AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

June 1, 2023

The Honorable Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1781-P
P.O. Box 8016
Baltimore, MD 21244-8016

Delivered Electronically

RE: Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2024 and Updates to the IRF Quality Reporting Program (CMS-1781-P)

Dear Administrator Brooks-LaSure:

On behalf of the American Medical Rehabilitation Providers Association (AMRPA), we appreciate the opportunity to comment on the Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) for Federal Fiscal Year (FY) 2024 Proposed Rule, published in the Federal Register on April 7, 2023. AMRPA is the national trade association representing more than 700 freestanding IRFs and rehabilitation units of acute care hospitals, which focus on the care and functional recovery of some of the most vulnerable Medicare beneficiaries – including patients with traumatic brain injury, stroke, and spinal cord injury.

Overall, AMRPA supports numerous payment and coverage changes proposed by CMS in this year's rulemaking. As AMRPA has previously discussed with CMS, the IRF field is simultaneously shifting from the COVID-19 Public Health Emergency (PHE) declaration while facing acute and prolonged financial challenges tied to staffing shortages, contract labor costs (and related workflow issues), and inflationary pressures. In light of the current environment facing our member hospitals and units, we urge CMS to be particularly mindful of (1) the need for payment updates that most adequately reflect the current fiscal pressures, and (2) the importance of ensuring that the IRF quality reporting program is a meaningful and manageable system for both patients and IRF providers.

With these overarching goals in mind, a summary of our recommendations for the FY 2024 IRF PPS follows, and our recommendations are detailed in full in Attachment A:

A. IRF PPS Payment-Related Proposals

1. CMS should update the base year for the market basket as proposed while encouraging greater attention to the costs and data needed to support payment updates in the future.
2. CMS should update the IRF market basket cost weights with the most recently available data in the final rule.

Anthony Cuzzola · Chair, AMRPA Board of Directors
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3. CMS should deviate from its typical methodology on a one-time basis to update IRF payments in a manner that addresses rising costs and reductions in reimbursement to ensure there are no disruptions to IRF services for Medicare beneficiaries.
4. CMS should further analyze implementing a three-year rolling average for calculating the outlier threshold as a stabilizing factor for the IRF PPS.
5. CMS should further analyze the increasing concentration of outlier payments and provide that analysis for discussion with the field.
6. CMS should develop and implement an outlier reconciliation policy for the IRF PPS, similar to what is used for the acute inpatient PPS (IPPS).
7. CMS should take additional steps to address rising labor costs for all hospitals, including IRFs.
8. CMS should apply any other relevant changes it makes to the acute IPPS wage index to the IRF PPS to avoid creating harmful disparities in payment across sites of care.

B. IRF PPS Quality-Focused Proposals

1. While AMRPA supports efforts to encourage vaccination for COVID-19 and other infectious diseases, CMS should not adopt the modification of the COVID-19 Vaccination Coverage among Healthcare Personnel measure for the technical reasons outlined in our comments. With the end of the COVID-19 PHE declaration and related policy changes, CMS should consider removing this measure from the IRF Quality Reporting Program (QRP) altogether.
2. CMS should not adopt the COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date measure.
3. CMS should not adopt the Discharge Function Score measure for the IRF QRP.
4. CMS must consider adding realistic costs related to education, training, and technological improvements required to implement new quality measures as the agency undertakes burden estimates in future rulemaking.
5. AMRPA supports CMS' proposed removal of the Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function measure from the IRF QRP.
6. CMS should not remove the IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients and the IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients from the IRF QRP.
7. CMS should focus on patient-centric and functional measures as the agency develops principles for selecting and prioritizing measures.

C. AMRPA Supports CMS' Proposal to Offer New Flexibility for New Units to be Paid under the IRF PPS

1. CMS should finalize its proposal to allow hospitals to open a new IRF unit and begin being paid under the IRF PPS at any time during the cost reporting period.

D. AMRPA Urges CMS to be Mindful of Patient Access & Transparency-Related Concerns Ahead of the Pending IRF Review Choice Demonstration

1. CMS should define specific, robust, and consistent processes for publicly and regularly reporting data over the course of the Review Choice demonstration on how inpatient rehabilitation admissions and services are impacted.

AMRPA has greatly appreciated the close engagement regarding waivers and regulatory changes throughout the PHE and looks forward to a continued partnership as our members navigate the fiscal and operational challenges of the post-PHE landscape. We particularly appreciate your attention to matters impacting patient access and provider burden given the strains on the inpatient rehabilitation field right now and the critical importance of assuring that patients can receive medically necessary inpatient rehabilitation on a timely basis.

If you have any questions, please do not hesitate to contact Kate Beller, AMRPA Executive Vice President for Policy Development and Government Relations (202-207-1132, kbeller@amrpa.org).

Sincerely,

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Attachment A
AMRPA's Comments and Recommendations on the Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2024 and Updates to the IRF Quality Reporting Program, Proposed Rule; 88 Fed. Reg. 20950 (April 7, 2023)

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AMRPA's Comments and Recommendations on the Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2024 and Updates to the IRF Quality Reporting Program, Proposed Rule; 88 Fed. Reg. 20950 (April 7, 2023)

A. AMRPA Response to CMS' Payment-Related Proposals

1. 2021-Based IRF Market Basket

For FY 2024, CMS is proposing to rebase and revise the 2016-based IRF market basket cost weights to a 2021 base year, reflecting the 2021 Medicare cost report data submitted by both freestanding and hospital-based IRFs. CMS believes it is appropriate to incorporate more recent data to reflect updated cost structures and is therefore proposing to use 2021 as the base year.

The 2021-based IRF market basket consists of seven major cost categories and a residual derived from the 2021 Medicare cost reports for freestanding and hospital-based IRFs. CMS states that the proposed methodology used to develop the proposed 2021-based IRF market basket is generally similar to the methodology used to develop the 2016-based IRF market basket.

AMRPA generally supports this update as it reflects more recent data on the cost of inpatient rehabilitation care. We note that our review of the cost categories, however, only shows modest increases, including with respect to labor and capital-related costs, despite our members experiencing much more significant actual increases in expenditures compared to 2016. We generally believe that using FY 2023 data, when available, may more accurately capture the full inflationary costs being incurred to operate IRFs, and we encourage the agency to use the most recently available data when determining the cost weights for the final rule. We recognize that CMS is relying on the cost report data for these updates but note that such data may not always be adequately recorded or prioritized for input. Accordingly, CMS should continue educating stakeholders to ensure that accurate and robust data is being submitted through the cost reports. We also ask that CMS consider increases in wages, salaries, benefits, and contract labor, among other categories, in its methodology.

Recommendations:

- **CMS should update the base year for the market basket as proposed while encouraging greater attention to the costs and data needed to support payment changes in the future.**
- **CMS should update the IRF market basket cost weights with the most recently available data in the final rule.**

2. Market Basket, Productivity, Labor-Related Share, and Standard Payment Conversion Factor for FY 2024

CMS is proposing to implement market basket, productivity, labor-related share, and wage index adjustments utilizing the same methodology and factors it has utilized in prior years.

For FY 2024, CMS is proposing to use an estimate of the proposed 2021-based IRF market basket increase factor (discussed above) to update the IRF PPS base payment rate. AMRPA has historically supported this approach, and the field appreciates the stability this provides in terms of expected reimbursement. However, given some of the extraordinary pressures facing hospitals and health care providers at the present time, AMRPA urges CMS to consider deviating from its standard methodology.

AMRPA members have consistently reported major increases in labor costs over the past few years. Many IRFs have been forced to limit their admissions due to insufficient staffing, which has a direct impact on Medicare beneficiary access to care. Our anecdotal evidence is supported by numerous analyses concluding that hospitals have seen double-digit percentage increases in costs over the last several years.[1-2] This is particularly true for labor costs, where estimates consistently place the increases since 2019 at more than 10%.[3] More recently, projected increases in hospital expenses in 2022 over 2021 top $130 billion, including nearly $60 billion in employed labor increases and nearly $30 billion in contract labor increases.[4] These rising labor costs mean that IRFs may be particularly undercompensated given that the IGI market-basket forecast uses more generalized hospital goods and services. This type of forecast fails to account for the more specialized training and experience IRFs require of their therapists, rehabilitation nurses, and other clinicians, who in turn require higher compensation compared to the more generalized hospital setting.

Labor, however, is not the only part of the market basket for IRFs that is more specialized (and expensive) compared to other settings. Services commonly provided during an IRF stay, such as advanced rehabilitation technologies and specialized drugs, may also be outpacing services offered in other hospital-level settings of care and are not properly captured in the market basket. Additionally, supply expenses for hospitals were up 15.9% through the end of 2021 and have continued to increase due to inflation.[5]

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[1] *Massive Growth in Expenses and Rising Inflation Fuel Continued Financial Challenges for America's Hospitals and Health Systems*; American Hospital Association (April 2022) (https://www.aha.org/system/files/media/file/2022/04/2022-Hospital-Expenses-Increase-Report-Final-Final.pdf).
[2] *National Hospital Flash Report*; Kaufman Hall (January 2022) (https://www.kaufmanhall.com/insights/research-report/national-hospital-flash-report-january-2022).
[3] *PINC AI™ Data: CMS Data Underestimates Hospital Labor Spending*; Premier (April 12, 2022). (https://premierinc.com/newsroom/blog/pinc-ai-data-cms-data-underestimates-hospital-labor-spending).
[4] *2023 Health Care Workforce Scan*; American Hospital Association (November 2022) (https://www.aha.org/aha-workforce-scan).
[5] *Massive Growth in Expenses and Rising Inflation Fuel Continued Financial Challenges for America's Hospitals and Health Systems*; American Hospital Association (April 2022) (https://www.aha.org/system/files/media/file/2022/04/2022-Hospital-Expenses-Increase-Report-Final-Final.pdf).

Despite IRF costs growing at a demonstrably higher rate, CMS is proposing a standard payment rate of $18,471, which is just 3.3% higher than the FY 2023 standard payment rate of $17,878. With inflationary pressures impacting staffing throughout the entire economy, this increase is wholly inadequate for IRFs.

In addition, the continued application of an inequitable productivity adjustment further undercuts reimbursement for providers. AMRPA has previously pointed out the incongruity between the total factor productivity (TFP) adjustment applied to the IRF market basket and the real-world economics of IRF services. We appreciate CMS' responsiveness to AMRPA's past comments, including producing a report that found hospital productivity consistently lags behind economy-wide TFP.[6] However, despite CMS' apparent recognition of the inequity produced by the TFP application, no action has been taken to address this imbalance. With inflation at its current levels, the currently used TFP will prove especially harmful to hospitals.

While IRFs face uniquely acute pressures, other post-acute care (PAC) payment systems also offer illustrations of how CMS' current updates inadequately capture the rising costs of patient care in volatile fiscal circumstances. For example, in the latest Skilled Nursing Facility (SNF) PPS proposed rule, CMS has proposed a forecast error of 3.6% to account for the underestimate of the market basket update for FY 2024. Given there is no forecast error provision in the IRF PPS, AMRPA believes CMS should do more to account for the unique inflationary challenges currently facing the IRF field.

As CMS knows, one significant factor contributing to the rising costs to hospitals is the ongoing impact of COVID-19. As a result of the pandemic, hospitals have had to make appreciable adjustments to their operations, which will continue indefinitely, even though the formal PHE declaration has now ended. These adjustments include the enhanced use of personal protective equipment (PPE), the need for additional staffing, COVID-19 testing for staff and patients, and other infection control protocols, among numerous other examples. Many of these factors, such as the need for increased quantities of materials like PPE, are not captured in market basket forecasts. One potential solution would be to provide a one-time forecast error update to account for the PHE costs as well as to acknowledge the limitations of CMS' own forecasting tools. While we understand that the statutory language of the IRF PPS does not account for this problem in annual payment updates for IRFs, we believe that a one-time accounting related to the PHE would be appropriate to resolve past underestimations by the agency. Overall, such an adjustment would ensure continued and robust patient access to inpatient rehabilitation care.

For these reasons, AMRPA urges CMS to provide additional financial relief for rehabilitation hospitals and units. Such support would address the long-term inflationary challenges facing hospitals and provide the type of predictability that providers need to continue operations and ensure patient access. AMRPA believes CMS could find authority in its market basket, productivity factor, labor-related share calculations, or other updates to assist hospitals with these challenging factors, and we strongly encourage CMS to do so.

[6] Spitalnic et al., *Hospital Multifactor Productivity: An Updated Presentation of Two Methodologies* (February 22, 2016) (https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/ProductivityMemo2016.pdf).

Recommendation:

- **CMS should deviate from its typical methodology to update payments in a manner that addresses rising costs and reductions in reimbursement to ensure there are no disruptions to IRF services for Medicare beneficiaries.**

3. Proposed Case-Mix Groups (CMGs) and Average Lengths of Stay (ALOS)

CMS proposes to use FY 2022 IRF claims and FY 2021 IRF cost report data, which is the most recently available data, to update the CMG and tier relative weights and ALOS values. According to CMS' analysis, found in Table 3 on page 20,959 of the proposed rule, CMS estimates that the proposed CMG changes will result in 99.4% of cases falling in CMGs and tiers that will receive a less than 5% increase or decrease in weight. CMS further estimates that 0.2% of cases will be in CMGs and tiers that will receive a decrease of between 5% and 15%, with the remainder being cases in CMGs and tiers that will receive an increase between 5 and 15%.

In general, AMRPA supports CMS' proposal to generally maintain consistency across the CMGs. As the agency notes, the majority of CMGs will not see significant deviations if finalized as proposed, which allows our members to adequately plan and predict reimbursement from year to year.

AMRPA highlights, however, that certain complex cases are bearing the brunt of the proposed reductions; for example, the CMGs for a traumatic spinal cord injury patient (CMG 0404) and major multiple trauma with brain or spinal cord injury (CMG 1801). Our members further noted that these CMG adjustments may reflect health equity concerns, given that these CMGs are more populated by minorities and patients of lower socioeconomic status. We also note that some of CMS' data may be affected by COVID-19, as patient acuity, mix, and length of stay were likely impacted in recent years, especially as there was limited availability of other post-acute care beds. We, therefore, ask CMS to consider this potential distortion to the data as it finalizes the CMGs for FY 2024.

Similarly, AMRPA generally supports the proposals related to ALOS. We note, however, that CMG 0404 is proposed to see a significant increase compared to the other proposed changes. We are concerned that this drastic swing may be due to distortions in the data rather than actual care changes. In particular, we believe there are relatively fewer cases accounted for in this CMG, which makes it particularly prone to distortion. We also note that CMS almost doubles the ALOS without proposing any similar increase in reimbursement. We, therefore, ask the agency to review and evaluate the CMG and ALOS changes in combination with one another.

4. Proposed Update to Payments for High-Cost Outliers Under the IRF PPS

AMRPA continues to support CMS' policy of setting outlier payments at 3% of total payments, consistent with prior years. CMS estimates the current outlier threshold of $12,526 would result in outlier payments accounting for 2.3% of total IRF payments. Therefore, CMS proposes to lower the outlier threshold to $9,690 for FY 2024.

AMRPA recognizes the outlier threshold for the IRF PPS has fluctuated across fiscal years, which creates a lack of stability and predictability for our members. This is especially challenging for those hospitals and units that see a sizable number of complex patients and are unable to rely on a consistent threshold amount. Accordingly, AMRPA encourages CMS to further analyze and consider a three-year rolling average as a stabilizing factor for the outlier threshold, similar to the approach CMS has taken in the past for facility-specific adjustments. We believe that this approach could reduce the annual outlier changes and provide greater predictability.

AMRPA has also observed that outlier payments have continued to be concentrated among an increasingly smaller number of providers. In the past, we have asked CMS to review this change and provide more detail to ensure that outlier cases and changes are not disproportionately impacting certain regions, patients, and overall beneficiary access to rehabilitation care. We again encourage the agency to provide additional data regarding this concern.

AMRPA would also like to reiterate our recommendation that CMS incorporate a reconciliation methodology into its outlier projections. AMRPA agrees with the rationale articulated in the FY 2020 acute IPPS final rule, wherein CMS finalized a policy that will account for cost report outlier reconciliation in its outlier threshold projections.[7] AMRPA agrees that this policy will allow CMS to achieve a more accurate projection of total outlier payments and will also provide stability for providers in total expected reimbursement.

Recommendations:

- **CMS should further analyze implementing a three-year rolling average for calculating the outlier threshold as a stabilizing factor.**
- **CMS should further analyze the increasing concentration of outlier payments and provide that analysis for discussion with the field.**
- **CMS should develop and implement an outlier reconciliation policy for the IRF PPS, similar to what is used for the IPPS.**

5. Proposed Policy for Wage Index Adjustments

In the FY 2023 rule, CMS finalized a permanent 5% cap on annual wage index decreases to smooth year-to-year changes in providers' wage index payments. CMS proposes to maintain the policies and methodologies described in the FY 2023 final rule for FY 2024. AMRPA continues to support this policy and believes it will provide predictability and stability to IRFs.

AMRPA would like to reiterate its concerns about rising labor costs and how the current wage index may fail to fully capture the true cost of inflation. As demonstrated by recent reports on the nursing shortage and staffing concerns, hospitals have been forced to become more reliant upon

[7] Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2020; 84 Fed. Reg. 42,044, 42,625 (Aug. 15, 2019).

contract labor, and that contract labor has seen outsized pricing increases.[8, 9] This contract labor is often fulfilled by national staffing companies, who are less tied to localized costs. Therefore, as the use of contract labor grows, the local wage index is less reflective of actual costs incurred by hospitals. Therefore, AMRPA encourages CMS to explore how the increased use of contract labor may be distorting the accuracy of actual costs borne by hospitals and make non-budget neutral changes to account for the rise in these costs.

The IRF payment system also fails to fully account for the impact of teaching costs, low-income beneficiaries, and the greater challenges facing rural providers. AMRPA continues to believe that the only way to implement an accurate payment system that reflects the regional variation of wages is to utilize the same wage adjustments for all hospitals (e.g., those paid under the IPPS *and* IRF PPS) in the same area. Therefore, AMRPA reiterates its longstanding call for CMS to ensure parity between IPPS and IRF hospitals.

Recommendations:

- **CMS should take additional steps to address rising labor costs for hospitals.**
- **CMS should apply any other relevant changes it makes to the IPPS wage index to the IRF PPS to avoid creating harmful disparities in payment across sites of care.**

B. AMRPA Response to CMS' Proposed Additions and Refinements to the IRF Quality Reporting Program (QRP)

1. Proposed Modification of the COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) Measure Beginning with the FY 2025 IRF QRP

CMS proposes to modify the HCP COVID-19 Vaccination measure to replace the term "complete vaccination course" with the term "up to date" in the HCP vaccination definition. CMS also proposes to update the numerator to specify the time frames within which an HCP is considered up to date with recommended COVID-19 vaccines, including booster doses, beginning with the FY 2025 IRF QRP. The numerator would be the cumulative number of HCP in the denominator population who are considered up to date with COVID-19 vaccines recommended by the Centers for Disease Control & Prevention (CDC). CMS is also proposing that public reporting of the modified version of the HCP COVID-19 Vaccine measure would begin by the September 2024 Care Compare refresh or as soon as technically feasible.

While AMRPA has supported COVID-19 vaccination efforts for IRF personnel and patients during the PHE, we do not support the modification of this measure and with the PHE now officially over, further request CMS consider removing this measure from the IRF QRP altogether. In consideration of this measure and the recommendation to not support the proposed modification, AMRPA members expressed the following concerns:

[8] The Financial Effects of Hospital Workforce Dislocation; Kaufman Hall (May 2022). (https://www.kaufmanhall.com/insights/research-report/special-workforce-edition-national-hospital-flash-report).
[9] *2023 Health Care Workforce Scan*; American Hospital Association (November 2022) (https://www.aha.org/aha-workforce-scan).

- *Reporting requirements may lead to inaccurate reporting of performance and a need to continually re-ask HCP based upon the evolving nature of the "up to date" definition.*

  The requirement to report one week every month and now having to continuously reconsider the most recent definition of "up to date" places an inordinate amount of administrative burden on IRFs and their clinicians, especially as IRFs are dealing with unprecedented workforce issues. Having to continually track and update vaccination status for a workforce that constantly changes based upon the availability of temporary/contract personnel is already challenging, and the proposed modification will complicate matters further. This will result in reporting issues as well as the inaccurate display of performance on the publicly reported outcome for this measure.

- *Requirements are not consistent with federal/state mandates which required only a primary vaccination series, and with the PHE ending, many (if not all) of these mandates are being lifted.*

  Vaccination mandates from CMS and various states largely required that healthcare personnel complete their primary series of COVID-19 vaccinations. These mandates did not extend the HCP vaccination requirement to include the bivalent booster or any other booster. Additionally, CMS recently announced that with the end of the COVID-19 PHE, the mandate for vaccination of healthcare personnel will be lifted, under the updated Omnibus COVID-19 Health Care Staff Vaccination final rule (CMS-3415). When the mandate is lifted, we believe that the need for HCP to be "up to date" with vaccinations will be diminished, and the resulting benefit of this measure may be compromised.

- *Inconsistent application of the measure or concerns over exclusions for medical contraindications and religious beliefs.*

  While the measure does exclude HCP with medical contraindications, the measure does not exclude those HCP with deeply held religious beliefs that were granted exemption from vaccinations. Additionally, while HCP with medical contraindications are excluded from the measure, we believe that this exclusion may be inconsistently applied among IRFs and other health care settings.

- *Continued issues with the CDC National Healthcare Safety Network (NHSN) data submission portal and CMS quality measure systems have negative consequences for IRFs.*

  In recent years, IRFs have inappropriately received 2% payment penalties because of a failure to reconcile data between the CDC NHSN system and the CMS quality measure system. Technical issues between CDC and CMS have required IRFs to spend additional (and significant) administrative effort to prove that they submitted the appropriate information and have CMS reconsider the 2% payment penalties that are instituted for failure to provide information for the IRF QRP (for example, numerous members report having to invest in forensic technology to demonstrate their compliance). Given these issues, we do not believe that this measure should be modified until such a time as the data collection system issues are fully resolved.

AMRPA recognizes the importance of vaccinations and the benefits that vaccinations offer to patients and providers. We note, however, that the end of COVID-19 PHE declaration and the Administration's decision to lift various vaccination mandates will significantly impact the value of this measure. We, therefore, recommend that this measure not be modified as proposed and request that the agency consider removing this measure from the IRF QRP.

Recommendation:

- **CMS should not adopt the modification of the COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) measure, and with the end of the COVID-19 Public Health Emergency (PHE), should consider removing this measure from the IRF QRP altogether.**

2. Proposed COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date Measure Beginning With the FY 2026 IRF QRP

CMS is proposing to adopt the COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date (Patient/Resident COVID-19 Vaccine) measure for the IRF QRP beginning with the FY 2026 IRF QRP, citing numerous rationales for the measure's relevance and meaningfulness to patients.

Consistent with our position on the HCP Vaccination measure, AMRPA supports efforts to promote vaccination across all populations, including patients. However, we do not support the proposed adoption of this measure, especially given the recent end of the PHE declaration and our significant concerns that this measure does not offer any reflection of the quality of care provided within IRFs. AMRPA members have also identified several logistical and clinical concerns regarding this measure's implementation in the IRF QRP. Specifically, AMRPA members expressed the following concerns:

- *Some IRFs may not have the ability to provide the vaccination to their patients, and for those that do, vaccine side effects may impede the ability of patients to participate in IRF care.*

  AMRPA members, especially those in freestanding IRFs, may not have the storage facilities, staff, or supply to administer COVID-19 vaccines, as is suggested in CMS' justification for adoption. Additionally, with the end of the PHE, many of these facilities would not be requesting supplies to administer vaccinations moving forward. Some IRFs may see a lower score on this measure solely due to the fact that the IRF has not previously administered vaccinations or has not been able to administer vaccinations since the beginning of the pandemic.

  For those IRFs that may have the ability to administer vaccinations, potential side effects of the vaccination may impede the ability of patients to participate in the intensive therapy programs provided by IRFs. For patients who are administered a COVID-19 vaccine in an IRF, any side effects could impact the patient's ability to participate in therapy for at least one day, if not more. Additionally, severe side effects could cause a readmission back to acute care or delay the patient's course of rehabilitation and extend their length of stay

beyond the average time frame for payment. These negative impacts would make it difficult for IRFs to manage and potentially improve their performance on this measure, and we question whether this measure truly represents the quality of care provided in an IRF.

- *The measure does not provide response options for patients who refuse to answer, refuse the vaccination, or are excluded due to medical contraindications or closely held religious beliefs.*

  AMRPA members are extremely concerned that the measure does not account for instances where patients would not be up to date with vaccination status, refuse to provide a vaccination status or get vaccinated, or do not know their vaccination status. Each of these situations may negatively impact the public display of IRF performance on this measure and would not provide a true picture of quality or performance. These concerns were the main reason that the Measure Applications Partnership (MAP) reached 81% consensus on its voted recommendation of "Do not support with potential for mitigation." CMS suggests that patient and family/caregiver advocates (PFA) suggested a measure "…capturing raw vaccination rate, irrespective of any medical contraindications, would be most helpful in patient and family/caregiver decision-making." However, this discussion and determination was made well before the announcement of the end date for the PHE, meaning that the discussion did not consider when or whether vaccination mandates and other PHE requirements would still be in place.

  If CMS decides to move forward with implementing this measure, <u>we believe that CMS must mitigate these concerns and modify the measure accordingly</u>.

- *The "Yes/No" response options are unreliable and may lead to inconsistent reporting of the measure.*

  Building off the prior concern, even if CMS does not change the response options, the proposed "Yes/No" responses may prove to be extremely unreliable. Even CMS suggests that the measure will need to be tested for reliability and validity once enough data is collected, meaning that this measure has not yet been fully tested to know whether it will capture patient vaccination status correctly. The draft measure specifications[10] suggest that "Providers would be able to use all sources of information available to obtain the vaccination data, such as patient interviews, medical records, proxy response, and vaccination cards provided by the patient/caregivers." However, the draft specifications do not specify what the preferred source would be, or how facilities should deal with conflicting information from different sources (such as the patient responding that they are vaccinated, but the medical record suggesting they are not). Furthermore, the proposal does not address how IRFs should handle patients who may not know or understand the changing definitions of "up to date." Further, some patient stays may overlap between the period when new boosters become available and/or the definition of up to date changes –

[10] COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date Draft Measure Specifications, Acumen, LLC (January 2023) (https://www.cms.gov/files/document/patient-resident-covid-vaccine-draft-specs.pdf).

yet the proposal does not address how providers should account for such "bridge" cases. For these reasons, AMRPA members have significant concerns about the reliability of the "Yes/No" response options and believe that this measure should not be adopted at least until such time as it has been fully tested and until guidance addresses these issues.

- *The end of the COVID-19 PHE and the lack of continued CDC updates/requirements may impact performance.*

  As we noted for the COVID-19 HCP Vaccination measure, the end of the PHE declaration will significantly impact the need or desire to continually vaccinate. Without mandates or requirements, the choice patients make on their own regarding their vaccination status will impact the resulting performance on this measure. We also anticipate that there will be significant variances in patient vaccination rates based on IRFs' geographical locations that will affect performance based on circumstances outside their control. Accordingly, we believe that it would be inappropriate to adopt this measure at this time, as it will not provide quality information to patients, caregivers, providers, or payers.

- *The burden estimate does not account for costs associated with the education/training of clinicians, reconciling patient vaccination status among the various sources, administering vaccinations, or providing payment for technological solutions to obtain this information via other sources.*

  Similar to our concerns with the Discharge Function Score measure, the CMS burden estimate does not account for many additional efforts that will be required to ensure that the data collected is valid and reliable. First, the measure and CDC definition of "up to date" vaccination status will require the education and training of clinicians and will be a moving target with the passage of time. While the response options for the measure are simple, the educational content on the "up to date" status and the various sources of information could still require a full hour for one clinician, which is a cost of between about $50 (Licensed Vocational Nurses) to about $90 (Physical Therapists) per clinician, which is between $55,000-$99,000 in total across the over 1,100 IRFs nationwide. This cost should be considered on top of the existing burden estimate in the proposed rule.

  CMS' burden estimate of 0.3 minutes at discharge to obtain this information also does not accurately reflect the time necessary to conduct a patient interview nor reconcile the information provided by the patient. Especially for those patients with cognitive deficits (who make up a significant portion of IRF patients), it may be very difficult to obtain this information or determine the correct information needed to record this measure. Further, the burden estimate does not include cases where a provider may need to contact a proxy or caregiver, nor does it include time spent searching through medical records to try and reconcile the patient response with documented evidence. The CMS estimate needs to be corrected to account for instances when this information is not readily available or needs to be ascertained or confirmed through multiple sources of information.

  Finally, CMS needs to account for any costs associated with software development and technological advances that would make the collection of this information easier or more timely for IRFs and other providers. CMS has spent significant time and resources on

interoperability; however, very little development has occurred within the post-acute care space. Having information related to vaccinations and other patient characteristics included in interoperability standards is necessary to alleviate administrative burden that is currently unaccounted for in the burden estimates or various payment systems. In the meantime, we ask that CMS add to the burden estimate potential costs for software development and other technical updates.

Recommendation:

- **CMS should not adopt the COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date measure.**

3. Proposed Adoption of Discharge Function Score Measure Beginning With the FY 2025 IRF QRP

CMS is proposing to adopt the Discharge Function Score (DC Function) measure in the IRF QRP beginning with the FY 2025 IRF QRP. Performance on this measure is established by calculating the percentage of IRF patients who meet or exceed an expected discharge function score. CMS is proposing that this measure would replace the topped-out Application of Functional Assessment/Care Plan cross-setting process measure.

The proposed DC Function measure would follow a calculation approach similar to the existing functional outcome measures, with some modifications. The measure combines a subset of items from both self-care and mobility activities and uses a statistical imputation approach to recode "missing" functional status data to the most likely value had the status been assessed. CMS states that a benefit of statistical imputation is that it uses patient characteristics to produce an unbiased estimate of the score on each item with a "missing" value. The proposed measure also utilizes a risk-adjusted expectation value for each patient that is based upon several patient characteristics that are captured as part of the admission assessment.

AMRPA does not support the adoption of this measure. In consideration of this measure and the recommendation to not support its proposed adoption into the IRF QRP, AMRPA members expressed the following concerns:

- *The imputation method should not be used to recode instances where the assessment data is not "missing."*

  CMS and the measure developer (Acumen) suggest that "missing" functional status data include patients who are coded with the following assessment values:

  - Code 07, Patient refused: if the patient refused to complete the activity.
  - Code 09, Not applicable: if the patient did not attempt to perform the activity and did not perform this activity prior to the current illness, exacerbation, or injury.
  - Code 10, Not attempted due to environmental limitations: if the patient did not attempt this activity due to environmental limitations. Examples include lack of equipment, weather constraints.

- Code 88, Not attempted due to medical condition or safety concerns: if the activity was not attempted due to medical condition or safety concerns.
- Skipped Value, Item was skipped based upon a prior response.
- Dash Value, Indicates "No information."

Except for the Dash Value (where no information was available for the assessment), all other values are indicative of an affirmative functional assessment value and should not be considered as "missing." Each code represents a circumstance where the patient is not capable of performing the activity, suggesting that their performance should be considered at least at the most severe level (Code 01 – Dependent, where if the activity was attempted it would require a helper to complete the entire activity for the patient or require two or more helpers to complete the activity). Code 07, Patient Refused rarely occurs and, in these situations, the refusal from the patient to perform the activity suggests that it would require a helper to complete the activity for the patient. Code 09, Not Applicable indicates that the patient did not perform the activity and did not perform the activity prior to the IRF stay, suggesting that it would require a helper to complete the activity for the patient. Code 10, Environmental Limitations indicates that if the activity was attempted without equipment or in a compromised weather situation, the patient would have required a helper to complete the activity for them. Code 88, Medical Condition or Safety Concerns indicates that, if the activity was attempted, it would impact the patient's medical condition or put the patient in an unsafe situation, unless the activity was completed by a helper. Finally, Skipped Value indicates that the patient was unable to perform a prior activity of a similar nature, meaning that the patient would be similarly unable to perform this activity without a helper. In these scenarios, the data is not "missing" and, instead, the coded value represents a situation where the most dependent level is the only clinically relevant option. Therefore, the statistical imputation model should not be used for these code values and instead should only be used when the Dash Value, representing no information, is coded.

- *The imputation method specifications do not account for a minimum population of patients from which to base the imputation method; the time period for the measure suggests that imputed values may be unknown until the end of the 12-month target period; and the imputation does not account for new IRFs who may not have data available for lookback.*

  The Discharge Function Score for Inpatient Rehabilitation Facilities (IRFs) Technical Report[11] defines the calculation of the proposed imputation method. Step 1 of this process states to "Identify eligible stays where the item score is not missing (i.e., had a score of 1-6) at admission." For smaller IRFs, it is possible that this process could result in a very small number of eligible stays available for the imputation method calculation. The measure developer does not specify a minimum number of eligible stays necessary to apply the imputation method, meaning that the resulting imputed value may be based upon a very small number of eligible stays, which may bring into question the statistical validity of the result. The measure testing appears to have restricted the analyses to IRFs with at least 20 eligible stays; however, that criteria is not found in any of the measure calculations.

[11] Discharge Function Score for Inpatient Rehabilitation Facilities (IRFs) Technical Report, Acumen, LLC (February 2023) (https://www.cms.gov/files/document/irf-discharge-function-score-technical-report-february-2023.pdf-0).

We are also concerned that the imputation method does not explicitly state the time period for identifying the eligible stays available for the imputation method. If it is the 12 months (four quarters) of data identified as the Measure Time Period, we are concerned that IRFs with eligible stays in the first quarter of the measure that require the imputation method may not know the imputed value for their patient(s) until the entire 12-month period ends. Additionally, after the first 12-month period ends and a new quarter begins, imputed values from prior quarters may change based upon new information being added. The amount of uncertainty for patient-level values creates significant concern about the ability of IRFs to manage and improve performance.

The specifications also fail to identify how data from a new IRF are to be handled, where a full 12 months of data may not exist. Will new IRFs be excluded from the measure until they have a full 12 months of data, or will their information be available for public reporting if they have a minimum number of eligible stays? Also, without a full 12 months of data, will the imputation method be able to accurately calculate what the imputed value should be for a limited population? AMRPA members are concerned that this measure might prohibit new IRFs from accurately measuring their performance and understanding what their patient values represent. We urge CMS to delay implementation of this measure until these critical questions are clarified.

- *The imputation method will be operationally difficult for clinicians to know the patient values and manage performance.*

  Without a technological/software solution or other means to calculate the imputed values in real-time, clinicians will be left to wonder what the patient's function score will be at admission or discharge and would have to wait for CMS to publish measure data to know whether their patient met or exceeded the expected discharge score. Under these circumstances, where the values are not readily available, performance on this measure becomes guesswork for any patient requiring the use of an imputed value. Quality measures are meant to be actionable and meaningful; however, the imputation method will make it extremely difficult for IRFs to know what is needed to improve performance and provide meaningful results to patients.

- *Costs associated with managing this measure have not been considered, such as software updates associated with the various measure calculations and training/education for clinicians.*

  While CMS states that "…this measure adds no additional provider burden since it would be calculated using data from the IRF-PAI that IRFs are already required to collect," IRFs will still need to educate and train their clinicians on the new measure, incorporate discussion of this measure into their interdisciplinary team meetings, and create a solution that will calculate imputation values and the risk-adjusted expected discharge function score values in order to manage performance. Clinicians will need to understand which items are included in this new discharge function score measure, the implications of the imputation method and the use of the "missing" codes, and how performance on this

measure may differ from other quality measures. Clinicians will also need to understand how to review measure results on Provider Preview Reports and other CMS reporting tools. We would estimate that the time necessary to educate/train one clinician on this measure would take at least one hour, and the review of Provider Preview Reports and other CMS quality measure reports to take at least one hour every quarter, or 4 hours annually. Using the adjusted hourly wages provided in the proposed rule, the cost of educating, training, and managing this measure for one clinician would be between $250 (Licensed Practical and Licensed Vocational Nurses) to $450 (Physical Therapists) annually. Across the over 1,100 IRFs, this would represent an annual cost burden of between $275,000 and $495,000. Should additional education and training be provided to other clinicians, this will add another $50-90 per clinician.

Technology-related costs should also be considered, as the imputation method and risk-adjusted expected scores require advanced calculations to be able to monitor patient progress toward their expectation. We will not speculate what the average cost for such software development may be, but instead note that any costs associated with these needs have not been considered as part of the proposed adoption of this measure.

AMRPA members believe that these costs must be considered, as they would significantly impact the values in the IRF QRP Impact Table, Accounting Statement Table, and conclusion of estimated payment changes per discharge displayed in the proposed rule. We further encourage CMS to consider these costs when assessing all new or modified measures in order to more accurately reflect the burden IRF QRP changes pose for IRFs and other providers.

- *The DC Function measure is duplicative of the Discharge Self-Care and Discharge Mobility measures already adopted into the IRF QRP and will create confusion among clinicians, patients, caregivers, and payers who review publicly displayed quality measure information.*

  AMRPA would like to highlight that the DC Function measure was not endorsed by a consensus-based entity (CBE) and received only a Conditional Support for Rulemaking designation at the MAP, with the condition being CBE endorsement. If and when this proposed measure is submitted for CBE endorsement, a CBE would conduct a competing measure review, which would likely identify the two existing IRF QRP measures as duplicative. If these are found to be competing, a determination must be made as to which of the measures will continue to be utilized in the program before endorsement would be granted. Since the Discharge Self-Care Score and Discharge Mobility Score measures have already been endorsed, CMS should not adopt the new DC Function measure until such time as the endorsement process and the competing measure discussion is completed. Alternatively, if CMS intends to adopt the DC Function measure, the Discharge Self-Care Score and Discharge Mobility Score measures should be removed.

If the DC Function measure is adopted without considering removal of existing duplicative measures, the resulting IRF QRP would require management and public display of three different measures assessing discharge function, with varying outcomes based on differences in the items used, recording practices, and measure calculations (including risk-adjustment methodologies). This will engender confusion among clinicians, patients, caregivers, and payers as to making informed decisions on the quality of care provided. AMRPA members identified numerous questions that exist at this stage, including whether they should prioritize the combined DC Function measure over the Discharge Self-Care and Discharge Mobility measures, or, for a patient who has more functional deficits with mobility, would it be more appropriate to focus on the Discharge Mobility Score? Having all three measures present and active in the IRF QRP will be extremely difficult to manage and will cause a great deal of confusion among those who review public reporting for decision-making purposes.

For all the reasons noted above, AMRPA recommends that this measure not be adopted into the IRF QRP. Should CMS wish to move forward with this measure, we believe that this measure should go through an endorsement process and competing measure discussion. Additionally, we believe that the imputation method must be examined more closely and be revised to apply only in those instances where the data is actually missing. Finally, CMS needs to provide IRFs and other post-acute care providers with the ability to manage the measure in real-time, either through the inclusion of additional payments to offset the costs of education, training, and software development, or through a means where CMS provides real-time access to patient-level values and expectations.

Recommendations:

- **CMS should not adopt the Discharge Function Score measure for the IRF QRP.**
- **CMS should consider adding costs related to education, training, and technological improvements required to implement new quality measures to burden estimates.**

4. Proposed Removal of the Application of Percent of Long-Term Care Hospital Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function Beginning With the FY 2025 IRF QRP

CMS is proposing to remove the Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function measure from the IRF QRP beginning with FY 2025. CMS stated that this measure satisfies two of the eight factors for removal: (1) measure performance among IRFs is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made, and (2) there is an available measure that is more strongly associated with desired patient functional outcomes. CMS suggests that the newly proposed Discharge Function Score measure would be the measure available to replace the Application of Percent of Long-Term Care Hospital Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function measure.

CMS also proposes that with the removal of this measure, IRFs would no longer be required to report a Self-Care Discharge Goal or a Mobility Discharge Goal on the IRF-PAI beginning with patients admitted on October 1, 2023. CMS would remove the items for Self-Care Discharge Goals and Mobility Discharge Goals with the next release of the IRF-PAI. Under the proposal, these items would not be required to meet IRF QRP requirements beginning with the FY 2025 IRF QRP.

AMRPA supports the removal of this measure, as well as the removal of the goal items from the reporting requirements. We do not believe that removal of this measure should be tied to the adoption of the Discharge Function Score measure (which AMRPA does not support), as the first measure removal factor provides more than enough evidence that this measure is "topped out" and is no longer meaningful and representative of the quality of care provided by IRFs.

Recommendation:

- **CMS should remove the Application of Percent of Long-Term Care Hospital Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function measure from the IRF QRP.**

5. **Proposed Removal of the IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients and Removal of the IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients Beginning With the FY 2025 IRF QRP**

CMS is proposing to remove the IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (Change in Self-Care Score) and the IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (Change in Mobility Score) measures from the IRF QRP beginning with the FY 2025 IRF QRP. CMS' stated reason for removing these measures is that the associated costs outweigh the benefits. CMS also indicated that the two Change measures were highly correlated with the Discharge measures, and that 6 out of 12 Technical Expert Panel (TEP) panelists preferred the Discharge measures to the Change measures moving forward.

AMRPA does not support the removal of these measures. In consideration of this proposal and the recommendation to not support the proposed removal of these measures from the IRF QRP, AMRPA members expressed the following concerns:

- *Functional change is a key performance measure for IRFs and provides the ability to show results beyond expectations.*

  AMRPA members appreciate CMS reviewing measures to potentially reduce the administrative burden and cost that has been added over the past few years, and AMRPA is highly supportive of the removal of "topped out" or low value measures. However, these particular measures represent a key performance indicator for IRFs that has been reported in various ways well before the implementation of the IRF PPS. One of the core values of IRF care is to provide intensive therapy to restore functional abilities that were diminished

from a recent traumatic event or exacerbation of serious illness. The amount of functional change is often a key determinant of whether the patient can return to the community and is representative of the interdisciplinary therapeutic interventions provided to the patient during the IRF stay.

Additionally, while these measures may be highly correlated with the Discharge score measures, *only* the "functional change" measures capture performance that exceeds expectation, providing enhanced opportunity to differentiate quality and performance across IRFs. The Discharge Self-Care Score and Discharge Mobility Score measures report performance as the percentage of patients who meet or exceed expectation, where performance that exceeds expectation counts the same as performance that meets expectation. The Change in Self-Care and Change in Mobility measures report performance by taking the national average functional change and adding the difference of the average functional change minus the average risk-adjusted expected functional change. For the two change measures, patient performance that exceeds the risk-adjusted expected value provides additional value toward the measure value, differentiating performance against patients who only meet their expectations. This offers significantly greater opportunity to differentiate IRF performance from those who do what is expected versus those that exceed expectations. Since there is greater variability in performance with the Change in Self-Care and Change in Mobility measures, we do not believe these measures should be removed from the IRF QRP.

- *If CMS chooses to adopt the Discharge Function Score measure, the Discharge Self-Care and Discharge Mobility measures should be removed instead of the Change in Self-Care and Change in Mobility measures.*

  As CMS looks to remove duplicative measures and reduce costs to manage and maintain measures, AMRPA recommends that the Discharge Self-Care and Discharge Mobility measures should be the measures removed from the IRF QRP (assuming the proposed Discharge Function Score measure is adopted). CMS has already noted that the performance on the Discharge measures is highly correlated with the functional change measures, and in consideration of the Discharge Function Score measure, CMS notes that the proposed measure utilizes similar methodology, items, and calculations as the existing (and CBE-endorsed) Discharge Self-Care and Discharge Mobility measures. Therefore, rather than removing the Change measures, which have a different meaning and result, CMS should remove the measures that are actually duplicative: the Discharge Self-Care and Discharge Mobility measures.

  Recommendation:

  - **CMS should not remove the IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients and the IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients from the IRF QRP.**

6. Solicitation of Comments

CMS is inviting general comments on the principles for identifying future IRF QRP measures, as well as additional comments about measurement gaps and suitable measures for filling these gaps. CMS also seeks input on data available to develop new measures, approaches for data collection, perceived challenges or barriers, and approaches for addressing challenges.

AMRPA appreciates the opportunity to provide general comments related to the IRF QRP. In consideration of this opportunity, we offer the following comments:

- *CMS should add "patient centricity" or "patient-focused" to the principles for selecting and prioritizing measures.*

  While the "Guiding Principles for Selecting and Prioritizing Measures" deal directly with provider burden, performance, and impact, the guidelines do not address whether the measures are patient-centered or focus on what is meaningful to the patient. The IRF QRP has had several quality measures and standardized patient assessment data elements (SPADEs) implemented over the past few years that address domains important to CMS and industry stakeholders, yet very little is known as to whether these measures or data elements are meaningful for the patient. We believe that it is imperative to obtain patient perspectives in the selection and prioritization of QRP measures. We suggest that CMS obtain these perspectives, not just going forward, but also in reviewing those measures that are currently implemented as part of the IRF QRP.

- *CMS should only adopt or implement measures that are endorsed by a CBE and fully tested in the setting for which they are being proposed.*

  As we have noted in prior comments about proposed new measures, CMS has frequently implemented measures regardless of the recommendations of the MAP, which often suggest that CMS should obtain endorsement from a CBE prior to implementation. The endorsement process is extremely important, as it requires that sufficient testing of the measure be provided as well as consideration of competing or duplicative measures. By skipping the endorsement process, CMS continually implements measures that are incomplete and need revisions or modifications after a year or two of data collection, which raises questions around the reliability and validity of the measure in the first place. Additionally, measures that are not supported by the MAP should require that mitigation be provided prior to proposed adoption and implementation of the measure. CBE endorsement is critical to ensure that measures are reliable, valid, and effective at measuring the quality of care being provided.

  To avoid ongoing issues with the IRF QRP, AMRPA respectfully asks that CMS not overlook the endorsement process and require that any measures proposed for the IRF QRP are fully endorsed and fully tested in the IRF setting.

- *CMS should not move forward with the Patient Experience and Patient Satisfaction measures mentioned and should continue research on this measurement gap.*

Both of the tools mentioned for potential consideration in the proposed rule (the IRF Experience of Care Survey and the CoreQ: Short Stay Discharge (CoreQ: SS DC) measure for SNFs) are not ready for implementation in the IRF QRP. The IRF Experience of Care Survey was nine pages long and entirely too detailed in nature to meet the needs of capturing patient experience/satisfaction in IRFs. The CoreQ: SS DC measure has not yet been adopted into the SNF QRP, so further testing would be needed for applicability for IRF patients. Of note, the CoreQ draft specifications indicate the need to coordinate with outside vendors and potentially subcontractors to meet the requirements for the measure, which may place an undue burden upon IRFs to collect this information.

AMRPA members are interested in working with CMS on developing meaningful Patient Experience and Patient Satisfaction measures. AMRPA members stand ready to participate in ongoing research related to these measures and how they may best represent the care provided in an IRF setting.

- *CMS should limit patient-reported outcome tools for patients with cognitive deficits or behavioral and mental health conditions that are already present in medical records.*

  CMS continues to add SPADEs to try to capture perceived gaps in measurement in cognitive function and behavioral and mental health conditions; however, clinicians are already capturing these patient characteristics through other means. Continuing to ask pre-identified patients questions related to these topics may impact the reliability and validity of the data collection and could agitate patients further, potentially leading to safety issues for patients and clinicians. CMS should consider limiting the data collection of SPADEs related to cognitive deficits or behavioral and mental health conditions for those patients already identified with these conditions.

  Comorbid conditions are currently captured in the data collection process that can be used to identify patients with these conditions. Physicians and other clinicians can utilize screening tools that are specific to the patient that they are treating in circumstances where a condition is not already documented in the patient medical history or other medical records. More data collection is not needed in these areas, and CMS should utilize the information that is already available in the current data collection process.

C. AMRPA Support for CMS' Proposal to Offer New Flexibility for New Units to be Paid under the IRF PPS

Currently, IRF units within acute care hospitals face certain rules with respect to when they can be excluded from the IPPS and paid separately under the IRF PPS that are tied to the start of the cost reporting period. Program rules also specify certain procedures that must be followed when an excluded unit (paid under the IRF PPS) can change its status to not excluded. The current regulations specifically require:

- A unit may be changed from not excluded to excluded only at the start of the cost reporting period. If a unit is added to a hospital after the start of a cost reporting period, it cannot be excluded from the IPPS before the start of a hospital's next cost reporting period.

- The status of a hospital unit may be changed from excluded to not excluded at any time during a cost reporting period, but only if the hospital notifies the fiscal intermediary and the CMS Regional Office in writing of the change at least 30 days before the date of the change, and maintains the information needed to accurately determine costs that are or are not attributable to the excluded unit.

- A change in the status of a unit from excluded to not excluded that is made during a cost reporting period must remain in effect for the rest of that cost reporting period.

Freestanding rehabilitation hospitals do not face these challenges because they have no preexisting cost report year. The hospital can thus open whenever they are ready and will be paid according to the appropriate IRF PPS rate beginning on day one. The regulatory environment, therefore, creates parity issues across units and freestanding IRFs in the context of hospital openings and payment.

For many years, AMRPA members have reported that unanticipated construction, approval delays, and difficulty securing clinical personnel can all result in units missing their specific opening deadline. In these circumstances, units face a prolonged period of payment under the IPPS. The payment differential can be significant, imposing what is in essence a multi-million-dollar penalty based on an arbitrary opening day requirement.

AMRPA has previously engaged with CMS[12] regarding the challenges that stem from the current regulatory structure and urged the agency to consider modernizing these rules in light of the major changes in the IRF PPS since these rules took effect (in fact, these rules were initially adopted in the cost-based payment system that predated the implementation of the IRF PPS). We have appreciated CMS' continuous refinements to this policy in recent years, such as allowing IRF units to make changes in bed size and square footage after the beginning of the cost reporting period in FY 2012. We also applauded CMS' identification of this policy as a potential area for burden reduction in the FY 2018 IRF PPS proposed rule, and AMRPA thanks the agency for its continued engagement with AMRPA since that time regarding the potential implementation of this policy.

For these reasons, AMRPA strongly supports CMS' proposal to amend the coverage regulations such that: (1) a hospital can open a new IRF unit any time within the cost reporting year, as long as the hospital notifies the CMS Regional Office and Medicare Administrative Contractor (MAC) in writing of the change at least 30 days before the date of the change; and (2) if a unit becomes excluded during a cost reporting year, this change would remain in effect for the rest of that cost reporting year. AMRPA believes that this regulatory change will address a major and unnecessary

[12] *See, e.g.*, AMRPA's comments in response to the FY 2018 IRF PPS & QRP proposed rule, in which AMRPA asserted that addressing current IRF unit/freestanding IRF opening-related rules would "harmonize the payments across all new IRFs [and] prevent an arbitrary policy from restricting when a hospital can open, or worse, imposing an arbitrary multi-million-dollar penalty on hospital-based rehabilitation units."

disparity across freestanding IRFs and IRF units, and most importantly, will improve patient access to inpatient rehabilitation care in certain markets.

As a technical note, several AMRPA freestanding IRF members have reported issues in communicating with certain MACs in recent months and procuring the requisite data (such as a CMS Certification Number, or CCN) to operate and be paid under the IRF PPS. We encourage CMS to ensure that MACs are appropriately educated on the opening processes and have the bandwidth to provide timely responses and assistance to all IRFs, especially given the expanded role that MACs will play for IRF units throughout the year if this proposal goes into effect.

In closing, we appreciate CMS' responsiveness to a longstanding AMRPA policy priority and encourage CMS to finalize the policy as proposed in the final rule.

Recommendation:

- **CMS should finalize its proposal to allow hospitals to open a new IRF unit and begin being paid under the IRF PPS at any time during the cost reporting period.**

D. AMRPA Urges CMS to be Mindful of Patient Access & Transparency-Related Concerns Ahead of the Pending IRF Review Choice Demonstration

Recently, the Center for Program Integrity (CPI) announced that it would begin implementing a large-scale "Review Choice Demonstration" (RCD) for IRF services, effective August 21, 2023. The first phase of the RCD applies to all IRFs in the state of Alabama; it will then expand to Texas, California, and Pennsylvania before covering approximately half the country. This demonstration will subject IRFs in target states to either 100% pre-claim or post-payment review for *all* admissions. CPI has previously stated that the audits will focus on compliance with Medicare coverage rules, including determinations of medical necessity and clinical documentation requirements. AMRPA and numerous other rehabilitation stakeholders have raised significant concerns with the impact of this demonstration on patient access to care and will continue to engage closely with CPI as more details are released regarding the specific operational considerations. AMRPA has previously submitted detailed comments on the RCD.[13]

While AMRPA recognizes that the proposed rule does not directly address the RCD, the field believes that this will be a major challenge for all impacted IRFs over the course of the demonstration and one of the largest impacts on Medicare coverage for IRF services during FY 2024 and beyond.

As of this writing, CPI has indicated that it will review MAC decisions under the RCD to ensure accuracy and will "regularly" assess MAC data. However, the details of this agency review and monitoring remain elusive. The IRF field needs to understand whether and how this data will be made public, how often data will be assessed, or the levers the agency intends to employ if and when

[13] AMRPA Comments on Agency Information Collection Activities; Proposed Collection; Comment Request; CMS-10765 (Sept 8, 2021) (https://amrpa.org/Portals/0/AMRPA%20Response%20to%20IRF%20RCD%20Second%20Notice%20with%20Appendix_Final.pdf).

reductions in patient access are demonstrated. Among numerous other recommendations, AMRPA has previously urged CMS to incorporate specific guardrails to ensure that stakeholders can evaluate the demonstration's impact on patient care and access, including public reporting and disclosure requirements.

AMRPA urges CMS to work across the agency to ensure that any barriers to patient access imposed by the RCD are monitored, evaluated, and rectified in a timely manner. We specifically request that CMS and CPI commit to publicly disclosing this information as expeditiously as possible, including data regarding admissions and denials (both pre-claim and post-payment denials), as well as information about any trends identified by the agency when comparing admissions prior to and after the implementation of the RCD in impacted states. Such data should certainly be reported in the FY 2025 proposed rule, but we stress the importance of more regular public reporting so that the agency and stakeholders can respond to any limitations of access in a timely fashion.

Recommendation:

- **CMS should define specific, robust, and consistent processes for publicly and regularly reporting data on how inpatient rehabilitation hospital patients (i.e., admissions and services) are impacted by the implementation of the IRF Review Choice Demonstration over the course of the demonstration.**