



June 17, 2019

The Honorable Seema Verma  
Administrator  
Centers for Medicare and Medicaid Services  
U.S. Department of Health and Human Services  
Attention: CMS-1710-P  
Hubert H. Humphrey Building  
200 Independence Avenue, Southwest  
Washington, D.C. 20201

*Delivered Electronically*

***RE: CMS-1710-P "Medicare Program; Inpatient Rehabilitation Facility (IRF) Prospective Payment System for Federal Fiscal Year 2020 and Updates to the IRF Quality Reporting Program" 84 Fed. Reg. 17244 (April 24, 2019).***

Dear Administrator Verma:

The American Medical Rehabilitation Providers Association (AMRPA) is pleased to submit our comments regarding the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) and Quality Reporting Program Federal Fiscal Year (FY) 2020 Proposed Rule, published in the *Federal Register* on April 24, 2019. AMRPA is the national trade association representing more than 650 freestanding inpatient rehabilitation hospitals and rehabilitation units of general hospitals (collectively referred to as inpatient rehabilitation facilities (IRFs, hereinafter referred to as IRH/Us) by the Centers for Medicare and Medicaid Services (CMS)), outpatient rehabilitation service providers, long-term care hospitals (LTCHs), and several skilled nursing facilities (SNFs). The vast majority of our members are Medicare participating providers.

In 2017, IRH/Us served 340,000 Medicare beneficiaries with more than 380,000 IRH/U stays.<sup>1</sup> On average, Medicare Part A payments represent approximately 60 percent of IRH/U revenues.<sup>2</sup> Any alterations to the Medicare payment system have substantial implications for these medical providers. IRH/Us provide hospital-level care, which is significantly different in intensity, capacity, and outcomes from care provided in non-hospital, post-acute care (PAC) settings. 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 substantive comments are found in the attachment to this letter. These comments reflect extensive feedback from the medical rehabilitation industry, including professionals involved in every aspect of the treatment of rehabilitation hospital patients. Over the past two months, AMRPA

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<sup>1</sup> Medicare Payment Advisory Commission (MedPAC), "Chapter 10: Inpatient Rehabilitation Facility Services," Report to the Congress: Medicare Payment Policy, March 2019.

<sup>2</sup> *Id.*

has convened multiple committees and workgroups with experts from the field to closely analyze aspects of the proposed rule with heightened focus on the impact on IRH/Us and their patients.

### **Summary of Recommendations**

AMRPA appreciates the opportunity to comment on this proposed rule and CMS' careful consideration of the issues raised in this letter. Our primary concerns pertain to: (1) the lack of sufficient data and technical information regarding the proposed IRF PPS case-mix groups (CMGs), including the proposal to use a weighted motor score in FY 2020, and (2) the expansion of the IRF Quality Reporting Program (QRP) to encompass multiple new standardized patient assessment data elements (SPADEs).

Our complete analysis, comments, and recommendations on the IRF PPS rule are included in Attachment A. A summary of our recommendations follow.

## **PROPOSALS REGARDING THE FY 2020 CASE MIX GROUPS**

### **I. Proposed Refinements to the CMGs and CMG Relative Weights Beginning in FY 2020**

CMS must provide critical, additional information regarding the proposed CMGs and their potential impact on how patients are classified under the IRF PPS. This information should encompass:

1. How patients in the CMGs removed from RIC 01—Stroke, RIC 02—Traumatic Brain Injury, RIC 05—Non-traumatic spinal cord injury, and RIC 08—Replacement of Lower Extremity Joint will be classified under the proposed new CMGs, and the impact to IRH/U reimbursements as a result of these changes;
2. Any modeling performed to examine whether the proposed CMGs exhibit compression and, if so, how this will impact reimbursement rates for higher-acuity patient conditions;
3. Information and data to explain why there appears to be compression in the proposed CMGs; and
4. Studies or tests that CMS and RTI performed to affirm that the new CMGs will adequately reimburse IRH/Us for treating the most resource-intensive patients.

### **II. Proposed Use of a Weighted Motor Score Beginning with FY 2020**

AMRPA urges CMS to continue to refine the IRF PPS patient classification system (and the sub-components therein, such as motor weights) and to engage stakeholders throughout the process in a comprehensive and timely manner. While AMRPA continues to believe that a weighted motor score is more likely than an unweighted motor score to account for key drivers of patient resource use, CMS has not taken the necessary actions in this rulemaking to assure stakeholders that its proposed weighting methodology will adequately and accurately account for IRH/U patients' complexity and resource use.

### **III. Concerns Pertaining to the Exclusion of Cognitive Status Function in the Proposed CMGs**

1. AMRPA urges CMS to conduct further study into the relationship between cognitive function and resource use in IRH/Us in future rulemaking. It is imperative a case-mix system for medical rehabilitation patients thoroughly accounts for cognitive impairment by using truly clinically sensitive data items.

2. AMRPA urges CMS to continue to work to identify appropriate cognitive function status items suitable for inpatient rehabilitation patients.

## **FINANCE AND LABOR PROPOSALS**

### **I. Proposed FY 2020 Wage Index Policies**

AMRPA supports use of the concurrent year's IPPS wage index to ensure uniformity among different provider types. However, AMRPA urges CMS to apply any other applicable changes it makes to the IPPS wage index to the IRF PPS to avoid creating any additional disparities.

### **II. Proposed IRF Market Basket Rebasement and Labor-Related Share for FY 2020**

AMRPA supports use of 2016 Medicare cost reports and price inputs as proposed. However, AMRPA recommends CMS not finalize its proposed changes to the Home Office Contract Labor Cost category and labor-related share as proposed. Instead, CMS should finalize use of the previous methodology relating to this category and revisit this potential change with adequate explanation and data in future rulemaking.

### **III. Proposed FY 2020 Market Basket Update and Productivity Adjustment**

1. AMRPA respectfully requests CMS provide access to the analyses done by IGI to calculate the market basket and productivity adjustment.
2. AMRPA recommends that CMS conduct an analysis to determine whether the productivity adjustment appropriately reflects the ability of IRH/Us to improve productivity or whether the nature and requirements of IRH/U services make such changes unlikely.
3. AMRPA respectfully requests that CMS update the market basket and productivity amounts using the latest available data in the IRF PPS final rule.

### **IV. Proposed Facility-Level Adjustment Factors for FY 2020**

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. We continue to recommend a minimum interval for any change in IRH/Us' provider-level adjustment factors of once every three years.

### **V. Proposed Update to Payments for High-Cost Outliers Under the IRF PPS for FY 2020**

In order to ensure CMS projects outlier payments as accurately as possible, CMS should include historical outlier reconciliation dollars in its outlier threshold projections as it proposes to do for acute-care hospitals.

## **PROPOSALS FOR THE IRF QUALITY REPORTING PROGRAM (IRF QRP)**

### **I. General Recommendations for IRF QRP**

1. AMRPA urges CMS to account for the costs associated with this rule's IRF QRP proposals by upwardly adjusting the IRF PPS payment update in the FY 2021 rulemaking to reflect higher provider resource use (and therefore costs). This recommendation is consistent with AMRPA's recommendation for the FY 2018 IRF PPS proposed rule in which CMS first proposed adding new SPADEs to the IRF-PAI.

2. CMS should address in the FY 2020 final rule whether it is still considering a reduced completion threshold for the IRF QRP, as was discussed in the FY 2018 IRF PPS final rule.
3. AMRPA urges CMS to propose a reduced IRF QRP threshold percentage that is aligned with other PAC QRPs (i.e., 80 percent) in FY 2021 rulemaking and prior to the October 2020 implementation of the new SPADEs and all-payer IRF-PAI reporting requirement.
4. AMRPA urges CMS to conduct ample provider education, including multiple in-person and virtual IRF QRP training events, well in advance of October 1, 2020.

**II. Proposed Method for Applying the Reduction to the FY 2020 IRF Increase Factor for IRFs That Fail To Meet the Quality Reporting Requirements**

1. AMRPA continues to ask CMS to provide flexibility in its application of the IRF QRP payment penalty for IRH/Us that make a good-faith effort to comply and submit quality reporting data.
2. AMRPA requests CMS provide more flexibility in its application of the noncompliance penalty to allow providers an opportunity to correct any errors when a good faith effort to submit data is undertaken and reserve such harsh penalties for egregious offenders who are flouting their responsibilities under the IRF QRP.

**III. Proposed Standard Patient Assessment Data Elements (SPADEs) Reporting Beginning With the FY 2022 IRF QRP (October 1, 2020)**

1. AMRPA recommends CMS consider IRH/Us' admission assessment for the following SPADEs as also fulfilling the discharge assessment requirement:
  - a. PHQ-2/9;
  - b. Special Services, Treatments, and Intervention SPADEs (with the exception of the Nutritional Approach item, which AMRPA supports for collection at admission and discharge);
  - c. Pain Interference; and
  - d. Social Determinant of Health SPADEs.
2. AMRPA recommends collecting the PHQ-2/9 at admission only.
3. AMRPA cautions CMS against relying on BIMS, CAM, and PHQ2-9 items as cognitive function case-mix indicators/characteristics until CMS is able to determine that these items do not exhibit floor or ceiling effects for IRH/U patients.
4. CMS should explore how it can glean information regarding Special Services, Treatments and Interventions (SSTI) by utilizing Medicare claims data already at its disposal rather than by imposing additional provider reporting requirements. AMRPA recommends that SSTI SPADEs be required for data collection at admission only.
5. AMRPA does not support adopting High-Risk Drug Classes – Use and Indication (Items N0415A-J).
6. AMRPA supports the Pain Interference item, but recommends that it is required only at admission.
7. AMRPA supports adopting the Hearing and Vision items as proposed.
8. AMRPA supports the inclusion of the Social Determinants of Health (SDOH) SPADEs. AMRPA recommends that CMS require these items data be assessed *at some point* during the patient's stay instead of during the admission assessment time window. Furthermore, AMRPA does not support requiring any SDOH SPADEs on

the discharge assessment; these patient characteristics are not influenced by the IRH/U intervention and therefore would not change over the patient's stay.

9. AMRPA recommends CMS explore a methodologically sound approach to risk-adjust certain quality outcomes for patient socioeconomic and sociodemographic status factors.

#### **IV. IRF QRP Quality Measure Proposals Beginning With the FY 2022 IRF QRP**

1. AMRPA supports adoption of the Transfer of Health Information measures. We also respectfully request CMS address the following issues in the final rule:
  - a. If the N/A response option will be made available on the HHA version of measure A2121, CMS should make it available as a response option for all PAC settings.
  - b. CMS should clarify why there is an overlap of "Patients discharged home under care of an organized home health service organization or hospice" in the measures' inclusion criteria and address how it may affect measure performance.
2. AMRPA appreciates and supports CMS' proposed modifications to the Discharge to Community measure.

#### **V. Proposed IRF-PAI Data Reporting On All-Payer Patients for the IRF QRP Beginning October 2020**

1. AMRPA is unable to support CMS' proposal to expand the IRF QRP reporting requirements to include IRF-PAI data for all patients, regardless of payer, because CMS has not provided an adequate explanation regarding how this proposal will be operationalized. Specifically, the proposed rule lacks the necessary details regarding how CMS will implement the inclusion of all-payer patient data in determining an IRH/U's compliance with the IRF QRP requirements.
2. AMRPA recommends CMS develop methods to stratify the display of patient data by payer status prior to any public reporting of all-payer quality measure data.

#### **VI. Proposed Policies Regarding Public Display of Measure Data for the IRF QRP**

AMRPA supports public display of the Drug Regimen Review measure.

#### **VII. Proposed Migration to the Internet Quality Improvement and Evaluation System (iQIES)**

AMRPA supports the proposed migration to iQIES. We recommend CMS begin educating and preparing IRH/Us about this transition as soon as possible.

#### **VIII. Proposed Removal of the List of Compliant IRFs**

AMRPA recommends that CMS make the List of Compliant IRH/Us available to stakeholders upon request.

#### **IX. Request for Information: IRF QRP Quality Measures, Measure Concepts, and Standardized Patient Assessment Data Elements Under Consideration for Future Years**

1. While AMRPA supports the agency's efforts to assess interoperability and identify measure gaps, we oppose the use of mandatory PAC quality reporting programs as the data collection vehicles for this work. CMS should utilize other avenues to research and otherwise inform its understanding of interoperability issues across care settings.

2. AMRPA supports CMS' commendable efforts currently implemented across its programs that aim to address the opioid crisis.
3. CMS should work with stakeholders to prioritize which patient conditions would benefit from a cognitive complexity assessment, and then engage the research community to identify tests that were designed for and validated in those patient populations.
4. AMRPA continues to encourage CMS to develop a way of capturing for family/caregiver status and/or community supports and accounting for it in discharge disposition outcomes. Our members welcome the opportunity to work with CMS to develop caregiver status data items.
5. Because IRH/Us already communicate continence needs at discharge to the patient caregiver/family or to the next site of care, it would be regulatory duplication to require additional data collection regarding bowel/bladder SPADEs.
6. AMRPA recommends CMS explore beneficiary-matching methods with its governmental colleagues at the U.S. Department of Veterans Affairs.

## **PROPOSAL TO CLARIFY THE DEFINITION OF A REHABILITATION PHYSICIAN**

### **I. Proposed Amendments to § 412.622 To Clarify the Definition of a Rehabilitation Physician**

AMRPA supports CMS' proposal to clarify the definition of a rehabilitation physician as presented.

#### **Conclusion**

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 Kate Beller, J.D., AMRPA Executive Vice President for Policy Development and Government Relations, ([kbeller@amrpa.org](mailto:kbeller@amrpa.org) / 202-207-1132).

Sincerely,



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



Mark J. Tarr  
Chair, AMRPA Regulatory and Legislative Policy Committee  
President and Chief Executive Officer, Encompass Health



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**Attachment A**

*American Medical Rehabilitation Providers Association's Analysis, Comments, and Recommendations on the Medicare Program; Inpatient Rehabilitation Facility (IRF) Prospective Payment System for Federal Fiscal Year 2020 and Updates to the IRF Quality Reporting Program 84 Fed. Reg. 17244 (April 24, 2019).*



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## Appendix A

*American Medical Rehabilitation Providers Association's Analysis, Comments, and Recommendations on the Medicare Program; Inpatient Rehabilitation Facility (IRF) Prospective Payment System for Federal Fiscal Year 2020 and Updates to the IRF Quality Reporting Program*  
84 Fed. Reg. 17244 (April 24, 2019)

### **PROPOSED REFINEMENTS TO THE CASE-MIX CLASSIFICATION SYSTEM BEGINNING WITH FY 2020**

As a preliminary matter, AMRPA commends CMS for using two fiscal years of Quality Indicator (Sections GG/H) data to develop the revised FY 2020 IRF PPS case-mix groups (CMGs). The IRH/U community has had a rich history of building its Medicare payment and case-mix policies on at least two years of data collection. AMRPA strongly believes that accurate and effective case-mix policies can only be developed by using robust and appropriate data, and therefore, we support the use of two fiscal years of data rather than the one fiscal year included in last year's proposed rule.

However, despite this positive step related to Quality Indicator data, AMRPA is deeply concerned about the lack of other supporting data and technical information provided by CMS in conjunction with this year's proposed rule. As we stated in our April 30, 2019 email correspondence and our May 24, 2019 initial comment letter to the agency, these data are critical to stakeholders' analysis of the rule and ability to respond meaningfully. In its absence, AMRPA fears that we, and all IRH/U stakeholders, are significantly hindered from being able to offer truly comprehensive and constructive input to CMS as part of this rulemaking process.

We are particularly concerned that in response to our email correspondence, CMS directed AMRPA to submit our request for technical data through the rulemaking process "so that the agency can respond to them and provide any necessary clarification in the final rule." Receiving additional data and clarifications *after* the proposed rule comment deadline provides AMRPA with no meaningful way of: (1) further assessing the impact of the proposed CMGs, (2) expressing concerns relating to specific patient populations, or (3) proposing alternative approaches or policies to CMS. Given the critical importance of technical data for our assessment of the revised case-mix policies, we implore CMS to provide more extensive data as timely as possible as our members prepare for the upcoming FY 2020 payment year.

We also note that CMS proposes to implement the FY 2020 CMGs in a budget-neutral manner across the IRF PPS, and this has the effect of redistributing payments across the sector. Payment impacts on individual providers range from a 17.8 percent payment decrease to a 27.3 percent increase based on CMS' analysis.<sup>3</sup> As the new CMGs have the potential to be highly disruptive for some IRH/Us, it is incumbent upon CMS to be as transparent and informative as possible about the dynamics underlying these reimbursement effects. We also ask that CMS be responsive to the industry as the new case-mix policy is implemented to enable a fast and effective response for unforeseen payment or access impacts on certain patients and providers.

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<sup>3</sup> AMRPA analysis of CMS FY 2020 IRF PPS Proposed Rule Provider-Specific CMG Revision Analysis file.

**I. Proposed Refinements to the CMGs & CMG Relative Weights Beginning in FY 2020**

Under CMS’ proposed FY 2020 CMG definitions, there would be fewer CMGs in four Rehabilitation Impairment Categories (RICs): Stroke, Traumatic brain injury, Non-traumatic spinal cord injury, and Replacement of lower extremity joint.

<b>There would be fewer CMGs in the following RICs:</b>	<b>Number of FY 2019 CMGs</b>	<b>Proposed number of FY 2020 CMGs</b>
RIC 01 – Stroke	10	7
RIC 02 – Traumatic brain injury (BI)	7	5
RIC 05 – Non-traumatic spinal cord injury (SCI)	6	4
RIC 08 – Replacement of lower extremity joint	6	4

These four RICs represent approximately 32 percent of all IRH/U patients in FYs 2017 and 2018.<sup>4</sup> Notably, stroke is the highest volume patient condition treated in IRH/Us. It is unclear to AMRPA and our member hospitals why, based on the information CMS has provided to date, a high-volume RIC would collapse from ten CMGs to seven CMGs. We request that CMS in the final rule address why RTI’s regression model resulted in fewer CMGs for these RICs, particularly for relatively high volume conditions such as stroke and TBI.

To reiterate our April 30<sup>th</sup> email to the agency, AMRPA seeks information regarding how patients in the removed CMGs will be reclassified under the proposed new CMGs, and the resulting impact and changes to reimbursement rates as a result of these changes. To that end, we request data such as a frequency and distribution table showing how the subset of FYs 2017 and 2018 stays used in RTI’s analysis (N=551,503) were classified under the current CMG system, how those same stays would be classified under the proposed CMG system, and the net payment impact associated with those changes.

AMRPA similarly requests CMS share additional information and data to explain the compression observed in the proposed CMGs. We believe that the revised CMGs introduce additional compression into the IRF PPS (“additional” because compression has been observed in the IRF PPS since its implementation).<sup>5</sup> Compression exists when predicted payments for higher-weighted cases are below the cost of the care, and payments for lower-weighted cases are greater than costs. Based on our conversations with member hospitals and IRF-PAI vendors, this appears to be the case with the revised CMGs.

AMRPA is highly concerned that this compression in the new CMGs will, on the whole, result in decreased reimbursement to IRH/Us that treat higher proportions of high-acuity patients. Short of data and evidence from CMS to the contrary, our members share a grave concern that the net effect of the compression will result in a transfer of Medicare reimbursement away from IRH/Us that treat high proportions of lower-functioning patients. Given the lack of technical data from CMS such as cost reports, claims, and IRF-PAI assessment data, we are not able to

<sup>4</sup> Sources: eRehabData@ and Uniform Data Systems for Medical Rehabilitation@, Medicare FFS patients, FYs 2017-2018.

<sup>5</sup> Centers for Medicare and Medicaid Services, Medicare Program; Prospective Payment System for Inpatient Rehabilitation Facilities, 66 FR 41353. August 7, 2001.

appropriately and quantitatively substantiate how compression in the revised CMGs potentially impacts IRH/Us and their patients.

AMRPA requests that CMS provide stakeholders with any modeling that was performed to examine whether the proposed CMGs exhibit compression and, if so, how this will impact reimbursement rates for higher-acuity patient conditions. We are especially interested in any studies or modeling CMS or RTI performed to affirm that the new CMGs will adequately reimburse IRH/Us for treating the most resource-intensive patients. As demonstrated by the preceding requests for additional information, AMRPA and other stakeholders fundamentally lack the data necessary to fully assess the impact and consequences of the proposed CMGs. Due to this limitation, we are unable to offer constructive input – as well as potential alternative approaches – for CMS’ consideration as it develops the final rule. We remain concerned that the proposed rule will negatively impact those providers who care for patients in the highest acuity CMGs, and we implore CMS to ensure that IRH/Us caring for the most resource intensive patients will be adequately reimbursed, such that payments at least cover the cost of care, under the revised CMGs starting October 1, 2019.

**Recommendation:**

CMS must provide critical, additional information regarding the proposed CMGs and their potential impact on how patients are classified under the IRF PPS. This information should encompass:

1. How patients in the CMGs removed from RIC 01—Stroke, RIC 02—Traumatic Brain Injury, RIC 05—Non-traumatic spinal cord injury, and RIC 08—Replacement of Lower Extremity Joint will be classified under the proposed new CMGs and the impact to IRH/U reimbursements as a result of these changes;
2. Any modeling performed to examine whether the proposed CMGs exhibit compression and, if so, how this will impact reimbursement rates for higher-acuity patient conditions;
3. Information and data to explain why there appears to be compression in the proposed CMGs; and
4. Studies or tests that CMS and RTI performed to affirm that the new CMGs will adequately reimburse IRH/Us for treating the most resource-intensive patients.

**II. Proposed Use of a Weighted Motor Score Beginning with FY 2020**

In the FY 2020 IRF PPS proposed rule, CMS proposes to use a weighted motor score due to stakeholder feedback in the FY 2019 IRF PPS rulemaking. RTI’s analysis of FYs 2017 and 2018 data “suggest[s] that the use of a weighted motor score index slightly improves the ability of the IRF PPS to predict patient costs.”<sup>6</sup> As such, CMS states that it “now believe[s] that a weighted motor score would improve the accuracy of payments to IRH/Us, and [is] proposing to replace the previously finalized unweighted motor score with a weighted motor score to assign patients to CMGs beginning with FY 2020.” CMS proposes the use the following items and weights for the motor subscore.

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<sup>6</sup> Centers for Medicare & Medicaid Services, Medicare Program; Inpatient Rehabilitation Facility (IRF) Prospective Payment System for Federal Fiscal Year 2020 and Updates to the IRF Quality Reporting Program, 84 FR 17250. April 24, 2019.

<b>Proposed FY 2020 Motor Score Index for 18 SPADEs</b>		
<i>Item Description</i>	<i>Item Number</i>	<i>Weight</i>
Eating	GG0130A1	2.7
Toileting hygiene	GG0130C1	2.0
Toilet transfer	GG0170F1	1.6
One-step curb	GG0170M1	1.4
Bladder continence	H0350	1.3
Sit to stand	GG0170D1	1.1
Chair/bed-to-chair transfer	GG0170E1	1.1
Lower-body dressing	GG0130G1	1.0
Putting on/taking off footwear	GG0130H1	1.0
Walk 10 feet	GG0170I1	0.8
Walk 50 feet with two turns	GG0170J1	0.8
Walk 150 feet	GG0170K1	0.8
Shower/bathe self	GG0130E1	0.7
Bowel continence	H0400	0.7
Upper-body dressing	GG0130F1	0.5
Oral hygiene	GG0130B1	0.3
Sit to lying	GG0170B1	0.1
Lying to sitting on side of bed	GG0170C1	0.1

While AMRPA continues to believe that a weighted motor score is more likely than an unweighted motor score help further refine the IRF PPS, we have serious reservations about the accuracy and fairness of CMS’ proposed weights because CMS has not made available to stakeholders any technical data needed to make a more informed assessment. Again, AMRPA and all IRH/U stakeholders’ understanding of the rule’s potential impacts are limited by the lack of background information pertaining to the proposed weighted score.

There are significant changes between the current motor subscore weights (used under the FIM™) and the proposed weights (used for the related Quality Indicator items (SPADEs) under IRF-PAI Sections GG and H). While we understand that the weight of motor items will not be identically distributed under Section GG/H reporting as it was with FIM™, we ask that more information be provided on some notable changes – for example, why the Eating sub-item weight would change from 0.6 (current) to 2.7 (proposed).

As a broader issue, AMRPA also notes that self-care items were generally assigned lower weights under the FIM™, with mobility items receiving higher weights. Under the proposed weights applied to Section GG/H items, it appears that CMS is taking the inverse approach – assigning higher weights to self-care items and lower weights to mobility items. AMRPA requests additional justification for this change and supporting data, such as Sections GG/H patient assessment data, to help analyze the impact of the weighted motor score as proposed.

It is absolutely critical that all components of the IRF PPS patient classification system adequately capture and accurately reflect rehabilitation hospital patients’ complexity, burden of

care, and resource use. Yet our members are far from assured that the policies in this rule – such as the proposed motor weights – achieve these objectives. In addition to our request for technical data, AMRPA requests CMS’ receptivity to stakeholder input regarding continued refinements on these CMG issues in future rulemakings and via other avenues we have recommended previously, such as technical expert panels (TEPs). Throughout this comment period, we have engaged our members extensively on the proposed motor weights; however, the dearth of necessary data and technical information, discussed above, has significantly hindered stakeholders from being able to identify a robust and evidence-based position to recommend to CMS. This is reflected in some of the different conclusions reached within our Association regarding the most effective path forward for FY 2020 (e.g., recommendations regarding the use of a weighted or unweighted motor score). AMRPA acknowledges that some of our members have recommended to CMS that it should not finalize the weighted motor score methodology as proposed, a position we are strongly sympathetic with in light of data transparency concerns. These are highly complex issues with significant clinical and operational impacts that warrant thorough deliberation between the agency and the provider community, and ideally beyond a 60-day rulemaking period. AMRPA urges CMS to continue to refine the IRF PPS patient classification system (and the sub-components therein, such as motor weights) and to engage stakeholders throughout the process in a comprehensive and timely manner.

**Recommendation:**

AMRPA urges CMS to continue to refine the IRF PPS patient classification system (and the sub-components therein, such as motor weights) and to engage stakeholders throughout the process in a comprehensive and timely manner. While AMRPA continues to believe that a weighted motor score is more likely than an unweighted motor score to account for key drivers of patient resource use, CMS has not taken the necessary actions in this rulemaking to assure stakeholders that its proposed weighting methodology will adequately and accurately account for IRH/U patients’ complexity and resource use.

**III. Exclusion of Cognitive Status Function in the Proposed CMGs**

The proposed FY 2020 CMGs definitions do not include the cognitive function status, despite the inclusion of two years of data in the CART analysis. Specifically, the memory score did not emerge as a potential split point in the CART analysis and the communication score was not ultimately selected as a determinant for the proposed CMGs, though both scores were considered as possible elements in developing the proposed CMGs. The communication score resulted in a split point in RICs 12 and 16, but CMS states that it believes the inclusion of the communication score in these CMG definitions would result in lower payments for patients with higher cognitive deficits. To avoid this adverse perceived outcome, CMS proposes to combine the CMGs within these RICs.

In the technical report accompanying the rule, RTI states:

“Though cognitive status is considered an important factor in resource use, current cognitive status items may not sufficiently measure the complexity of cognitive status, which may contribute to these results. Even without the explicit use of cognitive items in the CMG definitions, the function rating scale for the standardized patient assessment data

elements may capture aspects of cognitive status; the scale measures need for assistance, including supervision.”<sup>7</sup>

AMRPA urges CMS to conduct further study into the relationship between cognitive function and resource use in IRH/Us in future rulemaking. AMRPA remains concerned that the SPADEs cognitive items finalized in the FY 2019 IRF PPS rule do not capture the true burden of patient care and would therefore not paint an accurate picture of patient severity, level of impairment, resource use and therefore cost. It is imperative that a case-mix system for medical rehabilitation patients thoroughly accounts for cognitive impairment by using truly clinically sensitive data items.

It was recognized early in the development of the IRF PPS case-mix classification system and research that the FIM™ cognitive assessment items would benefit from further refinement or expansion in order to better reflect the needs of medical rehabilitation patients. A clinical advisory panel convened by CMS and RAND around that time suggested that “certain cognitive areas, currently unmeasured by the FIM, might be important additional predictors of resource use” for the IRF PPS.<sup>8</sup> Researchers involved in creating the payment system also recommended that future refinements should incorporate new dimensions of performance to the cognitive scale such as executive function, motivation, or depression. CMS is currently evaluating data from the Beta Test of SPADEs as mandated by the Improving Medicare Post-Acute Care Transformation (IMPACT) Act, and several cognitive assessment items have been collected in that test, such as the BIMS, CAM, and other cognitive items. Hence, it remains to be seen whether any of these items may be adequately sensitive to detect or reflect various cognitive deficits.

Given the longstanding recommendations to enhance cognitive assessment for payment purposes and the future direction of the PAC field under the IMPACT Act, AMRPA urges CMS to continue to work to identify appropriate cognitive function status items suitable for inpatient rehabilitation patients.

**Recommendations:**

1. AMRPA urges CMS to conduct further study into the relationship between cognitive function and resource use in IRH/Us in future rulemaking. It is imperative that a case-mix system for medical rehabilitation patients thoroughly accounts for cognitive impairment by using truly clinically sensitive data items.
2. AMRPA urges CMS to continue to work to identify appropriate cognitive function status items suitable for inpatient rehabilitation patients.

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<sup>7</sup> RTI International, Analyses to Inform the Use of Standardized Patient Assessment Data Elements in the Inpatient Rehabilitation Facility Prospective Payment System, 2-8 (March 2019).

<sup>8</sup> RAND, A Classification System for Inpatient Rehabilitation Patients: A Review and Proposed Revisions to the Functional Independence Measure-Function Related Groups, 68 (1998).

## FINANCE AND LABOR PROPOSALS

### I. Proposed FY 2020 Wage Index Policies

CMS proposes to use the current year's pre-floor, pre-reclassified Inpatient Prospective Payment System (IPPS) wage index for geographic wage adjustments to IRF PPS payments. Historically, CMS has used the prior year's pre-floor, pre-reclassified IPPS wage index. As AMRPA stated in response to previous years' proposed rules, we support CMS using the concurrent year's IPPS wage index for several reasons. First, as Medicare payment policy continues moving towards a unified post-acute care payment system, it will be important for all post-acute care provider settings to use the same wage index. As CMS is aware, other PAC providers (e.g., LTCHs, SNFs, and Home Health Agencies) currently utilize the current fiscal year IPPS wage index. In addition, utilizing a prior year's wage index for IRH/Us created a distinct lack of parity between IRH/Us and other settings of care all of which must recruit from the same labor market for the same clinical and other hospital personnel. Therefore, AMRPA supports CMS using the current year's IPPS wage index in order to establish uniformity for geographic payment adjustments between IRH/Us and other settings of care.

While AMRPA is encouraged that CMS is creating parity for wage adjustments by proposing to utilize the concurrent year's IPPS wage index, we are disappointed to see the agency simultaneously creating another rift between sites of care through policies in the IPPS proposed rule. In the IPPS/LTCH proposed rule, CMS proposes to address wage index disparities through an upwards adjustment for low wage index hospitals and a corresponding downward adjustment to high wage index hospitals.<sup>9</sup> These adjustments would not apply to IRH/Us and would again create a lack of parity between IRH/Us and acute-care hospitals competing for skilled personnel in the same labor markets.

Due to the concerns AMRPA has outlined for numerous years to CMS, a lack of consistency in wage adjustments among providers in the same geographic area is disruptive. In this instance, IRH/Us in low wage areas would be at an unmistakable disadvantage because acute-care hospitals would begin receiving a higher wage adjustment than IRH/Us in that area, while still being held to the same standards in terms of utilizing qualified clinicians and other requirements applicable to all hospitals. This proposal would put considerable strain on IRH/Us' ability to recruit and retain staff with competitive pay. Conversely, acute-care hospitals in high wage areas would be disadvantaged since IRH/Us in its market would not have their wage index adjustment lowered like the acute-care hospitals in their area.

It is clear, based on CMS' proposals in both this proposed rule and the IPPS proposed rule, that the agency has a desire to reduce wage disparity among providers. However, by not applying its IPPS proposal to IRH/Us, CMS is creating an imbalance between hospital provider types. Therefore, AMRPA recommends CMS apply all adjustments it makes to the IPPS wage index to the IRF PPS. This change will ensure a fairer, more level playing field with all providers receiving adequate adjustments to payments to enable recruitment of clinical and other hospital staff.

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<sup>9</sup> Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2020 Rates, 84 Fed. Reg. 19158, 19373 (May 3, 2019).

**Recommendation:**

AMRPA supports use of the concurrent year's IPPS wage index to ensure uniformity among different provider types. However, AMRPA urges CMS to apply any other applicable changes it makes to the IPPS wage index to the IRF PPS to avoid creating any additional disparities.

**II. Proposed IRF Market Basket Rebasings and Labor-Related Share for FY 2020**

CMS proposes to update the IRF PPS market basket. CMS proposes to utilize 2016 Medicare cost reports and generally apply most of the same methodologies it used to calculate the current, 2012-based IRF PPS market basket. One notable proposed change in the calculation of the market basket is the creation of an additional major cost category – Home Office Contract Labor. In the 2012-based market basket, CMS did not have a separate Home Office Contract Labor Cost category, and it included these costs as a subcategory of the Residual Cost category. In addition, CMS used inputs from the Bureau of Economic Analysis (BEA) to determine the weight of this subcategory. This year, CMS proposes to include Home Office Contract Labor Cost as its own separate major category. It also proposes to use Medicare cost reports, and not BEA inputs, to determine this category's weight.

AMRPA has multiple concerns with this proposed change in methodology. First, CMS provides no rationale or explanation for why it chose to create a new major cost category. The preamble of the proposed rule is completely devoid of even a hint as to the thinking behind this proposed change. There is similarly no analysis as to what the direct effects of this change will be. Without this information, stakeholders have no ability to comment on whether this creates a more (or less) accurate market basket or whether CMS' rationale behind the change is sound and consistent.

Similar to the addition of the new major cost category, CMS also provides no explanation or analysis regarding its proposal to switch to using Medicare cost reports, rather than BEA inputs, to determine the weight of this category. This lack of explanation and analysis is especially troubling given the nature of the reporting of this specific information on Medicare cost reports. Based on our analysis of publically available cost report data, we observed that only 65% of all IRH/Us completed Worksheet S-3, Part II, Column 4, Lines 14, 14.01, 14.02, 25.50, or 25.51 of the cost report. This percentage drops down to 50% for freestanding IRH/Us, as some of the larger freestanding chains did not report this data. These lower completion rates are due to the fact that this Worksheet and line numbers are optional for IRH/U reporting purposes under Medicare cost reporting requirements. Further, this information is painstaking to determine, and AMRPA is concerned the data reported to CMS may be incomplete and inaccurate. However, and as previously mentioned, CMS has provided no underlying analysis, data, or even a rationale to support this change, so stakeholders cannot determine the veracity of the data. Therefore, AMRPA has no ability to provide informed comment on the proposed switch and is gravely concerned these data may be flawed.

AMRPA asserts that this portion of the market basket is hardly a *de minimis* input. CMS estimates Home Office Contract Labor costs at 3.7 percent of all IRH/Us costs. In addition, the cost weight influences changes in other areas of payment, such as the total labor-related share. In fact, it appears the changes proposed here are responsible, at least in large part, for the notable proposed jump of approximately two percent of the labor-related share. Therefore, it is



imperative that CMS and stakeholders have the opportunity to ensure the cost weight is as accurate as possible and continues to properly account for IRH/U costs.

Since stakeholders were not provided with a rationale or analysis of the proposed changes pertaining to Home Office Labor Costs, CMS should finalize use of the previous methodology, including using BEA inputs and including the costs as a subcategory of the Residual Cost Category. CMS should also recalculate the labor-related share using this method. Delaying these changes to the market basket and labor-related share will enable CMS to provide stakeholders an explanation and supporting information regarding this change. Subsequently, the agency can revisit this potential change in future rulemaking. As mentioned elsewhere in this letter, AMRPA has grown increasingly concerned about the lack of transparency and opportunity for meaningful comment to proposed changes to the IRF PPS.

**Recommendation:**

AMRPA supports use of 2016 Medicare cost reports and price inputs as proposed. However, AMRPA recommends CMS not finalize its proposed changes to the Home Office Contract Labor Cost category and labor-related share as proposed. Instead, CMS should finalize use of the previous methodology relating to this category and revisit this potential change with adequate explanation and data in future rulemaking.

**III. Proposed FY 2020 Market Basket Update and Productivity Adjustment**

CMS proposes to update the standard payment conversion factor for IRH/U payments by a 3.0 percent market basket adjustment, reduced by a mandated 0.5 percentage productivity adjustment and then further adjusted slightly by a budget neutrality factor for changes to the CMGs, wage-index and labor-related share. CMS states that a contractor, IHS Global Inc. (“IGI”), performs the market basket update and productivity adjustment calculations.

As with other portions of this proposed rule, AMRPA is concerned about the lack of transparency by which CMS puts forward these payment updates. Despite the fact that IGI’s forecast seems to have been procured specifically for the purpose of CMS updating the IRH/U market basket and productivity adjustment, CMS does not provide IGI’s analyses or report to the public as part of this proposed rule. This lack of information is concerning given the key role the market basket and productivity adjustment plays in updating the payment system each year. The absence of this information denies stakeholders the ability to evaluate the soundness of the update and provide meaningful comment on the proposed changes.

Last year, in response to AMRPA’s comments on this matter, CMS linked to a webpage that contains a summary of recent updates. However, this page does not include the actual analysis or report used to create these forecasts and just includes the final figures. Therefore, this information still does not provide an opportunity to evaluate the analysis used to reach these final figures. AMRPA reiterates its request that CMS release the IGI report and analysis used to update the IRH/U market basket and standard payment conversion factor so that stakeholders can evaluate the soundness of the proposed changes.

AMRPA also wishes to reiterate its concerns about the continued application of the productivity adjustment to IRH/Us. We very much appreciate CMS’ response to AMRPA’s comments last year that the agency will monitor the effects of the productivity adjustment on payments and

patient care. In addition to monitoring its effects on overall payments as CMS stated it would do, we encourage CMS to conduct an analysis of whether the productivity adjustment is reflective of the services delivered in an IRH/U. Specifically, AMRPA encourages CMS to evaluate whether IRH/Us are able to achieve the same level of productivity improvement as workers across the U.S. economy, which is the theory that underlies the application of the productivity adjustment. As AMRPA stated in previous years, due to the labor-intensive nature of rehabilitation care, and the strict Medicare guidelines regarding the manner in which these services are delivered, it is doubtful IRH/Us have the ability to match productivity improvements found in other sectors.

**Recommendation:**

1. AMRPA respectfully requests CMS provide access to the analysis done by IGI to calculate the market basket and productivity adjustment.
2. AMRPA recommends that CMS conduct an analysis to determine whether the productivity adjustment appropriately reflects the ability of IRH/Us to improve productivity or whether the nature and requirements of IRH/U services make such changes unlikely.
3. AMRPA respectfully requests CMS update the market basket and productivity amounts using the latest available data in the IRF PPS final rule.

**IV. Proposed Facility-Level Adjustment Factors for FY 2020**

CMS proposes to keep the facility-level adjustment factors, including the rural, Low-Income Patient (LIP), and teaching status adjustment frozen at the same level that has been used since FY 2014. AMRPA remains concerned that CMS has not evaluated, or at least not publicly disclosed an evaluation, of the continued use of these payment factors. AMRPA urges CMS to update these factors no less than every three years, especially as the number of rural and teaching facilities and the number of uninsured beneficiaries continues to fluctuate.

In last year's final rule, CMS did not even respond to AMRPA's concerns regarding the continued use of these factors. In previous years, CMS has stated that comments on the decision to continue to freeze these factors were beyond the scope of those proposed rules since no changes had been proposed. AMRPA respectfully disagrees with that logic. The decision to continue to freeze the factors is itself a policy decision subject to notice and comment rulemaking, akin to any other provisions of the proposed rule that are consistent with the prior year, and thus comments on the issue must be properly addressed.

Either CMS is failing to analyze the effect of these factors on a timely basis, or it is not making its decision making and analysis of the data public for proper notice and comment. Given the importance of these factors, CMS should make regular efforts to ensure the factors are reflective of provider resources. Therefore, AMRPA recommends CMS conduct an analysis and update all three factors no less than once every three years.

**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. We continue to recommend a minimum interval for any change in IRH/U's provider-level adjustment factors of once every three years.

- V. Proposed Update to Payments for High-Cost Outliers Under the IRF PPS for FY 2020**  
CMS proposes to update the outlier threshold from \$9,402 to \$9,935 for FY 2020 to ensure outlier payments are three percent of total payments to IRH/Us. CMS estimates show that outlier payments would be 3.2 percent of total payments for FY 2020 if kept at the current threshold. AMRPA generally agrees with CMS that outlier payments should be three percent of total payments. However, AMRPA notes that CMS often makes notable changes to the outlier threshold as it receives more updated data. AMRPA agrees with this approach to ensure that CMS accurately projects the total outlier payments to providers.

In the interest of ensuring accurate outlier payments, AMRPA recommends CMS take further steps to ensure outlier payments accurately compensate providers for high cost IRH/U cases. In the FY 2020 IPPS proposed rule, CMS proposes to account for cost report outlier reconciliation in its outlier threshold projections.<sup>10</sup> CMS states in the IPPS proposed rule that including historical outlier reconciliation dollars in its projections of future outlier payments will provide a more accurate projection of total outlier payments. There is no reason that factoring in outlier reconciliation dollars from IRH/U cost reports would not also enhance the accuracy of outlier payments for IRH/Us. Therefore, AMRPA recommends CMS apply the same methodology relating to outlier reconciliations that it applies to IPPS hospitals.

**Recommendation:**

In order to ensure CMS projects outlier payments as accurately as possible, CMS should include historical outlier reconciliation dollars in its outlier threshold projections as it proposes to do for acute-care hospitals.

**PROPOSALS FOR THE IRF QUALITY REPORTING PROGRAM (IRF QRP)**

**I. General Comments**

In this rule, CMS proposes to add 28 new standardized patient assessment data elements (SPADEs) and two Transfer of Health Information quality measures to the IRF-PAI, and proposes to expand IRF-PAI data collection to all-payer patients for the purposes of determining IRH/Us' compliance with the IRF QRP. Taken together, these changes will add a significant burden to IRH/Us' quality reporting mandates beginning on October 1, 2020. AMRPA provides feedback on the various proposals in greater detail below. We also recommend specific actions CMS should take in the FY 2020 final rule and in FY 2021 rulemaking to mitigate the increased resource intensity required by the IRF QRP proposals in this rule.

As CMS continues to implement the quality measures and assessment data collection requirements of the IMPACT Act, it must do so in a practical and minimally burdensome manner that adds value to PAC providers and to patients. This would be consistent with CMS' Patients over Paperwork and Meaningful Measures initiatives which aim to reduce providers' administrative burden (specifically with regard to burden from quality measures) and ensure that federal reporting mandates prioritize actionable, patient-centered information.

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<sup>10</sup> *Id.* at 19593.

**A. CMS Should Account for the Added Reporting Burden in FY 2021**

CMS estimates that the new proposed IRF-PAI items will add at least 18.9 total minutes to each patient assessment, *at a minimum* (CMS does not have estimated times for the Social Determinants of Health SPADEs). CMS bases these estimates on results from the National Beta Test of the IMPACT Act SPADEs and tests of the Transfer of Health Information measures. Following consultation with our member hospitals and clinicians, AMRPA thinks CMS' estimates significantly underestimate the provider burden associated with training, assessing, and reporting these new items. For one, while the proposed items underwent time-testing, the IRH/Us participating in those tests received training directly from CMS and/or its contractors and also had access to CMS/contractor guidance throughout the test period. These simply are not benefits afforded to all IRH/Us despite CMS' commendable efforts with providing IRF QRP training events and the IRF QRP Technical Helpdesk. Furthermore, several of the assessment items require clinical information that can be obtained only through a detailed chart review, and it is unclear if CMS' tests accounted for that additional time in the reported results.

Most notably, the proposed IRF-PAI items add 18 pages to the IRF-PAI. CMS must recognize that any addition, revision, or adjustment to the IRF-PAI has a considerable ripple effect in terms of increased burden on providers' operations. Changes to Medicare's mandatory patient assessment instruments not only add more time to every patient assessment, but also consume provider resources to adapt to these changes in their clinical practice, administrative workflow, not to mention working with their EHR and IRF-PAI vendors to update IT systems.

**Recommendation:**

For these reasons, AMRPA urges CMS to account for the costs associated with this rule's IRF QRP proposals by upwardly adjusting the IRF PPS payment update in the FY 2021 rulemaking to reflect higher provider resource use (and therefore costs). This recommendation is consistent with AMRPA's recommendation for the FY 2018 IRF PPS proposed rule in which CMS first proposed adding new SPADEs to the IRF-PAI.

**B. CMS Should Lower the IRF QRP Completion Threshold**

In the FY 2018 IRF PPS rulemaking, CMS adopted a policy to apply the IRF QRP data completion threshold to the submission of standardized patient assessment data beginning with the FY 2019 IRF QRP. The IRF QRP completion threshold is 95 percent, meaning that at least 95 percent of an IRH/U's required IRF-PAI submissions (Medicare Parts A and C patient assessments) must have 100 percent completion of the required data elements. In contrast, the SNF QRP and LTCH QRP completion thresholds are 80 percent.

In the FY 2018 IRF PPS final rule, CMS signaled a willingness to consider an alternative data completion threshold, due to AMRPA and others' objection to the agency perpetuating discrepant standards in QRP reporting requirements across PAC settings. Although the agency did not specify a lower completion threshold in the FY 2018 IRF PPS final rule, it stated (emphasis added):

"We also appreciate the importance of consistency across programs and agree that the IRF QRP has evolved to include additional measures and data reporting. Taken

together, we believe that while we would agree that working with stakeholders on new approaches to fair and consistent thresholds would be informative and useful, we also believe that our current policy, as commented on, requires revision due to the growth of the program. ... While we appreciate that the suggestion regarding lowering the threshold for the first year of data reporting will address the concerns provided by commenters, we believe that addressing the concerns by reducing the overall threshold to a level that is consistent with the other programs, and maintained until we are able to further evaluate the data, would resolve the immediate concerns regarding our current policy pertaining to the fairness given the amount of data elements that must be coded 100 percent of the time on at least 95 percent of all assessments, which will likely expand as the program expands, as described. We believe that we should take such input into consideration.”<sup>11</sup>

To AMRPA’s disappointment, however, the FY 2020 IRF PPS proposed rule does not propose a reduced IRF QRP completion threshold. In fact, CMS wholly neglected to address the completion threshold in this rule, despite proposing multiple changes which, taken in the aggregate, dramatically increase providers’ IRF QRP compliance burden starting in October 2020. As proposed in this rule, in order to avoid the two percent IRF QRP non-compliance payment reduction and receive the full FY 2022 payment update, IRH/Us would need to: (1) assess patients on a version of the IRF-PAI that is twice as long as the current version, and (2) complete and submit the expanded IRF-PAI for all patients, regardless of payer. As discussed above, the successful implementation of these changes will require a significant investment of time and dollars from IRH/Us.

AMRPA respectfully requests CMS address in the FY 2020 final rule whether it is still considering a reduced completion threshold for the IRF QRP, as discussed in the FY 2018 IRF PPS final rule. Furthermore, AMRPA urges CMS to propose a reduced IRF QRP threshold percentage that is aligned with other PAC QRPs (i.e., 80 percent) in FY 2021 rulemaking and prior to the October 2020 implementation of the new SPADEs and all-payer IRF-PAI reporting requirement (if adopted as proposed). At a minimum, the IRF QRP completion threshold should be lower than 95 percent in the first reporting year the new SPADEs and all-payer reporting are required. It is critical for CMS to afford providers the flexibility needed to adjust their assessment practices to adapt to this increase in the reporting burden. AMRPA also urges CMS to conduct ample provider education, including in-person and virtual IRF QRP training events, well in advance of October 1, 2020.

Taken in combination, our recommendations – increasing the FY 2021 IRF PPS payment update to account for the added IRF-PAI reporting burden and reducing the IRF QRP completion threshold – will help ensure that Medicare: (1) appropriately recognizes the increase in IRH/Us’ costs due to the new quality reporting mandates, and (2) does not perpetuate discrepant and more stringent requirements for IRH/Us compared to other PAC settings.

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<sup>11</sup> CMS, Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2018 (CMS-1671-F), 82 FR 36294, August 3, 2017.

**Recommendations:**

1. AMRPA urges CMS to account for the costs associated with this rule's IRF QRP proposals by upwardly adjusting the IRF PPS payment update in the FY 2021 rulemaking to reflect higher provider resource use (and therefore costs).
2. CMS should address in the FY 2020 final rule whether it is still considering a reduced completion threshold for the IRF QRP, as was discussed in the FY 2018 IRF PPS final rule.
3. AMRPA urges CMS to propose a reduced IRF QRP threshold percentage that is aligned with other PAC QRPs (i.e., 80 percent) in FY 2021 rulemaking and prior to the October 2020 implementation of the new SPADEs and all-payer IRF-PAI reporting requirement.
4. AMRPA urges CMS to conduct ample provider education, including multiple in-person and virtual IRF QRP training events, well in advance of October 1, 2020.

**II. Proposed Method for Applying the Reduction to the FY 2020 IRF Increase Factor for IRFs That Fail To Meet the Quality Reporting Requirements**

As anticipated, CMS proposes to apply a two-percentage point reduction to the applicable FY 2020 market basket increase factor for those IRH/Us that did not meet the reporting requirements of the IRF QRP. Application of the two-percentage point reduction may result in a negative payment update for one fiscal year. CMS invites public comment on the proposed method for applying the IRF QRP's noncompliance payment penalty.

AMRPA continues to ask CMS to provide flexibility in its application of the IRF QRP payment penalty for IRH/Us that make a good-faith effort to comply and submit quality reporting data. AMRPA and our member hospitals wholly support the goals of the IRF QRP and recognize the importance of timely submission of quality data. However, due to the unreasonably high likelihood of errors in reporting (particularly through the National Healthcare Safety Network (NHSN)) and lack of a confirmatory checkpoint, this inflexible and outsized financial penalty should be reexamined. If data are not properly submitted to NHSN, IRH/Us have insufficient notice before CMS imposes the two percent financial penalty through a reduction to the provider's annual payment update. These penalties can be very significant.

Given its complicated nature, the potential for data transmission issues between the CDC and CMS, and the absence of a data receipt confirmation process, this system and CMS' reliance on it creates an unnecessarily high likelihood that providers may encounter a problem in submitting some of their required quality information. Without confirmation of successful data submission to notify IRH/Us, there is no opportunity to correct any data submission issues. Despite their good faith efforts to report all of the data, due to clerical errors while inputting the information to the NHSN or the unknown software problems mentioned above, many IRH/Us have been hit with a payment reduction of hundreds of thousands of dollars, which would be devastating to any provider. Throughout this process, as one example, an IRH/U did not receive a timely notice that the data have been entered incorrectly, nor was the hospital offered any opportunity to correct the mistake.

AMRPA urges CMS to provide more flexibility in its application of the noncompliance penalty to allow providers an opportunity to correct any errors when a good faith effort to submit data is undertaken. Correspondingly, we ask that CMS reserve harsher penalties for egregious offenders who fail to consistently submit IRF QRP data in a timely or thorough manner.

**Recommendations:**

1. AMRPA continues to ask CMS to provide flexibility in its application of the IRF QRP payment penalty for IRH/Us that make a good-faith effort to comply and submit quality reporting data.
2. AMRPA urges CMS to provide more flexibility in its application of the noncompliance penalty to allow providers an opportunity to correct any errors when a good faith effort to submit data is undertaken, and reserve such harsh penalties for egregious offenders who are flouting their responsibilities under the IRF QRP.

**III. Proposed Standard Patient Assessment Data Elements (SPADEs) Reporting Beginning With the FY 2022 IRF QRP (October 1, 2020)**

**A. Proposed Schedule for Reporting the Standardized Patient Assessment Data Elements Beginning with the FY 2022 IRF QRP**

CMS proposes to require IRH/Us to report SPADEs for all patients discharged on or after October 1, 2020 at both admission and discharge, with the exception of the Hearing, Vision, Race, and Ethnicity SPADEs, which only needs to be submitted once. AMRPA appreciates CMS recognizing that some patient characteristics, such as Hearing, Vision, Race, and Ethnicity, do not change throughout the course of a patient's IRH/U stay and hence only need to be collected at the patient's admission. By that reasoning, AMRPA recommends that CMS consider IRH/Us' admission assessment for other SPADEs (as detailed further in our following comments) as also fulfilling the discharge assessment requirement. This approach would significantly reduce the SPADEs' reporting burden, minimize regulatory duplication, and free up valuable clinician time for direct patient care.

Our specific comments on the proposed SPADEs follow.

**1. Cognitive Function and Mental Status SPADEs**

Overall, AMRPA supports the inclusion of the Brief Interview of Mental Status (BIMS), Confusion Assessment Method (CAM), and the Patient Health Questionnaire-2 to 9 (PHQ-2/9) to the IRF-PAI. We recommend collecting the PHQ-2/9 at admission only, as the underlying depression and anhedonia captured by the PHQ-2/9 are not likely to change over patients' stay at an IRH/U, as they are shorter than stays in more residential PAC settings.

Having reviewed the items CMS previously proposed to satisfy the Cognitive Function and Mental Status IMPACT Act domain, AMRPA appreciates that CMS proposes lower-burden items for adoption at this time. Nonetheless, consistent with AMRPA's prior comments on these cognitive assessment items, AMRPA remains concerned that the BIMS, CAM, and PHQ2-9 are not sensitive enough to capture the full range of cognitive impairments seen in IRH/U patients. Given these limitations, AMRPA cautions CMS against relying on these items as cognitive function case-mix indicators or characteristics until CMS is able to determine that these items do not exhibit floor or ceiling effects for IRH/U patients.

As discussed in other sections of this letter, AMRPA believes it is critically important to assure that IRH/U patients' cognitive function is fully assessed and measured. It was

recognized early in the research and development of the IRF PPS classification system that the FIM™ cognitive function assessment items would benefit from further refinement or expansion in order to better reflect the needs of medical rehabilitation patients. A clinical advisory panel convened by CMS and RAND around that time suggested that “certain cognitive areas, currently unmeasured by the FIM™, might be important additional predictors of resource use” for the IRF PPS.<sup>12</sup> Furthermore, researchers involved in creating the payment system also recommended that future refinements should incorporate new dimensions of performance to the cognitive scale such as executive function, motivation, or depression.<sup>13</sup> As CMS continues to implement the IMPACT Act, it should involve stakeholders in the medical rehabilitation research community to help identify cognitive function items that would be suitable and sufficiently sensitive to IRH/U patients.

## **2. Special Services Treatments and Interventions (SSTI) SPADEs**

CMS proposes to add the following items to the IRF-PAI to cover the Special Services, Treatments, and Interventions (SSTI).

- Cancer Treatment – Chemotherapy (IV, Oral, Other)
- Cancer Treatment – Radiation
- Respiratory Treatment – Oxygen Therapy (Intermittent, Continuous, High-concentration Oxygen Delivery System)
- Respiratory Treatment – Suctioning (Scheduled, As needed)
- Respiratory Treatment – Tracheostomy Care
- Respiratory Treatment – Non-invasive Mechanical Ventilator (BiPAP, CPAP)
- Respiratory Treatment – Invasive Mechanical Ventilator
- Intravenous Medications (Antibiotics, Anticoagulants, Vasoactive Medications, Other)
- Transfusions
- Dialysis (Hemodialysis, Peritoneal dialysis)
- Intravenous (IV) Access (Peripheral IV, Midline, Central line)
- Nutritional Approach – Parenteral/IV Feeding
- Nutritional Approach – Feeding Tube
- Nutritional Approach – Mechanically Altered Diet
- Nutritional Approach – Therapeutic Diet
- High-Risk Drug Classes – Use and Indication (Anticoagulants, Antiplatelets, Hypoglycemics (including insulin), Opioids, Antipsychotics, and Antibiotics)

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. AMRPA questions the utility of requiring providers to comb through medical records at admission and discharge for clinical information solely to populate PAC

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<sup>12</sup> RAND, A Classification System for Inpatient Rehabilitation Patients: A Review and Proposed Revisions to the Functional Independence Measure-Function Related Groups, 68 (1998).

<sup>13</sup> Carter, G., Relles, D., Ridgeway, G. & Rimes, C., Measuring Function for Medicare Inpatient Rehabilitation Payment, 24(3) HEALTH CARE FIN. REV., 25-44 (Spring 2003).



assessment forms. Yet again, 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.<sup>14</sup> CMS should minimize regulatory duplication and instead explore how it can 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.

If CMS proceeds to adopt the SSTI SPADEs, AMRPA recommends they be required for data collection at admission only, with the exception of Nutritional Approach (Item K0520). This item has utility for admission and discharge collection in that it helps providers monitor positive outcomes such as the number of patients progressed to a regular food diet over the course of their stay. In that sense, it is an improvement over the current admission-only item Nutritional Approaches Item (K0110), upon which AMRPA has commented previously to CMS.

AMRPA does not support adopting High-Risk Drug Classes – Use and Indication (Items N0415A-J). These items add undue burden, have limited clinical utility in rehabilitation hospitals, and could actually cause more confusion for assessors and patients. From the assessor’s perspective, for example, would aspirin be considered an antiplatelet for the purposes of completing this item? For patients, they may be confused or needlessly guarded against any medication labeled as a “High-Risk Drug” by Medicare on federal clinical documentation. CMS should be cognizant of potential patient perceptions of and reactions to its terminology choices for medications.

### **3. Medical Condition and Comorbidity Data**

CMS propose to add Pain Interference: Pain Effect on Sleep, Pain Interference with Therapy Activities, and Pain Interference with Day-to-Day Activities over the previous five days. In prior comments on potential pain assessment SPADEs, AMRPA cautioned that these items must not focus on the presence or severity of pain, but address the interference of pain on patient quality of life. We appreciate CMS’ consideration of our input. AMRPA supports the Pain Interference item, but recommends that it be required only at admission. Due to the highly intensive nature of therapy services delivered in IRH/Us, it is not uncommon for medical rehabilitation patients to experience some degree of pain during their stay; we find that the limited clinical value this item contributes is outweighed by its reporting burden on the discharge assessment.

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<sup>14</sup> 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. § 1395III(b)(2).

#### 4. Impairments

CMS proposes to add Hearing and Vision items and require reporting at admission only. AMRPA supports adopting these items as proposed.

#### 5. Social Determinants of Health

CMS proposes to collect data about social determinants of health (SDOH) on the IRF-PAI and proposes to add the following data items as SPADEs:

- Race
- Ethnicity
- Preferred Language and Interpreter Services
- Health Literacy
- Transportation Access
- Social Isolation

AMRPA supports the inclusion of SDOH SPADEs. AMRPA recommends that CMS require these items data be assessed *at some point* during the patient's stay, instead of during the admission assessment time window. Furthermore, AMRPA does not support requiring any SDOH SPADEs on the discharge assessment; these patient characteristics are not influenced by the IRH/U intervention and therefore would not change over the patient's stay. AMRPA agrees with CMS that SDOH data could provide Medicare with valuable information about the role that non-clinical factors play in PAC patient outcomes. The impact of socioeconomic status (SES) factors are oftentimes much more pronounced for lower-functioning patients who are likely to require multiple professional services after discharge; however, low SES individuals are less likely to be insured and are more likely to avoid medical care due to cost.<sup>15</sup>

It is undeniably more challenging for certain patients to reenter the community following their IRH/U stay. As an example, some brain injury patients with cognitive impairments demonstrate risk-seeking behavior and might not have the adequate social resources (family or friends) to turn to for support. Similarly, many frail older patients do not have living relatives or friends nearby to turn to for caregiver support. In these instances where patients lack a social support network for a hospital to turn to, the hospital case worker recognizes that lifelong institutionalization may be a likely discharge disposition for these patients. CMS must remain cognizant of these dynamics, and AMRPA recommends the agency explore a methodologically sound approach to risk-adjust certain quality outcomes for patient socioeconomic and sociodemographic status factors.

#### Recommendations:

1. AMRPA recommends CMS consider IRH/Us' admission assessment for the following SPADEs as also fulfilling the discharge assessment requirement:
  - a. PHQ-2/9;
  - b. Special Services, Treatments, and Intervention SPADEs (with the exception of the Nutritional Approach item, which AMRPA supports for collection at admission and discharge);

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<sup>15</sup> Institute of Medicine, America's uninsured crisis: consequences for health and health care. National Academies Press; 2009. p. 214.

- c. Pain Interference; and
  - d. Social Determinant of Health SPADEs.
2. AMRPA recommends collecting the PHQ-2/9 at admission only.
3. AMRPA cautions CMS against relying on BIMS, CAM, and PHQ2-9 items as cognitive function case-mix indicators/characteristics until CMS is able to determine that these items do not exhibit floor or ceiling effects for IRH/U patients.
4. CMS should explore how it can glean information regarding Special Services, Treatments and Interventions (SSTI) by utilizing Medicare claims data already at its disposal rather than by imposing additional provider reporting requirements. AMRPA recommends that SSTI SPADEs be required for data collection at admission only.
5. AMRPA does not support adopting High-Risk Drug Classes – Use and Indication (Items N0415A-J).
6. AMRPA supports the Pain Interference item, but recommends that it is required only at admission.
7. AMRPA supports adopting the Hearing and Vision items as proposed.
8. AMRPA supports the inclusion of the Social Determinants of Health (SDOH) SPADEs. AMRPA recommends that CMS require these items data be assessed *at some point* during the patient’s stay instead of during the admission assessment time window. Furthermore, AMRPA does not support requiring any SDOH SPADEs on the discharge assessment; these patient characteristics are not influenced by the IRH/U intervention and therefore would not change over the patient’s stay.
9. AMRPA recommends the agency explore a methodologically sound approach to risk-adjust certain quality outcomes for patient socioeconomic and sociodemographic status factors.

#### **IV. IRF QRP Quality Measure Proposals Beginning With the FY 2022 IRF QRP**

##### **A. Proposed Transfer of Health Information Measures**

CMS proposes to add “Transfer of Health Information to the Provider – Post-Acute Care (PAC)” and “Transfer of Health Information to the Patient – Post-Acute Care (PAC)” to the IRF QRP starting with discharges beginning October 1, 2020. The measures assess whether or not a current reconciled medication list is given to either the subsequent provider or to the patient/family/caregiver when the patient is discharged or transferred from his or her current PAC setting. Reporting the measure will be taken into account for the purposes of determining IRH/Us’ FY 2022 IRF QRP payment update and beyond.

Since 2016, AMRPA has provided input to CMS on these measures throughout the course of their development, and we thank the agency and its partners at the National Quality Forum for the multiple stakeholder engagement opportunities on these important measures. It is critical to ensure that clinically relevant, valuable, and actionable patient information is transferred to the patient/family or to a downstream provider at discharge from PAC.

In reviewing the proposed measure specifications, AMRPA appreciates CMS’ responsiveness to our and other stakeholders’ requests to scale back the measures and be less prescriptive regarding how providers reconcile medications and transfer that information, for which IRH/Us, as hospitals, already have standard practices. We are pleased to see CMS provide *guidance* regarding the definition of a current reconciled medication list. AMRPA is also

pleased to see that patients discharged against medical advice (AMA) are excluded from the measure for hospital-based PAC settings, as we suggested.

While AMRPA supports adoption of the Transfer of Health Information measures, we respectfully request CMS clarify or address the following issues in the final rule:

**1. Measure Alignment across PAC Settings**

Previously, CMS proposed that “Not Applicable – The agency was not made aware of this transfer timely” would be a third response option available to home health agencies (HHAs) on the following item:

A2121. Provision of Current Reconcile Medication Profile Transferred to Subsequent Provider at Discharge
At the time of discharge/transfer to another provider, did your facility provide the patient’s current reconciled medication profile to the subsequent provider?
<ol style="list-style-type: none"> <li>1. Yes – Current medication profile provided to the subsequent provider</li> <li>2. No – Current medication profile not provided to the subsequent provider</li> </ol>

AMRPA recommends the Not Applicable (N/A) option not be limited to HHAs, as other PAC settings also experience unexpected patient discharge/transfers due to emergent incidents. This is recognized as the “interrupted stay” payment adjustment under the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS). In these cases, the IRH/U will certainly prioritize the patient’s timely transfer to the necessary care setting, and it would be inappropriate for CMS to hold providers accountable to a reporting process over patient well-being. If the N/A option will be made available on the HHA version of this measure, CMS should make it available as a response option for all PAC settings. Cross-setting IMPACT Act quality measures should be harmonized as much as possible across settings.

**2. Clarifying Included Patient Subsets**

Both of the Transfer of Health measure inclusion criteria include patients who are discharged/transferred to “home under care of an organized home health service organization or hospice.” Since the two measures are intended to differentiate between patients who transfer to a subsequent provider versus those who return to home/community, this measure specification would seem to double count a subset of patients. We request CMS clarify why there is an overlap and address how it may affect measure performance.

**3. Ensuring Measure Accuracy**

Finally, because these measures are process measures, it is important for CMS to evaluate how provider performance would be validated. While some PAC settings are accredited by the Joint Commission and already adhere to medication reconciliation requirements, it is not standard practice across PAC settings. The Transfer of Health Information measures will be implemented across PAC settings and could potentially be viewed as a quality indicator to compare PAC settings. As such, it is critical for CMS to ensure measure accuracy across settings.

## **B. Proposed Modification to Discharge to Community Measure**

CMS proposes to modify the Discharge to Community (DTC) – Post Acute Care measure to exclude baseline nursing facility (NF) residents from the measure calculation beginning with the FY 2020 IRF QRP. AMRPA supports this proposal, having recommended it in prior comment opportunities, and we applaud CMS’ success in linking Medicare and Medicaid administrative data to facilitate this modification. Although AMRPA agrees that baseline NF residents should not be included in the Discharge to Community measure, we continue to encourage CMS to look for ways to address these beneficiaries’ needs in quality reporting programs and not wholly exclude them from nursing facilities’ accountability.

### **Recommendations:**

1. AMRPA supports adoption of the Transfer of Health Information measures. We also respectfully request CMS address the following issues in the final rule:
  - a. If the N/A response option will be made available on the HHA version of measure A2121, CMS should make it available as a response option for all PAC settings.
  - b. CMS should clarify why there is an overlap of “Patients discharged home under care of an organized home health service organization or hospice” in the measures’ inclusion criteria, and address how it may affect measure performance.
2. AMRPA appreciates and supports CMS’ proposed modifications to the Discharge to Community measure.

## **V. Proposed IRF-PAI Data Reporting On All-Payer Patients for the IRF QRP Beginning October 2020**

### **A. Data Collection**

In the FY 2018 IRF PPS rulemaking, CMS sought input on expanding the reporting of quality measures to all patients regardless of payer. In response, AMRPA firmly agreed with CMS that quality improvement is an appropriate goal for all patients and supported expanding collection of quality measure data to all patients. In this year’s rule, CMS proposes to expand the IRF QRP to be inclusive of IRF-PAI data on all patients, regardless of payer, beginning with patients discharged on or after October 1, 2020 for the FY 2022 IRF QRP. Currently, the IRF QRP includes only data on Medicare Parts A and C beneficiaries.

The vast majority of AMRPA members already complete the IRF-PAI for all of their patients. Although it will be a significant workload increase due to the added SPADEs, the members we spoke with intend to continue this practice with IRF-PAI version 4.0 effective October 1, 2020.

However, the proposed rule lacks the necessary details about how CMS will implement this change when determining an IRH/U’s compliance with the IRF QRP requirements. AMRPA is unable to support the proposal because CMS has not provided an adequate explanation of how it will be fully operationalized. Specifically, it is unclear to our members how CMS will collect or facilitate the submission of all-payer IRF-PAI data or, more importantly, validate them against all-payer discharges for the purposes of determining reporting compliance when CMS does not have access to other payers’ claims. Of great concern is that IRH/Us and IRF-PAI vendors report that the CMS’ contractor

responsible for IRF QRP compliance determinations has issued erroneous non-compliance decisions or experienced technical errors and miscalculations in the past, and providers have had to scramble to prove that they are compliant to avoid receiving an unjust two percent payment penalty or file a cumbersome IRF QRP Reconsideration Request.

Adding all-payer IRF-PAI data “into the mix” would add substantial complexity to CMS’ administration of the IRF QRP compliance determination process. IRH/Us need stronger assurances from CMS that this proposal will not result in faulty non-compliance determinations or other errors that add more burden to complying with the IRF QRP.

## **B. Public Reporting**

CMS proposes to publicly report all-payer IRF-PAI data. Any public reporting of all-payer patient data must be adequately risk adjusted and displayed in a way that reflects the underlying patient differences across different payers. AMRPA recommends CMS develop methods that stratify non-Medicare quality data by payer status. Different SES/SDS patient populations disproportionately utilize private versus public payers and, as such, payer status is akin to a risk adjustment factor. CMS should solicit input from stakeholders through future rulemaking or other engagement opportunities in order to develop the appropriate adjustment and stratification methods before it publicly displays all-payer patient data.

### **Recommendations:**

1. AMRPA is unable to support CMS’ proposal to expand the IRF QRP reporting requirements to include IRF-PAI data for all patients, regardless of payer, CMS has not provided an adequate explanation regarding how this proposal will be operationalized. Specifically, the proposed rule lacks the necessary details regarding how CMS will implement the inclusion of all-payer patient data in determining an IRH/U’s compliance with the IRF QRP requirements.
2. AMRPA recommends CMS develop methods to stratify the display of patient data by payer status prior to any public reporting of all-payer quality measure data.

## **VI. Proposed Policies Regarding Public Display of Measure Data for the IRF QRP**

CMS proposes to begin publicly displaying data for the Drug Regimen Review measure in CY 2020 or as soon as technically feasible. The displayed data will be based on four rolling quarters and initially use discharges from calendar year 2019. AMRPA supports adopting this proposal.

### **Recommendations:**

AMRPA supports public display of the Drug Regimen Review measure.

## **VII. Proposed Migration to the Internet Quality Improvement and Evaluation System (iQIES)**

CMS proposes to migrate to iQIES as the data submission system for the IRF QRP beginning October 1, 2019. AMRPA supports this proposal, and we recommend CMS begin educating and preparing IRH/Us about this transition as soon as possible. CMS says that iQIES will allow providers greater access to real-time data. AMRPA members request that CMS use iQIES to provide much more timely feedback about IRF QRP compliance for both the ongoing data submissions throughout the year as well as for the annual compliance determination notice.

**Recommendation:**

AMRPA supports the proposed migration to iQIES. We recommend CMS begin educating and preparing IRH/Us about this transition as soon as possible.

**VIII. Proposed Removal of the List of Compliant IRFs**

Effective with the FY 2020 payment determination, CMS proposes to discontinue its practice of publishing annually a list of IRH/Us that were compliant with IRF QRP reporting requirements for the applicable payment determination on the IRF QRP website. AMRPA urges CMS to make this information available to stakeholders upon request in the interest of transparency. Given the growing length of the IRF-PAI and expansion of the IRF-QRP to non-Medicare patient data, it is important that interested stakeholders are able to examine the sector's compliance with growing quality reporting requirements in the future.

**Recommendation:**

AMRPA recommends that CMS make the List of Compliant IRH/Us available to stakeholders upon request.

**IX. Request for Information: IRF QRP Quality Measures, Measure Concepts, and Standardized Patient Assessment Data Elements Under Consideration for Future Years**

CMS seeks input on the following quality measures, measure concepts, and SPADEs which it is considering for future use in the IRF QRP.

**A. Exchange of Electronic Health Information and Interoperability Quality Measures**

AMRPA supports CMS' work to develop consensus around measure concepts that could inform its evaluation of providers' engagement in information exchange across settings, as demonstrated by its recent proposed rule for advancing interoperability. The measurement of interoperability to date has largely focused on the use of certified technology and the percentage of information exchanged. This domain will continue to be relevant if efforts are being made to enhance EHR adoption and exchange capabilities to care settings, such as PAC, that previously were excluded from Meaningful Use funding. CMS already intends to collect information on PAC providers' use of electronic patient information transfer via the Transfer of Health quality measures. While AMRPA remains supportive of the agency's efforts to assess interoperability and identify measure gaps, we oppose the use of mandatory PAC quality reporting programs as the data collection vehicles for this work. This approach unnecessarily adds burden to IRH/Us when valuable clinician time and attention should be dedicated to addressing the needs of patients. CMS should utilize other avenues to research and otherwise inform its understanding of interoperability issues across care settings.

**B. Opioids Quality Measures**

According to our member hospitals, an opioids-based quality measure would not be value added for the IRF QRP. Many IRH/U patients have experienced traumatic, life-altering injuries and are prescribed opioid medications to help manage their pain during the rehabilitation hospital stay and oftentimes post-discharge as well. Our member hospitals are cautious that patients with disabilities and chronic disabling pain who have long relied on opioid medications to manage their symptoms could potentially be misconstrued as not

using opioids in a legitimate way. HHS has already identified a strategy to combat opioid abuse, misuse, and overdose, and this effort is commendable.<sup>16</sup>

**C. Cognitive Complexity (Such As Executive Function And Memory) SPADEs**

AMRPA believes that it is critically important to assure that patients' cognitive function is fully assessed and measured. Unfortunately, the IRF PPS does not adequately reflect the cognitive status of a large number of patients because the IRF-PAI cognitive items are not sufficiently sensitive to do so. The RAND Corporation acknowledged this issue in its initial development of the IRF PPS and particularly in the subsequent revisions which were implemented in FY 2006. Hence, the payment system actually may not satisfactorily recognize patients with these deficits and may therefore underestimate these patients' resource use intensity. IRH/U patients present with a range of cognitive function ability and cognitive impairments. There is no one tool designed to assess executive function or memory in every IRH/U patient and it would be overly and unnecessarily burdensome for IRH/Us to conduct a cognitive complexity test on every patient. CMS should instead work with stakeholders to prioritize which patient conditions would benefit from a cognitive complexity assessment and then engage the research community to identify tests that were designed for and validated in those patient populations.

**D. Caregiver Status SPADEs**

AMRPA continues to encourage CMS to develop a way of capturing for family/caregiver status and/or community supports and accounting for it in discharge disposition outcomes. IRH/Us serving patients without a caregiver or community support often have higher readmission rates and lower community discharge rates. 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. The willingness and ability, not just the presence, of a caregiver are critical drivers for IRH/Us when deciding upon a patient's appropriate discharge destination. Even when the caregiver's presence is expected at the outset, situations often change and families/caregivers' involvement may shift as they come to appreciate the extent of support needed. CMS should be cognizant of these factors as it continues to consider options to increase transparency in Medicare's quality programs, and AMRPA welcomes the opportunity to work with CMS to develop caregiver status data items.

**E. Bowel and Bladder Continence SPADEs**

AMRPA members agree that information on a patient's continence and bowel/bladder needs is necessary for understanding the burden of care, and the IRF-PAI collects bowel and bladder items on admission for care planning purposes. Our members report that IRH/Us already communicate continence needs at discharge to the patient caregiver/family or to the next site of care, and it would be regulatory duplication to require collecting these SPADEs at discharge.

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<sup>16</sup> U.S. Department of Health and Human Services, *Strategy to Combat Opioid Abuse, Misuse, and Overdose: A Framework Based on the Five Point Strategy* (2017).



## **F. Veteran Status SPADEs**

AMRPA members take great pride in working with veterans to help them rehabilitate from serious injuries and illness, maximize their health, functional skills, independence, and participation in society so they can return to service, to work, and to their communities. CMS does not detail why or for what purpose it seeks this information. If CMS wishes to identify veteran patients of IRH/Us, AMRPA recommends CMS first explore beneficiary-matching methods with its governmental colleagues at the U.S. Department of Veterans Affairs.

### **Recommendations**

1. While AMRPA supports the agency's efforts to assess interoperability and identify measure gaps, we oppose the use of mandatory PAC quality reporting programs as the data collection vehicles for this work. CMS should utilize other avenues to research and otherwise inform its understanding of interoperability issues across care settings.
2. AMRPA supports CMS' commendable efforts currently implemented across its programs that aim to address the opioid crisis.
3. CMS should work with stakeholders to prioritize which patient conditions would benefit from a cognitive complexity assessment, and then engage the research community to identify tests that were designed for and validated in those patient populations.
4. AMRPA continues to encourage CMS to develop a way of capturing for family/caregiver status and/or community supports and accounting for it in discharge disposition outcomes. Our members welcome the opportunity to work with CMS to develop caregiver status data items.
5. Because IRH/Us already communicate continence needs at discharge to the patient caregiver/family or to the next site of care, it would be regulatory duplication to require additional data collection regarding bowel/bladder SPADEs.
6. AMRPA recommends CMS explore beneficiary-matching methods with its governmental colleagues at the U.S. Department of Veterans Affairs.

## **PROPOSAL TO CLARIFY THE DEFINITION OF A REHABILITATION PHYSICIAN**

### **I. Proposed Amendments to § 412.622 To Clarify the Definition of a Rehabilitation Physician**

CMS proposes to amend the IRH/U coverage regulations at 42 C.F.R. § 412.622 to clarify that the IRH/U shall make the determination of whether a physician qualifies as a rehabilitation physician (i.e., a licensed physician with specialized training and experience in inpatient rehabilitation). The proposal focuses only on the eligibility determination aspect, and leaves the current regulatory definition in place. CMS proposes this change because the agency believes "it is important to clarify this definition to ensure that IRH/U providers and Medicare contractors have a shared understanding of these regulatory requirements." AMRPA supports this clarification and encourages CMS to finalize the change as proposed.

The rehabilitation physician plays a critical role within IRH/Us; for example, the rehabilitation physician is charged with reviewing and verifying the results of a preadmission screening to facilitate a patient's admission to an IRH/U. AMRPA members, therefore, are committed to ensuring that rehabilitation physicians are sufficiently trained and experienced in IRH/U-level care in order to administer such a significant role with respect to IRH/U admission and access. AMRPA agrees with CMS that the IRH/U itself – rather than an external Medicare contractor –



is in the best position to determine whether a physician meets the eligibility criteria to serve as a rehabilitation physician by granting appropriate hospital medical staff privileges and periodically re-assessing the physician’s performance in that role.

At the same time, AMRPA recognizes that physiatrists – as well as other physicians who are admissible or certified by the American Board of Physical Medicine and Rehabilitation (ABPM&R) (or its equivalent) – are almost by definition well-equipped to serve as rehabilitation physicians. AMRPA recognizes that there may be circumstances (for example, physician availability shortages) that may prevent IRH/Us from utilizing physiatrists or other ABPM&R-certified physicians as rehabilitation physicians. Nevertheless, AMRPA members rely on ABPM&R-certified physicians when possible to provide care to IRH/Us’ complex patient population.

AMRPA appreciates CMS’ efforts to clarify this regulatory requirement for IRH/Us and Medicare contractors to prevent unnecessary disagreements between them regarding the qualifications of the physicians providing care to patients in the rehabilitation hospital.

**Recommendation:**

AMRPA supports adopting CMS’ proposal to clarify the definition of a rehabilitation physician as presented.