AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

May 16, 2024

The Honorable Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1804-P
P.O. Box 8016
Baltimore, MD 21244-8016

Delivered Electronically

RE: Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2025 and Updates to the IRF Quality Reporting Program (CMS-1804-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) 2025 Proposed Rule, published in the Federal Register on March 29, 2024. AMRPA is the national trade association representing more than 700 freestanding IRFs and rehabilitation units of acute and long-term care hospitals, which are providers that focus on the care and functional recovery of some the most vulnerable Medicare beneficiaries – such as patients with traumatic brain injury, stroke, and spinal cord injury. We value the Centers for Medicare and Medicaid Services' (CMS) ongoing engagement with AMRPA and our members and the agency's commitment to ensuring that IRF payment, coverage, and quality reporting requirements align with the current operational and fiscal challenges facing our hospitals.

Overall, AMRPA appreciates CMS' proposals to maintain general stability in the IRF PPS and update payment rates in accordance with prior years' methodologies. We continue to raise concerns with the prolonged financial challenges facing the health care industry and IRFs in particular, especially regarding staffing shortages, labor costs, and inflationary pressures. Additionally, as CMS considers potential new undertakings within the IRF Quality Reporting Program (QRP), we urge careful consideration of stakeholder feedback to ensure that changes adequately account for additional burden on providers as well as provide meaningful benefit to patients.

With these overarching goals in mind, a summary of our recommendations for the FY 2025 IRF PPS follows, and our recommendations are detailed in full in Attachment A:

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Vice President & Chief Operations Officer, Madonna Rehabilitation Hospitals
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A. IRF PPS Payment-Related Proposals

1. CMS should explore all available avenues to update IRF PPS payments in a manner that addresses rising costs and reductions in reimbursement to ensure there are no disruptions in access to IRF services for Medicare beneficiaries.
2. CMS should further analyze implementing a three-year rolling average for calculating the outlier threshold as a stabilizing factor.
3. CMS should further analyze the increasing concentration of outlier payments in the IRF PPS and make such analysis publicly accessible.
4. CMS should develop and implement an outlier reconciliation policy for the IRF PPS, similar to what is used for the Inpatient PPS.
5. CMS should finalize its proposed phase-out policy for those hospitals being reclassified from rural to urban to alleviate steep payment reductions for impacted hospitals.
6. CMS should take additional steps to address rising labor costs for hospitals, including efforts to better capture the impact of staffing agency costs.
7. CMS should apply any other relevant changes it makes to the Inpatient PPS wage index to the IRF PPS to avoid creating harmful disparities in payment across different types of hospitals in the same market.

B. IRF QRP Quality-Focused Proposals

1. CMS must evaluate the reliability and validity of the proposed Social Determinants of Health (SDOH) items in the IRF Quality Reporting Program.
2. CMS should exclude certain patients – such as patients with cognitive deficits or patients under the age of 18 - from any potential IRF QRP data collection requirements related to the proposed SDOH items.
3. Prior to the proposed removal of the Admission Class item, CMS must evaluate the number of patients potentially impacted by the removal of this item and its use in IRF-PAI data collection requirements.
4. CMS must update its IRF QRP administrative burden estimates to account for the costs associated with training and education, the time to administer and reconcile patient assessments, and software development and associated technical updates.
5. CMS should continue to provide feedback opportunities for Technical Expert Panels, industry experts, and patients as it identifies future concepts to capture in the IRF QRP.
6. CMS must address the accuracy-related concerns related to the Star Ratings programs and Care Compare prior to considering an IRF-specific Star Ratings program.

If you have any questions, please do not hesitate to contact Kate Beller, AMRPA President (202-207-1132, kbeller@amrpa.org).

Sincerely,

Chris Lee
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Vice President & Chief Operations Officer, Madonna Rehabilitation Hospitals

Robert Larrison
Chair, AMRPA Legislative & Regulatory Policy Committee
Enterprise Group Vice President, Atrium Health Rehabilitation Network and President, Carolinas Rehabilitation

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Ariel Cress, Program Coordinator, IRF QRP

Attachment A
AMRPA's Comments and Recommendations on the Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2025 and Updates to the IRF Quality Reporting Program, Proposed Rule; 89 Fed. Reg. 22,246 (March 29, 2024)

Attachment A

AMRPA's Comments and Recommendations on the Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2025 and Updates to the IRF Quality Reporting Program, Proposed Rule; 89 Fed. Reg. 22,246 (March 29, 2024)

A. AMRPA Response to CMS' Payment-Related Proposals

1. Market Basket, Productivity, Labor-Related Share, and Standard Payment Conversion Factor for FY 2025

CMS proposes to implement market basket, productivity, labor-related share, and other payment adjustments utilizing the same methodology and factors used in prior years. AMRPA has historically supported the general approach taken by CMS to update payment factors each year with regards to stability and predictability for the field; however, we continue to note the abnormal economic pressures that hospitals face in recent years and urge CMS to explore all options to ensure that provider reimbursement is adequate to meet patient needs.

While we recognize that the final market basket adjustment may be further adjusted in the final rule based on the most recently available data, we urge CMS to recognize that a 2.8% proposed increase is simply inadequate given the rising costs facing hospitals and providers. Over the last several years, hospitals have seen severe (double-digit) increases in costs, with economy-wide inflation growing by more than 12% since 2021.[1] Labor costs, especially, continue to skyrocket amid ongoing staffing shortages, increasing by more than $42 billion between 2021 and 2023.[2] These costs are only expected to grow as shortages persist and clinician burnout continues to drive staff significant turnover.

As we have stated in prior years, CMS' market basket forecast process calculates generalized hospital goods and services, which tends to underrecognize the specialized training and experience IRFs require of their therapists, nurses, and other clinicians (in turn requiring a higher salary than their counterparts in general hospitals). We also note that IRFs, by nature of the multi-disciplinary services they provide and the complex patients they treat, typically pay higher costs for advanced rehabilitation technologies and specialized drugs that are likely not properly captured in the market basket.

In addition to the market basket update, we continue to hold significant concerns with the incongruity between the total factor productivity adjustment (TFP) applied to the IRF market basket and the real-world economics of IRF services. We appreciate that CMS previously started to address these concerns, including producing (and later updating) a report that found hospital productivity consistently lags behind economy-wide TFP.[3] However, despite the apparent

[1] *America's Hospitals and Health Systems Continue to Face Escalating Operational Costs and Economic Pressures as They Care for Patients and Communities;* American Hospital Association (May 2024) (https://www.aha.org/costsofcaring).
[2] *Id.*
[3] Spitalnic et al., *Hospital Multifactor Productivity: An Updated Presentation of Two Methodologies Using Data through 2019* (June 2, 2022). (https://www.cms.gov/files/document/productivity-memo.pdf).

recognition of this imbalance, CMS has not taken any action to address this incongruity. Especially with inflation remaining at such high levels, the currently used TFP will continue to prove especially harmful to hospitals. We encourage CMS to explore all available avenues to provide additional financial relief for rehabilitation hospitals and units, working within the agency's existing authority under the IRF PPS statute.

Recommendation:

- **CMS should explore all available avenues to update IRF PPS payments in a manner that addresses rising costs and reductions in reimbursement to ensure there are no disruptions in access to IRF services for Medicare beneficiaries.**

2. Proposed Update to High-Cost Outliers Under the IRF PPS

CMS estimates that the current outlier threshold of $10,423 would result in outlier payments accounting for approximately 3.2% of total IRF payments. Therefore, CMS proposes to increase the outlier threshold to $12,158 for FY 2025. AMRPA continues to support CMS' policy of setting outlier payments at 3% of total payments, consistent with prior years, and therefore, we support this proposed increase in the FY 2025 IRF PPS.

AMRPA continues to note that 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, we continue to encourage 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. While CMS has asserted that using the most recent full fiscal year of data is the best predictor for outlier cases in the coming year, we continue to recommend the use of a multi-year rolling average approach, which could reduce the annual outlier changes and provide greater predictability for the field.

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 continue to encourage the agency to provide additional data regarding outlier payment distribution.

Finally, AMRPA reiterates our past recommendation that CMS incorporate a reconciliation methodology into its outlier projections. We agree with the rationale articulated in the FY 2020 acute IPPS proposed rule, wherein CMS finalized a policy that will account for cost report outlier reconciliation in its outlier threshold projections.[4] AMRPA agrees that this policy will allow CMS

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

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 make such analysis publicly accessible.**
- **CMS should develop and implement an outlier reconciliation policy for the IRF PPS, similar to what is used for the IPPS.**

3. Proposed Phase-Out Policy for Loss of Rural Adjustments

As in prior years, CMS proposes to adopt new Core-Based Statistical Areas (CBSAs), as determined by the Office of Management and Budget, to determine the specific wage index amount for each hospital, as well as to designate hospitals as located in urban or rural counties. Accordingly, CMS projects that eight hospitals that were formerly in rural counties are set to be reclassified as urban hospitals, which would result in a loss of the facility-specific rural payment adjustment under the IRF PPS of nearly 15%.

Recognizing the steeper and more abrupt payment reduction that these hospitals face compared to others experiencing standard changes in payment adjustments under the IRF PPS, CMS proposes a new "phase-out" policy for these IRFs. Under this proposal, any IRF set to lose its rural status (and payment adjustment) in FY 2025 would instead retain two-thirds of the adjustment for FY 2025, one-third of the adjustment in FY 2026, and fully "lose" this adjustment by FY 2027. This policy is consistent with a similar policy implemented in FY 2006.[5] AMRPA supports this policy as a reasonable method to ensure no hospital faces a dramatic cut to their reimbursement levels as a result of the new OMB delineations.

The proposed rule states that this phase-out policy, if implemented, would not impact the permanent 5% cap on annual wage index decreases, finalized in the FY 2023 rule.[6] AMRPA continues to support this policy as providing increased predictability and stability for IRFs, and we appreciate CMS' consistent application of this policy regardless of the final determination regarding the rural phase-out policy.

Recommendation:

- **CMS should finalize its proposed phase-out policy for those hospitals being reclassified from rural to urban to alleviate steep payment reductions for impacted hospitals.**

[5] Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for FY 2006; 70 Fed. Reg. 47,880, 47,925 (Aug. 15, 2005).
[6] Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2023 and Updates to the IRF Quality Reporting Program; 87 Fed. Reg. 47,038, 47,056 (Aug. 1, 2022).

4. Wage Index Adjustments

In addition to the proposed phase-out policy for reclassified hospitals, AMRPA would like to reiterate our concerns about rising labor costs and how the current wage index fails to fully capture the true cost of inflation. As demonstrated by numerous reports on the ongoing nursing shortage across the entire health care field and other staffing concerns, hospitals have been forced to become more reliant upon contract labor, and that contract labor continues to see outsized pricing increases. This contract labor is often fulfilled by national staffing companies, whose prices are generally not 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. Given these current staffing cost dynamics, AMRPA encourages CMS to explore how the increased use of contract labor are distorting the accuracy of actual costs borne by hospitals and make corresponding (non-budget neutral) adjustments to account for the rise in these costs.

Furthermore, and as AMRPA has previously noted, the current IRF PPS does not fully account for certain fiscal challenges facing rural providers. We again recommend that CMS utilize the same wage index adjustments for all hospitals (i.e., those paid under the IPPS *and* IRF PPS) in the same area. This will help advance AMRPA's longstanding efforts to ensure parity between IPPS and IRF PPS hospitals with respect to wage index policy.

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 different types of hospitals in the same market.**

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

1. Proposal To Collect Four New Items as Standardized Patient Assessment Data Elements Beginning with the FY 2028 IRF QRP

CMS is proposing to require IRFs to collect and submit four new items as standardized patient assessment data elements (SPADEs) under the Social Determinants of Health (SDOH) category using the IRF–PAI: one item for Living Situation, two items for Food, and one item for Utilities.

CMS selected the proposed SDOH items from the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool developed for the AHC Model. The AHC HRSN Screening Tool is a universal, comprehensive screening for HRSNs that addresses five core domains as follows: (1) housing instability (for example, homelessness, poor housing quality), (2) food insecurity, (3) transportation difficulties, (4) utility assistance needs, and (5) interpersonal safety concerns (for example, intimate partner violence, elder abuse, child maltreatment).

Overall, AMRPA supports the collection of standardized assessment data elements which have been identified as impacting care use, cost, and outcomes for Medicare beneficiaries and may address the health equity challenges across the continuum of care. However, our members have expressed concerns with the four proposed items and question whether these items will practically improve coordination with other health care providers, facilities, and agencies during transitions of care. We address each of these in turn:

- For the proposed Living Situation item, AMRPA members expressed concerns about some of the wording and response options, as well as the utility of this item for the purposes of the IRF QRP or transitions of care. While AMRPA understands that these items are already in use on the AHC HRSN Screening Tool, we believe that they may not be appropriate for the IRF-specific population or other post-acute care venues. The wording of this item asks the patient to identify their living situation "today," which for patients in an IRF following a traumatic injury or other serious medical event may be difficult to determine or recall. In these instances, the patient's medical condition may prevent them from responding appropriately or may prohibit them from knowing whether they will be able to return to the living situation they had prior to the traumatic injury/event. In responding to this item, IRF patients may also need to take into consideration whether their existing living situation is appropriate for their continued use following their injury or illness (for example, whether their living situation can accommodate new wheelchair use). Additionally, IRF patients may be experiencing cognitive deficits as part of the traumatic injury/event, such that the patient response may be unreliable or invalid. In these instances, the utility of the response may be compromised and not provide the ability to coordinate any transition of care. Finally, AMRPA members note that the IRF-PAI already captures *Item 44D. Discharge Destination/Living Setting* and *Item 45. Discharge to Living With*, both of which could serve as proxies for determining a patient's living situation.

- For the two proposed Food items, AMRPA members expressed concerns primarily about the use of the "Within the last 12 months" verbiage, as well as the utility of the response items over that time frame. For example, a patient admitted in December who was unemployed in January may have had food security concerns roughly 11 months prior, but those concerns may have been ameliorated for an extensive time prior to the assessment in the IRF. In this example, the suggested response item would likely be "Sometimes True;" however, that patient may not require any assistance or coordination of care specific to food security as part of their transition home or to another provider. Additionally, IRF patients may be experiencing cognitive deficits as part of the traumatic injury/event, such that the patient response may be unreliable or invalid.

  AMRPA members recognize that these items came from the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE®) tool which, as noted in the FAQs on the PRAPARE website, recommends that the assessment be

performed at least annually.[7] However, AMRPA members recommend that CMS consider a much shorter time frame for this assessment, such as within the last 3 months, given these concerns specific to IRF populations.

- For the Utilities item, AMRPA members expressed similar concern about the "Within the last 12 months" verbiage. As stated in the Food items comments above, the time frame for this assessment is so broad that it may not capture reliable, valid, or timely information to better coordinate with other healthcare providers, facilities, and agencies during transitions of care. Additionally, the inclusion of all utilities (electric, gas, oil, or water) as well as the term "threatened" may lead to inconsistent, unreliable, or invalid responses. Additionally, IRF patients may be experiencing cognitive deficits as part of a traumatic injury/event, which could also result in unusable or unreliable responses. AMRPA members again recommend that CMS consider a much shorter time frame for this assessment, such as within the last 3 months, given these same concerns specific to the IRF population.

Finally, for all of the proposed items, AMRPA members are concerned that these SPADEs will be required for patients from all payers, including patients under the age of 18. As stated on the PRAPARE® website FAQs:

> *"Currently there is no PRAPARE version that is specifically tailored for pediatrics/adolescents. There are health centers who have modified PRAPARE to be used with their pediatric and adolescent populations, which varies based on their staffing model and engagement of family members. The National NACHC team hopes to develop a Pediatric/ Adolescent version of PRAPARE in the coming years."*[8]

Since these items have not been validated or tailored for the Pediatric/Adolescent population, we believe that CMS should exclude these items from any data collection requirement for patients under the age of 18.

Recommendations:

- **CMS must evaluate the reliability and validity of the proposed SDOH items and their potential responses for the population of cases that are referred to IRFs and other post-acute care settings.**
- **CMS should consider reducing the time frame – such as a three-month period – for these assessments to provide more reliable, valid, and actionable information as part of any transition of care.**
- **CMS should exclude patients with cognitive deficits or patients under the age of 18 from any potential IRF QRP requirements for data collection on these items.**

[7] https://prapare.org/FAQ/.
[8] *Id.*

2. Proposal To Modify the Transportation Item Beginning with the FY 2028 IRF QRP

CMS is proposing to modify the current Transportation item in the IRF–PAI so that it aligns with a Transportation item collected on the AHC HRSN Screening Tool available to the Inpatient Psychiatric Hospital Quality Reporting (IPFQR) and Hospital Inpatient Quality Reporting (IQR) Programs. Consistent with the AHC HRSN Screening Tool, CMS is proposing to modify the *A1250 Transportation* item currently collected in the IRF–PAI in two ways: (1) revise the look-back period for when the patient experienced lack of reliable transportation; and (2) simplify the response options.

As noted in our comments about the four new items proposed as SPADEs, AMRPA members are concerned with the time frame of the assessment and the limitations of the response options to provide reliable and valid information. Using the last 12 months for the time frame of assessment may include a one-time occurrence due to unforeseen circumstances that occurred 6-12 months ago and would not require any coordination of care or other action as part of a transition. Additionally, the "Yes/No" response options do not provide any consideration for the frequency of this issue or the reason(s) why reliable transportation was not available.

AMRPA members also have concerns about the requirement to collect this item for patients from all payers, including patients under the age of 18. As previously noted, the PRAPARE® tool items have not been validated or tailored for the Pediatric/Adolescent population, and we believe that CMS should exclude these items from any data collection requirement for patients under the age of 18.

AMRPA members are also concerned that the transportation item does not include consideration for patients with a disability that requires special accommodations for transportation, such as wheelchair accessibility. Also, IRF patients may be experiencing cognitive deficits as part of a traumatic injury/event, such that the patient response may be unreliable or invalid.

Finally, AMRPA members are concerned about the utility of the existing transportation item and the IRF QRP requirement to collect and submit this item as part of the existing IRF-PAI. If CMS believes that there is ambiguity in the existing item that requires modification, we question how CMS is currently utilizing this information and why IRFs and other post-acute care providers are required to continue data collection on this item in the interim before the revised item (if finalized) is effective. AMRPA members recommend that CMS consider a much shorter time frame for this assessment, such as within the last 3 months, as well as consideration for patients with requiring special accommodations or cognitive deficits to provide IRFs and other post-acute care providers the ability to better coordinate with other healthcare providers, facilities, and agencies during transitions of care.

Recommendations:

- **CMS must evaluate the reliability and validity of the proposed modification and the potential responses for the population of cases that are referred to IRFs and other post-acute care venues.**

- **CMS should consider reducing the time frame for this assessment – such as a three-month period - to provide more reliable, valid, and actionable information as part of any transition of care.**
- **CMS should exclude patients with cognitive deficits or patients under the age of 18 from any potential IRF QRP requirements for data collection on this item.**
- **If CMS finalizes the proposed modification, the existing Transportation item should be removed from data collection requirements for the IRF QRP.**

3. Proposal To Remove the Admission Class Item From the IRF–PAI Beginning October 1, 2026

CMS is proposing to remove *Item 14. Admission Class* entirely from the IRF–PAI, beginning October 1, 2026. As part of this proposal, CMS states that "[w]e have identified this item is currently not used in the calculation of quality measures already adopted in the IRF QRP. It is also not used for previously established purposes unrelated to the IRF QRP, such as payment, survey, or care planning."

AMRPA members are generally supportive of the removal of the Admission Class item. As a technical matter, however, we note that CMS modified the collection and submission of certain IRF-PAI items within the past year by implementing a skip pattern for "Incomplete Stays" that utilizes the Item 14 value of 4 – Unplanned Discharge. In consideration of the removal of this item, we believe that CMS should provide an impact analysis related to the number of patients that require this item. We also ask that the response should be identified as "Incomplete Stays" and skip the various items that are a part of required data collection for the IRF QRP.

Recommendations:

- **Prior to removal, CMS must evaluate the number of patients potentially impacted by the removal of this item and its use in IRF-PAI data collection requirements.**

4. Estimate of Change in Burden related to IRF QRP Changes

CMS produced a projected impact related to additional administrative burden resulting from the proposed addition of four items, modification of one item, and removal of one item. CMS projects an estimated change in annual burden of 5.20 hours per IRF which equates to an estimated change in annual cost of $339.79 per IRF. In total, CMS projects an estimated change in annual burden of 6,003.88 hours, which equates to an estimated change in annual cost of $392,113.40.

As has been noted in past AMRPA comments, the CMS burden estimate does not account for the time and resources that will be required to ensure that the data collected is valid and reliable. We urge CMS to take the following issues into account:

- First, the CMS estimate of additional burden does not account for the training and education needed for clinicians responsible for conducting these assessments, as these clinicians must have a full understanding of the items and the various assessment guidelines. This could require a full hour for at least one clinician, which is a cost of

between $52.52 for Licensed Practical and Licensed Vocational Nurse (LPN/LVN) to $78.10 for Registered Nurse (RN) per clinician, which is between roughly $57,000-$90,000 in total cost across the over 1,100 IRFs nationwide.

- Second, CMS' burden estimate 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 (such as information from the acute care stay). CMS' estimate needs to accurately account for instances when this information is not readily available or must 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 timelier 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 SDOH 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 must update their administrative burden estimates to account for the costs associated with training and education, actual time to administer and reconcile patient assessments, and software development and associated technical updates.**

5. IRF QRP Quality Measure Concepts under Consideration for Future Years – Request for Information (RFI)

In consideration of the feedback CMS has received from interested parties through recent Technical Expert Panel (TEP) activities, CMS is seeking input on three concepts for the IRF QRP.

- A composite of vaccinations, which could represent overall immunization status of patients such as the Adult Immunization Status measure in the Universal Foundation;
- The concept of depression for the IRF QRP, which may be similar to the Clinical Screening for Depression and Follow-up measure in the Universal Foundation; and
- The concept of pain management.

AMRPA appreciates the opportunity to provide feedback on the three measure concepts included in this RFI. We also appreciate the opportunity to have one of our members (Bruce Pomeranz, MD of Kessler Institute for Rehabilitation) participate on the CMS TEP related to consideration of

these measure concepts. We believe that our response to the RFI is similar to the discussion of these concepts at the TEP. Our responses to each of the three concepts follow:

A. Composite of Vaccinations

AMRPA members have expressed significant issues and concerns related to the existing vaccination measures already included in the IRF QRP. While AMRPA commends the Administration's efforts to promote vaccination among patients and healthcare workforce, the current complications surrounding the vaccination-specific reporting in the QRP make an expansion to a composite vaccination measure much more difficult to support. AMRPA members believe that the responsibility for reporting a patient's vaccination status and administering vaccinations should be assigned to a primary care physician, with the vaccination information shared among the various health care providers should a patient require their services. A requirement for IRFs to assess and document a patient's vaccination status will be administratively difficult, and the information obtained from this measure by an IRF could conflict with the patient's actual vaccination status. Additionally, should a patient suggest that they have not received certain vaccinations, we have concerns as to whether it would be appropriate (or even feasible) for the IRF to verify this information and/or administer these vaccinations as part of the IRF stay.

We also question what, if any, considerations CMS will provide if certain vaccinations have side effects that impact the ability for a patient to receive and benefit from IRF care. Finally, AMRPA members expressed significant concerns over what vaccinations would be included in the composite vaccination measure, and whether this measure would account for exceptions such as medical contraindications, deeply held religious beliefs and/or pediatric/adolescent patients included as part of the all-payer IRF-PAI data collection requirement. We also note that some states have enacted legislation or other policies that may impact patients' willingness to offer personal vaccination information. Without consideration for these populations, a composite vaccination measure may lack the reliability and validity necessary for use in the IRF QRP, as well as cause unintended impacts on a patient's IRF care delivery.

B. Depression Concept

In consideration of the Clinical Screening for Depression measure, AMRPA members expressed concern as to whether the ultimate screening may require additional resources to treat depression in addition to the services required to treat the primary impairment and any additional comorbid conditions. IRFs generally do not have a psychiatrist or psychologist on staff to provide all of the comprehensive services needed to treat depression. Additionally, IRFs and other post-acute care providers are already collecting information and utilizing physician documentation as a means to identify mental health conditions such as depression, anxiety, and other mental or behavioral health issues. Consideration for an additional screening requirement will add administrative burden without improving the quality of care provided to the patient.

C. Pain Management Concept

AMRPA members continue to express concerns over any measurement of pain management. The intensive therapy and associated services provided by an IRF may, by nature, induce pain as part of the recovery process. The consideration for measuring pain management should not include an expectation of an improvement in pain as part of IRF services nor any other post-acute care service. Additionally, any consideration of pain management measurement also needs to consider the potential implications of such measure on the utilization of opioids or other pain management medications.

Recommendations:

- **CMS should evaluate the reliability, validity, and effectiveness of existing vaccination measures before expanding efforts to a composite measure.**
- **CMS should not consider the Clinical Screening for Depression without determining the availability of resources to treat depression within IRFs and other post-acute care venues.**
- **CMS should reconsider pain management measures for use in the quality reporting program given concerns over how such measures impact opioid and other pain medication utilization.**

6. Future IRF Star Rating System: Request for Information (RFI)

CMS is seeking feedback on the development of a five-star methodology for IRFs that can meaningfully distinguish between quality of care offered by IRFs. Star ratings for IRFs would be designed to help consumers effectively identify differences in quality when selecting a provider. As part of this effort, CMS specifically seeks comment on whether (1) there are specific criteria CMS should use to select measures for an IRF star rating system, and (2) how CMS can present IRF star ratings information in a way that it is most useful to consumers.

AMRPA appreciate CMS' engagement with the field as it considers whether to establish this type of program for IRFs, and if so, the best way of implementing an effective star-rating system. At the same time, AMRPA members (many that are part of systems that also include skilled nursing facilities (SNFs)) are concerned with this potential effort given the current reliability and useability concerns reported with the SNF Five-Star rating program.[9] Furthermore, AMRPA has concerns with the accuracy of Care Compare data that is used to populate these ratings. Until these issues are resolved, CMS should delay efforts to create new Star Ratings programs for other providers, including IRFs.

AMRPA also recommends that, if CMS continues to evaluate existing measures for potential inclusion in any Star Ratings or rankings system in the future, providers must have timely access to all data and information utilized for the measures in order to monitor and potentially improve performance. Currently, the IRF QRP includes a number of claims-based measures that utilize

[9] See, e.g., New York Times, *Maggots, Rape and Yet Five Stars: How U.S. Ratings of Nursing Homes Mislead the Public*; https://www.nytimes.com/2021/03/13/business/nursing-homes-ratings-medicare-covid.html (March 21, 2021).

claims data from other providers as part of the measure calculation process. Without access to all the claims data attributable to IRF patients, IRFs are unable to identify which patients are negatively impacting their performance on these measures and whether there are any risk factors they can evaluate to improve performance or reduce readmissions.

Finally, AMRPA recommends that any measures considered for use in a Star Ratings system or similar program must be timely and patient-focused. A number of measures currently included in the IRF QRP and displayed on Care Compare utilize information that is 2-3 years old and includes 2 years' worth of information. This lag in information makes it difficult to recognize and display any performance improvement that has occurred in the more recent term and does not represent the current performance of these providers (which is critical for patients making care decisions). AMRPA members also note that several measures currently included in the IRF QRP fulfill measure domains and concepts identified by CMS but may not be patient-focused or relevant to the patients and their caregivers. We also note that certain measures may be misrepresentative for certain patients if they are only based on Medicare data. We therefore urge CMS to obtain extensive feedback from patients or patient advocates about measures that are important and meaningful to patients in order to support their reliability and useability in any future Star Ratings or related rankings system. This exercise may also be useful as CMS works to ensure that the QRP system overall is meaningful for patients and caregivers.

Recommendations:

- **CMS must address the issues and concerns related to existing Star Ratings programs and Care Compare prior to considering any sort of new program for IRFs.**
- **CMS should provide IRFs with all data and information utilized for any measure included in the IRF QRP and any future Sar Ratings system.**
- **CMS must ensure that any measure consider for inclusion in any future Star Ratings system is timely and patient-focused.**