American Academy of Physical Medicine and Rehabilitation

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June 13, 2017

Seema Verma
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1677-P
P.O. Box 8011
Baltimore, MD 21244-1850

Re: CMS-1677-P 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 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices

Dear Administrator Verma:

On behalf of the more than 10,000 physiatrists of the American Academy of Physical Medicine and Rehabilitation (AAPM&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 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices that was published in the Federal Register on April 28, 2017. 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. Many provisions in the proposed rule will impact physiatrists nationwide. We therefore appreciate your consideration of the following comments.

II. Proposed Changes to Medicare Severity Diagnosis-Related Group (MS-DRG) Classification and Relative Weights

F.9. MCD 23 (Factors Influencing Health Status and Other Contacts with Health Services): Updates to MS-DRGs 945 and 946 (Rehabilitation With CC/MCC and Without CC/MCC, Respectively)

AAPM&R supports the intention to incorporate ICD-10-CM coding for encounters for rehabilitation services to MS-DRGs 945 and 946 once such codes are available. We agree that the current lack of ICD-10-CM codes to indicate that an encounter was for rehabilitation is problematic. AAPM&R finds the decrease in the number of cases under MS-DRGs 945 and 946 very concerning and indicative of the significant gap in ICD-10-CM coding. We appreciate and support CMS's intent to rectify this issue once appropriate ICD-10-CM codes are available.

F.17.a.(45) Prosthetics

AAPM&R opposes the proposal to remove ICD-10-PCS codes F0DZ8ZZ, F0DZ9EZ, F0DZ9FZ, F0DZ9UZ, and F0DZ9ZZ from the list of O.R. procedures. There are instances in which it is appropriate to apply an orthosis in the operating room. We are concerned that the proposed change would limit the placement of an immediate postoperative prosthesis, which is done in the operating room immediately after amputation. AAPM&R urges CMS to more closely consider the implications of this proposal before making these potentially negative changes.

<u>Comments on Social Risk Factors</u>

V. Other Decisions and Proposed Changes to the IPPS for Operating System

I. 11. 11. Accounting for Social Risk Factors in the Hospital Readmissions Reduction Program

J. 2. 2. Accounting for Social Risk Factors in the Hospital VBP Program

K.5. Accounting for Social Risk Factors in the HAC Reduction Program

IX. Quality Data Reporting Requirements for Specific Providers and Suppliers

A.1.d. Accounting for Social Risk Factors in the Hospital IQR Program

C.2.b. Accounting for Social Risk Factors in the LTCH QRP

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, including the ASPE report. The AAPM&R strongly believes that measures should include sociodemographic factors such as socioeconomic status of the individual/family, the resources available in the community in which the patient resides, and work status. 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 confidential 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 if kept confidential. Furthermore, we believe that self-report offers a reasonably valid estimate of differences in utilization of health care between socioeconomic groups. 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 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.

V. Other Decisions and Proposed Changes to the IPPS for Operating System

K.6.6. Request for Comments on Inclusion of Disability and Medical Complexity for CDC NHSN Measures

AAPM&R agreed with CMS's approach based on ASPE's analysis and considerations, to risk-adjust the CDC NHSN measures for disability or medical complexity. AAPM&R looks forward to commenting on potential future action.

IX. Quality Data Reporting Requirements for Specific Providers and Suppliers

A.6.a. Refining the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey (NQF #0166) Measure for the FY 2020 Payment Determination and Subsequent Years

AAPM&R strongly urges CMS to revisit how pain is captured and monitored. Solely asking about the presence of pain does not provide enough information to help an individual's overall quality of life improve. Pain levels may never change, even when the function/ability of the patient does. Therefore, *the focus on pain should be on how pain limits function*. Opioid abuse is on the rise and

the more focus that is solely on pain level and not the relationship of pain to function, the more risk there is of over prescribing and overuse of opioid medications. The importance of both *Pain Presence and Pain Severity* must be assessed by their relationship to function.

IX. Quality Data Reporting Requirements for Specific Providers and Suppliers

C.7. *LTCH QRP Quality Measures Proposed Beginning with the FY 2020 LTCH QRP*

While AAPM&R appreciates the opportunity to comment on measures being proposed in FY 2020, it can be difficult when not all measure specifications are complete. We hope that CMS will provide more opportunity to comment on these again in the future. AAPM&R would also like to suggest that CMS continues to align new measures in every Post-Acute Care setting. During our review of the quality measures being proposed, we noticed that not all proposed measures cover every setting. We believe the measures make sense and could be implemented in every PAC setting.

- Percent of Residents Who Self-Report Moderate to Severe Pain (Short Stay)
    - AAPM&R does not believe that pain experience alone should be a quality measure. As we stated above, solely asking about the presence of pain does not provide enough information to help an individual's overall quality of life improve. Pain levels may never change, even when the function/ability of the patient does. "Pain as the fifth vital sign" caused opioid prescribing to soar and rephrasing these measures could be a huge opportunity for change. AAPM&R suggests modifying this measure to reflect the proportion of patients for which moderate to severe pain interferes with or prevents important daily functional tasks.
- Percent of SNF Residents Who Newly Received an Antipsychotic Medication
    - AAPM&R does not believe this is an actual "quality" measure since there is no baseline. We urge CMS to either reconsider this measure or continue the development of it.

IX. Quality Data Reporting Requirements for Specific Providers and Suppliers

E. Clinical Quality Measurement for Eligible Hospitals and Critical Access Hospitals (CAHs) Participating in the EHR Incentive Programs

AAPM&R would like to commend CMS for aligning the EHR Incentive Programs amongst the different quality reporting programs.

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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 Carolyn Winter-Rosenberg, Manager of Reimbursement and Regulatory Affairs in the AAPM&R Division of Health Policy and Practice Services. She may be reached at cwinterrosenberg@aapmr.org or at (847)737-6024.

Sincerely,

Annie Purcell, DO
Chair
Reimbursement and Policy Review Committee
American Academy of Physical Medicine and Rehabilitation