June 17, 2019

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
US Department of Health and Human Services
Attn: CMS-1710-P
7500 Security Boulevard
Baltimore, MD 21244

RE: Medicare Program; Inpatient Rehabilitation Facility (IRF) Prospective Payment System for Federal Fiscal Year 2020 and Updates to the IRF Quality Reporting Program [CMS-1710-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) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) Inpatient Rehabilitation Facility (IRF) Prospective Payment System for Federal Fiscal Year (FY) 2020 and Updates to the IRF Quality Reporting Program (QRP) 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.

Recommendations

Proposed Transfer of Health Information to the Provider and Patient PAC Measures

APTA supports CMS’ proposal to adopt the Transfer of Health Information to the Provider–PAC quality measure and Transfer of Health Information to the Patient–PAC quality measure. We agree that transfer of a medication list between providers is necessary for
medication reconciliation interventions, which have been shown to be a cost-effective way to avoid adverse drug events by reducing errors, especially when medications are reviewed by a pharmacist using electronic medical records. However, we have concerns that the proposed Transfer of Health Information to the Provider-PAC quality measure denominator fails to recognize the importance of transmitting the medication list to other providers, beyond those included in the current definition of “subsequent provider.”

Outpatient physical therapy is often provided following a patient’s discharge from the IRF, and in many instances the physical therapist in private practice serves as the first provider subsequent to discharge. Physical therapists performing medication management in accordance with their state practice act is a critical element of a physical therapist’s patient evaluation. It is imperative that the physical therapist is aware of the risk of potential adverse events that may occur due to current, changed, and/or new medications. Addressing medications in a drug regimen review and medication reconciliation should be an integral part of practice to help ensure that appropriate patient care is delivered and optimal clinical outcomes are obtained. APTA has issued a statement on the role of physical therapists in medication management as related to home care, which states: “It is within the scope of the physical therapist to perform a patient screen in which medication issues are assessed even if the physical therapist does not perform the specific care needed to address the medication issue. The physical therapist is competent and qualified to serve as case manager and facilitate coordination of care with physicians and nurses.”

Moreover, physical therapists have the professional capability and ability to refer to others in the health care system for identified or possible needs that are beyond the scope of physical therapist practice. Therefore, although physical therapists are not acknowledged as a “subsequent provider” under the measure definition, APTA requests that CMS monitor whether there may be a need to include physical therapists as a “subsequent provider” under the Proposed Transfer of Health Information to the Provider quality measure denominator in the future, given the frequency that physical therapists in private practice receive the medication list following discharge.

Proposed Update to the Discharge to Community – PAC IRF QRP Measure
APTA supports CMS’s proposal to exclude baseline nursing facility residents from the Discharge to Community–PAC IRF QRP measure beginning with the FY 2022 IRF QRP, with baseline NF residents defined as IRF residents who had a long-term NF stay in the 180 days preceding their hospitalization and IRF stay, with no intervening community discharge between the NF stay and hospitalization.

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1 The measure denominator is the number of SNF resident stays, ending in discharge to a “subsequent provider,” which is defined as a short-term general acute-care hospital, SNF, intermediate care (intellectual and developmental disabilities providers), home under care of an organized home health service organization or hospice, hospice in an institutional facility, IRF, long-term care hospital, Medicaid nursing facility, inpatient psychiatric facility, or critical access hospital.

2 See https://www.apta.org/uploadedFiles/APTAorg/Payment/Medicare/Coding_and_Billing/Home_Health/Comments/Statement_MedicationManagement_102610.pdf
IRF QRP Quality Measures, Measure Concepts, and Standardized Patient Assessment Data Elements (SPADEs) Under Consideration for Future Years: Request for Information

CMS seeks input on the importance, relevance, appropriateness, and applicability of each of the measures, SPADEs, and concepts under consideration listed in Table 19 for future years in the IRF QRP.3

Assessment-Based Quality Measures and Measure Concepts

- Opioid use and frequency
- Exchange of electronic health information and interoperability

SPADEs

- Cognitive complexity, such as executive function and memory
- Dementia
- Bladder and bowel incontinence including appliance use and episodes of incontinence
- Care preferences, advance care directives, and goals of care
- Caregiver status
- Veteran status
- Health disparities and risk factors, including education, sex and gender identity, and sexual orientation

**APTA supports the inclusion of the proposed SPADEs in future years of the IRF QRP.** Each of these categories represents element(s) that will provide a fuller picture of the patients that physical therapists and physical therapist assistants serve in the IRF setting, and therefore could be used for a variety of purposes including informing payment and creating and risk-adjusting quality measures.

Proposed Standardized Patient Assessment Data by Category

Cognitive function and mental status data

*While APTA supports the inclusion of standardized items such as the Brief Interview for Mental Status and Confusion Assessment Method to collect data regarding cognition and mental status, these assessments lack the appropriate sensitivity for identifying mild-to-moderate cognitive impairments that may impact performance of activities of daily living. We appreciate, however, that CMS recognizes that these assessments are imperfect and seeks data to support the identification of better cognitive assessments. We also encourage CMS to consider the inclusion of other elements in future years to increase the sensitivity of these assessments. Further, while we would support CMS’ efforts to use these data elements as risk adjusters for quality measures, we recommend that CMS continue to monitor these risk adjusters in the future and make appropriate adjustments to the risk-adjustment methodology as warranted. For instance, if there is a high use of cancer services in this patient population and CMS believes that question should be explored further to stratify that population more appropriately, we would support the expansion of the category. Finally, APTA supports inclusion of the Patient Health Questionnaire 2 to 9. We appreciate CMS’ proposal to include these data elements within the definition of standardized patient assessment data under the category of cognitive function and mental status.*

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Special services, treatments, and interventions

**APTA supports the collection of data on special services, treatments, and interventions.** Collecting this data will help to better inform CMS and IRF providers on the severity and needs of patients in this setting in the future. Patients who receive services such as dialysis, ongoing oncology care, and nutritional support are often more complex in their clinical presentation. APTA does not have any additional suggestions for data elements in this category.

Medical condition and comorbidity data

**APTA supports the inclusion of pain interference.** Pain interference is an important dimension in assessing the impact of pain. Including pain interference questions on sleep, therapy, and day-to-day activities will provide a more accurate picture of how pain impacts a patient’s ability to function throughout the day. Such information also will support providers in their efforts to deliver pain treatment and management services, including pharmacological and nonpharmacological interventions, in a more effective manner.

Impairments

**APTA supports the collection of information on hearing and vision in the assessment.** Vision and hearing impairments can impact multiple aspects of care and the quality of life of patients across settings.

Social determinants of health

**APTA supports CMS’ proposal to adopt the following 7 data elements as SPADE under the proposed Social Determinants of Health category: race, ethnicity, preferred language, interpreter services, health literacy, transportation, and social isolation.**

Proposed Data Reporting on Patients for the IRF QRP Beginning with the FY 2022 IRF QRP

**APTA supports the shift to quality reporting on all payer data in this setting.** This is consistent with other quality programs (such as the Merit-based Incentive Payment System) and will allow multiple payers to use the same quality measure information in the future. Additionally, reporting all payer data offers consumers a fuller picture of the quality of care in a given setting.

Proposed Policies Regarding Public Display of Measure Data for the IRF QRP

**APTA supports the public display of data for the Drug Regimen Review Conducted With Follow-Up for Identified Issues-PAC IRF QRP measure beginning with calendar year 2020 or as soon as technically feasible.**

Replacement of Unweighted With Weighed Motor Score

CMS proposes to replace the previously finalized unweighted motor score with a weighted motor score to assign patients to case-mix groups (CMGs) and remove 1 item from the score beginning with FY 2020. The agency also proposes to revise the CMGs and update the CMG relative weights and average length of stay values beginning with FY 2020, based on analysis of 2 years of data (FY 2017 and FY 2018).

The previously finalized motor score is calculated by summing the scores of the 19 data items, with equal weight applied to each item. The 19 data items are (83 FR 38535):
Our central concern with CMS’ proposal to use a weighted motor score is the significant and unexplained differences we see from the current weighting approach. Key constructs of the proposed weighted motor score, including items to assess patients’ mobility and self-care abilities and deficits, have significantly different weight values from those of the current weighted motor score framework used for 2019, indicating diverging interpretations of what should be comparable functional status data. For example, the eating item has gone from a 0.6 under the current weighted motor score framework to a proposed item weight value of 2.7. Overall, the proposed motor score weight index allocates greater weight value to patient self-care.
abilities and deficits than to patient mobility abilities and deficits, a reversal from the current motor score system.

*APTA is concerned about the de-emphasis on patient mobility and that the proposed motor score weight index may compromise access to physical therapy in the IRF setting. APTA would like more information from CMS as to the construction of the underlying approach used by CMS to develop the individual weight values for the items as part of the proposal for a weighted motor score.* The lack of access to data described above substantially limits our ability to examine potential alternatives to the weight values proposed for each individual item and to understand the impact of the large shift in the relative importance of mobility versus self-care.

**Conclusion**

APTA thanks CMS for the opportunity to provide comments on the FY 2020 IRF PPS and QRP proposed rule. Should you have any questions, please contact Steve Postal, senior specialist, regulatory affairs, at stevepostal@apta.org or 703/706-3391. Thank you for your consideration.

Sincerely,

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

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