
D. Proposed Update to the High Cost Outliers and Cost to Charge Ratio Ceiling and Urban/ Rural Averages for FY 2018

CMS proposes to update the outlier threshold amount from $7,984 for FY 2017 to $8,656 for FY 2018 to account for increases in IRF PPS payments and estimated costs, and to maintain outlier payments at approximately 3 percent of total estimated aggregate IRF payments for FY 2018. CMS also estimates that it achieved last year’s goal of paying outlier payments equal to 3 percent of total aggregate IRF payments.

Recommendation:
AMRPA supports the policy of setting outlier payments at 3 percent of total estimated aggregate payments. We are encouraged that CMS states it has met the goal of paying out 3 percent as outlier payments for FY 2017. However, our analyses of past rules show that material changes can occur between publication of proposed and final rules. Therefore, we ask that CMS update the final rule outlier threshold amount using the latest available data to ensure that the entire 3 percent outlier pool will be paid to IRF providers. AMRPA also recommends that CMS modify its methodology for determining outlier payments so the full 3 percent is paid out every fiscal year.

AMRPA has no comment with respect to the Rural and Urban National Cost to Charge Ratio (CCR) ceilings or the National Geometric Mean CCR.

VI. Proposed Update to the Case-Mix Group (CMG) Relative Weights and Average Length of Stay Values for FY 2018

A. Data Used to Update the CMG Relative Weights

CMS proposes to use the most up to date information available, which at this time is FY 2016 IRF claims data and the FY 2015 cost report data. This is the same data (recent claims and cost report data) CMS used to update the CMG weights for FY 2017.

Recommendation:
We agree with use of the FY 2016 IRF claims data and the FY 2015 cost report data. However, as described more thoroughly below, it is difficult for stakeholders to provide feedback on the application of that data to the updated methodologies. We request that CMS make available each year the report or analyses it performs to determine the updated relative weights for comorbidities and tiers. Without that information, stakeholders have no way of knowing whether the data is being applied to the existing weights in a way that is consistent with our understanding or whether the calculation is being done accurately.

B. Process for Calculating the CMG Relative Weights

CMS proposes to use the same process it used in FY 2017 to update the CMG relative weights. This involves using a hospital-specific relative value method to estimate operating (routine and ancillary services) and capital costs of IRFs.

Recommendation:
AMRPA supports the stated process for calculating the CMG relative weights. However, as stated before, CMS should make available the report or analyses it performs to determine the updated relative weights for comorbidities and tiers. Without that information, stakeholders have no way of knowing whether the data is being applied to the existing weights in a way that is consistent with our understanding or whether the calculation is being done accurately.
As an example, AMRPA understands the annual average length of stay (ALOS) of a CMG is to be correlated generally with the CMG’s weight. This year, however, for CMG 1903, Guillain Barre M<18.05, Tier 1, CMS proposes a dramatic 11 day decline (22%) in its ALOS, but proposes an increase in its weight value from 3.4585 to 3.6781. Providing the underlying report or analyses to explain this apparent discrepancy would better equip and educate providers to respond to CMS’ proposed changes. Without this information, there is not a genuine opportunity for comment by stakeholders on these proposed changes.

C. Average Length of Stay
CMS utilizes the same methodology used in prior years to calculate ALOS by CMG and tier. In 2014, CMS published on the IRF PPS website under “Research” the methodology it used to calculate the ALOS value for each CMG and tier. While that information is helpful, AMRPA urges CMS to include this information in the proposed rule. CMS already includes methodologies for the standard payment conversion factor, budget neutrality factors, recalculation of the CMG weights, and national cost to charge ratio ceiling, among other factors.

Recommendation:
1. As stated in prior comment letters, AMRPA recommends that CMS publish its methodology for calculating the annual ALOS for each CMG and tier, just as it does for the CMG weights and other components of the payment system. The ALOS has a substantial impact on the payment policy for IRFs. Therefore it should be subject to the same notice and comment rulemaking as other methodologies used to determine IRF payments.
2. As stated previously in this section, AMRPA urges CMS to provide the underlying analyses and report it uses to update the ALOS for CMGs, including any cost data on comorbidities. Without this information, stakeholders cannot properly understand the way the data is applied to the CMGs and tiers, and respond to the proposed rule.

VII. Proposed Revisions to the IRF PAI

A. Remove Voluntary Item 27–Swallowing Status
CMS proposes to remove from the IRF PAI voluntary Item 27–Swallowing Status for discharges on or after October 1, 2017. AMRPA does not support this proposal and recommends that CMS retain Item 27 until October 1, 2018 when IRF PAI version 2.0 is implemented. On the current IRF PAI (version 1.4), there are two assessment items that track a patient’s swallowing status/nutritional approach: Item 27, voluntarily assessed at admission and discharge; and Item K0110, assessed only at admission. Although they may seem duplicative, only Item 27 tracks patients’ feeding modalities at both admission and discharge and thereby captures information on a patient’s improvement through the course of their IRF stay. As a voluntarily reported item, Item 27 is not burdensome and allows providers to monitor positive outcomes such as number of patients progressed to a regular food diet. Effective October 1, 2018, IRF PAI version 2.0 will add Item K0520–Nutritional Approaches to admission and discharge assessments (if adopted as proposed). Hence, we do not see a gain in removing a voluntary item from one year of IRF PAI data collection.
Recommendation:
AMRPA recommends that CMS retain Item 27--Swallowing Status as a voluntary item until Item K0520–Nutritional Approaches is added to the IRF PAI for admission and discharge assessments.

B. Use IRF PAI information to determine patient BMI greater than 50 for cases of lower extremity single joint replacement and count qualifying patients in the presumptive methodology for the 60 Percent Rule
CMS proposes to use the information recorded for Item 25A-Height and Item 26A-Weight on the IRF PAI in to determine if a patient’s BMI is greater than 50 and to use that data to determine and presumptively count lower extremity single joint replacement cases toward an IRF’s compliance percentage. AMRPA is not supportive of this proposal since it is inconsistent with the other methods in which CMS calculates presumptive compliance, i.e. through ICD-10 codes. There is an ICD-10-CM code – Z68.43 – which reflects a BMI of greater than 50. We believe it may be more reliable to determine BMI>50 by utilizing this code on the IRF PAI, as an etiologic diagnosis or as a comorbid condition. Using the available code for a clinical criterion, rather than the adding a calculation based on two items that have been unrelated to presumptive compliance, is clearly more straightforward. Since CMS uses ICD-10-CM codes to determine presumptive compliance in other instances, the use of a code, and not a calculation done using two items from the IRF PAI, should be what is used to determine compliance.

Recommendation:
AMRPA recommends CMS not implement this proposal as it is inconsistent with the current methodology of determining presumptive compliance, i.e. using ICD-10 diagnosis codes.

C. Remove the 25 Percent Payment Penalty for Late IRF PAI Submissions of the IRF Patient Assessment Instrument (IRF PAI) beginning October 1, 2017
CMS proposes to remove the 25 percent payment penalty that results from a late transmission of the IRF Patient Assessment Instrument (IRF PAI). AMRPA agrees with CMS assessment that the penalty is redundant since timely submission of the IRF PAI is already incentivized by being tied to provider payments. AMRPA appreciates CMS recognizing the unnecessary burden placed on providers by having to apply for a waiver for this penalty.

Recommendation:
AMRPA recommends that CMS finalize its proposal to remove the 25 percent penalty for all discharges beginning on or after October 1, 2017.