American Academy of Physical Medicine and Rehabilitation

aaPM&R

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June 22, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1632–P
P.O. Box 8013, Baltimore, MD 21244–1850

Re: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2016; Proposed Rule

Dear Mr. Slavitt:

On behalf of the more than 8,000 physiatrists of the American Academy of Physical Medicine and Rehabilitation (AAMP&R), we appreciate the opportunity to submit comments to the proposed rule: *Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2016; Proposed Rule* that was published in the Federal Register on April 27, 2015. Physiatrists are specialists in the field of physical medicine and rehabilitation (physiatry) and treat adults and children with acute and chronic pain, persons who have experienced catastrophic events resulting in paraplegia, quadriplegia, traumatic brain injury, spinal cord injury, limb amputations, rheumatologic conditions, musculoskeletal injuries, and persons with neurologic disorders or any other disease process that results in impairment and/or disability.

Proposed FY 2016 IRF PPS Payment Update

Creating an IRF-Specific Market Basket

For CY 2016, the Centers for Medicare and Medicaid Services (CMS) is proposing to create and adopt a 2012-based inpatient rehabilitation facility (IRF) market basket, using Medicare cost report data for both freestanding and hospital-based IRFs. AAPM&R supports CMS's proposal to develop an IRF-specific market basket and we believe that the proposed market basket will be an improvement over the current Rehabilitation, Psychiatric and Long-Term Care (RPL) market basket used to update the IRF prospective payment system payments. However, we have some concerns with the way some of the IRF-specific market basket cost categories were determined. AAPM&R believes that these cost categories' proposed weights fall below the actual weight, as a consequence of CMS' failure to appropriately allocate overhead costs to the ancillary cost centers. Furthermore, 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 lack accuracy.

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Wages and Salaries Costs

In this Proposed Rule, CMS proposes to use only a portion of the ancillary costs in the market basket cost weight calculations because the agency believes that hospital-based IRF only use a portion of the hospital's ancillary services. The Academy does not disagree with CMS that IRFs use only a portion of the hospital's ancillary services, however, we believe that there may be inaccuracies in CMS's calculation of the wages and salaries costs because this data is so heavily embedded in the hospital data.

AAPM&R believes that the proposed calculations do 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). The Academy believes that 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. **AAPM&R seeks further clarification on the methodology used to calculate the Wages and Salaries cost category for the IRF-specific market basket.**

Employee Benefit and Contract Labor Costs

Prior to CMS's implementation of CMS Form 2552–10, Employee Benefits and Contract Labor data was derived by multiplying the 2008-based RPL market basket Wages and Salaries cost weight by the ratio of the IPPS hospital market basket Contract Labor cost weight to the IPPS hospital market basket Wages and Salaries cost weight. As a result of the implementation of CMS Form 2552-10, IRF providers now have a way to report this data. However, in this rule the agency states "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. AAPM&R supports the continued collection of this data, however, we believe that there may be inaccuracies in CMS's calculation of the Employee Benefits and Contract Labor cost weight. **AAPM&R recommends 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 is sufficient data for all IRFs, so as to more accurately represent the costs IRFs incur for these cost categories.**

AAPM&R recommends that CMS continue to encourage all providers to report these data points on the Medicare cost report. In addition, the Academy recommends that CMS develop educational materials related to the Medicare cost reports to help providers understand the importance of completing the reports, what the data is utilized for, and how to complete the reports. As a result of potential inaccuracies in the data the Academy also recommends that CMS use

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IPPS data as a source for calculating weights for the these three categories making up the 2012-based IRF-specific market basket.

Revisions and Updates to the IRF QRP

AAPM&R believes that quality measures and instrument(s) that can transcend and ultimately break down the silos that currently exist in the post-acute care sector are pertinent to quality patient care. In order for such measures and instruments to be used effectively and to enable further reforms to PAC service delivery and to associated payment models (such as a free flow of patients to appropriate settings during the rehabilitation process, site-neutral payments, payment bundling, or the transition away from individual setting regulations), the instrument(s) must be used in conjunction with other data to demonstrate the aspects of medical rehabilitation programs and services that promote best-care practices, in the appropriate setting, based on the needs of the individual patient and family/care-giver.

Proposed Additional IRF QRP Quality Measures for the FY 2018 Payment Determination and Subsequent Years

In this CY 2016 Proposed Rule, CMS is proposing to adopt six additional quality measures beginning with the FY 2018 payment determination. The Academy has major concerns with the adoption of these measures.

The six new quality measures proposed in this rule have a different scale (6 versus 7 points), different measurement periods (look back periods differ) and different definitions (average score versus lowest score) than the current IRF Patient Assessment Instrument (IRF-PAI) utilized for payment. Implementation of these new measures would thus require a separate data collection system to report the quality measures and a different collection system for payment. It is important that such a mechanism be applied at a full scale and tested before enabling further payment reforms. **The Academy urges CMS to analyze data received from these new measures over a period in conjunction with other data collected, such as through the IRF-PAI, and ensure they are receiving meaningful data that can inform best-care practices in order to support future payment reforms.**

AAPM&R continues to believe that new proposed measures should undergo validity and reliability testing, with reference to individual patient subpopulations. Additionally, research studies should be conducted to:

- Compare the Continuity Assessment Record and Evaluation (CARE) items against other valid and reliable instruments that are designed to measure function in diverse PAC populations, and the data then should be used to improve the CARE items or to replace it with other measures for the measurement of functional status across the continuum of care

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- Study the tool's effectiveness in tracking functional improvements and decline longitudinally across the entire care trajectory, in particular to address the potential for ceiling and floor effects of the measure
- Compare models of care for subpopulations in order to find best practices for patients with moderate to severe disabling conditions; outcome measures should include reduction of disability, disease and symptom management, prevention of primary and secondary complications, and mortality, patient and family/care-giver training, and patient satisfaction with the care experience.

AAPM&R is also concerned that the new proposed quality measures, while addressing functional improvement, do not address the practical value of the measurable improvement or the ability of a patient to return to the community. For example, a patient with a complete cervical spinal cord injury or dense hemiplegia from a stroke may not make significant functional gains (i.e., they may remain dependent in many domains of mobility and/or activities of daily living). However, with expert and comprehensive patient and family/care-giver education and training by the rehabilitation team, the patient may return to the community despite not meeting the thresholds that are suggested by the quality measures. The Academy believes that measurement of patient and family engagement with the process of care and with education and training must be considered in the evaluation of models of PAC. In addition, without factors related to psychosocial and family financial support in prediction models, changes in function from admission to discharge do not tell the entire story. **The Academy urges CMS to support the development of quality measures that relate to patient and family engagement as PAC reform implementation evolves.**

We appreciate the opportunity to comment on this proposed rule. The AAPM&R looks forward to continuing dialogue with CMS on these important issues. If you have any questions about our comments, please contact Jenny Jackson, Manager of Finance and Reimbursement in the AAPM&R Division of Health Policy and Practice Services. She may be reached at jjackson@aapmr.org or at (847)737-6024.

Sincerely,

Phillip Bryant, DO
Chair
Reimbursement and Policy Review Committee
American Academy of Physical Medicine and Rehabilitation