AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

September 1, 2023

Ariel Cress
Inpatient Rehabilitation Facility and Long-Term Care Hospital Quality Reporting Program Lead
Center for Clinical Standards and Quality
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Re: IRF QRP Non-Compliance Determinations and Reconsideration Requests

Dear Ms. Cress:

On behalf of our members, the American Medical Rehabilitation Providers Association (AMRPA) would like to request that CMS seriously consider exercising leniency with Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP) Reconsideration Requests for Fiscal Year (FY) 2024. AMRPA has conveyed to CMS throughout the past year our well-documented concerns with the roll-out of the IRF Patient Assessment Instrument (PAI) version 4.0, as well as reports from the field about conflicting guidance and inadequate technical assistance provided to IRFs by the relevant helpdesks.

As a broader matter, and to avoid annual disputes between the field and CMS regarding QRP compliance, we urge CMS to engage with AMRPA and IRF stakeholders on commonsense revisions to the process of confirming timely reporting of quality data, IRF QRP Non-Compliance Determinations, and the imposition of 2% payment penalties. We urge CMS to reconsider its policy of imposing such a reduction against providers uniformly, whether there is blatant noncompliance or the most minor of discrepancies or errors in their data submissions. As more thoroughly discussed below, such a policy is disproportionate to the offense, fundamentally unfair, does not advance compliance with the QRP program, and runs contrary to the intent of the QRP program. We provide a more technical overview of the history of the QRP and the current technical and administrative issues facing providers in the Addendum to this letter.

AMRPA and our IRF members recognize the importance of including diverse and well-designed quality measures that distinguish high-quality care in the IRF QRP. We also recognize how critical it is for IRFs to provide the data necessary for these measures to support the ability for CMS to publicly report performance on Care Compare and for patients to make post-acute care decisions. However, what started as an incentive for providers to prompt them to submit their quality reporting data in a timely and compliant matter has become a mechanism that often punitively withholds Medicare payments to IRFs that substantially comply with the ongoing expansion of QRP obligations but are impeded by unreliable and overly complex reporting systems.

Each measure has its own specific and varied instructions for collecting and reporting the required data, set forth in the applicable Federal Register notice and in the various manuals and

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instructions issued by CMS. For instance, for the COVID-19 Vaccination Coverage among Healthcare Personnel measure, IRFs were required to input monthly data based on a single week selected from that month, and for Influenza Vaccination among Healthcare Personnel, IRFs were required to submit a single summary report covering the entirety of the 2022-2023 influenza season. Because the CDC NHSN measures are typically the responsibility of an infection control specialist, IRFs often encounter difficulties in meeting reporting requirements when there is turnover, illness, or other issues impacting the availability of those who are infection control specialists or the primary individual responsible for the CDC NHSN measures who have been trained in complying with the variances in reporting formats.

For the IRF-PAI measures, data are submitted through the Internet Quality Improvement Evaluation System (iQIES). However, since IRF-PAIs are completed contemporaneously with each patient's admission and submitted shortly after patient discharge, there are sometimes data elements that cannot be completed, especially if a patient is discharged emergently or otherwise unexpectedly. While some IRF-PAI fields include an option for "Patient Unable to Respond," not all impacted sections include such a selection option. For those elements of the IRF-PAI lacking such an option, CMS has previously instructed IRFs to use "dashes" in these fields. The IRF-PAIs for patients with unplanned discharges, therefore, require special consideration and review by CMS in order to ensure that the inclusion of dashes in certain fields did not improperly cause the IRF's compliance percentage to drop below the required 95% threshold for submissions to be considered "complete".

AMRPA believes that a 2% payment penalty applied over a full fiscal year is often a disproportionate sanction to the hospitals' level of non-compliance, especially when IRFs do not fail to submit data but instead complete the submission of their data a day or two after the deadline. In other instances, providers face penalties because they submit data at a detail level instead of a summary level because of a misunderstanding of requirements (but nonetheless provide all required data). Very little flexibility is provided to IRFs that may have submitted information after CMS deadlines but did not actually fail to report data as defined in statute. However, CMS tends to grant relief only to IRFs that provide evidence of "extraordinary circumstances," as determined by the CMS reviewer.

Despite the approach taken on QRP disputes in recent years, the Medicare statute does not actually set a deadline or format for data submission and grants CMS considerable discretion to specify the format and timing of quality reporting. The statute states: "Such data shall be submitted in a form and manner, and at a time, specified by" CMS.[1] The statute requires CMS to publish in the Federal Register any removal, suspension, or addition of a quality measure. No such publication is necessary, however, for CMS to waive or modify the form, manner, or time for submitting quality data, therefore offering more leniency than CMS has historically practiced with respect to QRP penalties.

As part of quarterly and annual notifications, IRFs continually ask for assistance from both the iQIES and CDC NHSN help desks to identify specifically what the alleged issues of non-

[1] 42 U.S.C 1395ww(j)(7)(c)

compliance may be. These help desks often provide limited information in response to inquiries from IRFs, and responses may not be provided in a timely manner—causing delays in the IRFs' ability to reconcile any perceived issues. This adds to the administrative burden being placed on IRFs and takes time away from caring for patients. When IRFs are informed that they will be assessed a financial penalty, reconsideration requests must be completed within 30 days from receipt of notice of non-compliance. This 30-day window provides a very limited amount of time for IRFs to identify and communicate the non-compliance status internally, identify the measure(s) with potential issues, and perform research and analysis into any extraordinary circumstances that caused the information to be considered non-compliant, not to mention the time required to prepare a formal reconsideration request to CMS.

We therefore appreciate CMS' consideration of both immediate relief for the penalties set to take effect for FY 2024, as well as longer-term efforts to ensure the IRF QRP is meaningful and viable for patients and providers alike. AMRPA would appreciate CMS considering the following recommendations to alleviate some of the issues and concerns our members have expressed with the IRF QRP compliance determinations and 2% penalty:

Short-Term Recommendations for Immediate Relief

1. CMS should exercise leniency and reverse the imposition of financial penalties in FY 2024 for all determinations where IRFs made good faith efforts to provide complete and timely reporting, particularly in light of this being the first full year of the expanded IRF PAI v. 4.0.
2. CMS should proactively identify the issues that lead to noncompliance with the IRF QRP when providing the quarterly and annual notifications to providers based on the lessons learned from the first full year of the IRF PAI v. 4.0 being in effect.

Long-Term Recommendations for IRF QRP System Reform

3. CMS should take a closer look at the CDC NHSN system for opportunities to simplify the access and collection of required data and provide more effective real-time verification and confirmation of data submission.
4. CMS should provide opportunities to correct for technical non-compliance or provide hardship exemptions that are broadly construed, especially when implementing significant new quality reporting requirements.
5. CMS should extend the reconsideration deadline to 90-days to provide IRFs the ability to research and compile the information necessary to respond to the non-compliance letters.
6. CMS should provide data on the numbers of IRFs that receive the penalty and identify if there is a disproportionate number of small and rural providers who are impacted by the penalty. This is particularly important given the fact that many of these types of IRF providers are sent into negative margins when faced with a 2% payment withhold.
7. CMS should reduce the administrative burden that has been created by the continued expansion of IRF QRP measures and data collection requirements through the review and removal of IRF QRP measures that do not meet the objectives laid out in the CMS

Meaningful Measures Initiative or that meet one or more of the eight factors that are considered for measure removal from the IRF QRP.

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AMRPA has greatly appreciated the close engagement with CMS on issues and concerns related to the IRF QRP. As you are aware, AMRPA and our members take quality assurance and reporting seriously and have looked to partner with the CMS CCSQ team in facilitating field-wise education and technical assistance. **We ask CMS to seriously consider our short-term and long-term recommendations enumerated in this letter and stand ready to discuss these issues in greater depth**.

Please do not hesitate to contact Troy Hillman, AMRPA Director of Quality and Health Policy ((202) 207-1129, thillman@amrpa.org) to schedule a meeting or if you have any questions. Thank you for your consideration of our views on the IRF QRP.

Sincerely,

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Chair, AMRPA Board of Directors
VP/Administrator, JFK Johnson Rehabilitation Institute, Hackensack Meridian Health

CC: Dora Hughes, MD
Jean Moody-Williams

Addendum: Key QRP Background & AMRPA's Evolving Position on the IRF QRP Penalty Structure

A. Applicable Statutes

The Medicare program reimburses IRFs for the operating costs of inpatient rehabilitation hospital services furnished to Medicare beneficiaries based on a prospectively-determined amount per patient discharge. This system of payment is known as the IRF Prospective Payment System (IRF PPS). The IRF PPS per-discharge rate during a fiscal year is based on the average payment per discharge for inpatient operating and capital costs of IRFs using the most recent data available, adjusted by a variety of factors. The per-discharge payment rate is increased each year by an annual update to account for the increase in the costs of providing care.

In 2010, Congress passed the Affordable Care Act (ACA). Section 3004(b) of the ACA amended the Social Security Act (SSA) § 1886(j) (42 U.S.C. § 1395ww(j)) to add a new subclause (7) to revise the increase factor of the annual update. Specifically, under this revision, an IRF is subject to a reduction in its annual update of two percentage points if it fails to report data on certain quality indicators. This reduction may result in the increase factor for a given fiscal year being less than 0.0, and in payment rates for an IRF for a fiscal year being less than the payment rates for the preceding fiscal year. A 2% update penalty on all Medicare patients served in a coming year can quickly represent a significant financial burden for an IRF. This can be particularly devastating for hospitals with revenues that barely cover expenses.

On a quarterly and an annual basis, CMS and their contractor, Swingtech, issue reports to providers indicating whether quality measure data has been submitted. Typically, the quarterly reports are produced just prior to the CMS data submission deadlines and are sent only to the primary contact at the IRF. The timing of these notices provides very little opportunity to IRFs to resolve any perceived issues, especially when a notice is not provided to those individuals who have access to the various data entry systems and are responsible for making the required information available.

When IRFs are informed that CMS intends to penalize them, IRFs are afforded an opportunity to submit a reconsideration request. These reconsideration requests must be completed within 30 days from receipt of a notice of non-compliance. This 30-day window provides a very limited amount of time for IRFs to identify and communicate the non-compliance status internally, identify the measure(s) with potential issues, and perform analysis and research into any extraordinary circumstances which caused the information to be considered non-compliant. A formal, written reconsideration request must also be prepared within this 30-day timeframe. This reconsideration process is effectively the final decision on imposition of the 2% penalties, as appeals to the Provider Reimbursement Review Board (PRRB) are time consuming, costly, and seldom successful due to the PRRB's lack of equitable jurisdiction.

B. Implementation of IRF QRP by CMS

Following Congress' passage of the ACA, CMS began implementing the IRF QRP. The quality measures on which a hospital must report for each quarter of a calendar year are established through formal rulemaking. Initially, for FY 2014, the IRF QRP program measured reporting for only two quality measures. Over time, CMS has significantly expanded the measures included in the IRF QRP, though some measures have been removed or modified as well.

The quality measures applicable for the FY 2024 reporting period include some measures that are reported through the IRF Patient Assessment Instrument (IRF-PAI), a series of measures separately reported through the Centers for Disease Control and Prevention's National Health Safety Network (NHSN), and claims-based measures.

From the IRF-PAI, the following measures were reported:

- Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (CBE #0674);
- Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function;
- IRF Functional Outcome Measure: Change in Self-Care for Medical Rehabilitation Patients (CBE #2633);
- IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (CBE #2634);
- IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (CBE #2635);
- IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (CBE #2636);
- Drug Regimen Review Conducted with Follow-Up for Identified Issues–PAC IRF QRP; and
- Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury.

The measures reported through NHSN were:

- National Healthcare Safety Network (NHSN) Catheter Associated Urinary Tract Infection (CAUTI) Outcome Measure (CBE #0138);
- National Healthcare Safety Network (NHSN) Influenza Vaccination among Healthcare Personnel (CBE #0431);
- National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure (CBE #1717); and
- COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) (CBE #3636).

(The claims-based measures are automatically compiled by CMS based on the claims submitted by each IRF and are not subject to separate reporting.)

The annual notifications of non-compliance determinations are provided to IRFs in two different ways.

- First, a letter from the Medicare Administrative Contactor (MAC) is sent to the IRF primary contact who typically is responsible for submitting IRF claims. This first letter is typically a form letter which states that the facility has been identified as being non-compliant with IRF QRP requirements but does *not* specifically identify which of the measures have produced the non-compliant determination. This letter places the administrative burden on IRFs to perform a comprehensive review of both IRF-PAI and CDC NHSN data to determine which measures may have caused a potential decision on non-compliance.

- Second, a letter from CMS is placed in the iQIES system, accessible by IRF staff who submit IRF-PAI data. This letter states that the facility has been identified as being non-compliant with IRF QRP requirements and identifies which measures have produced the non-compliant determination. This letter typically comes after the first letter from the MAC and informs the IRF of the 30-day window available for reconsideration requests.

AMRPA members have noted that CMS should improve the process of notifying IRFs of the issues that lead to noncompliance with the IRF QRP. Quarterly notifications provide an inadequate amount of information and time to correct or resolve perceived issues. Similarly, annual notifications from the MAC do not provide enough information and create additional administrative burden on the IRF to try and understand what specifically is needed to meet IRF QRP requirements.

C. Updating IRF QRP Measures

With the continued expansion of IRF QRP measures and data collection requirements, CMS annually increases the administrative burden and risk of financial penalties on IRF providers. AMRPA believes that CMS must review and remove IRF QRP measures that do not meet the objectives laid out in the CMS Meaningful Measures Initiative or that meet one or more of the eight factors that are considered for measure removal from the IRF QRP as identified in Section 412.634(b)(2) of CMS regulations. As it relates to the Meaningful Measures Initiative, a number of measures that are frequently identified for non-compliance do not meet the following objectives:

1. Make measures patient-centered and meaningful to patients;
2. Minimize the level of burden for measured entities;
3. Make opportunity for improvement.

Additionally, there are several measures currently included in the IRF QRP that meet the following factors that are considered for measure removal:

1. Measure performance among IRFs is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made;
2. Performance or improvement on a measure does not result in better patient outcomes;

3. The costs associated with a measure outweigh the benefit of its continued use in the program.

To alleviate administrative burden and reduce the disproportionate penalties associated with IRF QRP measures that lack value to patients and providers, AMRPA believes that CMS should work with AMRPA and other IRF industry stakeholders to identify additional measures for removal from the IRF QRP.