AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

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Delivered Electronically via IRFQRPfeedback@rti.org

RE: CMS IRF Listening Session – Revising the Transmission Schedule for IRF-PAI Assessment Data

Dear Ariel, Holly, and Anne:

On behalf of the American Medical Rehabilitation Providers Association (AMRPA), we appreciate the opportunity to provide additional comments and feedback related to the October 22, 2024 CMS and RTI Listening Session entitled, "Revising the Transmission Schedule for IRF-PAI Assessment Data". AMRPA is the national trade association representing over 800 inpatient rehabilitation facilities (IRFs), including freestanding IRFs and rehabilitation units of acute care hospitals, which 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. Our members are committed to working with CMS to achieve comprehensive and accurate patient assessment reporting for the IRF field, while at the same time ensuring that the reporting instruments do not result in undue burdens, unnecessary costs or inconsistent reporting.

With those goals in mind, and as noted in AMRPA comments in advance of and during the IRF Listening Session, AMRPA members are concerned about continued modifications and changes to the IRF-PAI and the transmission of IRF-PAI data. While AMRPA members appreciate that CMS and RTI are evaluating opportunities to ease some of the administrative burden related to the IRF-PAI, we are very concerned that proposals may require additional investment in technology, additional training of clinicians, and potentially produce unintended consequences impacting the IRF payment system. We ask that CMS and RTI carefully consider these additional costs and impacts when evaluating the potential proposal. AMRPA looks forward to any opportunity to work with CMS and RTI on solutions that are beneficial to both IRF providers and patients.

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As it relates to each of the topics discussed during the CMS IRF Listening Session, AMRPA would like to provide the following specific recommendations:

- CMS and RTI should reconsider its proposal to separate the IRF-PAI submission in "multiple time points," as such reform will create serious new administrative burdens without producing improved data from a quality or payment perspective.
- AMRPA recommends that CMS and RTI evaluate additional skip logic for IRF incomplete stays for those data elements where LTCHs and other post-acute care providers are not required to submit information.
- As CMS and RTI contemplate any submission-related changes to the IRF-PAI, the entities must take into account the implications for quality measurement accuracy, the validity of publicly reported data, and payment
- CMS should reconsider the requirement to complete and submit IRF-PAI information for pediatric, adolescent, and all other patients under the age of 18, and exclude these patients from the IRF QRP compliance determination until such a time as fully tested age-appropriate assessment items are available for use.
- CMS and RTI should evaluate opportunities to remove IRF-PAI items that are not used for quality or payment and produce unnecessary administrative burden.

Our more detailed concerns and suggestions follow:

Discussion Topic 1: Data Collection and Submission Considerations

With respect to "separating the submission of the IRF-PAI into multiple time points, e.g., admission, planned or unplanned discharge, or patient expiration", AMRPA members are concerned that this will create unnecessary administrative burden that provides little to no value to the provider and patients. To collect and submit the IRF-PAI records at multiple times will create additional costs to providers as they will need to update existing technologies to meet new data submission requirements as well as train and educate clinical staff on changes to existing requirements. Additionally, the administrative burden to submit a patient record multiple times is unnecessary as this will not improve the information available for quality or payment. These additional costs are not accounted for in the existing payment system and will take time away from patient care, negatively impacting the quality of care provided by IRFs. We further note that any policy change would also be particularly ill-timed as providers are already adjusting to major changes with all-payer IRF-PAI reporting in the FY 2025 program year.

While AMRPA members are not supportive the separation of the IRF-PAI assessments, AMRPA members would support updating IRF-PAI skip logic to be consistent with the data collection requirements for SNFs, LTCH, and Home Health Agencies. As detailed on Slide 9 of the presentation, it appears that certain data elements that are not required at the time of discharge for LTCH patients who are identified as an unplanned discharge are required for IRFs. While this may require some updates to technology, AMRPA members suggest that additional skip logic would require less effort than separating and submitting multiple IRF-PAI assessments, using existing skip logic already incorporated into the IRF-PAI software for other assessment items. AMRPA recommends that CMS and RTI evaluate additional skip logic for IRF incomplete stays for those data elements where LTCHs and other post-acute care providers are not required to submit information.

Discussion Topic 2: Subset of IRF-PAI to be used when a patient changes payers

CMS and RTI suggested that an interim assessment to calculate the CMG could alleviate issues related to changes in payer source that occur during the stay. AMRPA members are concerned that this could potentially impact the identification of tiered comorbidities which are included for payment since, as stated in the CMS IRF-PAI Manual, comorbidities can be identified up until the day before discharge. If the interim assessment for payment is to be completed by a particular day (as the MDS does), it may not provide proper payment for conditions that occur and require additional resources and cost during the stay.

AMRPA members are also concerned about potential implications for quality measures and public reporting. If CMS intends to only collect the information necessary for payment at the time that Medicare becomes the payer, then quality measures publicly reported for Medicare patients will be based upon either inconsistent information or IRF-PAI data that was collected when the patient was not a Medicare beneficiary. For example, the payment CMG does not require the collection of all Section GG Self-Care and Mobility functional items and instead utilizes a subset of these items to calculate a Motor score for the CMG. Since the Discharge Self-Care Score and Discharge Mobility Score measures utilize all Section GG items in the measure calculations, this suggests that these measures: (1) utilize complete Section GG information from the admission assessment when the patient was not a Medicare Beneficiary, (2) use blended Section GG information from the interim payment assessment and the original non-Medicare admission, or (3) exclude these patients from the measures due to incomplete or inconsistent information. Furthermore, since these measures utilize a risk-adjustment methodology that incorporates additional admission assessment data that would have to come from when the patient was not a Medicare beneficiary, one could question the reliability and validity of the public reporting where measures based upon Medicare data are now incorporating data from a non-Medicare stay.

AMRPA members also noted that the identification of a change in payer source often occurs at the time when the patient is discharged. This suggests that any opportunity for the completion of an interim CMG-only assessment may be lost by the time the need for such an assignment is identified. Since changes in payer source are relatively rare, AMRPA members suggest that CMS not change the current process and requirements. As previously noted, any change creates additional costs to providers as they will need to update existing technologies to meet new data submission requirements as well as train and educate clinical staff on changes to existing requirements.

Discussion Topic 3: Other Issues CMS Should Consider

As part of the questions for discussion topic, CMS and RTI indicated consideration for a pediatric IRF-PAI Assessment which could reduce burden, streamline the assessment process, and focus on age-appropriate assessment items. As was noted during the listening session, AMRPA appreciates CMS and RTI evaluating opportunities to make the IRF-PAI more appropriate for pediatric, adolescent, and all other patients under the age of 18. As AMRPA had discussed with CMS prior to the implementation of the All-Payer IRF-PAI requirement, AMRPA members who provide inpatient rehabilitation services to younger patients are concerned about the ability to complete certain IRF-PAI assessments when the items have not been tested or validated for use on the younger population and do not measure age-appropriate clinical domains. For example, CMS has recently moved towards collecting more information on Social Determinants of Health (SDOH) such as Health Literacy, Transportation, and as of October 1, 2026 Living Situation, Food Insecurity, and Utilities Insecurity. Each of these SDOH items have been tested for the adult population but have not been tested and are not appropriate for pediatric, adolescent, and all other patients under the age of 18. While AMRPA understands that there are response options such as "Patient Unable to Respond" for younger patients, the administrative burden to collect and report this information is inappropriate and unnecessary. Aside from the SDOH items, AMRPA members have also indicated concerns with the cognitive and functional assessment items, especially for pediatric and adolescent patients who should not be measured against tools designed to evaluate the normative performance of fully developed adults. The requirement that these assessment items be considered and completed, even with the use of non-response codes, is inappropriate and creates considerable unnecessary administrative burden and the transmission of information that should be considered as invalid and unreliable for use. As AMRPA suggested to CMS earlier this year, we ask that CMS reconsider the requirement to complete and submit IRF-PAI information for pediatric, adolescent, and all other patients under the age of 18, and exclude these patients from the IRF QRP compliance determination until such a time as fully tested age-appropriate assessment items are available for use on the IRF-PAI.

Finally, AMRPA would like to take this opportunity to suggest the removal of IRF-PAI items that are not used for quality or payment and produce unnecessary administrative burden. Through the IMPACT Act of 2014, CMS has implemented a significant amount of additional Standardized Patient Assessment Data Elements (SPADEs) for use in the IRF QRP, causing the IRF-PAI to go from a 3-page document to now a 30-page document. While SPADEs have been implemented to address the various clinical domains required by the IMPACT Act, relatively few have proceeded to be included for use in either publicly reported quality measures or payment system updates. The collection of this information is extremely burdensome yet appears to not provide actionable information for use in the IRF QRP or IRF PPS. Accordingly, AMRPA would like to recommend the removal of the following IRF-PAI assessments items to alleviate administrative burden:

- Therapy minutes for Week 1 (Items in O0401) and Week 2 (Items in O0402)
    - CMS initially started collecting these items for analyses on the "3-Hour" guideline, however these items have not been used for payment, quality, or any other analysis since they were first implemented. These items require a significant amount of administrative burden and are not utilized as part of audit determinations of IRF payment and coverage requirements. Instead, medical record documentation is utilized to review whether a patient receives the required amount of intensive multidisciplinary therapy.

- J0510. Pain Effect on Sleep, J0520. Pain Interference with Therapy Activities, J0530. Pain Interference with Day-to-Day Activities
- N0415. High-Risk Drug Classes: Use and Indication
- O0110. Special Treatments, Procedures, and Programs
    - CMS added these items as SPADES to the IRF-PAI in October 2022 and has yet to incorporate them into the payment system, a quality measure of their own, or as a covariate for risk-adjustment on existing IRF QRP measures. If the information being collected does not have utility within the IRF QRP or IRF PPS, CMS should remove these items and reduce the administrative burden.

AMRPA appreciates the opportunity to provide comments, and we look forward to any opportunities to collaborate with CMS and RTI on modifications to the IRF-PAI, Transmission Schedule, IRF QRP and IRF PPS. If you have any questions, please do not hesitate to contact Troy Hillman, AMRPA Director of Quality and Health Policy (202-207-1129, thillman@amrpa.org).

Sincerely,

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