

June 12, 2015

Andrew M. Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1624-P
Room 445-G, Hubert Humphrey Building
200 Independence Ave., S.W.
Washington, DC 20201

Submitted electronically

RE: CMS-1624-P; Medicare Program – Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2016

Dear Acting Administrator Slavitt:

On behalf of the 90,000 physical therapist, physical therapist assistant, and students of physical therapy members of the American Physical Therapy Association (APTA), I respectfully submit comments regarding the Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) for Fiscal Year (FY) 2016. Physical therapists are licensed health care professionals who diagnose and manage movement dysfunction and enhance physical and functional status in all age populations. In the inpatient rehabilitation facility (IRF) setting, physical therapy is critical to patients with a number of conditions.

In this proposed rule, CMS proposes to update the IRF PPS payments for FY 2016 by a market basket increase factor based upon the most current data available. After the applicable adjustments, the proposed FY 2016 IRF market basket is 1.9 percent. APTA commends CMS on this proposed increase to ensure appropriate payment levels for services in the IRF, and we wholly support the finalization of this increase.

We ask that the Agency carefully consider the comments that we have articulated below regarding pertinent sections of the proposed rule.

Creation of an IRF-Specific Market Basket

Beginning with the FY 2006 IRF PPS final rule, CMS adopted a Rehabilitation, Psychiatric, and Long-Term Care (RPL) market basket for the IRF PPS. This market basket reflected the operating and capital cost structures for freestanding IRFs, freestanding Inpatient Psychiatric Facility (IPFs), and Long-term Care Hospitals (LTCHs). In the FY 2010 IRF proposed rule,

CMS solicited comments in the development of a stand-alone IRF, or IRF-specific, market basket that reflects the cost structures of only IRF providers. One issue that arose was that Medicare cost report data revealed differences between cost levels and cost structures for freestanding and hospital based IRF facilities. Since the FY 2015 IRF PPS final rule, CMS has conducted additional research on the Medicare cost report data available for hospital-based IRFs and evaluated these concerns. CMS concluded that Medicare cost report data for both hospital-based IRFs and freestanding IRFs can be used to calculate the major market basket cost weights for a stand-alone IRF market basket. For FY 2016, CMS is proposing to create and adopt a stand-alone IRF market basket, using Medicare cost report data for both freestanding and hospital-based IRFs.

APTA supports the adoption of a stand-alone IRF-market basket. We believe that this is an integral step that must be taken as we move toward the goal of the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT) which is a “*unified PAC payment system that establishes, payment rates according to characteristics of individuals instead of according to the PAC setting, where the Medicare beneficiary involved is treated.*” A stand-alone IRF market-basket will help to more accurately capture the costs and resources for inpatient rehabilitation services. By statute, IRFs are required to provide a much higher intensity of therapy services than LTCHs, skilled nursing facilities and home health agencies. There are regulatory mandates for IRFs to ensure that this level intensity is met such as the “three hour rule”, “60 percent compliance threshold” and IRF medical necessity requirements. We believe that all of these mandates affect the cost and resources associated with IRF care and should be appropriately assessed in isolation of inpatient psychiatric facilities and LTCHs.

APTA also believes that the creation of a stand-alone IRF market basket is an integral step in any plan to create site neutral payment between IRFs and SNFs as discussed by the Medicare Payment Advisory Commission (MedPAC) as well as the House Ways and Means Subcommittee on Health and the President’s Budget. In its June 2014 report to Congress, MedPAC examines the feasibility of paying IRFs and SNFs at the same payment level for three conditions: stroke, major joint replacement and other hip and femur procedures. MedPAC analyzed for the three conditions, the IRF “base” payments in 2011 with what those payments would be if paid under SNF payment policy. They found that if IRFs were paid under 2014 SNF policy, their aggregate payments for the three select conditions would decline. The impact of this policy was consistent across freestanding and hospital-based IRFs. Overall, MedPAC found that IRF payments would not be negatively affected because add-on payments for outlier cases and payment for other conditions outside of the site-neutral designations would be sufficient to cover IRF costs of care.

APTA is not opposed to the exploration of site-neutral payment but believes that the appropriate steps to more accurately capture the cost of services in each setting should be taken before a final policy is implemented. Therefore, we believe that the stand-alone market basket for IRFs would help to lend more accurate and useful data in this regard. In addition, we still remain concerned about the disparities in cost and resources between freestanding and hospital-based IRFs. We understand that CMS updated analysis since 2010 reveals that these differences should not pose a statistical difference, but APTA urges CMS to stay vigilant in its continual analysis of changes in costs between these two types of IRFs, once an IRF stand-alone market basket is implemented.

Any significant data derived from CMS analysis should be shared with stakeholders in periodic reports and notices of proposed rulemaking for feedback on how the IRF market basket and payment system should be refined.

Proposed Revisions and Updates to the Quality Reporting Program for IRFs

Section 3004(b) of the Affordable Care Act amended section 1886(j)(7) of the Act, requiring the Secretary to establish the IRF QRP. Beginning with the FY 2014 payment determination and subsequent years, the Secretary is required to reduce any annual update to the standard federal rate for discharges occurring during such fiscal year by 2 percentage points for any IRF that does not comply with the requirements established by the Secretary.

CMS is not proposing to make any changes to its previously adopted measures for FY2018 for the IRF quality reporting program. CMS is proposing to retain 2 measures for the FY2018 reporting year as previously discussed: Percent of residents or patients with pressure ulcers that are new or worsened (short-stay) (NQF #0678), and All-cause unplanned readmission measure for 30 days post-discharge from IRFs (NQF #2502). These two measures meet the requirements of the IMPACT Act.

CMS is proposing 6 new measures for the FY2018 that are also intended to satisfy the IMPACT Act requirement of standardized data reporting across 4 post-acute care settings, including home health agencies, inpatient rehabilitation facilities, skilled nursing facilities and long term care hospitals.

CMS proposes 6 new quality measures for the FY 2018 IRF Quality Reporting Program (QRP) and subsequent years, addressing 2 quality domains identified in the IMPACT Act:

- Incidence of major falls (outcomes measures): application of percent of residents experiencing one of more falls with major injury (long stay NQF #0674)
- Functional status, cognitive function, and changes in function and cognitive function (process measure): application of percent of patients or residents with an admission and discharge functional assessment and a care plan that addresses function (NQF#2631; under review)
- IRF Functional Outcome Measure: Change in self-care score for medical rehabilitation patients (NQF #2633; under review)
- IRF Functional Outcome Measure: Change in mobility score for medical rehabilitation patients (NQF #2634; under review)
- IRF Functional Outcome Measure: Discharge self-care score for medical rehabilitation patients (NQF #2635; under review)
- IRF Functional Outcome Measure: Discharge mobility score for medical rehabilitation patients (NQF #2636; under review)

APTA supports the goal of improving quality of health care. Physical therapists are committed to providing high-quality, timely care and to the promotion of evidence-based practice and patient-centered practice. Furthermore, APTA feels that it is essential that we move towards a core set of functional items to assess patients across the continuum of care. APTA is pleased to see that

these measures proposed for IRFs move in that direction. However, the APTA does have some concerns regarding the proposed measure methodology which are discussed below.

Incidence of major falls (outcomes measures): Application of Percent of Residents Experiencing One of More Falls with Major Injury (Long Stay) (NQF #0674)

APTA supports this measure in concept. Although this measure is endorsed by NQF for long stay nursing residents and does satisfy the requirement of a major falls domain measures under IMPACT, this measure is not yet endorsed in the IRF or LTCH settings. Additionally, this measure does not include a risk adjustment methodology as required under IMPACT. APTA recognizes that the IMPACT timeline for implementation of the major falls measure for SNFs, IRFs and LTCHs is October 2016, however, we are concerned that this measure needs to include appropriate risk adjustment methodology.

The other widely used falls with injury measure (NQF #0202), which is currently in use in the acute care setting, employs a risk stratification methodology by nursing unit. The risk stratification utilized in the acute care setting for measure #0202 does allow for the identification of different patient populations, based on nursing unit type, for more accurate reporting of falls with injury in higher risk patient populations. There is a concern that implementing the long stay major falls measure into other PAC settings may result in wide variations in reported falls without taking into account patient acuity or other variables that may impact falls risk. Additionally, using this measure in the home health setting will pose even greater challenges as the setting is not structured like the other PAC settings, with the patients residing in their home without continual monitoring. For these reasons APTA would encourage CMS to continue to work on refining this measure to incorporate a risk stratification or adjustment methodology.

Functional status, cognitive function, and changes in function and cognitive function (process measure): Application of Percent of Patients or Residents with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF#2631; under review)

APTA supports this measure in concept. APTA believes that measuring function is important in every care setting. APTA is pleased to see this measure being proposed for multiple PAC settings in accordance with the IMPACT requirements. Additionally, we feel that facilities should be monitoring the percentage of complete functional assessments, and we note that this measure does align conceptually with the finalized changes to the home health quality reporting requirements for the submission of OASIS data in an attempt to capture “Quality Assessments Only”.

However, APTA has significant concerns as the proposed rule indicates that CMS intends to use “an application” of this measure for the purposes of the IRF (as well as SNF and LTCH) quality reporting program. While we understand that CMS has latitude in implementing endorsed measures in settings for which measures have not yet received endorsement, we are concerned that this measure, as proposed, is inconsistent with the measure that is still under review by NQF. Specifically, we noticed the following differences in the proposed CARE item set (*in italics*):

Inpatient Rehabilitation Facility Quality Reporting Program - Quality Measure Specifications for FY 2016 Notice of Proposed Rule Making	NQF Application (NQF#2631) Percent of Patients or Residents with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function
Self-Care Items	
<ul style="list-style-type: none"> • Eating • Oral hygiene • Toileting hygiene 	<ul style="list-style-type: none"> • Eating • Oral hygiene • Toileting hygiene • <i>Wash upper body</i>
Mobility Items	
<ul style="list-style-type: none"> • Sit to lying • Lying to sitting on side of bed • Sit to stand • Chair/bed-to-chair transfer • Toilet transfer For patients walking: • Walk 50 feet with two turns • Walk 150 feet For patients who use a wheelchair: • Wheel 50 feet with two turns • Wheel 150 feet 	<ul style="list-style-type: none"> • <i>Roll left and right</i> • Sit to lying • Lying to sitting on side of bed • Sit to stand • Chair/bed-to-chair transfer • Toilet transfer For patients who walk: • <i>Walk 10 feet</i> • Walk 50 feet with two turns • Walk 150 feet For patients who use a wheelchair: • Wheel 50 feet with two turns • Wheel 150 feet
Cognitive Function	
<ul style="list-style-type: none"> • 	<p><i>Signs and Symptoms of Delirium (CAM © [Confusion Assessment Method]):</i></p> <ul style="list-style-type: none"> • <i>Acute onset and fluctuating course</i> • <i>Inattention</i> • <i>Disorganized thinking</i> • <i>Altered level of consciousness</i>
Communication: Understanding and Expression	
<ul style="list-style-type: none"> • 	<ul style="list-style-type: none"> • <i>Expression of ideas and wants</i> • <i>Understanding of verbal content</i>
Bladder Continence	
<ul style="list-style-type: none"> • 	<ul style="list-style-type: none"> • <i>Bladder Continence</i>

Additionally, as submitted for NQF review, measure #2631 requires the collection other data not initially required by the CARE demonstration project such as projected goal information. While APTA appreciates the need to easily identify patients/ residents who have a care plan that addresses function, we are worried that a collecting an estimated goal for a single CARE item is a poor proxy for the functional plan of care for patients/ residents as the plan of care typically address multiple functional limitations in the PAC settings. Furthermore, as this is a limited item set compared to the full self-care and mobility item set in the PAC CARE demonstration, there is a possibility that the functional issues that are being addressed may not be represented in this

measure. Lastly, it is also important to recognize that for many patients the goal of therapy is restorative, however in some instances skilled therapy services may focus on maintenance of a patient's function. Again, APTA recognizes that as the IMPACT measures are implemented and as we move to standardized assessment tools across the PAC settings, these measures may need modifications. We are hopeful that CMS will comment on these concerns in the final rule.

APTA recognizes that the overall goal of IMPACT is for PAC providers (HH, IRF, SNF and LTCH) to collect and report standardized and interoperable patient assessment data, quality and resource use measures. We acknowledge that during the initial IMPACT implementation years that there will be a transition period from existing data collection tools to incorporate standardized assessment tools. APTA is concerned about the duplicity in data collection that this measure introduces and the burden of data collection for the providers given the current data collection tools in the PAC settings. APTA encourages CMS to consider a short transition period to standardize the patient assessment data in order to decrease the issues around duplicity and provider burden in data collection, this includes considering the removal of items from the existing data sets where possible. Additionally, we believe that achieving a standardized and interoperable patient assessment data set as quickly as possible will allow for better cross-setting comparisons as well as the evolution of better quality measures with uniform risk standardization, thus achieving the true aim of IMPACT.

During the transition period CMS must consider not only the additional reporting burden to providers as the new standardized data items are implemented, but also the educational burden. Given the differences in the instructions and rating systems of all of the PAC functional assessment items, we strongly encourage CMS to offer standardized education that can be made available to all providers who will be using the new CARE items. This education will need to take place throughout the transition period in order to achieve high a degree of reliability of these items.

Lastly, APTA would like to encourage CMS to continue in ongoing stakeholder engagement in this process as we move toward PAC data standardization; this includes changes that are made through the regulatory process as well as the measures endorsement process through NQF. APTA and its members appreciate the opportunity to work with CMS during the implementation phase of IMPACT.

IRF Functional Outcome Measure: Change in self-care score for medical rehabilitation patients (NQF #2633; under review) AND

IRF Functional Outcome Measure: Discharge self-care score for medical rehabilitation patients (NQF #2635; under review)

IRF Functional Outcome Measure: Change in mobility score for medical rehabilitation patients (NQF #2634; under review) AND

IRF Functional Outcome Measure: Discharge mobility score for medical rehabilitation patients (NQF #2636; under review)

APTA supports these measures in concept. APTA has commented about specific concerns related to these measures in the past during their development through Research Triangle Institute (RTI). In our previous comments, we made suggestions for several of the risk

adjustment variables. APTA is pleased to see the inclusion of risk adjustment criteria for “prior mobility device/ aid” further stratified to include wheelchair use and scooter use as well as mechanical lift use and orthotics/ prosthetics. APTA encourages CMS to continue to examine data from this measure during the implementation phase to continue to assess the risk adjustment methodology.

As in our previous comments, APTA would also strongly suggest the inclusion of wheelchair mobility items in the two mobility measures (NQF # 2634 and #2636) as some patients in this setting may use a wheelchair as a primary method of mobility. Without items that assess wheelchair mobility, these measures may not accurately reflect the mobility of patients who use a wheelchair as a primary method of mobility in the IRF setting. APTA would refer CMS to NQF measure #2612 CARE: Improvement in Mobility, which does include wheelchair mobility items. NQF measure #2612 is a measure designed for the SNF setting and also currently under review for endorsement. APTA encourages CMS to continue to examine data from these measures during the implementation phase, as well as considering measure modifications as the data warrants.

APTA is pleased to see these 4 functional outcome measures proposed for the PAC setting. We do feel that it is important to note that that functional outcome measures were only included in proposed rulemaking this year for the IRF setting. APTA encourages CMS to incorporate functional outcome measures in future years in other PAC quality reporting programs, including LTCH, SNF, and home health settings, as timely comprehensive functional data will be needed in order to make informed decisions about quality of care and future payment systems for PAC settings.

APTA recognizes that the overall goal of IMPACT is for PAC providers (HH, IRF, SNF and LTCH) to collect and report standardized and interoperable patient assessment data, quality and resource use measures. We acknowledge that during the initial IMPACT implementation years that there will be a transition period from existing data collection tools to incorporate standardized assessment tools. APTA is concerned about the duplicity in data collection that these measures measure introduce and the burden of data collection for the providers given the current data collection tools in the PAC settings, specifically IRF-PAI in the IRF setting. APTA encourages CMS to consider a short transition period to standardize the patient assessment data in order to decrease the issues around duplicity and provider burden in data collection, including considering the removal of items from the existing data sets where possible. Additionally, we believe that achieving a standardized and interoperable patient assessment data set as quickly as possible will allow for better cross-setting comparisons as well as the evolution of better quality measures with uniform risk standardization, thus achieving the true aim of IMPACT.

Lastly, APTA would like to encourage CMS to continue in ongoing stakeholder engagement in this process as we move toward PAC data standardization; this includes changes that are made through the regulatory process as well as the measures endorsement process through NQF. We anticipate that the functional measures will evolve over time to include additional CARE self-care and mobility items that are not included in this first functional measure. The inclusion of new items should help to ensure true representation of patient function at the low, as well as the

high ends of the spectrum. Additionally, we would encourage CMS and other measure developers to consider functional items such as velocity or gait speed which may provide a more meaningful picture of the quality of mobility performance versus ambulation distance which is a measure of tolerance. APTA and its members appreciate the opportunity to work with CMS during the implementation phase of IMPACT.

Consistency in Regulations across PAC Settings

We urge CMS to be mindful that in order to create a cohesive post-acute care payment system there must consistency among documentation and billing requirements. Therefore, post-acute care reform must be supplemented by meaningful and carefully crafted regulations that reduce redundancies, eliminate administrative burden, and increase efficiency. In tandem with quality measure development, CMS should conduct a comprehensive analysis of existing rules and regulations. As a result of this analysis, CMS must eliminate or significantly revise current regulations, included but not limited to the home health functional reassessment, SNF Change of Therapy OMRA, SNF 3-day hospital stay admission requirement, definitions of group and concurrent therapy, IRF short stay policy and IRF 60 percent rule. The elimination or revision of onerous regulations should take place prior to full implementation of the new payment model.

Conclusion

APTA thanks CMS for the opportunity to comment on this proposed rule, and we look forward to working with the agency to craft patient-centered reimbursement policies that reflect quality health care. If you have any questions regarding our comments on the proposed payment polices, please contact Roshunda Drummond-Dye, Director, Regulatory Affairs at (703) 706-8547 or roshundadrummond-dye@apta.org . If you have questions regarding our comments on the IRF quality reporting program, please contact Heather Smith, Director of Quality at (703) 706-3140 or heathersmith@apta.org.

Sincerely,



Sharon L. Dunn, PT, PhD, OCS
President

SLD: rdd, hls