March 6, 2023
Lee Fleisher, M.D.
CMS Chief Medical Officer and Director
Center for Clinical Standards and Quality
7500 Security Boulevard
Baltimore, MD 21244

Dear Director Fleisher,

On behalf of the members of the American Medical Rehabilitation Providers Association (AMRPA) and the National Association of Long-Term Hospitals (NALTH), we write to you today regarding our concerns about the expansion of Standardized Patient Assessment Data Elements (SPADEs) captured over the past year in our respective quality reporting programs (QRPs). Our associations represent over 700 inpatient rehabilitation facilities and nearly 100 long-term care hospitals, respectively. Our joint experiences are that the expansion of reporting requirements and inflexible penalties have created significant administrative burden that is impacting patient care and exacerbating workforce challenges. These burdens stem from: (1) a lack of sufficient training and guidance on the new instrument measures, (2) an underestimation of the time necessary to conduct patient assessments, (3) the fact that lower-value quality measures and their associated data elements are not being removed as new measures and SPADEs are added, and (4) most significantly, the staffing shortages across the health care industry.

We ask that CMS provide relief for well-intentioned providers. As discussed below, we believe CMS has several opportunities to make the QRPs less punitive and more workable for both patients and providers. Most immediately, we ask CMS to either waive potential payment penalties or exclude the problematic new measures from the determination of whether a hospital meets the QRP reporting requirements until additional steps can be considered. In the long term, our organizations are willing to work with CMS to develop solutions, such as a reduction in data collection requirements or compliance thresholds. We appreciate your consideration of these options and request a meeting with CMS to discuss the best path forward for our respective QRPs.

I. QRP Background & Current Issues Facing the Field

Over the past few years, our data collection tools (IRF-PAI and LTCH Care Data Set) have nearly doubled in size. For Medicare discharges beginning on or after October 1, 2022, nearly 200 new data elements were added to the data collection tools. In addition to the implementation of data collection for these measures, CMS also expanded the list of SPADEs required for the FY 2024 Annual Update Determination, where IRFs and LTCHs would be subjected to a 2% reduction in the annual increase factor for the use of "non-informative" or "dash" responses. For IRFs, the recent expansion added 189 data elements to the existing 105 data elements required to avoid the 2% payment penalty, where the compliance threshold is 95%, suggesting that only 5% of recorded cases can contain "non-informative" or "dash" responses to required data elements. For LTCHs, the recent expansion added 200 data elements to the existing 102 data elements required to avoid the 2% payment penalty, where the compliance threshold is 80%, suggesting that only 20% of recorded cases can contain "non-informative" or "dash" responses to required data elements.

Due to the significant increase in data collection, the requirements for compliance nearly tripled without any relaxation or relief of the compliance threshold. The challenges posed by the expansion of our tools and high compliance threshold are exacerbated by the following factors:

A. Utility of Certain Measures & Underestimation of Reporting Burden

A major issue our organizations have with the expanded data collection requirements is that numerous SPADEs included in the quality reporting program data collection compliance determination are not actually used for quality reporting purposes and have not been proposed for use in any quality measure for the QRP. While we agree that certain public health domains are important, such as social determinants of health, CMS has not provided any additional information related to the intended use of this information other than the intent to levy payment penalties should the information not be collected. While limited testing was conducted on the feasibility of collecting the new SPADEs, consideration was not given to whether these new data elements would differentiate patient characteristics or provider performance. The testing efforts also failed to measure the additional burden being placed on providers to complete the assessments. Time estimates that have been provided by CMS measure only the amount of time it took for someone to enter the information onto a form after the assessments have already been conducted and completed. This neglects the actual time it takes to conduct an interview, obtain a patient response and changes in workflows to accomplish these efforts. The additional time required by clinicians to complete administrative data collection before it can be entered has grown significantly and takes time away from actual patient care without contributing to improved quality.

B. Continuous Addition of New Measures without the Corresponding Removal of "Topped Out" Measures

CMS continues to add new quality measures and SPADEs without consideration for removing existing data elements tied to "low value" or duplicative quality measures or those not used in any way for payment or quality. For example, while preventing falls with major injury is important, currently IRFs and LTCHs are collecting multiple data elements related to falls even though only one data element is used for quality measurement. Furthermore, the national average value for the fall with major injury quality measure is 0.1% for both IRFs and LTCHs. This measure fails to differentiate performance between providers and would be considered "topped-out" with little to no room for improvement across the national population. A much larger number of SPADEs are collected on pressure ulcers/injuries in support of the "Percentage of patients with pressure ulcers/pressure injuries that are new or worsened" quality measure, where the national average values are 1.2% for IRFs and 2.3% for LTCHs. While one would suggest that the ideal state is less than 1% or possibly even 0%, these values have remained consistent over the last few years indicating that the potential for improvement is very limited and therefore represents little to no value to the QRP. IRFs also collect many data elements related to minutes of therapy that were intended for CMS research purposes but to date have neither been reported on nor used in any way for payment or quality. While IRFs and LTCHs recognize the need for CMS to meet requirements of the IMPACT Act and collect data for measures related to certain domains of health care, the continued addition of SPADEs and quality measures has not been evaluated against the requirements of the Meaningful Measures Initiative and is creating unnecessary administrative burden that takes away from clinical care and quality outcomes.

C. Inadequate Education Provided to the Field

Additionally, the education, training, and guidance from CMS related to the SPADEs occurred about three months before implementation, with updates and revisions to guidance occurring frequently in the days/weeks prior to implementation. Over those three months, numerous instances of inconsistencies within guidance and data collection specifications were noted by industry stakeholders, with corrections, errata documents, and CMS statements made up until 3 days prior to the October 1st implementation date of the new data collection tools. This provided little to no time for IRFs and LTCHs to adequately educate and train their clinicians and created a lack of standardization in how the SPADEs would be collected.

CMS's statement on September 28th indicated that some cases may be excluded from the compliance review, given that existing CMS guidance related to unplanned discharges would cause a provider to not use assessed values for certain SPADEs, which would cause the provider to be at risk. To date, CMS has not provided any further guidance or information related to the specific exclusions that would be granted, leaving providers to question whether following CMS guidance will result in a 2% payment penalty for FY 2024 or not.

D. Reporting Burdens Exacerbated by Workforce Challenges

The challenges presented above have all occurred during a time of significant healthcare staffing shortages. Since the start of the COVID-19 Public Health Emergency (PHE), the healthcare workforce has experienced a large-scale departure of experienced clinicians, nurses, and therapists as well as a shift to increased utilization of temporary or contract staff to maintain staffing requirements and census and bed availability. Vaccination requirements, lack of availability of personal protective equipment, increased administrative burdens, and inflation have all played a key part in the current staffing shortage. The expansion of CMS education, training and reporting requirements placed on top of an ever-changing workforce has created disruption in the ability to care for patients and continually provide the quality of care that is expected.

II. AMRPA & NALTH Shared Recommendations & Questions to Improve the QRP & Reduce Burden

We know that CMS intends for the QRPs to encourage compliant reporting and provide meaningful information to patients. However, without these critical refinements, we fear the program has become overly punitive and burdensome and is starting to lack patient useability. Given these issues and challenges, AMRPA and NALTH would like to meet with CMS to discuss various areas to relieve the administrative burden placed upon IRFs and LTCHs to avoid or reduce the risk for the 2% payment penalties for providers who are following current CMS guidelines. We ask that CMS consider reducing the data collection requirements, reducing the compliance thresholds, and/or providing a waiver of the 2% payment penalty given the myriad of challenges outlined above. In advance of our meeting, we ask CMS to consider the following forms of relief and be prepared to discuss their potential implementation during our discussion:

- Waive any payment penalties for a certain period, such as a year following the end of the PHE or until such a time as CMS can make changes to the data collection specification and associated guidance.
- Update and revise the data collection requirements and document the exclusion of patients from the compliance determinations.
- Review and reduce the number of SPADEs and other data elements that are not tied to payment or quality.

We appreciate your time and consideration, and please let us know if we can provide any additional information related to this topic.

Sincerely,

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

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Ed Prettyman, PsyD
President
National Association of Long Term Hospitals

AMRPA is the national trade association representing more than 700 inpatient rehabilitation facilities (IRFs), which include freestanding inpatient rehabilitation hospitals and rehabilitation units of general hospitals, the overwhelming majority being Medicare-participating providers. Our member hospitals have actively engaged in the development and refinement of the SPADEs and measures included in QRP, and AMRPA supports CMS' efforts to represent the value of inpatient rehabilitation through QRP modernization.

NALTH is the only hospital trade association that is devoted exclusively to the needs of medically complex patients who require services provided by long-term acute care hospitals (LTCHs). NALTH is committed to research, education, and public policy development that further the interests of the very ill and often debilitated patient populations who receive services in LTCHs throughout the nation. Our members include the nation's leading LTCHs, including free-standing, hospital-within hospital, for-profit, and non-profit LTCHs.