American Academy of Physical Medicine and Rehabilitation

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June 20, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1647–P
Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

Re: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2017; Proposed Rule

Dear Mr. Slavitt:

The American Academy of Physical Medicine and Rehabilitation (AAPM&R) is the national medical specialty organization representing more than 9,000 physicians who are specialists in physical medicine and rehabilitation (PM&R). PM&R physicians, also known as physiatrists, treat a wide variety of medical conditions affecting the brain, spinal cord, nerves, bones, joints, ligaments, muscles, and tendons. PM&R physicians evaluate and treat injuries, illnesses, and disability, and are experts in designing comprehensive, patient-centered treatment plans. Physiatrists utilize cutting-edge as well as time-tested treatments to maximize function and quality of life.

Proposed FY 2017 IRF PPS Payment Update

Other Issues

Our members have informed the Academy about the effect the General Equivalency Mappings (GEMs), a tool developed by the Center for Disease Control and Prevention to convert from ICD-9-CM to the best matching ICD-10-CM code, have had on 60% presumptive compliance for cases assigned to IGC -2.21, Traumatic brain dysfunction, open injury, or IGC 02.22, Traumatic brain dysfunction, closed injury. For each of these IGCs, the pairing of the IGC and the etiologic diagnosis will exclude a case from presumptive compliance, regardless of the extent of the brain injury, the associated deficits, the medical prognosis, or the clinical management of the patient, if the documentation in the medical record does not specify whether the patient lost consciousness and does not identify the duration of any such loss. For CMS to exclude patients as non-compliant under the "60% rule" prevents access to the medically

necessary rehabilitation care needed by traumatic brain injury patients. Additionally, it puts the IRF at risk of non-compliance under the "60% rule."

Although AAPM&R acknowledges that clinical information should be as specific as possible, in certain patients, adding specificity to certain diagnosis codes, such as those applied to brain injury, can be difficult and in some instances, impossible to obtain when elements of the patient's history are not known or are unknowable (such as an exact period of time for which the patient was unconscious).

We urge CMS to modify the compliance-2 presumptive methodology and the accompanying code lists by incorporating all instances in which IRF-PAI data can be used to identify the defined qualifying conditions. Specifically, we recommend that CMS remove presumptive compliance etiologic diagnosis exclusions for traumatic brain injury patients in IGCs 02.21 and 02.22.

VII. Proposed Revisions and Updates to the IRF Quality Reporting Program (QRP)

F. IRF QRP Quality, Resource Use and Other Measures Proposed for the FY 2018 Payment Determination and Subsequent Years

In this Proposed Rule, CMS introduces four new quality and resource use measures for IRFs, three of which are in accordance with the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014. AAPM&R generally supports the addition of measures in the IRF setting, as we believe that it is important to measure quality of care. However, we continue to have concerns that CMS questions the use of sociodemographic factors beyond age. We also maintain our reservation with the addition of certain measures.

In this Proposed Rule, CMS states that the National Quality Forum (NQF) and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) are currently conducting research to examine the impact of sociodemographic status on quality measures, resource use, and other measures under the Medicare program, and its appropriateness. CMS also states "we continue to have concerns about holding providers to different standards for the outcomes of their patients of diverse sociodemographic status because we do not want to mask potential disparities or minimize incentives to improve the outcomes of disadvantaged populations." AAPM&R believes that the scientific literature contains many examples of sociodemographic factors that directly contribute to the development of disease and the validity of the utilization of this information to risk-adjust. The AAPM&R strongly believes that measures should include sociodemographic factors such as socioeconomic status of the individual/family and the resources available in the community in which the patient resides.

AAPM&R suggests that CMS consider the use of patient-reported data. Although we recognize that self-report has a possible risk related to sociodemographic differences in recall and reporting, we believe that it can be a valuable source of information. Furthermore, we believe that self-report offers a reasonably valid estimate of differences in utilization of health care between socioeconomic groups. In addition, the Academy recommends including functional status (activities of daily living, instrumental activities of daily living, and mobility) as a risk adjustment variable in order to accurately assess patients across post-acute care settings. The scientific literature contains many examples of the impact of functional limitations on mortality. For instance, use of a frailty adjustment factor or other metric would help adjust for variations in functional status of patients.

1. Proposal To Address the IMPACT Act Domain of Resource Use and Other Measures: Total Estimated MSPB-PAC IRF QRP

For FY 2018, CMS is proposing a Medicare Spending Per Beneficiary – Post-Acute Care (MSPB-PAC) IRF quality reporting program (QRP) measure for inclusion in the IRF QRP for the FY 2018 payment determination and subsequent years. The Academy agrees with CMS' proposal not to adjust the MSPB-PAC IRF QRP measure for socioeconomic and demographic factors at this time. Although AAPM&R believes that risk adjusting for sociodemographic factors is important, we agree that CMS should wait for the results of the NQF trial and study before deciding whether to risk adjust for these factors.

That being said, the Academy requests clarification on why CMS is proposing the adoption of the MSPB-PAC IRF QRP measure at this time, as the measure cannot be risk adjusted for factors that have an impact on patient outcomes and care patterns across PAC settings, especially for persons with disabilities and chronic conditions.

2. Proposal To Address the IMPACT Act Domain of Resource Use and Other Measures: Discharge to Community-Post Acute Care (PAC) Inpatient Rehabilitation Facility Quality Reporting Program

In this Proposed Rule, CMS is proposing to adopt the measure, Discharge to Community-PAC IRF QRP, for the IRF QRP for FY 2018. Measuring the rate that the various PAC settings discharge patients to the community, without an admission (or readmission) to an acute care hospital within 30 days, is one of the most relevant patient-centered measures that exists in the post-acute care area. During the measure development process, the Academy stressed to CMS the need for this measure to include function, be given greater consideration of available home and community supports, and address risk adjustment and exclusions more appropriately before adoption in any PAC setting. The Academy reiterates its comments on this measure during this rulemaking process.

Ideally, a post-acute care stay following an illness or injury will enable a person to recover and be rehabilitated so they may regain their health, lost skills and functions, and avoid readmission to the acute care hospital. Thus, permitting a person to regain enough function to return to independent living and resume their daily routine, their preferred community and social activities, employment if appropriate, as well as exercise and leisure activities. However, discharge to the community cannot occur unless an individual achieves sufficient functional improvement following illness or injury. Returning to one's previous home is only half the goal. The person should also be able to function to the greatest possible extent in the home and community setting and achieve the highest quality of life possible.

As proposed, the Discharge to Community-PAC IRF QRP, for the IRF QRP measure does not include metrics that assess, to a sufficient extent, the functional status/gains achieved by patients' subject to this measure. Existing functional measures in various PAC settings are well developed and are important indicators of recovery and achievement of rehabilitation goals. These factors must be more intimately embedded in the proposed discharge to community measure. If this were to occur, this measure would be invaluable to patients and their families in assessing and comparing outcomes of various PAC providers.

AAPM&R strongly urges CMS to delay its proposal to adopt this measure and work with the measure developers and interested stakeholders to more fully incorporate metrics that assess whether patients achieve functional and independence goals based on their plan of care and their specific condition.

3. Proposal To Address the IMPACT Act Domain of Resource Use and Other Measures: Potentially Preventable 30-Day Post-Discharge Readmission Measure for Inpatient Rehabilitation Facility Quality Reporting Program

The Academy generally supports CMS's proposal to adopt the Potentially Preventable 30-Day Post-Discharge Readmission Measure and separate measures in each post-acute care setting for 30-Day Potentially Preventable Readmission. However, at some point in the future, as the silos of PAC settings begin to break down, by design from CMS, a uniform measure that assesses potentially preventable readmission post-discharge from the acute care hospital (regardless of which PAC setting the patient is referred to) will become more relevant. There is nonalignment with the equivalent SNF measure, making the SNF measure out of sync with IRF measure collection, creating the potential for confusion and lack of clarity in terms of potentially preventable readmissions.

4. Potentially Preventable Within Stay Readmission Measure for Inpatient Rehabilitation Facilities (page 24206)
For FY 2018, CMS is proposing adoption of the Potentially Preventable Within Stay Readmission

Measure. This proposed measure focuses on potentially preventable hospital readmissions that take place during the IRF stay as opposed to during the 30-day post-discharge period. **AAPM&R urges CMS to delay adoption of this measure and separate measures until there is an equivalent measure in each PAC setting.** At some point in the future, as the silos of PAC settings begin to break down, by design from CMS, a uniform measure that assesses potentially preventable readmission post-discharge from the acute care hospital (regardless of which PAC setting the patient is referred to) will become more relevant.

G. IRF QRP Quality Measure Proposed for the FY 2020 Payment Determination and Subsequent Years

1. Quality Measure Addressing the IMPACT Act Domain of Medication Reconciliation: Drug Regimen Review Conducted With Follow-Up for Identified Issues-Post Acute Care IRF QRP

In this Proposed Rule, CMS proposes the adoption of the quality measure, Drug Regimen Review Conducted with Follow-Up for Identified Issues–PAC IRF QRP, for the IRF QRP as a patient assessment based, cross-setting quality measure. The Academy supports the general concept behind the medication reconciliation quality measure. However, we have reservations about CMS continuing to adopt measures that are not NQF endorsed. NQF is the national "gold" standard for verifying quality measures. Although most developers put their measures through a rigorous process long before NQF considers them for endorsement. NQF assess a measure to determine if the measure will have a positive impact on healthcare quality, is scientifically acceptable, is useable and relevant for quality improvement and decision making, and feasible to collect without undue burden. **Thus, the Academy urges CMS to allow the NQF to complete its vetting process for this measure before adoption.**

H. IRF QRP Quality Measures and Measure Concepts Under Consideration for Future Years (page 24209)

AAPM&R supports the development and adoption of relevant, appropriate, and applicable quality measures for future years in the IRF QRP. **However, the Academy has concerns with the current Request for Information process utilized by CMS to aid in the design and development of PAC measures. The current process is hurried and creates undue burden on most stakeholders who put their measures through a rigorous development process. Furthermore, the seven-and-fourteen-day comment periods with several last minute extensions are disruptive and unreasonable for stakeholders to adhere to.**

We appreciate the opportunity to comment on this proposed rule. The AAPM&R looks forward to continuing dialogue with CMS on these important issues. If you have any questions about our comments, please contact Jenny Jackson, Manager of Finance and

American Academy of
Physical Medicine and Rehabilitation

Reimbursement in the AAPM&R Division of Health Policy and Practice Services. She may be reached at jjackson@aapmr.org or at (847)737-6024.

Sincerely,

Phillip Bryant, DO
Chair
Reimbursement and Policy Review Committee
American Academy of Physical Medicine and Rehabilitation