American Medical Rehabilitation Providers Association

Bruce M. Gans, MD · Chair, AMRPA Board of Directors
Executive Vice President and Chief Medical Officer, Kessler Institute for Rehabilitation
National Medical Director for Rehabilitation, Select Medical Corporation

June 22, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1624-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Delivered Electronically
Ref: CMS-1624-P "Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2016, Proposed Rule" 80 F.R. 80 p. 23332, (April 27, 2015)

Dear Acting Administrator Slavitt:

This letter is submitted on behalf of the American Medical Rehabilitation Providers Association (AMRPA) regarding the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) for Federal Fiscal Year (FY) 2016 Proposed Rule, which was published the *Federal Register* on April 27, 2015. AMRPA is the national voluntary trade association representing more than 500 freestanding rehabilitation hospitals, rehabilitation units of general hospitals, and outpatient rehabilitation service providers. The vast majority of our members are Medicare participating providers. In 2013, inpatient rehabilitation hospitals and units (IRH/Us), or inpatient rehabilitation facilities (IRFs) as referred to by the Centers for Medicare and Medicaid Services (CMS), served 338,000 Medicare beneficiaries with more than 373,000 IRF stays.[1] IRFs provide hospital-level care, which is significantly different in intensity, capacity, and outcomes from care provided in non-hospital facilities. On average, Medicare Part A payments represent more than 60 percent of IRFs' revenues.[2] Hence, any alterations to the Medicare payment system have significant implications for these medical providers.

Our comments follow in two attachments. The first attachment summarizes AMRPA's recommendations; the second is a complete statement of our analyses, comments, and recommendations.

Summary
We respectfully request that CMS consider making the changes outlined below in the final rule.

[1] Medicare Payment Advisory Commission, *Report to the Congress, Medicare Payment Policy* Executive Summary at p. 240 (Mar. 2015).
[2] *Id*. In 2013, Medicare paid for 61 percent of IRFs' discharges.

1. **Proposed Inpatient Rehabilitation Facility-Specific Market Basket**
   As a policy, we are supportive of moving forward toward an IRF market basket and commend CMS on this effort. However, we urge the Agency to make several changes to the data and methodology before it can be implemented. These relate to the wages and salaries, employee benefits and contract labor cost categories and weights. AMRPA recommends that:

   a. CMS recalculate the cost categories of Employee Benefits, Contract Labor, and Wages and Salaries with consideration of ancillary costs so these categories better reflect the costs IRFs incur for these cost categories.

   b. Until a significant percentage that is demonstrated to be representative of all IRF providers submits complete cost reports, CMS should use the Hospital Inpatient Prospective Payment (IPPS) data as a source for calculating weights for the Employee Benefits and Contract Labor categories making up the 2012-based IRF-specific market basket.

   c. The major cost category weights for the IRF-specific market basket should be those identified in *Table 1: Impact of Corrections on Major Cost Category Weights* (see page 16).

2. **Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)**
   We are concerned about the burden of the many new quality measures, which reflect the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 requirements, being proposed for collection starting October 1, 2016. AMRPA believes any such measures should meet the specific criteria listed in our letter. Based on these criteria and other experience, AMRPA recommends that CMS:

   a. Implement only measures required by the IMPACT Act and suspend all measures that are not critical to the mission of rehabilitation;

   b. Continue reporting measures under the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF PAI) and conduct a study to transform the IRF PAI data to Continuity Assessment and Record Evaluation (CARE) Tool data for the purposes of the IMPACT Act; and

   c. Expand an existing study, "*Using CARE Items in the Medicare Inpatient Rehabilitation Facility Prospective Payment System,*" to use CARE tool data in developing new case mix groups (CMGs) for payment and quality reporting purposes.

AMRPA welcomes continued opportunities to collaborate with the Department of Health and Human Services (HHS) and CMS to refine and improve the IRF PPS.

If you have any questions about AMRPA's recommendations, please contact us or AMRPA's Executive Vice President for Government Relations and Policy Development, Carolyn Zollar, J.D. (czollar@amrpa.org / 202-223-1920).

Sincerely,

Bruce M. Gans, M.D.
Chair, AMRPA Board of Directors
Executive Vice President and Chief Medical Officer, Kessler Institute for Rehabilitation
National Medical Director for Rehabilitation, Select Medical

Mark J. Tarr
Chair, AMRPA Regulatory and Legislative Policy Committee
Executive Vice President and Chief Operating Officer, HealthSouth Corporation

cc: Laurence Wilson
Jeanette Kranacs
Susanne Seagrave
Gwendolyn Johnson
Charles Padgett

Attachments:

A. Summary of American Medical Rehabilitation Providers Association's Recommendations on the IRF PPS FY 2016 Proposed Rule

B. American Medical Rehabilitation Provider Association's Analysis, Comments, and Recommendations on the IRF PPS FY 2016 Proposed Rule

C. Supplemental Report: *Analysis of CMS Proposed Inpatient Rehabilitation Facility Specific Market Basket*, Dobson DaVanzo & Associates, LLC., May 22, 2015

TABLE OF CONTENTS

ATTACHMENT A

Summary of American Medical Rehabilitation Providers Association's Recommendations on the Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2016, Proposed Rule 80 F.R. 80 p. 23332, April 27, 2015

I. Proposed Update to the Case-Mix Group (CMG) Relative Weights and Average Length of Stay Values for FY 2016, p. 23337

A. *Case-Mix Group Relative Weights*

AMRPA Recommendation:
We request that CMS provide a complete description of how cost-to-charge ratios factor into its calculation of CMG weights.

B. *Length of Stay*

AMRPA Recommendation:
As stated in our comment letter on the FY 2015 IRF PPS proposed rule, AMRPA recommends that CMS publish its methodology for calculating the average length of stay (ALOS) annually for the IRF PPS proposed rule, just as it annually publishes the methodology for calculating the CMG weights, the standard payment conversion factors, and several other elements of the payment system. Additionally, we recommend that the Agency annually review and update its list of approved tiering co-morbidities. CMS should publish any changes in the IRF PPS proposed rule.

II. Continued Use of FY 2014 Facility-Level Adjustment Factors, p. 23341

AMRPA Recommendations:

1. We recommend that CMS be more transparent in setting forth the criteria it applies to establishing the provider-level adjustment factors and calculating provider-level adjustment payments.

2. We recommend that CMS establish a minimum interval for any changes in the IRFs' provider-level adjustment factors such as once every three years. Furthermore, we recommend that if any factor varies by a minimum amount, the factor should be adjusted and proposed with an opportunity for comment.

III. Proposed FY 2016 IRF PPS Payment Update, p. 23341

A. *Overview of the Proposed 2012-Based IRF Market Basket, p. 23342*

AMRPA Recommendation:
AMRPA supports moving forward with a separate rehabilitation facilities market basket such as the proposed 2012-based IRF market basket using Medicare cost report data for freestanding and hospital-based IRFs with some caveats as noted below.

B. ***Development of Cost Categories and Weights for the Proposed 2012-Based IRF Market Basket, p. 23342***

AMRPA Recommendations:

1. CMS should recalculate the cost categories of Employee Benefits, Contract Labor, and Wages and Salaries with consideration of ancillary costs so these categories better reflect the costs IRFs incur for these cost categories.

2. Until a significant percentage that is more representative of all IRF providers submits complete cost reports, CMS should use the Hospital Inpatient Prospective Payment System (IPPS) data as a source for calculating weights for the Employee Benefits and Contract Labor categories making up the 2012-based IRF-specific market basket.

3. The major cost category weights for the IRF-specific market basket should be those shown in *Table 1: Impact of Corrections on Major Cost Category Weights* (see page 16).

C. ***Wages and Salaries Costs, p. 23343***

AMRPA Recommendations:

1. CMS should recalculate the Wages and Salaries cost category for the 2012-based IRF market basket so as to include all routine, ancillary, and overhead costs attributable to IRFs, particularly IRF units, in its calculation of IRFs' overhead costs.

2. CMS should explain with greater specificity the methodology it used to calculate the Wages and Salaries cost category for the proposed 2012-based IRF market basket.

IV. Proposed FY 2016 Market Basket Update and Productivity Adjustment, p. 23355

AMRPA Recommendations:

1. AMRPA urges CMS to remain cognizant of the intensive labor time and costs required by state and/or federal regulations to which IRFs are bound, and which may be barriers to IRFs achieving further gains in productivity efficiencies. CMS should consider the unique needs of IRFs' rehabilitation patients and their interdisciplinary teams of highly skilled health care professionals when considering the productivity adjustment factor that it will apply to IRFs.

2. The Agency should be mindful of the additional labor costs that IRFs will incur as a result of having more items that must be reported on the newest version of the IRF PAI.

V. Proposed Labor-Related Share for FY 2016, p. 23356

A. ***Proposed Implementations of New Labor Market Delineations, p. 23358***

AMRPA Recommendations:

1. AMRPA shares CMS' concerns that an immediate transition to the new core-based statistical area (CBSA) delineations would have a dramatic impact of a 14.9 percent payment reduction for affected rural IRFs. We support a one-year transition to the altered CBSA delineations with a blended wage index for all IRFs.

2. We support CMS' proposal to implement a three-year phase-out of the rural adjustment for existing FY 2015 rural IRFs that will become urban in FY 2016 and consequently, experience a loss in payments due to changes from the new CBSA delineations.

B. ***Description of the Proposed IRF Standard Payment Conversion Factor and Payment Rates for FY 2016, p. 23364***

AMRPA Recommendation:
We support the proposed adjusted new IRF-specific market basket increase of 1.9 percent for FY 2016, as well as CMS' analysis leading to a proposed budget neutrality factors for the wage index and labor-related share of 1.0027 and its proposed budget neutrality factor of 1.000 for the revised CMG weights.

VI. Proposed Update to Payments for High-Cost Outliers under the IRF PPS, p. 23367

AMRPA Recommendation:
We support CMS' proposal to set the high-cost outlier threshold at $9,698 so that the Agency can maintain the estimated outlier payments at three percent of IRFs' total estimated payments for FY 2016.

VII. ICD-10 Implementation for IRF PPS, p. 23368

AMRPA Recommendations:
1. AMRPA urges CMS to add all of the ICD-10-CM codes listed in Table 2 (see page 19) to its list of presumptively compliant ICD-10-CM codes for FY 2016.

2. CMS should also add the ICD-10-CM codes in Table 3 (see page 20) to its list of tiering co-morbidities for FY 2016. If CMS does not do so, we recommend CMS reexamine the co-morbidities with which patients have presented for the last three years and revise the co-morbidity tiers for FY 2016.

VIII. Revisions and Updates to the IRF QRP, p. 23368

AMRPA Recommendations:
To address the burden and other problems of submitting data on two similar data sets for different purposes, AMRPA recommends that CMS:

1. Suspend implementation of any measures not required by the IMPACT Act and that are not critical to the mission of IRFs.

2. Continue allowing IRFs to report data for functional measures through the current IRF PAI using the Functional Independence Measure (FIM) as these are the measures with which IRF personnel are familiar and which would be the least disruptive for the industry.

   CMS could then undertake a study to transform the IRF PAI data to the CARE/IMPACT Act data. Several AMRPA members compared the FIM and CARE items and identified overlaps between the two. The proposed CARE tool items encompass almost all the IRF PAI items and add several other components. In addition to minimizing the burden on the

industry transforming the IRF PAI FIM data to the CARE tool items allows IRFs to continue to use legacy data to improve the quality of care they deliver the patients.

3. Expand the current Assistant Secretary for Planning and Evaluation (ASPE)/CMS/RTI International contract, "*Using CARE Items in the Medicare Inpatient Rehabilitation Facility Prospective Payment System*." As we understand it, the referenced study examined substituting the CARE tool items proposed for FIM items for use in the IRF PPS. The project's purpose was to "provide foundational analysis to the Assistant Secretary for Planning and Evaluation (ASPE) and the Centers for Medicare & Medicaid Services on the potential to substitute CARE items into the current case mix methodologies in the existing payment systems. Analyses conducted in this work examine the impact of using CARE items in the current case mix methodologies used to adjust payments under the Medicare IRF prospective payment system."

   In lieu of requiring all IRFs to collect, concurrently, the five proposed functional measures through CARE tool items as well as through IRF PAI FIM data, the study should be expanded to recruit and include a nationally representative sample of IRFs in order to examine the operational effect and practicalities of parallel data collection. The study participants would collect data using both tools. This data would be contemporaneous and we believe meets the IMPACT Act mandate of collecting such domains starting October 1, 2016. Once CMS has these data, the researchers could do several things:

   a. Seek to develop the cross-walk to transform the FIM to CARE data.

   b. Use the CARE data to develop a new case mix classification system that would then be tested to create new case mix groups and tiers.

Finally, AMRPA recommends that in the final rule CMS address exactly how it intends to implement all the new measures, provide training for all the providers, provide instruction through a revised IRF PAI Manual and transmittals, and other training/education opportunities such as open door forums or training webinars**.**

IX. Proposal of Previously Adopted IRF QRP Quality Measures for the FY 2018 Payment Determination and Subsequent Years, p. 23373

A. *Proposing Quality Measure to Reflect NQF Endorsement: All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from IRFs (NQF #2502)*

AMRPA Recommendations:
AMRPA supports CMS' proposal to adopt this version of the measure to reflect its endorsement by NQF as we believe endorsement by a consensus-building entity such as NQF is an important prerequisite designed to ensure the measure has been appropriately reviewed by stakeholders. However, the data for this measure is hard to benchmark or compare across the industry because it is collected via claims data and IRFs only have access to their own claims data. It also tends to reflect outdated information, since claims data tend to be more than a year old once they are provided to the IRF; hence, the data do not reflect more recent efforts an IRF may have made to prevent readmissions. Finally, readmissions measures indicate what may have occurred to a patient within 30 days of

discharge from the IRF; however, it is a challenge for an IRF to independently confirm what may have happened to a patient once he or she has been discharged. This is because there is no standardized way to collect data regarding what happened to a patient after discharge from the IRF. While we recognize the importance of minimizing readmissions in preventing additional and potentially unnecessary health care costs, limitations exist associated with this measure as a tool for improving the quality of care.

We suggest that CMS work with the industry to develop a standardize mechanism to determine what happens to patients once they are discharged from the IRF in "real time" (or close to real time) to further improve the utility of this measure.

B. ***Quality Measure Addressing the Domain of Skin Integrity and Changes in Skin Integrity: Percent of Residents or Patients with Pressure Ulcers That are New or Worsened (Short Stay) (NQF #0678)***

AMRPA Recommendation:
CMS should adopt measures already in use in the IRF QRP for the purposes of implementing the IMPACT Act. The pressure ulcer measure meets these criteria. However, we have concerns regarding the proposal to modify the numerator for this measure. Specifically, while we support the inclusion of unstageable pressure ulcers due to slough or eschar in the numerator, we do not believe it is appropriate to include suspected deep tissue injuries (sDTIs). This is because much is still unknown about sDTIs including whether there is an actual deep tissue injury. Many sDTIs heal without opening and it would be unfair to penalize a provider for these. In summary, we recommend that CMS update the numerator to include unstageable pressure ulcers as described above but exclude sDTIs.

X. Proposed Additional IRF QRP Quality Measures for the FY 2018 Payment Determination and Subsequent Years, p. 23375

A. ***An Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF 0674)***

AMRPA Recommendations:
AMRPA supports adopting this type of measure because it reflects an emphasis on falls with major injury. However, we recommend several changes to the measure to ensure it meets the objectives outlined in our comments before we can support its inclusion in the IRF QRP.

AMRPA is concerned that this measure has been endorsed by NQF only for long-stay residents in a nursing facility. To start, most IRF patients experience a much shorter length of stay when compared to these nursing home residents. More fundamentally, the SNF and IRF populations are quite different clinically and in their reason for being in the SNF or IRF – whereas the latter has a goal to be discharged, the former may reside in the facility long term. There is a difference between intensive rehabilitative care versus nursing home residency with regard to physical exertion and the need for patients to push themselves in order to rehabilitate. For example, an IRF rehabilitation program may teach patients safe techniques should they find themselves falling and hence include therapeutic falls. Clinicians take every precaution possible to avoid injuries in these situations. We recommend CMS recognize that there may be instances when IRF patients may experience therapeutic or intentional falls in

the course of rehabilitation. As such, we urge CMS to evaluate the appropriateness of this measure for application to IRFs and inclusion in the IRF QRP, and do so through NQF processes. Should NQF endorse it for IRFs, the measure should be updated to include a reference to patients as well as residents.

The measure specifications require reporting of all falls, not just falls with major injury, which does not appear appropriate given the intent of the measure is to determine falls that result in a major injury. We request CMS clarify or otherwise address this issue prior to implementation of this measure.

Finally, the measure specifications outline four examples of what constitutes a major injury including bone fractures, joint dislocations, closed head injuries with altered consciousness, or subdural hematoma. It is unclear if major injuries are limited to these four examples or if there is a broader list. It is imperative for the validity and reliability of the data that a full list of injuries associated with this measure be available. We believe that the four examples listed in the measure specifications are the most appropriate and should be considered a comprehensive list.

B. ***Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)***

AMRPA Recommendation:
Our overall concerns using the proposed new functional items (self-care, mobility) are addressed in greater detail in our comments. AMRPA is concerned that assessing for functional limitations or ability does not guarantee that the patient's plan of care will be reflective of this assessment or contain goals associated with it. There does not appear to be an adequate mechanism to ensure the patient's plan of care includes such a functional goal. Finally, some stakeholders, including the Medicare Payment Advisory Commission (MedPAC), question whether process measures such as this are appropriate or whether the focus should be on the adoption of outcomes measures.[3]

XI. IRF QRP Quality Measures and Measure Concepts under Consideration for Future Years, p. 23383

AMRPA Recommendation:
AMRPA recommends that CMS carefully consider the concerns we articulate as they pertain to discharge to community, patient experience of care, and patients experiencing moderate to severe pain to ensure measures in these domains are developed appropriately for this setting. Until the concerns we have raised are mitigated, we cannot support the inclusion of these measures in the IRF QRP.

XII. Proposed Form, Manner, and Timing of Quality Data Submission for the FY 2018 Payment Determination and Subsequent Years, p. 23384

[3] Comments of the Medicare Payment Advisory Commission re: File Code CMS-1624-P. May 27, 2015. http://medpac.gov/documents/comment-letters/medpac-comment-on-cms's-proposed-rule-on-the-inpatient-rehabilitation-facility-prospective-payment-system.pdf?sfvrsn=0

A. ***Proposed Revision to the Previously Adopted Data Collection Timelines and Submission Deadlines***

AMRPA Recommendation:
AMRPA supports this change, which will reduce the confusion and burden associated with reporting quality data. Therefore, we encourage CMS to consider that whenever changes to the IRF PAI are adopted, the new IRF PAI should also be implemented based on a calendar year approach.

B. ***Proposal of Previously Adopted IRF QRP Quality Measures for the FY 2018 Payment Determination and Subsequent Years***

AMRPA Recommendations:
We believe that CMS' estimates associated with the burden of the revised proposed IRF PAI are based on incorrect assumptions and should be revised to reflect the practical implications associated with such revisions. Additionally, given CMS' ambitious proposed quality agenda, we recommend the Agency adopt the minimum number of measures necessary to comply with the requirements of the IMPACT Act to minimize the burden on IRFs and ensure a successful transition to the post-IMPACT Act world.

In addition, CMS should clearly specify which items that are voluntary on the IRF PAI v. 1.3 will be mandatory on v. 1.4. For example, Item 17 of v. 1.3 is comprised of 12900A-D and 12900B-D is voluntary. On v. 1.4, 12900A-D are collapsed into one item so it now appears an item that was previously voluntary is now mandatory. CMS should clarify how such voluntary items will translate onto IRF PAI v. 1.4.

Finally, in Section C; Cognitive Patterns, Item C0200 requires the assessment of a patient's mental status by asking him or her to repeat three words – blue, socks, and bed. AMRPA is concerned that the use of these three words only will be required. The patient may memorize those three words and then it would appear that the mental status is improving when in fact the patient has simply memorized those three words as recommended. AMRPA recommends that clinicians be given the flexibility to select any three unrelated words to assess more accurately a patient's mental status.

XIII. Previously Adopted and Proposed Timing for New IRFs to Begin Submitting Quality Data under the IRF QRP for the FY 2018 Payment Determination, p. 23385

AMRPA Recommendation:
We support this proposal.

XIV. IRF QRP Data Completion Thresholds for the FY 2016 Payment Determination and Subsequent Years, p. 23386

AMRPA Recommendation:
CMS should suspend the data completion threshold and work with stakeholders to develop a more appropriate policy.

XV. Proposed Suspension of the IRF QRP Data Validation Process for the FY 2016 Payment Determination and Subsequent Years, p. 23386

AMRPA Recommendation:
We support CMS' proposal to suspend this process.

XVI. Previously Adopted and Proposed IRF QRP Reconsideration and Appeals Procedures for the FY 2017 Payment Determination and Subsequent Years, p. 23386

AMRPA Recommendation:
AMRPA supports CMS' proposal to provide notification via both USPS and the Quality Improvement and Evaluation System (QIES) beginning in FY 2016. Anything the Agency can do to communicate the results of an IRF's participation in the IRF QRP, including using the QIES, is important. We also recommend that CMS develop a way to notify providers mid-month every month regarding whether their data are being received or create a mechanism so that receipt can be verified to ensure that providers can correct any problems before the month's end.

XVII. Proposed Public Display of Quality Measure Data for the IRF QRP, p. 23387

AMRPA Recommendations:
While we recognize that CMS is statutorily required to publicly report IRF QRP data, we have serious reservations about implementing new requirements for IRF QRP data after the data collection period has already started. AMRPA is concerned with any proposal that would make public reporting contingent on a new policy that is based on data collected before the policy was even proposed. While every IRF strives to ensure successful participation in the IRF QRP and improve the quality of care delivered to the patients they treat, adding additional requirements to data already collected is unfair.

In addition, we are not sure the three measures that CMS proposes to publicly report are the most appropriate for public reporting purposes for several reasons. First, one of the stated goals of publicly reporting quality data is to help patients make more informed choices regarding the selection of health care providers. We are not convinced these measures will assist patients in this process. Second, if the purpose of quality reporting programs, including the public reporting of quality data, is to improve quality then the information collected and reported should allow providers to compare themselves to their peers in the industry to identify a need for improvement and mechanisms for that improvement. For example, of the three measures proposed for public reporting, only the CAUTI measure has benchmarking data, released in 2014, by which an IRF can assess its standing as compared to its peers.

At this time, the three measures under consideration for public reporting for the IRF QRP are outcomes measures; however, AMRPA encourages CMS to consider this important criteria if and when it decides to expand the number of measures for which public reporting will apply in the future. Until CMS demonstrates that it has addressed the concerns associated with the development of a star rating system raised by stakeholders including MedPAC, we cannot support CMS' future plan to use such a system for IRFs. Instead, we request that CMS work with the IRF industry to develop any form of a rating system before it is implemented.

We strongly support the ability of IRFs to review this data and suggest corrections before it is publicly reported.

ATTACHMENT B

American Medical Rehabilitation Providers Association's Analysis, Comments and Recommendations on the Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2016, Proposed Rule 80 F.R. 80 p. 23332, April 27, 2015

I. Proposed Update to the Case-Mix Group (CMG) Relative Weights and Average Length of Stay Values for FY 2016, p. 23337

CMS proposes to update the CMG weights for the FY 2016 IRF PPS. Conforming to this statutory requirement, CMS proposes to use the FY 2014 IRF claims and the FY 2013 IRF cost report data. The Agency would apply the same methodologies it has previously used to update the CMG relative weights and average length of stay (ALOS) values each fiscal year since it updated the methodology by choosing to use the more detailed cost-to-charge ratio (CCR) data from the cost reports of IRF sub-provider units of primary acute care hospitals, rather than CCR data from the associated primary care hospitals, to calculate IRFs' average costs per case.[4]

A. ***Case-Mix Group Relative Weights***

CMS illustrates the distributional effect of the CMG updates in Table 2 of the proposed rule. CMS finds that 99 percent of IRF cases fall into CMGs and tiers that would incur less than a five percent increase or decreases in the CMG relative weight. AMRPA continues to support the methodology CMS employs to calculate the CMG weights. We agree that CCR calculations are more accurate when CMS includes data from inpatient rehabilitation units instead of the acute care hospitals of which they are a part. However, the methodology description is unclear as to the role CCRs play in the Agency's calculation of CMG weights.

AMRPA Recommendation:

We request that CMS provide a complete description of how CCRs factor into its calculation of CMG weights.

B. ***Length of Stay***

CMS updated the ALOS for each CMG. The Agency states that the changes in ALOS between FY 2016 as proposed and FY 2015 are small and do not show any particular trends in IRF length of stay patterns.

AMRPA Recommendation:

As stated in our comment letter on the FY 2015 IRF PPS proposed rule, AMRPA recommends that CMS publish its methodology for calculating the ALOS annually for the IRF PPS proposed rule, just as it annually publishes the methodology for calculating the CMG weights, the standard payment conversion factors, and several other elements of the payment system. Additionally, we recommend that the Agency annually review and update its list of approved tiering co-morbidities. CMS should publish any changes in the IRF PPS proposed rule.

[4] *See* the FY 2009 IRF PPS final rule in Vol. 73, No. 154, at p. 46372 of the *Federal Register*, published on August 8, 2008.

II. Continued Use of FY 2014 Facility-Level Adjustment Factors, p. 23341

For FY 2016, CMS proposes to continue to hold the provider-level adjustment factors at the FY 2014 levels. These levels include: a low-income patient adjustment (LIP) factor of .3177; a rural adjustment of 14.9 percent; and a teaching adjustment factor of 1.0163.

AMRPA is concerned about the criteria the Agency is using to determine when it will make changes to the adjustors and the lack of clarity regarding how these changes will be made. CMS stated in the FY 2015 IRF PPS final rule that "it is better for the overall efficiency of the IRF PPS payment system to update the adjustment factors whenever it appears the benefits of updating (in terms of improved accuracy of payment rates) outweigh the costs (in terms of less stability in the annual payment rates)". Without more transparency and/or data from CMS, it is difficult for the IRF field to have clarity of when CMS would update these payment factors.

AMRPA Recommendations:

1. We recommend that CMS be more transparent in setting forth the criteria it applies to establishing the provider-level adjustment factors and calculating provider-level adjustment payments.

2. We recommend that CMS establish a minimum interval for any changes in the IRFs' provider-level adjustment factors such as once every three years. Furthermore, we recommend that if any factor varies by a minimum amount, the factor should be adjusted and proposed with an opportunity for comment.

III. Proposed FY 2016 IRF PPS Payment Update, p. 23341

A. *Overview of the Proposed 2012-Based IRF Market Basket, p. 23342*

CMS proposes creating and adopting an IRF-specific market basket, using Medicare cost report data for freestanding and hospital-based IRFs, with FY 2012 as its base period.

AMRPA Recommendation:

AMRPA supports moving forward with a separate rehabilitation facilities market basket such as the proposed 2012-based IRF market basket using Medicare cost report data for freestanding and hospital-based IRFs with some caveats as noted below.

B. *Development of Cost Categories and Weights for the Proposed 2012-Based IRF Market Basket, p. 23342*

We agree with the seven cost categories CMS has identified to comprise the 2012-based IRF market basket. However, we are concerned about the data and methodology utilized to establish the weights CMS has calculated for the 2012 IRF market basket cost categories of Employee Benefits, Contract Labor, and Wages and Salaries.[5] We believe that the cost categories' actual weights fall below what they should be as a consequence of CMS' failure to appropriately allocate overhead costs to the ancillary cost centers. Our analysis concluded that when these cost categories are appropriately allocated, the final weights attributed to them would exceed these cost categories' proposed weights under the current Rehabilitation,

[5] *See* Proposed Rule for the Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for the Federal Fiscal Year 2016, *Federal Register*, Vol. 80, No. 80, Monday, April 27, 2015, at pgs. 23343-23344.

Psychiatric and Long-Term Care (RPL) market basket, and the weight for the All Other Cost category would be lower.

Moreover, since only 20 to 35 percent of IRFs provided cost report data on their employee benefit and/or contract labor costs, CMS' calculations for these cost categories have not been shown to be representative.[6] We suggest that CMS continue to use the IPPS as a source for weights it attributes to the Employee Benefits and Contract Labor cost categories until there are sufficient data for all IRFs, so as to more accurately represent the costs IRFs incur for these cost categories.

AMRPA Recommendations:

1. CMS should recalculate the cost categories of Employee Benefits, Contract Labor, and Wages and Salaries with consideration of ancillary costs so these categories better reflect the costs IRFs incur for these cost categories.

2. Until a significant percentage that is more representative of all IRF providers submits complete cost reports, CMS should use IPPS data as a source for calculating weights for the Employee Benefits and Contract Labor categories making up the 2012-based IRF-specific market basket.

3. The major cost category weights for the IRF-specific market basket should be those shown in the following table:

Table 1: Impact of Corrections on Major Cost Category Weights

Major Cost Category	FY 2016 IRF PPS Proposed Rule	Correction to Overhead Wages, Employee Benefits and Contract Labor	Difference from NPRM
Wages and Salaries	45.5%	49.2%	3.7%
Employee Benefits	10.7%	13.7%	3.0%
Contract Labor	0.8%	1.9%	1.1%
Professional Liability Insurance	0.9%	0.9%	0.0%
Pharmaceuticals	5.1%	5.1%	0.0%
Capital	8.6%	8.6%	0.0%
All Other	28.4%	20.6%	-7.8%
Total	100.0%	100.0%	0.0%

Source: Dobson DaVanzo analysis of 2012 Medicare Hospital Cost Report Data

C. ***Wages and Salaries Costs, p. 23343***

As noted above, CMS has miscalculated the Wages and Salaries cost category for the newly established 2012-based IRF-specific market basket. Specifically, CMS' methodology for

[6] *See* Dobson DaVanzo & Associates, LLC, *Analysis of CMS Proposed Inpatient Rehabilitation Facility Specific Market Basket*. Vienna, VA., 2015, at pg. 6

wages and salary does not account for all of the overhead salary and wage costs allocated to the ancillary cost centers (*e.g.*, allocation of all housekeeping salary and wages cost provided in the Therapy Cost Center). CMS failed to include a line that would include overhead costs with direct ancillary salary and wages cost. To accurately account for IRFs' Wages and Salaries cost category, the Agency must look at all routine, ancillary, and overhead costs attributable to IRFs.

We ask CMS to explain the methodology it used for calculating the Wages and Salaries cost category for the IRF-specific market basket. Our analyses demonstrate that when calculated correctly to account for routine, ancillary, and overhead costs, the Wages and Salaries cost category weights for the 2012-based IRF-specific market basket should be 49.2 percent, which exceeds the Wages and Salary cost category that comprised 47.4 percent of the 2008-based RPL market basket.[7]

AMRPA Recommendations:

1. CMS should recalculate the Wages and Salaries cost category for the 2012-based IRF market basket so as to include all routine, ancillary, and overhead costs attributable to IRFs, particularly IRF units, in its calculation of IRFs' overhead costs.

2. CMS should explain with greater specificity the methodology it used to calculate the Wages and Salaries cost category for the proposed 2012-based IRF market basket.

IV. Proposed FY 2016 Market Basket Update and Productivity Adjustment, p. 23355

CMS proposes to apply a productivity adjustment to the FY 2016 newly established IRF-specific market basket increase factor of negative 0.6 percent. AMRPA understands that CMS cannot unilaterally reverse the productivity adjustment because it is mandated by statute. However, we do ask that CMS be mindful when contemplating IRFs' productivity adjustment of the unique needs of patients undergoing intensive medical rehabilitation and the highly skilled interdisciplinary care team responsible for their treatment.

The Agency should be aware of the limitations to achieving productivity efficiencies in IRFs. For example, some states have regulations mandating increased professional staffing ratios between health care providers and patients. Additionally, federal Medicare regulations specify a minimum of three hours of intensive therapy per day for each IRF patient. CMS has stated its policy is that the majority of patient therapy should be one on one, which is highly labor intensive. AMRPA believes the Agency should not mandate further efficiencies while simultaneously implementing new regulations or interpreting existing regulations in ways that preclude IRFs from adopting clinically appropriate innovations that would allow for greater efficiencies. Further, the Agency should be cognizant of how significant reimbursement and financial pressures compromise IRFs' capacity to provide Medicare beneficiaries with access to intensive medical rehabilitation.

Successful rehabilitation outcomes depend on the coordinated, intense, and sophisticated delivery of hands-on care by provider teams comprised of many health care professions, including, but not

[7] *See* Proposed Rule for the Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for the Federal Fiscal Year 2016, *Federal Register*, Vol. 80, No. 80, Monday, April 27, 2015, at p. 23345.

limited to, rehabilitation physicians, rehabilitation nurses, physical therapists, speech and language pathologists, and occupational therapists.

IRFs will experience heightened labor costs that cannot be offset by technology advances, due to additional items that soon must be reported in the newest iteration of the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF PAI). CMS' regulatory analysis does not accurately capture the additional labor costs IRFs will incur as a result of having additional items to report on the IRF PAI, which will further impede IRFs' ability to achieve greater productivity.

AMRPA Recommendations:

1. AMRPA urges CMS to remain cognizant of the intensive labor time and costs required by state and/or federal regulations to which IRFs are bound, and which may be barriers to IRFs achieving further gains in productivity efficiencies. CMS should consider the unique needs of IRFs' rehabilitation patients and their interdisciplinary teams of highly skilled health care professionals when considering the productivity adjustment factor that it will apply to IRFs.

2. The Agency should be mindful of the additional labor costs that IRFs will incur as a result of having more items that must be reported on the newest version of the IRF PAI.

V. Proposed Labor-Related Share for FY 2016, p. 23356

A. *Proposed Implementations of New Labor Market Delineations, p. 23358*

CMS proposes to implement new Office of Management and Budget (OMB) core-based statistical area (CBSA) delineations beginning in FY 2016 for the IRF PPS wage index. Concerned that a change in CBSA delineations could adversely affect the payments of a number of IRFs, CMS proposes to implement a one-year transition with a blended wage index for all IRFs, as it has done for other providers. The Agency also proposes to implement a three-year phase-out (FY 2016, FY 2017, and FY 2018) of the rural adjustment for existing FY 2015 rural IRFs that will be reclassified as urban in FY.

AMRPA Recommendations:

1. AMRPA shares CMS' concerns that an immediate transition to the new CBSAs would have a dramatic impact of a 14.9 percent payment reduction for affected rural IRFs. We support a one-year transition to the altered CBSA delineations with a blended wage index for all IRFs.

2. We support CMS' proposal to implement a three-year phase-out of the rural adjustment for existing FY 2015 rural IRFs that will become urban in FY 2016 and consequently, experience a loss in payments due to changes from the new CBSA delineations.

B. *Description of the Proposed IRF Standard Payment Conversion Factor and Payment Rates for FY 2016, p. 23364*

CMS proposes to increase the standard payment rate conversion factor to $15,529 in FY 2016 from the FY 2015 amount of $15,185, which is an increase of $344 or 2.265 percent.

AMRPA Recommendation:
We support the proposed adjusted new IRF-specific market basket increase of 1.9 percent for FY 2016, as well as CMS' analysis leading to a proposed budget neutrality factors for the wage index and labor-related share of 1.0027 and its proposed budget neutrality factor of 1.000 for the revised CMG weights.

VI. Proposed Update to Payments for High-Cost Outliers under the IRF PPS, p. 23367

CMS proposes to update the outlier threshold amount to $9,698 from $9,149 in FY 2015 to maintain estimated outlier payments at approximately three percent of estimated IRF aggregate payments for FY 2016. Maintaining outlier payments at three percent of total payments has been CMS policy since inception of the IRF PPS. We appreciate CMS reaffirming its commitment to establish outlier payments as three percent of the sum of total payments received by IRFs.

AMRPA Recommendation:
We support CMS' proposal to set the high-cost outlier threshold at $9,698 so that the Agency can maintain the estimated outlier payments at three percent of IRFs' total estimated payments for FY 2016.

VII. ICD-10-CM Implementation, p. 23368

In the proposed rule, CMS notes that it finalized conversions from ICD-9-CM to ICD-10-CM for IRF PPS. The Agency reminds providers that ICD-10-CM will be implemented beginning on October 1, 2015.

AMRPA members have invested much time and financial resources in ensuring IRFs are ready for the October 1, 2015 implementation of ICD-10-CM. AMRPA members have reviewed the updated ICD-10-CM code files CMS added to the IRF PPS website on Friday, May 15, 2015. Currently, CMS does not provide IRFs with the exact software specifications provided to the Agency's independent contractor that would enable providers to meet the presumptive compliance methodology utilizing ICD-10-CM codes as outlined by CMS in the final FY 2014 and FY 2015 IRF PPS rules.

AMRPA requests that CMS make available the software specifications that CMS' independent contractor is using to determine presumptive compliance methodology starting with compliance periods beginning after October 1, 2015. After reviewing the ICD-10-CM data files that CMS has posted online, AMRPA members have commented that the cross-walking of ICD-9-CM codes to ICD-10-CM codes resulted in some codes' elimination (*e.g.*, a patient's coma resulted in death, a patient's coma resulted in full recovery). AMRPA will contact CMS as it identifies any necessary codes omitted from the ICD-10-CM data files.

In response to the FY 2015 IRF PPS proposed rule, AMRPA identified ICD-10-CM codes for clinical conditions that should be included on CMS' list of ICD-10-CM codes that meet presumptive compliance criteria and its list of tiered co-morbidities. In its FY 2015 IRF PPS final rule, CMS responded by stating that at that time it would not add the ICD-10-CM codes that would add additional clinical conditions to these lists. However, CMS said it would "take the commenter's suggestions into consideration for future rulemaking."[8]

[8] FY 2015 IRF PPS final rule in Vol. 79. No. 151, at p. 45908 of the *Federal Register*, published on August 6, 2014.

AMRPA Recommendations:

1. AMRPA urges CMS to add all of the ICD-10-CM codes listed in Table 2 below to its list of presumptively compliant ICD-10-CM codes for FY 2016.

Table 2: Suggested ICD-10-CM Codes for Inclusion in CMS List of Codes That Meet Presumptive Compliance Criteria

ICD-10	Description
G911	Obstructive Hydrocephalus
G940	Encephalopathy NOS
G609	Idiopathic Peripheral Neuropathy NOS
I6991	Late Effect CV Disease-Cognitive Deficits
I69920	Late Effect CV Disease-Aphasia
I69922	Late Effects of Cerebrovascular Disease, Dysarthria
I69959	Late Effect Hemiplegia Side NOS
S72009A	Fracture Neck of Femur NOS-Closed
Z89231	Acquired absence of right shoulder
Z89232	Acquired absence of left shoulder
Z89239	Shoulder amputation status
Z89439	Foot Amputation Status
Z89432	Acquired absence of left foot
Z89431	Acquired absence of right foot
Z89441	Acquired absence of right ankle
Z89449	Ankle Amputation Status
Z89442	Acquired absence of left ankle
Z89519	Below Knee Amputation Status
Z89511	Acquired absence of right leg below knee
Z89512	Acquired absence of left leg below knee
Z89611	Acquired absence of right leg above knee
Z89612	Acquired absence of left leg above knee
Z89619	Above Knee Amputation Status
Z89622	Acquired absence of left hip joint
Z89629	Hip Amputation Status
Z89621	Acquired absence of right hip joint
Z44122	Encounter for fit/adjst of partial artificial left leg
Z44121	Encounter for fit/adjst of partial artificial right leg
Z44119	Encounter for fit/adjst of complete artificial leg, unsp leg
Z44109	Fitting and Adjustment of Artificial Leg (complete) (partial)
Z44112	Encounter for fit/adjst of complete left artificial leg
Z44111	Encounter for fit/adjst of complete right artificial leg
Z44109	Encounter for fit/adjst of unsp artificial leg, unsp leg

ICD-10	Description
Z44102	Encounter for fit/adjst of unsp left artificial leg
Z44101	Encounter for fit/adjst of unsp right artificial leg
Z44129	Encounter for fit/adjst of partial artificial leg, unsp leg

2. CMS should also add the ICD-10 codes in Table 3 below to its list of tiering co-morbidities for FY 2016. If CMS does not do so, we recommend CMS reexamine the co-morbidities with which patients have presented for the last three years and revise the co-morbidity tiers for FY 2016.

Table 3: ICD-10-CM Codes that Should be Included in the List of Tiering Co-morbidities for FY 16

ICD-10	Description	Percent
B952	Enterococcus Group D	1.01%
B9562	Methicillin resistant Staphylococcus aureus in conditions classified elsewhere and of unspecified site	0.97%
B961	Klebsiella Pnuemoniae	0.94%
B9620	Other and Unspecified E. Coli*	2.57%
B9629	Other and Unspecified E.Coli*	2.57%
E43	Malnutrition	0.74%
E440	Malnutrition Moderate Degree	0.55%
E46	Protein Calorie Malnutrition-NOS	3.29%
J9610	Chronic Respiratory Failure	0.71%
J9620	Acute and Chronic Respiratory Failure	0.56%
K592	Neurogenic Bowel	2.74%
R7881	Bacteremia	0.65%

VIII. Revisions and Updates to the IRF Quality Reporting Program (IRF QRP), p. 23368

The proposed rule includes numerous proposals to change the Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP) including measures to implement requirements of the Improving Post-Acute Care Transformation (IMPACT) Act of 2014 (P. L. 113-185). In addition, CMS proposes additions and modifications to the IRF PAI v. 1.4 to capture data associated with the proposed new measures. AMRPA recognizes that CMS' charge as a result of the IMPACT Act is significant and AMRPA stands ready to partner with CMS to ensure it is able to meet its obligation under the law while minimizing the burden on IRF.

Several of the proposals in the rule included purportedly to meet the requirements of the IMPACT Act raise a number of concerns. For example, we question whether five functional measures are necessary to meet the domain of functional status, cognitive function, and changes

in function and cognitive status. Additionally, although CMS is required to implement a measure associated with the domain of resource use by October 1, 2016, CMS proposes no such measure in this rulemaking.

Accordingly, we recommend several potential alternatives. To mitigate the expense and burden, CMS should move forward only with a few IMPACT Act items proposed in this rule, suspend several proposed items, and phase in additional changes in future years. Specifically, CMS should only move forward with the measures for domains associated with incidence of major falls, resource use, functional status, and skin integrity as required by October 1, 2016. Additionally, CMS should not move forward with five functional measures as it has proposed. CMS fails to justify in the proposed rule why five functional measures would be necessary to meet the requirements of the IMPACT Act. Other changes could be delayed pending the results of a research proposal(s) described below.

A. ***Background and Statutory Authority (p. 23368)***

CMS outlines the requirements of the IMPACT Act. Specifically, the law directs CMS to specify measures that relate to at least five quality domains including:

- Functional status, cognitive function, and changes in function and cognitive function;
- Skin integrity and changes to skin integrity;
- Medication reconciliation;
- Incidence of major falls; and
- Accurately communicating the existence of and providing for the transfer of health information and care preferences of an individual to the individual, family caregiver, and providers of services furnishing items and services to the individual when the individual transitions from a hospital or critical access hospital (CAH) to another setting (including PAC) or home; from a PAC provider to another setting including another PAC provider, hospital, CAH, or home.

The law also specifies resource use measures with respect to the following domains:

- Resource use measures including total estimated Medicare spending per beneficiary;
- Discharge to community; and
- Measures to reflect all-condition risk-adjusted potentially preventable hospital readmission rates.

In order to meet the IMPACT Act requirements for IRFs, CMS claims it selected measures that it maintains correspond to these domains and are:

- Setting-agnostic;
- Currently adopted for one or more CMS PAC quality reporting programs, are already National Quality Forum (NQF)-endorsed and in use or finalized for use, or already previewed by the Measure Applications Partnership (MAP) with support;
- Minimize added burden on IRFs;
- Minimize or avoid revisions to the existing items in assessment tools in use; and
- Avoid duplication of existing assessment items.

General Concerns and Recommendations Regarding Proposed New Measures

AMRPA appreciates CMS' consideration of the criteria measures must meet for purposes of the IMPACT Act. AMRPA supports CMS' intention to select measures that are already incorporated in the various quality reporting programs, including the IRF QRP. Doing so minimizes the burden on providers by limiting the adoption of additional quality measures which would unnecessarily inflate the number of measures on which IRFs must report.

AMRPA recommends that CMS adopt only NQF-endorsed measures in CMS quality reporting programs. This would ensure a measure has undergone vigorous review by stakeholders including patients and providers to make sure the measure is clinically appropriate.

AMRPA has several overarching concerns related to the proposed measures that would affect the FY 2018 payment adjustment. The changes proposed for the IRF QRP and IRF PAI are ambitious. AMRPA is concerned that implementing too many changes to the IRF QRP simultaneously risks mitigating the opportunity to improve quality for Medicare beneficiaries in that it imposes a significant burden on IRFs instead of allowing them to focus on patient care. It also fundamentally disrupts the longitudinal quality picture afforded by a greater degree of continuity in measure reporting. IRFs have a rich history of quality measurement, and changing the IRF functional measurement tool without establishing a crosswalk for conversion decreases the utility of historical assessment data.

In summary, we are concerned about the burden, potential duplication, data problems, and confusion these proposals portend for the IRF field as detailed below.

A. ***Additional Time and Expense***

The majority of the proposed changes to the IRF QRP, if not all of them, would result in changes to the IRF PAI, increasing it from eight pages to a total of eighteen pages. In the section of *Collection of Information Requirements*, CMS states that it estimates that data collection for the six proposed quality items will take an additional 41.5 minutes, or 238.75 hours per IRF annually. CMS estimates that the total cost related to these items is $21,239.33 per IRF annually. CMS also states that the amount is an "average increase of 124 percent to all IRF providers over the burden discussed in the FY 2015 IRF PPS final rule" (p. 22296).

AMRPA's Quality Committee and other members have considered the time, expense, and burden of collecting this information. Any modifications that increase the length of the IRF PAI inherently increase the amount of time it takes to complete the tool. First, providers anticipate perhaps an average of nine patients will need to be assessed daily. Given all the time and other responsibilities of the involved nurses and therapists, this equates to one new full time equivalent staff member and the concomitant salary and benefit expense which our members estimate to be approximately $45 an hour. Several members have tried to complete the proposed IRF PAI v. 1.4 referenced above. They found that while CMS' time estimate may prove to be correct, given that a new full-time employee would be needed, the total expense would exceed the estimated cost provided in the proposed rule. Additionally, for IRFs using an electronic health record (EHR), modifications to the system would be required which will be costly to develop and take time to implement. It will also be confusing to the staff due to the similarity of items for quality and payment.

B. ***Five New Proposed Functional Items***

AMRPA is concerned that several additions to the IRF PAI for quality reporting purposes duplicate reporting requirements for payment purposes. For example, for the self-care and mobility functional measures proposed for the FY 2018 payment determination, items from the Continuity Assessment and Record Evaluation (CARE) Tool would be added to the IRF PAI. These items duplicate IRF PAI items regarding function, in Section 39, for payment purposes. In a review of the CARE tool and IRF PAI items related to function, we found that 15 of the 18 IRF PAI items are also required under the CARE tool. As the Agency is aware, the IMPACT Act requires the Secretary to eliminate data elements that duplicate or overlap with standardized data as soon as practicable. Specifically, standardized data shall be in lieu of submission of other quality data.[9] This obligation aside, requiring completion of both data sets not only could prove confusing but also lead to errors that compromise the integrity of both data sets CMS will receive. We have raised this concern more than a year ago since these functional measures were first considered by CMS and NQF.

In addition to the burden and duplication of the CARE tool items, we believe there is room for improvement in the sensitivity of the CARE tool items which would improve the quality of data collected by IRFs and reported to CMS that helps stakeholders, including CMS and IRFs, understand if a meaningful change in a patient's functional status has occurred. This lack of sensitivity of the proposed CARE tool items has significant patient safety implications. For example, if a patient requires a walker, but has the same functional CARE assessment score as someone who does not need a walker, this could create obvious safety risks during handoff communications between clinicians. Although the Post-Acute Care Payment Reform Demonstration (PAC PRD) study design included inter-rater reliability testing to ensure consistency in assessment raters' use of the CARE tool, to date no external reliability or validity testing of the CARE tool items has been undertaken to assess its applicability across sites and provider types.

Five of the six items proposed for FY 2018 payment adjustment to fulfill the requirements of the IMPACT Act require the collection of functional and cognitive data. It is unclear why CMS believes five functional measures are required to satisfy the requirements of the IMPACT Act. In its comments to CMS on this proposed rule, the Medicare Payment Advisory Commission (MedPAC) raises a similar concern stating:

> While we support the inclusion of outcome measures, such as the proposed change in self-care and mobility measures, CMS should take care not to burden providers with too many measures. The Commission is mindful that Medicare is one of many payers that may be requiring providers to collect data for quality reporting. New measures should not be added to the IRF QRP without critical evaluation of the extent to which potential measures will contribute to meaningful differences in IRF patients' health outcomes or meaningful comparison of patient outcomes across post-acute settings. Further, CMS should give due consideration to removing

[9] 42 U.S.C. § 1395ww(j)(7)(G).

> required process measures that minimally advance or may actually reduce the overall quality of beneficiary care.[10]

AMRPA supports the concept of assessing function for quality proposes; however, we believe that selection of a measure should be based on the following criteria:

- It is administratively feasible to implement and not overly burdensome.
- It covers all domains related to complex medical and medical rehabilitation care.
- It provides for evaluation of patients' long-term outcomes of treatment.
- Floor and ceiling effects are identified when utilized on the patient populations in question. Patients who might be affected by these effects can generally be identified and allowance made for their treatment and admission and inclusion in the denominator and nominators of any metric.
- It utilizes the ICD-10-CM codes.
- In addition to medical and functional information and items, it incorporates the International Classification of Function (ICF) concept of Activity and Participation.
- Any measure of function needs to be valid, reliable, specific, and sensitive.
- Any measures required should not be duplicative of other data reporting requirements, which would represent undue burdens on providers and increase the allocation of resources to administrative rather than patient care purposes.
- It is not duplicative or similar enough to result in the diminished reliability of both measures.
- If new measures of function are required that would replace existing measures, there must be statistically sound ways to transform the existing measures to new measures so that patient performance and program performance data can continue to be reliably used and legacy data still relied upon.
- Any transitions to new measures must be introduced in an appropriately paced manner to allow providers to make adjustments to systems and procedures, as well as train staff in their new uses.

We do not believe that CMS' proposed approach with the two sets of functional items as mentioned above meet these principles.

AMRPA Recommendations:
To address the burden and other problems of submitting data on two similar data sets for different purposes, AMRPA recommends that CMS:

1. Suspend implementation of any measures not required by the IMPACT Act and that are not critical to the mission of IRFs.

2. Continue to allow IRFs to report data for functional measures through the current IRF PAI using the Functional Independence Measure (FIM), as these are the measures with which IRF personnel are familiar and which would be the least disruptive for the industry.

[10] Comments of the Medicare Payment Advisory Commission re: File Code CMS-1624-P. May 27, 2015. http://medpac.gov/documents/comment-letters/medpac-comment-on-cms's-proposed-rule-on-the-inpatient-rehabilitation-facility-prospective-payment-system.pdf?sfvrsn=0

CMS could then undertake a study to transform the IRF PAI data to the CARE/IMPACT Act data. Several AMRPA members compared the FIM and CARE items and identified overlaps between the two. The proposed CARE tool items encompass almost all the IRF PAI items and add several other components. In addition to minimizing the burden on the industry transforming the IRF PAI FIM data to the CARE tool items allows IRFs to continue to use legacy data to improve the quality of care they deliver the patients.

3. Expand the current Assistant Secretary for Planning and Evaluation (ASPE)/CMS/RTI International contract, "*Using CARE Items in the Medicare Inpatient Rehabilitation Facility Prospective Payment System*." As we understand it, the referenced study examined substituting the CARE tool items proposed for FIM items for use in the IRF PPS. The project's purpose was to "provide foundational analysis to the Assistant Secretary for Planning and Evaluation (ASPE) and the Centers for Medicare & Medicaid Services on the potential to substitute CARE items into the current case mix methodologies in the existing payment systems. Analyses conducted in this work examine the impact of using CARE items in the current case mix methodologies used to adjust payments under the Medicare IRF prospective payment system."

   In lieu of requiring all IRFs to collect, concurrently, the five proposed functional measures through CARE tool items as well as through IRF PAI FIM data, the study should be expanded to recruit and include a nationally representative sample of IRFs in order to examine the operational effect and practicalities of parallel data collection. The study participants would collect data using both tools. This data would be contemporaneous and we believe meets the IMPACT Act mandate of collecting such domains starting October 1, 2016. Once CMS has these data, the researchers could do several things:

   a. Seek to develop the cross-walk to transform the FIM to CARE data.

   b. Use the CARE data to develop a new case mix classification system that would then be tested to create new case mix groups and tiers.

Finally, AMRPA recommends that in the final rule CMS address exactly how it intends to implement all the new measures, provide training for all the providers, provide instruction through a revised IRF PAI Manual and transmittals, and other training/education opportunities such as open door forums or training webinars.

IX. Proposal of Previously Adopted IRF QRP Quality Measures for the FY 2018 Payment Determination and Subsequent Years, p. 23373

CMS proposes to modify two measures already adopted for the IRF QRP for the FY 2018 payment determination and subsequent years.

A. *Proposing Quality Measure to Reflect NQF Endorsement: All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from IRFs (NQF #2502)*

Measure #2502 was adopted for use in the IRF QRP in the FY 2014 IRF PPS final rule. The primary change associated with the measure noted in the proposed rule is to reflect that it is now endorsed by NQF.

AMRPA Recommendation:
AMRPA supports CMS' proposal to adopt this version of the measure to reflect its endorsement by NQF as we believe endorsement by a consensus-building entity such as NQF is an important prerequisite designed to ensure the measure has been appropriately reviewed by stakeholders. However, the data for this measure is hard to benchmark or compare across the industry because it is collected via claims data and IRFs only have access to their own claims data. It also tends to reflect outdated information, since claims data tend to be more than a year old once they are provided to the IRF; hence, the data do not reflect more recent efforts an IRF may have made to prevent readmissions. Finally, readmissions measures indicate what may have occurred to a patient within 30 days of discharge from the IRF; however, it is a challenge for an IRF to independently confirm what may have happened to a patient once he or she has been discharged. This is because there is no standardized way to collect data regarding what happened to a patient after discharge from the IRF. While we recognize the importance of minimizing readmissions in preventing additional and potentially unnecessary health care costs, limitations exist associated with this measure as a tool for improving the quality of care. We suggest that CMS work with the industry to develop a standardize mechanism to determine what happens to patients once they are discharged from the IRF in "real time" (or close to real time) to further improve the utility of this measure.

B. ***Quality Measure Addressing the Domain of Skin Integrity and Changes in Skin Integrity: Percent of Residents or Patients with Pressure Ulcers That are New or Worsened (Short Stay) (NQF #0678)***
This measure was previously adopted for use in the IRF QRP, the Long-Term Care Hospital (LTCH) QRP, and the Nursing Home Quality Initiative; however, CMS is now proposing to also use it for purposes of implementing the IMPACT Act. These items include:

- M0800A: Worsening in Pressure Ulcer Status Since Administration, Stage 2;
- M0800B: Worsening in Pressure Ulcer Status Since Administration, Stage 3; and
- M0800C: Worsening in Pressure Ulcer Status Since Administration, Stage 4.

While CMS does not propose to change the IRF PAI items associated with risk adjustment for the measure, it is considering a future update to the numerator of this measure which would hold providers accountable for the development of unstageable pressure ulcers, including suspected deep tissue injuries (sDTIs). The numerator would include unstageable pressure ulcers, including sDTIs, that are new or developed in the IRF as well as Stage 1 or 2 pressure ulcers that become unstageable due to slough or eschar.

AMRPA Recommendation:
CMS should adopt measures already in use in the IRF QRP for the purposes of implementing the IMPACT Act. The pressure ulcer measure meets these criteria.

However, we have concerns regarding the proposal to modify the numerator for this measure. Specifically, while we support the inclusion of unstageable pressure ulcers due to slough or eschar in the numerator, we do not believe it is appropriate to include sDTIs. This is because much is still unknown about sDTIs including whether there is an actual deep tissue injury. Many sDTIs heal without opening and it would be unfair to penalize a provider for these. In summary, we recommend that CMS update the numerator to include unstageable pressure ulcers as described above but exclude sDTIs.

X. Proposed Additional IRF QRP Quality Measures for the FY 2018 Payment Determination and Subsequent Years, p. 23375

We have discussed our concerns as they pertain to the functional measures in great detail above. We refer to CMS to those comments in addition to our recommendations below regarding the six new IRF QRP measures proposed with data collection starting October 1, 2016.

A. *An Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)*

CMS is proposing to add this measure to the IRF QRP to satisfy the IMPACT Act requirement for a measure of incidence of major falls. The measure was developed by CMS and has received NQF endorsement for long-stay residents of nursing facilities. NQF and CMS previously considered using a different fall measure, Patient Fall Rate (NQF #E0141), but stakeholders including AMRPA raised serious concerns about the measure. These concerns, and the fact that the IMPACT Act required CMS to use a falls measure that captured major injury, led the Agency to withdraw it from NQF consideration.

AMRPA Recommendations:

AMRPA supports adopting this type of measure because it reflects an emphasis on falls with major injury. However, we recommend several changes to the measure to ensure it meets the objectives outlined above before we can support its inclusion in the IRF QRP.

AMRPA is concerned that this measure has been endorsed by NQF only for long-stay residents in a nursing facility. To start, most IRF patients experience a much shorter length of stay when compared to these nursing home residents. More fundamentally, the SNF and IRF populations are quite different clinically and in their reason for being in the SNF or IRF – whereas the latter has a goal to be discharged, the former may reside in the facility long term. There is a difference between intensive rehabilitative care versus nursing home residency with regard to physical exertion and the need for patients to push themselves in order to rehabilitate. An IRF rehabilitation program may teach patients safe techniques if they find themselves falling and hence include some therapeutic falls. Clinicians take every precaution possible to avoid injuries in these situations. We recommend CMS recognize that there may be instances when IRF patients may experience therapeutic or intentional falls in the course of rehabilitation. As such, we urge CMS to evaluate the appropriateness of this measure for application to IRFs and inclusion in the IRF QRP and do so through NQF processes. Should NQF endorse it for IRFs, the measure should be updated to include a reference to patients as well as residents.

The measure specifications require reporting of all falls, not just falls with major injury, which does not appear appropriate given the intent of the measure is to determine falls that result in a major injury. We request CMS clarify or otherwise address this issue prior to implementation of this measure.

Finally, the measure specifications outline four examples of what constitutes a major injury including bone fractures, joint dislocations, closed head injuries with altered consciousness, or subdural hematoma. It is unclear if major injuries are limited to these four examples or if there is a broader list. It is imperative for the validity and reliability of the data that a full list of injuries associated with this measure be available. We believe that the four examples listed in the measure specifications are the most appropriate and should be considered a comprehensive list.

B. ***Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)***

Another IMPACT Act requirement is selection of measure(s) that address the domain of functional status, cognitive function, and changes in function and cognitive function for which, in part, CMS is proposing to adopt NQF #2631. In proposing functional measure(s), CMS acknowledges that all PAC settings treat patients with functional limitations but that the populations treated in these different settings vary in terms of their functional abilities at admission and goals for care. Additionally, while each of the four PAC settings currently collect functional data each employs a different assessment instrument, scales, and item definitions.

This process measure reports the percent of patients with both an admission and discharge assessment plus documentation of a goal for one of the function items. CMS acknowledges that discharge functional status data will not always be available. CMS notes its intent to develop outcomes-based quality measures in the future.

AMRPA Recommendation:

Our overall concerns using the proposed new functional items (self-care, mobility) are addressed above. In addition, AMRPA is concerned that assessing for functional limitations or ability does not guarantee that the patient's plan of care will be reflective of this assessment or contain goals associated with it. There does not appear to be an adequate mechanism to ensure the patient's plan of care includes such a functional goal. Finally, some stakeholders, including MedPAC, question whether process measures such as this are appropriate or whether the focus should be on the adoption of outcomes measures.[11]

XI. IRF QRP Quality Measures and Measure Concepts under Consideration for Future Years, p. 23383

Table 20 of the proposed rule lists eight measures under consideration for incorporation in the IRF QRP in the future. AMRPA appreciates the opportunity to provide preliminary feedback on these potential measures. We recognize that CMS may also use the NQF MAP PAC/LTC Workgroup to gain additional insight into the use of these measures for IRFs and would support that process. However, we have concerns regarding several measures under consideration.

A. ***Discharge to Community***

Discharge to community may not be an advisable measure for the 35 percent of Medicare beneficiaries who are hospitalized and who use PAC. The presence or absence of community or family supports may be a determinant when otherwise the patient could be discharged and thus the measure would not be a reflection of the quality of care delivered, but external factors. Additionally, without certain exclusions and other considerations, such a measure would lead to stinting on care and skewing the original admissions.

AMRPA cautions that if there is an emphasis on discharge to community without proper risk adjustment, this measure would readily create an incentive to decrease access and/or stint on care because the bundle holder may select patients who are more likely to return to community. Risk adjustment should include impairment categories, medical and functional

[11] Comments of the Medicare Payment Advisory Commission re: File Code CMS-1624-P. May 27, 2015. http://medpac.gov/documents/comment-letters/medpac-comment-on-cms's-proposed-rule-on-the-inpatient-rehabilitation-facility-prospective-payment-system.pdf?sfvrsn=0

status, demographic and other factors. AMRPA recommends including an adjustment for improving quality of life, particularly when it reduces the burden of care. It should be acknowledged that some patients may not be discharged to community but have their quality of life measurably improved. An example of this is improvement in the ability of a person with tetraplegia to master his or her environment. One approach is to exclude those patients who would not necessarily be discharged home because of such severity. In these scenarios, perhaps a more appropriate quality metric would be whether or not the patient met his or her care goals.

B. ***Patient Experience of Care***

While gaining a better understanding of a patient's experience of care is critically important, there is no standardized tool or method to collect these data for PAC settings including IRFs. The closest mechanism for collecting this type of data is the CMS Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) which, as its name implies, assesses the patient experience of care in the acute hospital setting. Revisions would need to be made to this tool in order to assess the patient experience of care in PAC. Until this is done, AMRPA does not recommend adopting this measure for the IRF QRP. Again, perhaps a measure assessing whether the patient met his or her care goals would be a more appropriate mechanism of assessing experience of care.

C. ***Percent of Patients with Moderate to Severe Pain***

As required under Medicare regulations, patients treated in IRFs must receive an intensive level of therapy services typically demonstrated by the participation in a minimum of 15 hours of therapy a week. This intensity of service is often delivered as three hours of therapy a day five days a week and known in the industry as the "three hour rule." Due to the highly intensive nature of therapy services delivered in IRFs it is not uncommon for some of these patients to experience some pain. As a result, a pain measure such as this should be carefully developed to account for the pain that might be experienced as a result of an intense course of therapy services.

AMRPA Recommendation:

AMRPA recommends that CMS carefully consider the concerns articulated above as they pertain to discharge to community, patient experience of care, and patients experiencing moderate to severe pain to ensure measures in these domains are developed appropriately for this setting. Until the concerns we have raised are mitigated, we cannot support the inclusion of these measures in the IRF QRP.

XII. Proposed Form, Manner, and Timing of Quality Data Submission for the FY 2018 Payment Determination and Subsequent Years, p. 23384

A. ***Proposed Revision to the Previously Adopted Data Collection Timelines and Submission Deadlines***

CMS proposes to change the data collection timeframe for IRF QRP measures to the calendar year unless there is a clinical reason for an alternative data collection timeframe. At this time, three of the measures submitted via the Centers for Disease Control (CDC) National Health Safety Network (NHSN) including the CAUTI (NQF #0138), MRSA (NQF #1716) and CDI (NQF #1717) use a quarterly data collection timeframe based on the calendar year. The pressure ulcer measure (NQF #0678) uses the fiscal year as it reported via the IRF PAI. And the two influenza vaccination measures, NQF #0680 and NQF #0431, track to the influenza

vaccination season, typically October 1 through March 31. This proposal would modify the data collection timeframes for all of these measures and other measures used in future years of the IRF QRP unless there is a clinical reason for an alternative data collection timeframe.

AMRPA Recommendation:
AMRPA supports this change, which will reduce the confusion and burden associated with reporting quality data. Therefore, we encourage CMS to consider that whenever changes to the IRF PAI are adopted, the new IRF PAI should also be implemented based on a calendar year approach.

B. ***Proposed Data Submission Mechanism for the FY 2018 and Subsequent Years Payment Determination for Additional IRF QRP Quality Measures and for Revisions to Previously Adopted Quality Measures***
CMS is proposing that IRFs would be required to collect data using a revised IRF PAI 1.4 for the proposed pressure ulcer measure and the additional six proposed quality measures for the FY 2018 payment determination. CMS states that it will release the technical data submission specifications and update the IRF PAI Training Manual in CY 2015.

AMRPA Recommendation:
One area of concern is that the additional data items required for quality purposes increases the length of the IRF PAI and, consequently, the burden on the provider. We believe that CMS' estimates associated with the burden of the revised proposed IRF PAI are based on incorrect assumptions and should be revised to reflect the practical implications associated with such revisions. Specifically, while the time it takes to complete the new items for one IRF PAI may in fact be less than one hour, IRFs are discharging numerous patients on any given day and the cumulative impact of completing an expansive IRF PAI for several discharges occurring on the same day could require the hiring of a new full time employee or diverting existing staff resources to complete the longer IRF PAI. In addition, for IRFs that use an electronic medical record, each revision of the IRF PAI requires a simultaneous modification of the record which is costly and can take considerable time. Finally, given CMS' ambitious proposed quality agenda, we recommend the Agency adopt the minimum number of measures necessary to comply with the requirements of the IMPACT Act to minimize the burden on IRFs and ensure a successful transition to the post-IMPACT Act world.

In addition, CMS should clearly specify which items that are voluntary on the IRF PAI v. 1.3 will be mandatory on v. 1.4. For example, Item 17 of v. 1.3 is comprised of 12900A-D and 12900B-D is voluntary. On v. 1.4, 12900A-D are collapsed into one item so it now appears an item that was previously voluntary is now mandatory. CMS should clarify how such voluntary items will translate onto IRF PAI v. 1.4.

Finally, in Section C; Cognitive Patterns, Item C0200 requires the assessment of a patient's mental status by asking him or her to repeat three words – blue, socks, and bed. AMRPA is concerned that the use of these three words only will be required. The patient may memorize those three words and then it would appear that the mental status is improving when in fact the patient has simply memorized those three words as recommended. Clinicians should be given the flexibility to select any three unrelated words to assess more accurately a patient's mental status.

XIII. Previously Adopted and Proposed Timing for New IRFs to Begin Submitting Quality Data under the IRF QRP for the FY 2018 Payment Determination, p. 23385

In the FY 2015 IRF PPS final rule, CMS established that beginning with the FY 2017 payment determination and subsequent years that new IRFs would be required to begin reporting data under the IRF QRP no later than the first day of the calendar quarter subsequent to the quarter in which it was designated as operating in the Certification and Survey Provider Enhanced Reports (CASPER) system. In the proposed rule, CMS suggests beginning with the FY 2017 payment determination, new IRFs will be required to report quality data for the purposes of the IRF QRP no later than the first day of the calendar quarter subsequent to 30 days after the date on its CMS Certification Number (CCN) notification letter. For example, if the IRF's CCN notification letter is dated March 15, then the IRF would be required to report quality data beginning July 1.

AMRPA Recommendation:

We support this proposal.

XIV. IRF QRP Data Completion Thresholds for the FY 2016 Payment Determination and Subsequent Years. p. 23386

In the FY 2015 IRF PPS final rule, CMS established that beginning with the FY 2016 payment determination, IRFs must meet or exceed two data completion thresholds. Specifically, for measures reported via the IRF PAI, 95 percent of the data must be complete; for measures submitted via the NHSN, 100 percent of the data must be complete. If this threshold is not met, the IRF will be subject to a two percent negative payment adjustment. CMS does not propose any changes to this policy.

While CMS is not proposing any changes to this policy, AMRPA remains concerned about its impact on our members as expressed in our comments in response to the FY 2015 IRF PPS proposed rule. Specifically, we are concerned that the threshold as established in the final rule was too high, particularly given CMS' own acknowledgment that achieving 100 percent data completion would be difficult at best. Additionally, CMS applied the data completion threshold to data collected in FY 2014 despite the fact that this new requirement was proposed after FY 2014 had already begun. CMS should avoid policies that have a retroactive impact on payment.

AMRPA Recommendation:

For the reasons stated above, CMS should suspend the data completion threshold and work with stakeholders to develop a more appropriate policy.

XV. Proposed Suspension of the IRF QRP Data Validation Process for the FY 2016 Payment Determination and Subsequent Years, p. 23386

In addition to establishing a data completeness threshold, CMS also finalized a data validation threshold in the FY 2015 IRF PPS final rule. However, in this proposed rule it suggests suspending the data validation threshold indefinitely.

AMRPA Recommendation:

AMRPA raised concerns about the data validation threshold in its FY 2015 IRF PPS comment letter. As a result of our continued concerns regarding the data validation threshold, we support CMS' proposal to suspend this process.

XVI. Previously Adopted and Proposed IRF QRP Reconsideration and Appeals Procedures for the FY 2017 Payment Determination and Subsequent Years, p. 23386

CMS does not propose to modify the reconsideration process discussed in the FY 2015 IRF PPS rule. However, CMS proposes to provide notification via both the USPS and the Quality Improvement and Evaluation System (QIES) beginning in FY 2016.

AMRPA Recommendation:

AMRPA supports CMS' proposal. Anything CMS can do to communicate the results of an IRF's participation in the IRF QRP, including using the QIES, is important. We also recommend that CMS develop a way to notify providers mid-month every month regarding whether their data are being received or create a mechanism so that receipt can be verified to ensure that providers can correct any problems before the month's end.

XVII. Proposed Public Display of Quality Measure Data for the IRF QRP, p. 23387

CMS is required to publicly report IRF QRP data after an IRF has had the opportunity to review and submit corrections prior to its release. CMS is proposing to begin the public display of this data by the fall of 2016 via the CMS website after a 30-day preview period by the IRF. While CMS is not proposing a specific process at this time, in the future it plans to report data using a quality rating system that gives each IRF a rating between one and five stars.

Initially, CMS will publicly report data associated with three quality measures: Percent of Residents or Patients with Pressure Ulcers that are New or Worsened, CAUTI, and All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from IRFs. For the pressure ulcer and CAUTI measures, CMS is proposing to publicly report data beginning with data collected for discharges occurring on or after January 1, 2015. Rates would be displayed based on four rolling quarters of data and would initially be reported using discharges from January 1, 2015 through December 31, 2015. Data for the readmissions measure would be based on data collected for discharges beginning January 1, 2013. Rates would be displayed based on two consecutive years of data and would initially be reported using discharges from January 1, 2013, through December 31, 2014.

CMS is developing reports that will allow providers to view the data prior to it being publicly reported that is submitted to CMS via the QIES ASAP system and the CDC's NHSN. Although initial reports will not allow providers to view these data, subsequent iterations of these reports will also include provider performance on any currently reported quality measure that is calculated based on CMS claims data that will be publicly reported. Although real time results will not be available, the report will refresh all of the data submitted at least once a month.

CMS proposes a process to allow providers an opportunity to review and correct data submitted to the QIES ASAP system or to the CDC's NHSN system by utilizing that report. Under this process, providers would to have the opportunity to review and correct data they submit on all assessment-based measures. Providers can begin submitting data on the first discharge day of any reporting quarter. Providers are encouraged to submit data early in the submission schedule so that they can identify errors and resubmit data before the quarterly submission deadline. The data would be populated into reports that are updated at least once a month with all data that have been submitted. That report would contain the provider's performance on each measure calculated based on assessment submissions to the QIES ASAP or CDC NHSN system. CMS believes that the submission deadline timeframe, which is 4.5 months beyond the end of each

calendar year quarter, is sufficient time for providers to be able to submit, review data, make corrections to the data, and view their data. CMS would not allow patient-level data correction after the submission deadline or for previous years. Before CMS displays this information, providers will be permitted 30 days to review their information as recorded in the QIES ASAP or CDC NHSN system. In addition, CMS is proposing to publish a list of IRFs who successfully meet the reporting requirements for the applicable payment determination on the IRF QRP website.

CMS would update the list after reconsideration requests are processed on an annual basis.

AMRPA Recommendation:
While we recognize that CMS is statutorily required to publicly report IRF QRP data, we have serious reservations about implementing new requirements for IRF QRP data after the data collection period has already started. AMRPA is concerned with any proposal that would make public reporting contingent on a new policy that is based on data collected before the policy was even proposed. For example, the readmissions measure would be based on data from 2013 which, by the time public reporting commences, will be three years old. Data for the pressure ulcer and CAUTI measures will be based on data beginning January 1, 2015. This proposed rule was published nearly five months after this date and will not be finalized until approximately nine months after this date. While every IRF strives to ensure successful participation in the IRF QRP and improve the quality of care delivered to the patients they treat, adding additional requirements to data already collected is unfair.

In addition, we are not sure the three measures that CMS proposes to publicly report are the most appropriate for public reporting purposes for several reasons. First, one of the stated goals of publicly reporting quality data is to help patients make more informed choices regarding the selection of health care providers. We are not convinced these measures will assist patients in this process. Second, if the purpose of quality reporting programs, including the public reporting of quality data, is to improve quality then the information collected and reported should allow providers to compare themselves to their peers in the industry to identify a need for improvement and mechanisms for that improvement. For example, of the three measures proposed for public reporting, only the CAUTI measure has benchmarking data, released in 2014, by which an IRF can assess its standing as compared to its peers.

As noted by the Medicare Payment Advisory Commission (MedPAC), the CMS five-star rating systems for providers are fraught with challenges. Specifically, in a letter to CMS dated April 16, 2015, regarding the development of a star rating system for home health, MedPAC raised concerns that such a system needs to be based on outcomes measures. At this time, the three measures under consideration for public reporting for the IRF QRP are outcomes measures; however, AMRPA encourages CMS to consider this important criteria if and when it decides to expand the number of measures for which public reporting will apply in the future. Until CMS demonstrates that it has addressed the concerns associated with the development of a star rating system raised by stakeholders including MedPAC, we cannot support CMS' future plan to use such a system for IRFs. Instead, we request that CMS work with the IRF industry to develop any form of a rating system before it is implemented.

We strongly support the ability of IRFs to review this data and suggest corrections before it is publicly reported.

Analysis of CMS Proposed Inpatient Rehabilitation Facility Specific Market Basket

Dobson | DaVanzo

Dobson DaVanzo & Associates, LLC Vienna, VA 703.260.1760 www.dobsondavanzo.com

Analysis CMS Proposed Inpatient Rehabilitation Facility Specific Market Basket

Submitted to:
HealthSouth Corporation

Submitted by:

Dobson | DaVanzo
Randy Haught
Allen Dobson, Ph.D.
Joan E. DaVanzo, Ph.D., M.S.W.
Eric Lin, M.S.

May 22, 2015— *Final Report*

Table of Contents

Introduction

HealthSouth Corporation commissioned Dobson DaVanzo & Associates, LLC (Dobson | DaVanzo) to perform a study of the impact of the inpatient rehabilitation facility (IRF) specific market basket proposed in the FY 2016 proposed rule.[1] This report builds on our prior analysis and work to examine the impact of a potential IRF-specific market basket and incorporates the detailed specifications provided in the Proposed Rule.

An IRF-specific market basket includes data for both freestanding and hospital-based IRFs and would replace the current rehabilitation, psychiatric and long-term care hospital (RPL) market basket for updating IRF prospective payment system (PPS) rates. The RPL market basket that is currently used for updating IRF PPS payment rates is derived from data for freestanding IRFs, freestanding IPFs, and LTCHs. Under an IRF-specific method, the market basket would be derived from data for freestanding and hospital-based IRFs only.

Creating an IRF-specific market basket requires a method for disentangling costs for hospital-based IRF units from the rest of the hospital in which they are located. Freestanding IRFs submit a Medicare cost report for their entire facility, making it relatively straightforward to identify the cost categories necessary to determine the major market basket cost weights. However, cost report data for hospital-based IRF units are embedded in the Medicare cost report for the entire hospital in which the IRF is a distinct part unit. Thus, an allocation method must be developed to separate costs for the hospital-based IRF unit.

For this analysis, we replicated the CMS methodology used in the Proposed Rule for the FY 2016 IRF PPS (referred to herein as the "Proposed Rule") for determining major cost category weights using Medicare Hospital Cost reports for 2012. The following sections present our findings from these analyses.

[1] "Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2016; Proposed Rule, 42 CFR Part 412, April 27, 2015

Study Findings

This section presents our findings from review and replication of the CMS methodology for developing an IRF-specific market basket. We first provide our comments on the overall methodology used to develop the IRF-specific market basket and then comment on specific technical issues regarding the calculation of the market basket cost weights.

Overall Methodology

Creating an IRF-specific market basket requires a method for disentangling costs for hospital-based IRF units from the rest of the hospital in which they are located. After reviewing the Proposed Rule, it affirmed the findings from our prior analysis that creating an IRF-specific market basket required CMS to develop a method for disentangling costs for hospital-based IRF units from the rest of the hospital using Medicare costs as a proxy for the split of IRF costs to total hospital costs. As a method for determining the portion of total hospital ancillary and overhead costs that are attributable to an IRF unit, CMS used a ratio of Medicare costs for IRF units to total Medicare inpatient services (IPPS, IRF, IPF and SNF) for each ancillary and overhead department.

We found the methodology to be complex and the accuracy of it would require assuming that all patients (Medicaid, commercial and self-pay patients) use hospital services and IRF unit services similar to Medicare patients and this approach only estimates total costs (denominator for the expenditure weights). A method for allocating total hospital wages and salaries including overhead departments to IRF units becomes increasingly more complex. Similarly, attempting to allocate total hospital capital-related costs, pharmaceutical costs and professional liability insurance (PLI) costs to IRF unit patients increases the complexity and decreases the reliability of the estimates even more.

In addition, the development of expenditure weights for an IRF-specific market basket requires combining data for both freestanding and hospital-based IRFs. This results in a "weighted" distribution of costs by category. Since there are substantially more hospital-based IRF units than freestanding IRFs, we estimate that 67 percent of the expenditure weights will be based on data for hospital-based IRF units. Thus, using potentially

unreliable allocated data that will account for more than two-thirds of the market basket information could be problematic and perhaps introduce error into the IRF specific market basket.

The prior RPL market basket method used data for only freestanding facilities (IRFs, IPFs and LTCHs) that did not require a complex methodology to parse out costs for hospital-based units from an entire hospital facility. Although there are differences in the types of patients treated and cost structures across the three types of facilities, the fact that all are freestanding hospitals makes the process of obtaining an accurate picture of their costs relatively straight forward. Prior CMS research on developing separate market baskets for each of these types of facilities concluded that "additional resources required to maintain, update, revise and rebase four separate market baskets would not provide noticeable improvement in their respective market basket updates".[2] Therefore, based on the complexity and possible unreliability in the methodology for developing an IRF-specific market basket and that there is not a noticeable improvement in the updates, CMS may want to consider continuing with the RPL methodology.

Calculation of Wage and Salary Cost Weights

For this analysis, we replicated the CMS methodology for determining major cost category weights using Medicare Hospital Cost reports for 2012. Our initial findings were consistent with the conclusion drawn by CMS on p.23345 that states, "The Wages and Salaries cost weight obtained directly from the Medicare cost reports for the proposed 2012-based IRF market basket is approximately 2 percentage points lower than the Wages and Salaries cost weight for the 2008-based RPL market basket. This is primarily a result of the inclusion of hospital-based IRF data into the 2012-based IRF market basket."

However, prior studies have shown that the wage and salaries component for freestanding IRFs was higher than the overall RPL average.[3] It was also conventional wisdom that salary costs for freestanding IRFs are lower than hospital-based IRFs. The conclusion that an IRF-specific market basket would reduce the wage and salary cost weights compared to the RPL method appeared to be inconsistent with our historical understanding of freestanding and hospital-based IRF wage and salary costs. Therefore, we examined three components of wage and salary costs (routine departments, ancillary departments and overhead departments) for both freestanding and hospital-based IRFs.

[2] Office of the Actuary, "Research on the Development of Specific Market Baskets for Excluded-Type Hospitals", April 2003
[3] Ibid.

Figure 1 shows that the percent of total costs attributed to wages and salaries from routine and ancillary departments are in fact lower in freestanding IRFs than hospital-based IRFs. The CMS methodology for estimating routine and ancillary department wage costs for hospital-based IRFs was very similar to the methodology used in our prior analyses.

Figure 1: Decomposition of Wage and Salary Cost Category Weights for Freestanding and Hospital-based IRFs Using Methodology Specified in the FY2016 Proposed Rule

Wage and Salary Cost Category	All IRFs	Freestanding IRFs	Hospital-based IRFs
Routine Cost Centers	18.1%	17.6%	18.3%
Ancillary Cost Centers	18.1%	16.9%	18.6%
Overhead Salaries	8.9%	15.9%	6.1%
Total Wages and Salaries	45.2%	50.4%	43.0%

Source: Dobson | DaVanzo analysis of 2012 Medicare Hospital Cost Report Data

However, overhead salaries calculated using the CMS methodology yields amounts that are significantly higher in freestanding IRFs than hospital-based IRFs. A possible reason for this is that CMS uses the following method to estimate the portion of overhead costs for the entire hospital that is attributable to inpatient IRF units as follows:

> "We calculate the portion of overhead salary costs attributable to hospital-based IRFs by multiplying the total overhead costs attributable to the hospital-based IRF (sum of columns 4–18 on Worksheet B, part I, line 41) by the ratio of total facility overhead salaries (as reported on Worksheet A, column 1, lines 4–18) to total facility overhead costs (as reported on Worksheet A, column 7, lines 4–18)."

This method effectively allocates overhead wages and salaries only to the routine portion of the IRF unit (i.e., worksheet B, line 41 contains costs for only the hospital-based IRF routine department) and disregards the associated ancillary departments. For all other cost categories for hospital-based IRFs, CMS made sure to account for associated ancillary department costs in their allocation method.

To correct for this omission, we calculated the portion of overhead salary costs attributable to hospital-based IRFs by first adding total overhead costs attributable to the hospital-based IRF routine department (sum of columns 4–18 on Worksheet B, part I, line 41) and ancillary departments. For each ancillary department, we computed the sum of columns 4–18 on Worksheet B, part I for each included ancillary cost center which was then multiplied by the ratio of IRF Medicare ancillary

costs for each cost center to total Medicare (IPPS, IRF, IPF, and SNF) ancillary costs for each cost centers. The sum of IRF routine and ancillary department costs was then multiplied by the ratio of facility wage and salary overhead costs (as reported on Worksheet A, column 1, lines 4–18) to facility total overhead costs (as reported on Worksheet A, column 7, lines 4–18).

The results of this approach would increase the overhead component of wages and salaries for hospital-based IRFs which in turn would increase the overall wage and salaries cost weight for hospital-based IRFs to 48.1% (***Figure 2***). With this correction, fewer freestanding IRFs will be excluded when the outlier trimming is performed. Overall, this adjustment to the methodology would increase the wages and salaries cost weight for all IRFs to 49.2%, which would be about 2 percentage points higher than the 2008-based RPL methodology.

Figure 2: Decomposition of Wage and Salary Cost Category Weights for Freestanding and Hospital-based IRFs with Adjustment to the Overhead Wage Allocation for Hospital-Based IRFs

Wage and Salary Cost Category	All IRFs	Freestanding IRFs	Hospital-based IRFs
Routine Cost Centers	18.2%	18.0%	18.2%
Ancillary Cost Centers	18.2%	17.5%	18.5%
Overhead Salaries	12.9%	16.1%	11.4%
Total Wages and Salaries	49.2%	51.6%	48.1%

Source: Dobson | DaVanzo analysis of 2012 Medicare Hospital Cost Report Data

Employee Benefit and Contract Labor Cost Weights

CMS changed its methodology for determining employee benefits and contract labor cost weights from the RPL method. Under the RPL methodology, CMS used data from IPPS hospitals as a proxy for determining these costs for RPL facilities. In the FY 2016 Proposed Rule, CMS states that:

> "For FY 2012 Medicare cost report data, while there were providers that did report data on Worksheet S–3, part V, many providers did not complete this worksheet. However, our analysis indicates that we had a large enough sample to enable us to produce a reasonable Employee Benefits [and Contract Labor] cost weight. Specifically, we found that when we recalculated the cost weight after weighting to reflect the characteristics of the universe of IRF providers (freestanding and hospital-based), it did not have a material effect on the resulting cost weight."

Study Findings

Our analysis of the Medicare hospital cost reports found that only 96 of 217 freestanding IRFs and 268 of 819 hospitals with IRF units provided data on employee benefit costs. We also found that 79 of 217 freestanding IRFs and 131 of 819 hospitals with IRF units provided data on contract labor costs.

Contrary to CMS evaluation that there was a sufficient volume of providers and that the revised methodology did not make a material difference in the cost weights for these categories, we found that data was available for very few providers and that it reduced the cost weight for employee benefits by 13% and reduced the cost weight for contract labor by 70%.

Conclusion

We found the overall methodology used by CMS for disentangling costs for hospital-based IRF units from the rest of the hospital to be complex as well as the validity and accuracy of it would require assuming that all patients use hospital services and IRF unit services similar to Medicare patients. Applying this method for allocating total hospital wages and salaries including overhead departments, capital-related costs, pharmaceutical costs, and professional liability insurance to IRF units becomes increasingly more complex and decreases the validity of the estimates. Since there are substantially more hospital-based IRF units than freestanding IRFs, using potentially unreliable and invalid data that will account for more than two-thirds of the market basket information could be problematic.

However, if CMS moves forward with an IRF-specific market basket, then it should correct the methodology for the omission of overhead wages and salaries allocated to ancillary departments. It should also consider continuing to use data from IPPS hospitals as a proxy for the level of employee benefits and contract labor costs of IRFs until there is sufficient data for IRFs. ***Figure 3***, shows the impact of these corrections on the major cost category weights for the IRF-specific market basket.

Determining the effect of these corrections on the IRF-specific market basket projections is unknown because information on Global Insight's inflation projections by category is not provided. For example, it is unknown if Global Insight is projecting wage growth to increase faster than costs for other hospital goods and services. In order to assess the impact of a revised market-basket methodology, it is important to understand the underlying components of the market basket inflation projections.

Figure 3: Impact of Corrections on Major Cost Category Weights

Major Cost Category	FY 2016 IRF PPS Proposed Rule	Correction to Overhead Wages, Employee Benefits and Contract Labor	Difference from NPRM
Wages and Salaries	45.5%	49.2%	3.7%
Employee Benefits	10.7%	13.7%	3.0%
Contract Labor	0.8%	1.9%	1.1%
Professional Liability Insurance	0.9%	0.9%	0.0%
Pharmaceuticals	5.1%	5.1%	0.0%
Capital	8.6%	8.6%	0.0%
All Other	28.4%	20.6%	-7.8%
Total	100.0%	100.0%	0.0%

Source: Dobson | DaVanzo analysis of 2012 Medicare Hospital Cost Report Data

The prior RPL market basket method used data for only freestanding facilities (IRFs, IPFs and LTCHs) that did not require a complex methodology to parse out costs for hospital-based units from an entire hospital facility. Although there are differences in the types of patients treated and cost structures across the three types of facilities, the fact that all are freestanding hospitals makes the process of obtaining an accurate picture of their costs relatively straight forward. Therefore, based on the complexity and possible unreliability and invalidity in the methodology for developing an IRF-specific market basket and that there is not a noticeable improvement in the updates, CMS may want to consider continuing with the RPL methodology. Thus the proposed fix may add more "noise" to the system than payment accuracy.