June 20, 2018

Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1688-P  
PO Box 8011  
Baltimore, MD 21244-1850

Submitted Electronically

Re: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2019 (CMS-1688-P)

Dear Administrator Verma:

On behalf of our more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) is pleased to submit comments on the Centers for Medicare and Medicaid Services’ (CMS) Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) for Fiscal Year (FY) 2019 proposed rule. The mission of APTA is to build a community to advance the physical therapy profession to improve the health of society. Physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability by serving as a dynamic bridge between health and health services delivery for individuals across the age span. While physical therapists are experts in rehabilitation and habilitation, they also have the expertise and the opportunity to help individuals improve overall health and prevent the need for avoidable health care services. Physical therapists’ roles may include education, direct intervention, research, advocacy, and collaborative consultation. These roles are essential to the profession’s vision of transforming society by optimizing movement to improve the human experience.

In its proposed rule, CMS plans to increase payments to IRFs by 0.9%, which accounts for the IRF market basket update and a productivity adjustment. APTA supports this increase in payment and urges CMS to conduct regular payment impact analyses to ensure appropriate payment levels for inpatient rehabilitation services.
We request that the agency carefully consider the comments we have articulated below regarding pertinent sections of the proposed rule, as well as our response to the request for information (RFI) on interoperability.

**Promoting Interoperability Program**

APTA supports CMS’s proposal to restructure the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs with the goal of improving interoperability among providers. While we support the agency’s focus on enhancing communication and information sharing between providers, we request that CMS include in the final rule clarification on the types of providers who will be eligible to report under the new Promoting Interoperability program, as physical therapists were not previously eligible to report under the Meaningful Use program.

**Reducing Administrative Burden in Quality-Reporting Programs**

APTA supports CMS’s proposal to remove from the IRF Quality-Reporting Program measures that are duplicative or overly burdensome for providers to report. The goal of capturing quality measures should be to improve patient care and outcomes. As such, we support the agency’s decision to reduce the number of measures that providers must report, allowing providers greater time to focus on furnishing efficient and effective care to their patients.

*Proposed Removal of Functional Independence Measure Instrument*

CMS has proposed to remove from the IRF-Patient Assessment Instrument (PAI) the Functional Independence Measure (FIM) instrument and associated function modifiers due to overlap with the data elements in the Quality Indicators section of the IRF-PAI, and because CMS can now use data items in the Quality Indicators section to assign patients to case-mix groups (CMGs) for payment under the IRF PPS. Additionally, CMS notes that removal of the FIM and associated modifiers supports the goal to standardize data collection across post-acute care settings.

APTA supports CMS’s efforts to promote consistency across post-acute care settings by implementing standardized patient assessment data elements. We encourage the agency to continue to align with the Improving Medicare Post-Acute Care Transformation Act (IMPACT Act) and move toward a unified payment and quality-reporting system for post-acute care settings.

APTA has concerns, however, that CMS’s proposal to remove the FIM and rely upon the Quality Indicators section (Section GG) for CMG assignment may be premature. Prior to finalizing its proposed policy, we recommend that CMS first address key concerns associated with replacing the FIM items in assigning CMGs with use of data items located in the Quality Indicators section of the IRF-PAI.
APTA agrees with CMS’s assessment that the data collected by the FIM instrument overlaps with data that is already collected through Section GG and that the duplicate reporting creates an unnecessary administrative burden for IRF providers. However, we have concerns that the accuracy and clinical efficacy of the new Section GG items that CMS is proposing to utilize as the basis for CMG assignment beginning in FY 2020 has not been sufficiently studied or validated. Therefore, prior to removing the FIM and associated function modifiers from the IRF-PAI, we recommend that CMS first verify the validity of the new data items.

The IRF setting poses challenges with respect to functional item replacement. The existing functional items in the IRF setting have a different construct from that of skilled nursing facility (SNF) or home health (HH) settings, which necessitates increased education of providers in this setting. Because IRF clinicians are far less familiar with these new data items than they are with the FIM instrument, we recommend the agency establish training and education for providers in IRF settings to ensure that Section GG data is appropriately used, particularly given CMS’s intentions to use Section GG to categorize patients into CMGs for purposes of payment.

Moreover, APTA recommends that CMS clarify in its final rule any discrepancies in the data collection process between the FIM instrument and Section GG to ensure that providers can make the necessary preparations prior to removal of the FIM from the IRF-PAI. For example, Section GG does not allow providers to collect data on patients during the first 3 days following their admission to an IRF. Similarly, Section GG does not include weighted measures that would clearly show the level of complexity of the patient’s self-care and mobility activities. We ask that CMS clearly address ways for providers to resolve such discrepancies that exist between the FIM instrument and Section GG data.

APTA is committed to exploring more methods to achieve administrative simplification for physical therapists to ensure that therapists have the flexibility to provide high-quality care as well as ensure that patients have access to necessary care. We look forward to working with CMS to identify policies that will further reduce administrative burden for physical therapists and other providers.

Changes to the Interdisciplinary Team Meeting Requirement
APTA supports CMS’s proposal to allow providers greater flexibility in satisfying the requirement for weekly interdisciplinary meetings. Under the proposed rule, CMS clarifies that rehabilitation physicians may attend interdisciplinary meetings remotely using video conferencing, telephones, or other modes of communication. As CMS points out in the proposed rule, it can be difficult for the rehabilitation physician to be physically present for the interdisciplinary meeting. We agree with CMS’s statement and recommend that the agency extend that same flexibility to other clinicians who participate in interdisciplinary meetings.
APTA recommends that CMS extend remote participation options to physical therapists, who are critical in determining the course of care for patients who have experienced a decline in their physical function. This new policy would be of particular importance to IRFs located in rural areas, where staffing shortages are most common. Further, APTA recommends that CMS consider allowing physical therapist assistants (PTAs) to attend interdisciplinary meetings on behalf of the physical therapist, so long as the PTA acts under the physical therapist’s specific direction given in advance of the meeting. APTA understands the integral role that each interdisciplinary team member plays in directing patients’ care in the IRF setting, and we urge CMS to consider increased flexibility for all providers who are members of these patient care teams.

**Changes to the Use of Non-Physician Practitioners in Meeting Coverage Criteria**

APTA supports the use of non-physician practitioners in the IRF setting to meet IRF coverage criteria that are currently in place for rehabilitation physicians. Many of the required functions of a rehabilitation physician may be carried out not only by physician assistants and nurse practitioners, but also by physical therapists and other licensed specialists. We request that CMS consider our responses to the questions posed by the agency on the use of non-physician practitioners to assess IRF patients.

1. **Do non-physician practitioners have the specialized training in rehabilitation that they need to have to assess IRF patients both medically and functionally?**

Non-physician practitioners, and, more specifically, physical therapists, are educated, trained, and have the expertise required to perform a physical therapy evaluation, examination, assessment, and plan of care. The evaluation includes a review of all bodily systems as well as a review of patient medications. While physical therapists are not licensed to perform medical examinations, there are some areas of cross-over between a medical examination and a physical therapy examination, including vital signs, neuromusculoskeletal review, and, where appropriate, cardiopulmonary review. Therefore, physical therapists have the training necessary to assess patient function.

2. **How would the non-physician practitioner’s credentials be documented and monitored to ensure that IRF patients are receiving high quality care?**

The non-physician practitioner’s credentials may be documented and monitored through the same mechanisms currently in use, which include peer and administrative review.

3. **Do stakeholders believe that utilizing non-physician practitioners to fulfill some of the requirements that are currently required to be completed by a rehabilitation physician would have an impact of the quality of care for IRF patients?**

The utilization of allied health service providers, including physical therapists, occupational therapists, and speech-language pathologists, can be effective to meet IRF requirements for patient assessments. Moreover, physical therapists and other allied health service providers can ensure that patients return to maximal function for safe
transfer or transition back into the community. These specialty providers may be useful in conjunction with physicians for the medical management and rehabilitation of IRF patients.

**Request for Information on Interoperability**

APTA appreciates the opportunity to provide feedback in response to CMS’s RFI on interoperability. After careful consideration, we offer the following suggestions:

1. **If CMS were to propose a new CoP/CfC/Rfp standard to require electronic exchange of patient medical records, would this help to reduce information blocking as defined in section 4004 of the 21st Century Cures Act?**

   The proposed standards to require the electronic exchange of patient medical records would help to prevent information blocking by providers, ensure that patients have access to their records, and facilitate information sharing with other providers. However, the proposed policies fail to create the same obligations for EHR vendors to ensure that vendors make patient information readily accessible to patients and providers. This unbalanced treatment of health care providers and EHR vendors can make it difficult, if not impossible, for providers to satisfy the proposed requirements to increase interoperability.

   APTA supports CMS’s proposals to ensure that providers make health information accessible to patients and other providers. However, we recommend that the agency, along with the Office of the National Coordinator (ONC), explore similar standards for EHR vendors as conditions for their certification. We recommend that CMS and ONC update EHR certification criteria to require EHR vendors to attest that they will not interfere with the exchange of patient data between providers and patients, and that they will address in a timely manner complaints from providers and patients regarding the exchange of and access to patient data.

2. **Are new or revised CMS CoPs/CfCs/RfPs for interoperability and electronic exchange of health information necessary to ensure patients/residents and their treating providers routinely receive relevant electronic health information from hospitals on a timely basis or will this be achieved in the next few years through existing Medicare and Medicaid policies, HIPAA, and implementation of relevant policies in the 21st Century Cures Act?**

   Rather than revise the existing Conditions of Participation (CoPs), we recommend that CMS require acute-care hospitals to comply with the QRP requirements of the IMPACT Act, along with the applicable penalties for failure to comply. Doing so would extend the current interoperability steps seen in post-acute settings to the entire continuum of care. At the same time, a hospital would not “lose the right” to accept patients (not a CoP); and they would still have penalties for not sharing this information across the continuum. Related to this, it is worth a reminder that hospitals and ambulatory doctors have received meaningful-use dollars that were not provided
to PAC settings. Even so, post-acute settings are now required to increase interoperability via the IMPACT Act, whereas hospitals and ambulatory clinics are not identified in the IMPACT Act. In essence, there are unfunded mandates placed on post-acute settings. Even so, the greatest “risk” during transition of care is from the acute hospital setting to any other setting. Post-acute providers’ EHRs are capable of receiving data; however, it is difficult for hospitals to share the data. While we disagree with the idea of mandating interoperability via the CoPs, we agree that CMS should put forth a policy to incentivize this data transaction, with no cost to post-acute providers.

With that said, we have concerns as to whether this would benefit or harm private physical therapy practices. For instance, the physical therapy practice could be pressured by the hospital to become part of the health information exchange if the practice wants access to the data. However, the fees to join the health information exchange could be too high for the private practice; hence, the private practice could be faulted for blocking information sharing, due to circumstances out of its control.

Moreover, we recommend harmonization of data elements across all settings with the ability to capture the functional status of the patient and the outcome based on the care provided. We believe hospitals and other providers should be able to share information on (1) the patient’s goals and preferences and on preparing patients and, as appropriate, their caregiver(s)/support person(s) to be active partners in their post discharge care; (2) ensuring effective patient transitions from hospital to post-acute care while planning for post-discharge care that is consistent with the patient’s goals of care and treatment preferences; and (3) reducing the likelihood of hospital readmissions.

We therefore recommend that CMS create standardized data elements for discharge and transfer that incorporate information regarding functional status across settings. The patient’s ability to function and participate in society is critical to obtaining positive outcomes. A growing number of people in the US have disabling conditions that limit their ability to carry out the major activities of their age group. As the number of older adults increases, their vulnerability to injury and limitations of their activities of daily living increases as well. The result is an escalation of the utilization of health care resources. A focus on ensuring that individuals remain independent and functioning members of society throughout their lives will lessen the burden of disability on health care resources.

3. Under new or revised CoPs/CfCs/RfPs, should non-electronic forms of sharing medically necessary information (for example, printed copies of patient/resident discharge/transfer summaries shared directly with the patient/resident or with the receiving provider or supplier, either directly transferred with the patient/resident or by mail or fax to the receiving provider or supplier) be permitted to continue if the receiving provider, supplier, or patient/resident cannot receive the information electronically?
Depending on the timeframe for implementation, the use of non-electronic forms of information sharing should be permitted, and we suggest that CMS offer a transition period to allow providers adequate time to adopt and implement interoperability. Should CMS implement new and revised CoPs, we also recommend that the agency consider the variety of care settings in which interoperability will be adopted, as this type of mandate could negatively impact providers that are rural and lack internet connectivity. For example, some rural providers use a satellite dish for their Internet connectivity and the speeds are not fast enough to support EHR systems; the cost to acquire a cable connection may be can be more than $50,000 in some geographic locations. Other providers, such as physical therapists, will also require a transition timeline to obtain and integrate EHR technology for their practices.

4. **What types of exceptions, if any, to meeting new or revised interoperability and health information exchange requirements, should be allowed under new or revised CMS CoPs/CfCs/RFPs if they are proposed and finalized in the future? Should exceptions under the QPP including CEHRT hardship or small practices be extended to new requirements? Would extending such exceptions impact the effectiveness of these requirements?**

APTA recommends that CMS afford small and rural practitioners and practices an exception to the interoperability and health information exchange requirements. Providers and practices in rural areas often experience difficulties in acquiring the necessary technology to support EHR systems at a reasonable cost. We do recognize, however, that CMS’s goal is to encourage as many providers as possible to improve interoperability across care settings. To incentivize more providers beyond hospitals and post-acute care facilities to satisfy, the interoperability and health information exchange requirements, we recommend that CMS offer financial incentives to providers who can show a financial hardship.

5. **We would also like to directly address the issue of communication between hospitals (as well as the other providers and suppliers across the continuum of patient care) and their patients and caregivers. MyHealthEData is a government-wide initiative aimed at breaking down barriers that contribute to preventing patients from being able to access and control their medical records.**

While APTA supports CMS efforts to increase patient access to their health data, we also have concerns that increasing access simultaneously increases the risk of unwanted disclosure of that health data. We therefore encourage CMS to implement increased safeguards to prevent data breaches and educate patients on protecting the privacy of their health data.

6. **To fully understand all of these health IT interoperability issues, initiatives, and innovations through the lens of its regulatory authority, CMS invites members of**
the public to submit their ideas on how best to accomplish the goal of fully interoperable health IT and EHR systems for Medicare- and Medicaid-participating providers and suppliers, as well as how best to further contribute to and advance the MyHealthEData initiative for patients. We are particularly interested in identifying fundamental barriers to interoperability and health information exchange, including those specific barriers that prevent patients from being able to access and control their medical records. We also welcome the public’s ideas and innovative thoughts on addressing these barriers and ultimately removing or reducing them in an effective way, specifically through revisions to the current CMS CoPs, CfCs, and RfPs for hospitals and other participating providers and suppliers.

APTA recommends that CMS describe in detail what is intended by “fully interoperable health IT and EHR systems for Medicare.” We would encourage the agency to ensure that all patient health data could be stored and accessed from a single database, to avoid inconsistencies that may occur with multiple databases of patient information. Further, we recommend that the IT and EHR system include secure verification processes and systems to verify providers and patients who wish to retrieve patient data. Finally, we recommend that the agency work with state Medicaid agencies to resolve any barriers that exist for the sharing of health data across state lines. We support the move to a fully interoperable health system, however, many federal and state regulatory barriers would first need to be addressed to allow for data sharing between states, providers, patients, and their families.

7. We have received stakeholder input through recent CMS Listening Sessions on the need to address health IT adoption and interoperability among providers that were not eligible for the Medicare and Medicaid EHR Incentives program, including long-term and post-acute care providers, behavioral health providers, clinical laboratories and social service providers, and we would also welcome specific input on how to encourage adoption of certified health IT and interoperability among these types of providers and suppliers as well.

Physical therapists and physical therapy practices are a critical component of the medical network across the care continuum. Hence, physical therapists may need additional time to obtain EHR systems and the technical and financial capacity to collect and share electronic health care data. Notably, physical therapists in private practice have not formally been included in the meaningful use/advancing care information program. As such, facility-based physical therapists have not yet been exposed to regulations that govern meaningful use in the facility setting. Our comments reflect the issues we have identified as a profession with respect to information technology adoption and interoperability.

APTA encourages CMS to address the unique health IT adoption and interoperability needs of physical therapists and physical therapy practices as the agency moves to
adopt the new and revised standards. We urge the agency to consider financial incentives to alleviate the costs that physical therapists will no doubt face in complying with new interoperability requirements. We look forward to more opportunities to work with CMS to address solutions to alleviate the burden on specialty providers who have not yet been included in previous EHR incentive programs.

**Conclusion**
Once again, we thank CMS for the opportunity to comment on the FY 2019 IRF PPS proposed rule. We look forward to working with the agency in making revisions to the proposed policies prior to its finalization to ensure that Medicare beneficiaries have access to medically necessary physical therapy services in the IRF setting. If you have any questions regarding our comments, please contact Kara Gainer, director of regulatory affairs, at karagainer@apta.org or 703/706-8547. Thank you for your consideration.

Sincerely,

\[Signature\]

Sharon L. Dunn, PT, PhD
Board-Certified Orthopaedic Clinical Specialist
President

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