American Academy of Physical Medicine and Rehabilitation

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June 25, 2018

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1688–P
P.O. Box 8016
Baltimore, MD 21244–8016.

Sent electronically to: *http / /www.regulations.gov*.

RE : **File code CMS–1688–P**.
Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2019

Dear Administrator Verma:

The American Academy of Physical Medicine and Rehabilitation (AAPM&R) thanks the Centers for Medicare & Medicaid Services (CMS) for the opportunity to offer comments on the proposed Inpatient Rehabilitation Facility (IRF) Prospective Payment System rule for fiscal year (FY) 2019. AAPM&R is the national medical specialty organization representing more than 9,000 physicians who are specialists in physical medicine and rehabilitation (PM&R). PM&R physicians, also known as physiatrists, treat a wide variety of medical conditions affecting the brain, spinal cord, nerves, bones, joints, ligaments, muscles, and tendons. PM&R physicians evaluate and treat injuries, illnesses, and disability, and are experts in designing comprehensive, patient-centered treatment plans. Physiatrists utilize cutting-edge as well as time-tested treatments to maximize function and quality of life.

CMS' proposals for care delivered in IRFs are of great interest to our members, given their expertise in rehabilitation and their extensive management of patients in this setting. This was clearly demonstrated by the significant input we received from our members in response to this rule, and as detailed in our feedback and recommendations provided below. The information contained in this letter synthesizes many thoughts from many different physiatrists. For each category, we have tried to sum up these opinions into a general consensus statement of the Academy's position.

The Academy is grateful for the efforts of CMS to remove burdensome requirements from the IRF regulations. However, while some of the proposed changes would be very helpful; others could potentially result in serious and negative consequences for the quality of care received by

the IRF patients and we would not recommend them. We also have some additional suggestions on certain regulations which we think would dramatically relieve some of the burden physicians face. Further information is provided below.

VII. Proposed Removal of the FIM™ Instrument and Associated Function Modifiers From the IRF–PAI Beginning with FY 2020 and Proposed Refinements to the Case-Mix Classification System Beginning with FY 2020

We understand and appreciate CMS' effort to remove a burden for the facility or clinician who is responsible for documenting FIM™ data in the IRF-PAI. However, by eliminating the duty to do so, many of our members expressed serious reservations with the idea that another set of data (Quality Indicators) could or would be used in place of FIM™, especially on the accelerated timeline CMS proposes, given that the proposed Quality Indicators have only been in use since FY 2016.

The FIM™ is largely considered the de facto language of rehabilitation, as it is well substantiated and broadly used in a consistent and reliable manner across the interdisciplinary team of providers who care for IRF patients, including physicians, nurses, therapists, and social workers. Moreover, FIM™ scores are used in other settings, including in acute settings when evaluating a patient for appropriate admission to an IRF, and by other private payers to make determinations about IRF coverage. Elimination of the FIM™, therefore, would have far-reaching consequences that would serve to worsen patient outcomes and increase provider burden, rather than reduce burden as CMS seeks.

Clinicians rely on data from the FIM™ to assess patients and make appropriate clinical decisions regarding a patient's function and needs. These data help clinicians assist patients in achieving the highest level of function possible in as efficient a manner as possible. Lack of comparability between FIM™ data elements and Quality Indicator data elements therefore creates a risk that clinicians would not have all the information necessary to assess and monitor patient function and develop a treatment plan that allows for comparable (or improved) treatment plans and patient outcomes. Additionally, eliminating the FIM™ instrument and instead relying on Quality Indicators data would also create a burden as clinicians and other care team members undertake this transition, including through training and education and modification to standard assessment and care management protocols. Moreover, clinicians may still be required to use the FIM™ instrument in other settings and with other payers, requiring them to adhere to two separate assessment mechanisms based on the patient's care setting and insurance coverage, which would create additional burden.

Furthermore, we also have concerns that discontinued use of the FIM™ instrument could stymy research and advancements in treatment and care management, as most rehabilitation research and other PM&R academic papers use FIM™ data to assess function and intervention outcomes.

In addition to the above noted concerns about patient harm, provider burden, and impacts on rehabilitation research, AAPM&R also has concerns that the proposed changes will have a differential impact on payments to IRFs, as demonstrated in Table 10 of the proposed rule, without any evidence to demonstrate that the payment changes reflect greater payment accuracy. We disagree that payment changes should be made primarily to address provider burden rather than payment accuracy, particularly when claims of burden reduction have not been validated.

Recommendation – ***AAPM&R recommends that CMS delay the removal of the FIM™ instrument and substitution of Quality Indicators (QI) data until such time as CMS is able to thoroughly study and address the concerns raised above, and until there is broader consensus among the health care community (including among providers, payers, and researchers) on appropriate steps forward.*** Such a delay will also provide additional time for CMS to test and improve the reliability and validity of the Quality Indicators data for the purposes of treatment planning and payment, in addition to quality measurement, and for practitioners (including physicians, therapists, nurses, and other clinical personnel) to master the use of the data elements for these new purposes.

VIII. Proposed Revisions to Certain IRF Coverage Requirements Beginning with FY 2019

A. Proposed Changes to the Physician Supervision Requirement Beginning with FY 2019

In this section, CMS responds to several stakeholder requests, asking for a decrease in the frequency of physician visits in an IRF and to either eliminate the post-admission physician evaluation (PAPE) or allow it to be counted as one of the three weekly face-to-face visits required. We appreciate CMS proposing to allow the flexibility for a physician to include the post-admission physician evaluation (PAPE) as one of his or her three-weekly required face-to-face visits. However, from the rule, we understand that the two types of visits are not the same. The requirement for three weekly visits is what CMS considers the way to meet the requirement that "the patient requires physician supervision by a rehabilitation physician." The purpose of requiring a PAPE "is to document the patient's status on admission, identify any relevant changes that may have occurred since the preadmission screening, and provide the rehabilitation physician with the necessary information to begin development of the patient's overall plan of care."

We believe that the value of face-to-face visits with IRF patients should not be minimized, and that there are a significant proportion of cases where patients require more than three visits in their first week, as well as far into their stay. As such, we appreciate CMS deferring to clinicians to use their clinical judgement to determine whether the patient needs to be seen more than three times in the first week of the IRF admission, but we also believe that CMS could send a stronger message regarding patients' entitlement to medically necessary physician care above the three weekly visits.

Separately, while CMS does not propose any changes to the 24-hour timeframe within which the PAPE must be completed, we believe this is a requirement where additional flexibility would be beneficial. Too often, our members have shared stories about entire admissions being denied when they are late in completing the PAPE – in one case by as few as six minutes. We believe this approach is too draconian and does not allow flexibility for unexpectedly high volumes of admissions for a given IRF on a given day. Additionally, we believe that additional flexibility would be consistent with CMS proposals to reduce burden included in its proposed rule to implement FY 2019 Inpatient Prospective Payment System (IPPS) policies, such as proposals to ease documentation requirements in admission orders.

Recommendation: While we understand and appreciate that CMS is increasing flexibility by allowing the PAPE to be counted as one of the required three weekly visits, ***AAPM&R recommends that CMS more clearly articulate that the requirement for three visits per week serves as a floor and that patients are entitled to additional physician visits as medically necessary based on their rehabilitation physician's clinical judgements. AAPM&R also recommends that CMS provide greater flexibility on the requirement to complete the PAPE within 24 hours, for example by allowing for additional time to complete the evaluation when there are multiple admissions on the same date, or by reducing the severity of the penalty.***

VIII. Proposed Revisions to Certain IRF Coverage Requirements Beginning with FY 2019

B. Proposed Changes to the Interdisciplinary Team Meeting Requirement Beginning with FY 2019

In this section of the proposed rule, CMS proposed a certain amount of flexibility be allowed for the rehabilitation physician participating in a team conference. Whereas CMS had previously allowed the rehabilitation physician to participate by phone if he or she documented in the chart that he had done so, CMS is now proposing to allow the rehabilitation physician to participate not only by phone but also through other methods such as video conferencing, without any additional documentation requirements.

AAPM&R agrees with the proposal in general although we are concerned that it could be abused by engaging in it too often when there is a real benefit to face-to-face engagement with the team. Members noted that leadership of the team was the most important consideration in an inter-disciplinary team conference (IDT). In-person attendance is a positive element for the team, and there should be some guardrails applied to distant team conferencing by the rehabilitation physician so as not to encourage the privilege being abused.

Recommendation: AAPM&R supports the idea of increased flexibility for rehabilitation physicians in leading the team conference through other remote communication mechanisms; however, we are also concerned that such flexibility could lead to abuse. Because of the importance of the team conference and the differing effect of in-person versus distant participation ***we recommend that CMS place guardrails on the ability of a physician to participate remotely.***

We also recommend that CMS retain its requirement that rehabilitation physicians with appropriate training must serve as the leaders of the inter-disciplinary team conferences.

VIII. Proposed Revisions to Certain IRF Coverage Requirements Beginning with FY 2019

C. Proposed Changes to the Admission Order Documentation Requirement Beginning with FY 2019

CMS notes broad stakeholder interest in eliminating duplicative requirements, which place an unnecessary administrative burden on facilities trying to make sure they comply with each nuance of each requirement. In response, CMS has proposed removing 42CFR §606(a) regarding physician admission order documentation requirements under the premise that the requirement for an admission order is already present through the enforcement of § 482.12(c)and § 482.24(c) of the hospital conditions of participation (CoPs), as well as the hospital admission order payment requirements 42 CFR § 412.3.

CMS also proposes changes to the regulations on admission orders in the FY 2019 IPPS rule, though the change is not equivalent. In the IPPS rule CMS frames the need for a change in the admitting order regulations as the need to remove the tie between documentation of the admitting order and payment of the claim. The proposed IPPS rule states that "Therefore, we are proposing to revise the regulations at 42 CFR 412.3(a) to remove the language stating that a physician order must be present in the medical record and be supported by the physician admission and progress notes, in order for the hospital to be paid for hospital inpatient services under Medicare Part A."

In the IRF rule, on the other hand, CMS instead notes that "we are proposing to remove § 412.606(a) as we believe that IRFs are already required to fulfill this requirement under §§ 482.12(c), 482.24(c), and 412.3." This appears to mean that the presence of an admissions order is necessary for an IRF claim to be paid, since there isn't anything about removing words in 412.3 as there is in the IPPS rule. Did CMS not specify this in the IRF rule because by changing the regulation under IPPS, the new version will also apply to IRFs, or was it an oversight, or was it intentional to have the requirement for admission orders differ between acute and rehabilitation hospitals? It is not clear why CMS would reduce burden for hospitals paid under IPPS, but not propose similar burden reduction for IRFs.

Recommendations: **AAPM&R requests that CMS clarify why the rule regarding admission orders for IRFs is different than the rule spelled out in the 2019 proposed IPPS rule.** In this IRF rule, it appears CMS has only proposed to remove one duplicative rule but has not removed the requirement for a written order in the records, as CMS only proposes to change 42CFR §606(a). In the IPPS rule, CMS specifically says they will remove the requirements in 42CFR§412.3, which ties payment to an order being evident in the chart. If it is because once CMS adjusts 42CFR§412.3 for the acute IPPS hospital, the revised rule will also apply to IRFs, AAPM&R recommends not including 42CFR§412.3 in the list of other existing duplicative requirements which allow for the removal of 42CFR §606(a), and/or adding that CMS add a paragraph to explain its proposal under the IPPS rule and how it will impact IRFs. **AAPM&R believes that there would be a much greater lessening of the burden if the requirement for admission orders was not tied to a payment rule.**

One other issue in need of clarification is that 42CFR § 412.606 (which CMS proposes for removal) requires that the admission orders be "physician orders" while §412.3 refers to "an order for inpatient admission by a physician or other qualified practitioner in accordance with this section and §§482.24(c), 482.12(c)." **Please specify any ramification from removing a requirement for "physician orders" for patient care in an IRF stay and substituting a requirement for inpatient admission orders that may be made by a "physician or other qualified practitioner."**

VIII. Proposed Revisions to Certain IRF Coverage Requirements Beginning with FY 2019

D. Solicitation of Comments Regarding Additional Changes to the Physician Supervision Requirement

In this section of the rule, CMS notes that when the IRF coverage criteria were initially implemented in 2010, CMS believed that the rehabilitation physician visits should be completed face-to-face to ensure that the patient receives the most comprehensive in person care by a rehabilitation physician throughout the IRF stay. CMS is now soliciting public comments on whether the rehabilitation physician should have the flexibility to determine that

some of the IRF visits can be appropriately conducted remotely via another mode of communication, such as video or telephone conferencing.

The Academy has significant concerns with CMS' consideration of allowing remote assessment of IRF patients. Physiatry and rehabilitation visits require hands-on care, and assessing patients in rehabilitation facilities requires expert physical exam skills. Remote visits would increase the risk of inaccurate assessment for both medical and functional needs and could result in inappropriate treatment, delayed rehabilitation, or even patient harm. While the Academy recognizes the challenges that facilities in rural areas face, we disagree that care provided by rehabilitation physicians can be appropriately furnished via remote technologies such as video or teleconferencing. We believe that patients in rural areas deserve access to the same high-quality care that other patients receive, and that for rehabilitation visits to serve their purpose, hands-on assessment is necessary.

Recommendation: ***AAPM&R recommends that there be no change in the requirement for face-to-face visits at this time.*** The Academy opposes allowing rehabilitation physicians to have the flexibility to decide if some IRF visits can be appropriately conducted remotely via another mode of communication, such as video or teleconferencing, as it is currently not best practice. The Academy believes direct clinical oversight requires direct hands-on patient care, not remote care. There may be further options for remote patient visits in the future, but most of the field is not ready for it at this time.

One suggestion for clarification to ensure quality care is maintained for beneficiaries is that CMS specifically define the three required weekly visits as a "floor" as it might be medically necessary for the physiatrist to see their patient more often, perhaps even daily, particularly early in their rehab program. By specifically noting that the three weekly visits requirement is a "floor," CMS may avoid their contractors insisting that only 3 visits are covered.

VIII. Proposed Revisions to Certain IRF Coverage Requirements Beginning with FY 2019

E. Solicitation of Comments Regarding Changes to the Use of Non-Physician Practitioners in Meeting the Requirements Under § 412.622(a)(3), (4), and (5)

In this section of the rule, CMS requests feedback regarding expanding the role of non-physician practitioners (referred to in these comments as "Advanced Practice Providers" or "APPs") to fulfill some of the requirements that rehabilitation physicians are currently required to complete.

The Academy appreciates the opportunity to answer CMS questions. The Academy strongly opposes expanding the role of APPs because of the disparity in physician training and APP training. It may increase, rather than decrease, physician burden and could impact patient care negatively. It should be noted that the Academy and its members value APPs, as approximately 70% of our members work with APPs in some capacity according to a recent Academy survey. The Academy considers APPs to be a vital part of the caregiving team and believe that by partnering with APPs, physiatry can fulfill a broader need and value in the delivery system. However, the Academy is concerned that increasing APP responsibilities in IRFs may reduce burden for IRFs at the expense of the quality of care patients receive, Specifically, our members consistently reported that the APPs who had supported their care teams were not qualified to take on the bulk of responsibilities currently shouldered by rehabilitation physicians in IRFs. APPs did not have the education, training, or experience to appropriately manage patient care or lead medical decision making; indeed, providing oversight of APPs' activities generally tended to increase physician burden rather than reduce it. For these reasons, the Academy has significant concerns and is skeptical that expanding the role of APPs would reduce physician burden.

APPs do not have the specialized training required. There is no required IRF rotation during APP training. APPs that work in IRFs are trained on the job by the supervising physician, whereas physiatrists are trained through a four-year residency program and continue to gain skills and experience through regular patient care and ongoing continuing medical education requirements that largely focus on physical medicine and rehabilitation. This disparity in training makes physiatrists wary of expanding the role of APPs in IRFs.

IRFs treat a specialized patient population, and the clinicians who treat them and manage their care therefore require specialized skills. PM&R physicians have significant training and experience in neurologic, neuromuscular, and musculoskeletal assessment and diagnosis, which APPs do not. Without this expertise, APPs' ability to comprehensively assess, diagnose, treat, and manage IRF patients is limited**.**

The Academy has not discovered any system in place for credentialing APPs in physiatric skills, but believes that credentialing APPs to demonstrate this competency could potentially be helpful. The Academy is currently developing educational resources both for physiatrists who are working with APPs and advanced practice providers (APPs) who are interested in working with physiatrists. The Academy hopes that we may be able to advise CMS further on educating APPs in the rehabilitation setting as we strengthen our partnership with APPs.

Recommendations

The Academy opposes expanding the roles of APPs into the role of rehabilitation physicians at this time. Physiatrists – who are most qualified to fill the role of IRF rehabilitation

physicians - follow a rather unique course of training, education, and experience, such that even other physicians may not be able to step into their role in IRFs without a substantial amount of training and experience beforehand. The rehabilitation physician's role in an IRF includes providing direct care to their patients, evaluation and management, not only of medical status but also of functional status, changes and goals, leading an interdisciplinary team of other clinicians, synthesizing information from multiple sources, complex medical decision-making, and advocating for the many unforeseen needs a newly disabled patient may have. Knowledge needed to accomplish these multiple roles is not often provided in many settings (including medical schools) and the rehabilitation physician's skill set is developed through education, experience, and mentoring, which provide him or her with a unique set of tools to use in treating patients. Perhaps in the future as the Academy's educational resources are expanded, some type of educational and experience track specific to physiatric skills could be developed that would provide an opportunity for APPs to obtain this specialized training. For now, most of our members do not think APPs have the ability or skills to take on tasks that are required to be completed by a rehabilitation physician, including evaluation for admission, leading a team conference, completing a PAPE, and other such roles.

The Academy would also like to request clarification on how CMS is defining a non-physician provider. In the rule CMS uses the following phrase: "enable IRFs to expand their use of non-physician practitioners (physician assistants and nurse practitioners)" yet in some of CMS' publications an APP is defined not only as both of those positions but also includes clinical nurse specialists. Are clinical nurse specialists included (i.e. did CMS leave them off unintentionally) or does the Agency mean to exclude them from the proposed changes? ***Please clarify either way in the final rule***

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Finally, as CMS considers the role that other providers, such as APPs, can contribute to care of patients in IRFs, AAPM&R respectfully suggests that this is an opportune time for CMS to add clarity to the current definition of a "rehabilitation physician" and "director of rehabilitation" of an inpatient rehabilitation hospital or any other site of practice. It is AAPM&R's position that clarification is needed to ensure Medicare beneficiaries continue to receive optimized rehabilitation care from the most qualified providers. As mentioned above, it is not always clear that even a physician who is not a physiatrist can step readily into their shoes. It has come to AAPM&R's attention that the terms used by CMS to describe a rehabilitation physician (particularly the words "specialized training and experience") have generated many differing and conflicting interpretations about who can properly claim the role of a rehabilitation physician, potentially placing beneficiaries at risk of receiving lower quality care. Because we feel that the best practice for treating physical medicine and rehabilitation patients is by someone with the unique training, skills, and experience of a physiatrist, we recommend updating the current definition as detailed below:

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CMS Definition of Rehabilitation Physician and Director of Rehabilitation

CMS has defined a rehabilitation physician in more than one place. For example, 42 C.F.R. § 412.622, currently states that for an IRF claim to be paid, certain criteria need to be met, including under subsection (a)(3)(iv) which states "(iv) Requires physician supervision by a **rehabilitation physician, defined as a licensed physician with specialized training and experience in inpatient rehabilitation"** (emphasis added)

42 C.F.R. § 412.29 further states that in order to be paid under the IRF prospective payment system rather than the general acute inpatient hospital Prospective Payment System, the IRF must have in effect certain procedures, one of which is to (e) "Have in effect a procedure to ensure that patients receive close medical supervision, as evidenced by at least 3 face-to-face visits per week by a **licensed physician with specialized training and experience in inpatient rehabilitation** to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process." (emphasis added)

The IOM 100-02 Medicare Benefit Policy Manual, Chapter 2, states, "The "rehabilitation physician" need not be a salaried employee of the IRF but must be **a licensed physician with specialized training and experience in rehabilitation**. For ease of exposition throughout this document, this physician will be referred to as a "rehabilitation physician". "(emphasis added)

CMS has also defined a director of rehabilitation in regulation:

42 C.F.R. § 412.29(g) contains a definition of a director of rehabilitation which is a bit more robust and suggests that the terms "specialized training and experience" would have the meaning specified as follows:

"(4) **Has had, after completing a one-year hospital internship, at least 2 years of training *or* experience in the medical-management of inpatients requiring rehabilitation services."** (emphasis added)

AAPM&R Suggested Guidelines

As a guideline to determine if the above regulations are met, AAPM&R recommends the following minimum standards to define a Director of Rehabilitation and Rehabilitation Physician.

- **Director of Rehabilitation Facility/Unit**: Physiatrist, defined as licensed physician (M.D. or D.O.) who has completed an Accreditation Council for Graduate Medical

Education (ACGMC) or American Osteopathic Association (AOA)-accredited residency in Physical Medicine &Rehabilitation (PM&R) and is either board eligible or has obtained board certification.

- **Rehabilitation Physician:** Physiatrist, defined as licensed physician (M.D. or D.O.) who has completed an ACGME- or AOA-accredited residency in PM&R and is either board eligible or has obtained board certification.

    - **Potential Hardship Exception if PM&R physician not available –** practicing under the supervision of the director of rehabilitation, a non-PM&R licensed physician (M.D or D.O.) who is board certified in an appropriate subspecialty board (e.g., Spinal Cord Injury, Brain Injury Medicine, Neuromuscular Medicine). It would be necessary to define precisely what is meant by "If a PM&R physician is not available."

Physiatrist Training

For information about the training received by physiatrists, the 2017 Accreditation Council of Graduate Medical Education (ACGME) program requirements for Graduate Medical Education in Physical Medicine and Rehabilitation state:

Physical medicine and rehabilitation is the medical specialty which focuses on the diagnoses, evaluation, and management of persons of all ages with physical and/or cognitive impairments, disabilities, and functional limitations.

The program must integrate the following ACGME competencies into the curriculum:

- Residents must demonstrate competence in the evaluation and management of patients with physical and/or cognitive impairments, disabilities, and functional limitations, including:
    - history and physical examination pertinent to physical medicine and rehabilitation;
    - assessment of impairment, activity limitation, and participation restrictions;
    - review and interpretation of pertinent laboratory and imaging materials for the patient;
    - providing prescriptions for orthotics, prosthetics, wheelchairs, assistive devices for ambulation, and other durable medical equipment or assistive devices;

- pediatric rehabilitation;
- geriatric rehabilitation;
- application of bioethics principles to decision making in the diagnosis and management of their patients;
- and providing prescription of evaluation and treatment by physical therapists, occupational therapists, speech/language pathologists, therapeutic recreational specialists, psychologists, and vocational counselors.

Residents must have direct and complete responsibility for the rehabilitative management of patients on the inpatient physical medicine and rehabilitation service. The inpatient experience should be at least 12 months in Physical Medicine and Rehabilitation. Each resident assigned to an acute inpatient rehabilitation service should be responsible for a minimum of six physical medicine and rehabilitation inpatients. Each resident assigned to an acute inpatient rehabilitation service should not be responsible for more than 14 physical medicine and rehabilitation inpatients. Residents should care for an average daily patient load of eight patients over the 12-month inpatient experience. Residents should have inpatient rounds to evaluate patients with faculty members at least five times per week. (https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/340_physical_medicine_rehabilitation_2017-07-01.pdf?ver=2017-05-25-083554-417)

In the Academy's viewpoint, the physiatrist's multidisciplinary training makes the PM&R physician the most qualified specialist to lead the team of medical specialists and therapists involved in a patient's rehabilitative care. We welcome the opportunity to further discuss our recommendations on the definition of rehabilitation physician and director of rehabilitation with CMS officials at any time.

Education of Advance Practice Providers

Although we do not propose that an APP can qualify as a rehabilitation physician, recognizing that APPs provide a critical pathway to maximize the workforce in physiatry and rehabilitation care, the AAPM&R, as mentioned, is developing educational resources both for physiatrists and advanced practice providers (APPs) to assist these clinicians in working collaboratively in the inpatient rehabilitation setting and all practice settings. We anticipate these resources will be available in the coming months.

IX. Proposed Revisions and Updates to the IRF Quality Reporting Program (QRP)
C. Proposed New Removal Factor for Previously Adopted IRF QRP Measures

CMS proposes to continue to rely on existing removal factors when considering whether to remove measures from the IRF Quality Reporting Program (QRP). CMS also proposes a new

removal factor: "Factor 8: The costs associated with a measure outweigh the benefit of its continued use in the program." In some instances when this factor is used as a justification for proposing to remove a measure, it may not be necessarily due to the "cost" imposed on the provider, but the cost imposed on CMS to administer the measure.

Recommendations - ***AAPM&R suggests this removal factor may be problematic if CMS proposes to remove a measure that clinicians or patients feel is important, but may be too costly to administer.***

IX. Proposed Revisions and Updates to the IRF Quality Reporting Program (QRP)

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

Under statute, CMS is required to establish procedures for making the IRF QRP data available to the public after ensuring that an IRF has the opportunity to review its data prior to public display. While CMS has implemented this requirement, we believe that Medicare beneficiaries and the public-at-large would also be better served if CMS were to implement user testing prior to public reporting to ensure that reported data are meaningful to and actionable by consumers. This would be comparable to processes CMS undertakes with respect to public reporting of quality measures under the Merit-based Incentive Payment System (MIPS).

Recommendations: ***AAPM&R recommends CMS adopt a similar consumer testing approach for public reporting of IRF quality payment program measures as it does for measures reported under the MIPS program to ensure these measures resonate with end-users.***

Thank you for your consideration of these comments. If you have any questions or would like further information, please contact AAPM&R's Health Policy Manager, Kate Stinneford, RN, JD, at kstinneford@aapmr.org or 847-737-6022.

Sincerely,

Scott Laker, MD
Chair, Quality, Practice, Policy and Research Committee