American Academy of Physical Medicine and Rehabilitation

aaPM&R

9700 W. Bryn Mawr Ave., Suite 200
Rosemont, Illinois 60018
www.aapmr.org

phone 847/737.6000
fax 847/754.4368
info@aapmr.org

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June 17, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1645–P
Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850.

Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2017 Rates; Quality Reporting Requirements for Specific Providers; Graduate Medical Education; Hospital Notification Procedures Applicable to Beneficiaries Receiving Observation Services; and Technical Changes Relating to Costs to Organizations and Medicare Cost Reports; Proposed Rule

Dear Mr. Slavitt:

On behalf of the more than 9,000 physiatrists of the American Academy of Physical Medicine and Rehabilitation (AAMP&R), we appreciate the opportunity to submit comments to the proposed rule: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2017 Rates; Quality Reporting Requirements for Specific Providers; Graduate Medical Education; Hospital Notification Procedures Applicable to Beneficiaries Receiving Observation Services; and Technical Changes Relating to Costs to Organizations and Medicare Cost Reports; Proposed Rule that was published in the Federal Register on April 27, 2015. Physical medicine and rehabilitation (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.

IV. Other Decisions and Proposed Changes to the IPPS for Operating Costs and Graduate Medical Education (GME) Costs

E. Indirect Medical Education (IME) Payment Adjustment

1. Indirect Medical Education Adjustment for FY 2017

Under the Inpatient Prospective Payment Systems (IPPS), an additional payment amount is made to hospitals with residents in an approved graduate medical education (GME) program in order to reflect the higher indirect patient care costs of teaching hospitals relative to non-teaching hospitals. AAPM&R supports this additional payment. The Academy continues to stress the importance of determining an appropriate indirect medical education (IME) adjustment factor that takes into consideration IME costs across all settings and adequately increases the IPPS payment to account for higher indirect patient costs. **The Academy urges CMS not to eliminate or decrease the proposed formula modifier for the FY2017 IME adjustment.**

J. Payment for Graduate Medical Education and Indirect Medical Education Costs

In this Proposed Rule, CMS proposes to extend the period for establishing full-time equivalent (FTE) resident caps for new rural track training programs from three years to five years. AAPM&R supports the concept of the proposed FTE revision and which, in turn, would affect IME adjustments. CMS's willingness and ability to address concerns expressed by the hospital community that rural training tracks, like any program, should have a sufficient amount of time for a hospital to "grow" and to establish a rural track FTE limitation that reflects the number of FTE residents that it will actually train, once the program is fully grown.

A. Hospital Inpatient Quality Reporting (IQR) Program

7. Proposed Additional Hospital IQR Program Measures for the FY 2019 Payment Determination and Subsequent Years

For FY 2019, CMS proposes the adoption of three clinical episode-based payment measures: Aortic Aneurysm Procedure Clinical Episode-Based Payment (AA Payment), Cholecystectomy and Common Duct Exploration Clinical Episode-Based Payment (Chole and CDE Payment), and Spinal Fusion Clinical Episode-Based Payment (SFusion Payment). AAPM&R has concerns with CMS's proposal.

The Academy has 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 assesses a measure to determine if the measure will have a positive impact on healthcare quality, is scientifically acceptable, is applicable and relevant for quality improvement and decision making, and feasible to collect without undue burden. Without NQF endorsement, the Academy is

concerned that the reliability, validity and feasibility for reporting these measures have not been appropriately assessed.

Additionally, these measures were reviewed by the Measure Application Partnership (MAP) and did not receive support. As a group charged with identifying core measures and prioritizing measure gaps in federal quality programs and providing pre-rulemaking guidance to the United States Department of Health and Human Services (HHS) for the inclusion of performance measures in public reporting and performance-based payment programs, the lack of support by MAP, should be a clear indication to the Agency that these measures are not ready for adoption. AAPM&R shares the same concern as the MAP, these measures overlap with the Medicare Spending per Beneficiary (MSBP) Measure.

Furthermore, the aforementioned measures are not adjusted for sociodemographic status. AAPM&R believes that the scientific literature has provided many examples of sociodemographic factors that directly contribute to the development of disease and the importance to risk-adjust for them. 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. The Academy does not believe that risk-adjusting for sociodemographic status holds providers to different standards. Risk-adjustment helps ensure that facilities are not financially penalized for serving vulnerable populations which can further reduce resource availability and worsen care disparities.

AAPM&R suggests that CMS consider the use of patient-reported data. Although we recognize that self-report poses possible risks 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 would help adjust for variations in functional status of patients.

Finally, clinical outcome measures should have discrete, patient-focused endpoints (e.g., readmission, length of stay, morbidity and mortality). When using outcomes for measuring the performance of health care delivery systems it is often necessary to develop an adjustment system that isolates the contribution of the health care system to the outcome. As proposed, the aforementioned measures do not reflect appropriateness of care, and would therefore not gauge quality of care.

AAPM&R strongly urges CMS to delay its proposal to adopt these measures and work with the measure developers and interested stakeholders to fully assess these measures to determine if the measures will have a positive impact on healthcare quality, are scientifically acceptable, are applicable and relevant for quality improvement and decision making, and feasible to collect without undue burden.

9. Possible New Quality Measures and Measure Topics for Future Years

a. Potential Inclusion of the National Institutes of Health Stroke Scale for the Hospital 30-Day Mortality Following Acute Ischemic Stroke Hospitalization Measure Beginning as Early as the FY 2022 Payment Determination (p.25196)

Mortality following stroke is an important adverse outcome that can and should be measured reliably and objectively. The National Institutes of Health (NIH) Stroke Scale has been researched and vetted by the American Heart Association and American Stroke Association and recommended in their guidelines. **AAPM&R endorsed these guidelines and supports this new quality measure.**

Proposed Changes to the Long-Term Care Hospital Prospective Payment System (LTCH PPS) for FY 2017

B. Proposed Modifications to the Application of the Site Neutral Payment Rate

The Academy continues to strongly urge CMS to delay any site-neutral payment proposals as these proposals are premature and untested. The Academy has long held the position that until the IMPACT Act produces better data on Post-Acute care services, these proposals serve little more than a financial disincentive to admit patients to inpatient rehabilitation centers based on diagnosis alone, not on medical and/or functional needs.

C. Long-Term Care Hospital Quality Reporting Program (LTCH QRP)

6. Long-Term Care Hospital QRP, Resource Use and Other Measures Proposed for the FY 2018 Payment Determination and Subsequent Years

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

In this Proposed Rule, CMS is proposing to adopt the measure, Discharge to Community-PAC LTCH QRP, for the LTCH QRP for the FY 2018 payment determination and subsequent years as a Medicare FFS claims-based measure. 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 LTCH QRP, for the LTCH 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.

c. Proposal To Address the IMPACT Act Domain of Resource Use and Other Measures: Potentially Preventable 30-Day Post-Discharge Readmission

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, 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 be more relevant once the silos of PAC settings break down by design from CMS. There is nonalignment with the equivalent IRF measure, making the SNF measure out of sync with IRF measure collection, creating the potential for confusion and lack of clarity of potentially preventable readmissions.

IX. MedPAC Recommendations

AAPM&R appreciates that CMS reviewed MedPAC's March 2016 ''Report to the Congress: Medicare Payment Policy'' and have given the recommendations in the report consideration. The Academy also appreciates the opportunity to comment on the five key areas highlighted in MedPAC's report.

Proposed changes to uncompensated care payments

AAPM&R supports the concept of an adjustment based on uncompensated care because this could be a marker of risk and complexity that hospitals face on a regular basis.

Adjustments for documentation and coding

The Academy supports accuracy in coding. We do, however, advise CMS to cautiously and carefully conduct reviews in regard to attribution of cause versus association. For example, when interpreting the case mix types and profitability especially since IRF service availability is so different geographically. We would encourage CMS consider alternative explanations for differences in coding, including expertise.

Advantage Plans

The Academy encourages CMS to preserve access to specialty services and products that are medically indicated for those with chronic disease, especially in cases where "standard" or benchmarked services would be clinically inappropriate and not standard of care for those with "outlier" conditions.

Changes in IPPS Quality Metrics and Incentives

The Academy agrees with "uniform definitions, specifications and risk-adjustment." We do however continue to object to Medicare Spending Per Beneficiary (MSPB) as a true quality measure and recommend that it by classified differently. MSPB is currently scheduled to be applied far earlier than is prudent. CMS stated that the measure development process may require up to two-years. The measure, however, though only initiated in summer 2015, has a specified application date of October 1, 2016, for inpatient rehabilitation facilities, long-term care hospitals and skilled nursing centers, and January 1, 2107 for home health agencies. The Academy is concerned that there is insufficient measure specification information available to conduct a thoughtful review of the proposed measure and no opportunity for CMS and its contract measure developers to adequately review the submitted stakeholder feedback prior to the submission to the National Quality Forum for review.

The Academy supports care coordination but recognizes that ineffective care coordination will cost the system more money. We question the feasibility of the expectation of better care coordination at a significantly decreased cost. We are also concerned that comparisons - such as benchmarking provider expenses with the national average – do not incorporate or account for the dynamics of regional care especially at the IRF and LTCH level. For example, there are regional auditors that provide different feedback details about what must be done that create regional differences. Additionally, expecting the cost of care e.g. SNF, IRF, HH in Alaska to be similar to the national average seems misguided and not the intent of the legislation. The Academy encourages CMS to consider alternatives for benchmarking. In addition, clarification is needed on who will be considered "accountable" if the PAC + 30 days occurs in multiple settings or institutions. Unfortunately, this is a very common occurrence. AAPM&R also questions whether the system is ready to effectively evaluate, even the basic, measures of the bundled episode of care and who is accountable. More work is needed before implementing these features.

Changes to the LTCH Payment System

The Academy continues to strongly urge CMS to delay any site-neutral payment proposals as these proposals are premature and untested. The Academy has long held the position that until the IMPACT Act produces better data on Post-Acute care services, these proposals serve little more than a financial disincentive to admit patients to inpatient rehabilitation centers based on diagnosis alone, not on medical and/or functional needs

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 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