June 20, 2016

SUBMITTED VIA REGULATIONS.GOV

Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: (CMS-1647-P) Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2017

Dear Acting Administrator Slavitt:

The undersigned members of the Coalition to Preserve Rehabilitation (CPR), and other supporting organizations, appreciate the opportunity to comment on the proposed rule entitled, *Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2017*. CPR is a coalition of national consumer, clinician, and membership organizations that advocate for policies to ensure access to rehabilitative care so that individuals with injuries, illnesses, disabilities and chronic conditions may regain and/or maintain their maximum level of health and independent function.

Overview

The proposed rule adopts a market basket update specific to Inpatient Rehabilitation Hospitals and Units (IRFs), and updates quality measures and reporting requirements under the IRF Quality Reporting Program (QRP), among other things. Due in part to enactment of the Improving Medicare Post-Acute Care Transformation ("IMPACT") Act of 2014, the proposed rule focuses heavily on implementation of quality reporting measures.

Notably, the rule does not include any pilots, demonstration projects, or more significant implementation of bundling of post-acute care, so-called "site-neutral" payment policies between IRFs and other settings of care, or other post-acute care proposals contained in the President's most recent budget, or in recent MedPAC recommendations. CPR is grateful to CMS for choosing not to include these types of provisions in this rule, considering the serious reservations CPR members have with many of these proposals and the challenges they create for Medicare beneficiaries in need of an intensive, coordinated inpatient hospital level of medical rehabilitation.

There is one omission in the proposed rule, however, about which CPR has major concerns. That omission involves the lack of any discussion or proposed solution to the unintended consequences of transitioning to the ICD-10 code set and the impact this transition is having on access to IRF care for select patients, particularly Medicare beneficiaries with brain injuries and other orthopedic impairments. Because of the importance of this issue in terms of access to IRF care, we begin our comment letter with this issue, despite the fact that we were surprised to learn that the proposed rule did not even address it, and we strongly urge CMS to offer a solution to this barrier to access to IRF care in the final rule.

Unintended Consequences of ICD-10 Conversion on Access to IRFs for Medicare Beneficiaries with Brain Injuries and Select Orthopedic Conditions

On October 1, 2015 all providers were required to start using the ICD-10-CM code set in their documentation of health care services. In previous rulemaking, CMS translated the ICD-9 codes that would qualify under the ICD-10 code set for purposes of meeting "presumptive compliance" with the 60% Rule, the IRF requirement that at least 60% of IRF patients must have one of 13 specified diagnoses in order for a hospital to quality as an IRF. The new ICD-10-CM codes were effective on or after October 1, 2015.

Soon after the new codes became effective, CPR started hearing from member organizations that conditions previously included in calculating a provider's presumptive compliance were being rejected for that purpose. In other words, there are a number of ICD-10-CM codes that are no longer accepted under presumptive compliance that had been routinely accepted under the ICD-9 code set. This has the effect of creating a major disincentive for IRFs who are close to the 60% margin to admit certain patients, those whose conditions are described by codes that are no longer being accepted by CMS for presumptive compliance with the 60% Rule.

Based on data generated by eRehabData®, a firm contracted by a CPR member (the American Medical Rehabilitation Providers Association) to analyze IRF data, this issue affects three different types of beneficiaries at this time, individuals with:

1. Traumatic brain injuries;
2. Fractures of the hip; and,
3. Major multiple fractures.

An early analysis of Medicare data suggested that approximately 18,700 brain injury cases in FY 2016 would not meet the presumptive test as a result of the transition from ICD-9-CM to ICD-10-CM code sets. A later assessment revealed that the following number of cases have not been included under the presumptive methodology since October 1, 2015:

	Cases Removed from Presumptive Compliance (FY16 YTD)	**Estimated Medicare National Cases Removed from Presumptive Compliance (FY16 YTD)***
Brain Injury (IGC 2.21, 2.22)	1,607	**5,541**

Hip Fracture (IGC 08.11)	1,329	**4,583**
Major Multiple Fracture (IGC 08.4)	479	**1,652**
TOTAL	3,415	**11,776**

Source: eRehabData®, Medicare discharges for FY 2015 (10/1/2014-9/30/2015) and FY 2016 YTD (10/1/2015 – 6/9/2016)
*Approximation based on eRehabData® capturing approximately 29% of total Medicare IRF discharges.

According to this data, compared to FY 2015, IRFs have experienced a -58.8 percent decrease in their presumptive compliance percentages for brain injury cases (IGCs 2.21, 2.22), -18.1 percent decrease in hip fractures cases (IGC 8.11) and -29.7 percent decrease for major multiple fracture (IGC 8.4).

	FY 2015		**FY 2016 YTD**		
	Discharges	**Presumptively Compliant Discharges (and as % of All Discharges)**	**Discharges**	**Presumptively Compliant Discharges (and % of All Discharges)**	***Change in IRF's Presumptive Compliance Due to FY16 IGC Etiologic Diagnoses Exclusions***
Brain Injury (IGCs 2.21, 2.22)	4,442	4,442 (100%)	2,735	1,128 (41.2%)	***-58.8%***
Hip Fracture (IGC 08.11)	12,930	12,930 (100%)	7,327	5,998 (81.9%)	***-18.1%***
Major Multiple Fracture (IGC 08.4)	1,299	853 (65.7%)	701	252 (36.0%)	***-29.7%***

Source: eRehabData®, Medicare discharges for FY 2015 (10/1/2014-9/30/2015) and FY 2016 YTD (10/1/2015 – 6/9/2016)

However, despite the unintended consequences of these coding changes which make it harder for IRFs to meet presumptive compliance with the 60% Rule, these providers do not seem to be limiting access to IRF care in the near term by denying access to brain injury, hip fracture, or major multiple trauma beneficiaries. The data shown below demonstrates that access to IRF care for these beneficiaries has remained relatively stable since the change in coding.

	FY15 Discharges	Percentage of All FY15 Medicare Discharges	FY16 Discharges (YTD)	Percentage of All FY16 Medicare Discharges (YTD)
Brain Injury (IGCs 2.21, 2.22)	9,235	**6.87%**	5,368	**6.91%**
Hip Fracture (IGC 08.11)	16,421	**12.22%**	8,979	**11.56%**
Major Multiple Fracture (IGC 08.4)	3,170	**2.36%**	1,722	**2.22%**

Source: eRehabData®. Medicare discharges for FY 2015 and FY 2016 YTD (10/1/2015 – 6/9/2016).

Despite these unintended restrictions in access to IRF care, beneficiaries do not yet appear to have felt the impact of these coding changes. However, the Coalition to Preserve Rehabilitation is seriously concerned that IRFs may, over time, be forced to tighten access to an IRF level of care to these beneficiaries because of the unintended consequences of this coding transition. The current treatment of these brain injury, hip fracture and major multiple fracture codes creates barriers to access to IRF care that, we believe, must be corrected by CMS in the final rule. CPR respectfully impresses upon CMS that any further delay in resolving these issues going forward may bring harm to beneficiaries in terms of potential barriers to access.

CPR strongly urges CMS to explicitly clarify in the final rule the ICD-10 codes that will precisely mirror the ICD-9 codes that were phased out, in order to maintain equal access to IRF care for these beneficiaries and eliminate the unintended consequences of the coding conversion. Further, we ask CMS to apply this clarification retroactively to October 1, 2015.

Medicare PAC Reform Requires Serious Deliberation and Reliable Data

All Medicare post-acute care (PAC) reforms that CMS considers should, first and foremost, preserve access to quality rehabilitation services provided at the appropriate level of intensity, in the right setting, and at the right time to meet the individual needs of Medicare beneficiaries. This is, of course, much easier said than done. Meeting this challenge, while making Medicare post-acute care payment policy more efficient, requires serious deliberation and should be based on reliable data that is comparable from one post-acute care (PAC) setting to another. Standardized data need to be collected across a variety of PAC settings with a major emphasis on appropriate quality standards and risk adjustment to protect beneficiaries against underservice. Implementation of the IMPACT Act is beginning to serve this data collection purpose.

CPR favors payment and delivery models that are based on sound evidence with fully developed quality measures and risk-adjusters so that any savings are achieved through genuine efficiencies, not achieved by stinting on care. Implementing the same set of quality measures across PAC settings, as the IMPACT Act requires and the rule proposes, helps facilitate meaningful comparisons between settings of post-acute care.

Standardized data and quality measures across PAC settings can be used to develop a uniform quality assessment instrument to measure outcomes across PAC settings and design appropriate risk adjustment methodologies that protect against underserving beneficiaries with the most significant medical and functional needs. Such tools would be invaluable to developing and enacting PAC reforms that do not compromise care for people with disabilities and chronic conditions. This is a

critical step in both adopting appropriate—and sufficiently granular—quality metrics to ensure PAC beneficiaries under a bundled Medicare payment system achieve good outcomes and to ensure that risk adjusters accurately capture the unique needs of individual beneficiaries.

Until these and other beneficiary protections are in place, we do not support regulating or legislating PAC reforms that bundle episodes of care, impose financial incentives to treat beneficiaries in the least intensive setting, or otherwise limit rehabilitation benefits under the Medicare program. Therefore, we thank CMS for refraining from proposing PAC policies through regulation that are simply not well developed at this stage.

Meaningful Quality Measures Needed

To satisfy requirements of the IMPACT ACT, CMS proposes to add five new measures to IRF QRP public reporting to complement those measures already in place:

- Medicare Spending Per Beneficiary-post-acute care (MSPB-PAC) IRF QRP (claims-based);
- Discharge to Community-PAC IRF QRP (claims-based);
- Potentially Preventable 30-Day Post-Discharge Readmission Measure for IRF QRP (claims-based);
- Potentially Preventable Within Stay Readmission Measure for IRFs (claims-based); and
- Drug Regimen Review Conducted with Follow-Up for Identified Issues (assessment-based)

We acknowledge the importance of these added measures, especially the measure that assesses the percentage of patients discharged from PAC settings into the community. Many of the measures being implemented in the PAC setting are process measures, and those that are more akin to outcome measures are fairly rudimentary. CPR favors quality measures in PAC environments that accurately assess beneficiaries' functional status, addresses the real-life needs of beneficiaries, beneficiary experience, engagement, and shared decision-making measures.

For instance, as PAC quality measurement matures, we urge CMS to ensure that community-based functional measures are implemented so that beneficiaries with disabilities and chronic conditions will be better informed of their key concerns following illness or injury. These concerns include the ability to live as independently as possible; to function at the maximum extent possible; to return to employment if desired and appropriate; to engage in recreational and leisure activities; to exercise with or without assistive aids; to engage in community, civic and social activities; and to maintain the highest quality of life possible.

We discuss two of these measures below. Additionally, CPR recommends that CMS further research and refine the development of risk adjusters for each of these measures that are more sensitive to the complexities of PAC beneficiaries, and to their levels of resource use. This would factor into the quality measures the real-life circumstances of beneficiaries and make the quality measures more sensitive to these important considerations.

Medicare Spending Per Beneficiary is Not a Quality Measure

CPR believes that the Medicare Spending Per Beneficiary post-acute care (MSPB-PAC) measure has very little to do with quality. Therefore, defining MSPB as a quality measure is not accurate. MSPB-PAC is nothing more than a measure of resource use across an episode of post-acute care. While relevant to assess how much the Medicare program invests in various levels of PAC services per patient, it does not inform the Medicare program, providers, or stakeholders of the value received for

the Medicare program's investment. CPR supports the fact that CMS proposes a separate MSPB measure for each PAC setting. Establishing separate MSPB measures for each setting of post-acute care will enable CMS and providers to draw comparisons between providers of the same type, as opposed to comparisons across different types of providers.

CPR believes that using MSPB as a "quality" measure to compare care delivered in different PAC settings will create a major disincentive for referring acute care hospitals to send patients to more intensive PAC settings that are often more expensive in the short term. Using MSPB as a benchmark in this manner is likely to lead to a systematic bias against referrals to more intensive PAC settings, even if the patient requires and can benefit from a more intensive and coordinated rehabilitation program. Further, MSPB scores do not reflect the longer-term savings that come from early functional gains by beneficiaries that may lead to independent living and less burden on health and social services and supports.

Therefore, in order to protect against diversion of beneficiaries to less intensive, inappropriate PAC settings as a result of widespread use of the MSPB measure, we recommend that the final rule include payment penalties that can be used by CMS to dissuade providers from using the MSPB measure to make referral decisions that inappropriately underserve beneficiaries with disabilities and chronic conditions.

Discharge to Community Is an Important Quality Measure for Institution-based PAC Settings

The proposed discharge to community measure assesses successful discharge to the community from an IRF or other post-acute care setting. Discharge to community is a critical measure to assess the ability of a PAC provider to rehabilitate patients to enable them to return to the home and community based setting, rather than remaining in an institution. This measure will be determined based on the code used for the "Patient Discharge Status Code" on the Medicare claim form. A beneficiary will be considered discharged to community if their Patient Discharge Status Code on Medicare claims is one of the following:

- 01 - Discharged to home/self-care
- 06 - Discharged/transferred to home under care of organized home health service organization
- 81 - Discharged to home or self-care with a planned acute care hospital readmission
- 86 - Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission.

Overall, CPR believes many of the elements of the measure specifications for the Discharge to Community (DTC) measure are appropriate. However, we are submitting for CMS's consideration several recommendations to strengthen the specifications.

Discharge to Community Definition

CPR would like to ensure that all PAC providers abide by the same standards in recording discharges to the community. We believe that discharging a beneficiary to a "residential" nursing home (*i.e.,* long-term care setting), especially if the patient is admitted from a Medicare-certified part of the same facility, should not be counted as a discharge to community. Unfortunately, the measure specifications as proposed would permit such a discharge to count as a community discharge. For instance, if a beneficiary in a skilled nursing facility (SNF) is discharged to a non-Medicare certified area within that same facility, the discharge may be interpreted as a discharge to a "group home," "foster care," or "other residential care arrangement." Such discharges are nevertheless included under guidance for

Patient Status Discharge Code 01, one of the codes that counts as a community discharge.[1] If such a discharge from a Medicare skilled nursing facility to another part of the same facility would indeed count as a community discharge, this would likely artificially improve the community discharge rates for SNFs with accompanying residential nursing home beds while holding other PAC providers to a different and potentially more stringent standard. As such, counting a discharge from a SNF to the residential/long-term care portion within the same facility as a discharge to community would not only negate the value of the measure itself, but would miscommunicate the actual discharge to community performance to the average Medicare beneficiary on any public reporting mechanism.

CMS has stated in the proposed rule that it will not adjust the quality measures, including the discharge to community measure, to account for the functional status of beneficiaries until such data is collected under the IMPACT Act. Adjusting for beneficiaries' functional status is critical and would enhance the accuracy of the discharge to community measure. Functional status has a direct and proven correlation with the setting to which a beneficiary is discharged, meaning that PAC providers who treat more functionally impaired beneficiaries will likely score lower on the discharge to community measure. With the present focus on care transitions and discharge planning, functional data will soon become a necessary component of quality measurement in both acute and PAC settings.

The presence of family or community supports is also a key indicator of a beneficiary's ability to be discharged to the community as well as their ability to remain in their home or community setting. Many PAC beneficiaries that live alone without the oversight or assistance of a family member or other community caregiver have a higher risk of readmission. Therefore, CPR recommends that CMS update the risk-adjustment factors for the discharge to community measure to include the functional status of beneficiaries, the presence of community supports available to beneficiaries.

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Thank you for the opportunity to submit these comments on the inpatient rehabilitation hospitals prospective payment system. If you have any questions, please contact Peter Thomas or Steve Postal at (202) 466-6550 or at peter.thomas@ppsv.com or steven.postal@ppsv.com.

Sincerely,

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[1] CMS Medicare Learning Network, *Clarification of Patient Discharge Status Codes and Hospital Transfer Policies*, MLN MATTERS NO. SE0801, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0801.pdf (updated Mar. 6, 2014).

Supporting Organizations

Academy of Spinal Cord Injury Professionals
ACCSES
American Academy of Physical Medicine and Rehabilitation
American Association on Health and Disability
American Congress of Rehabilitation Medicine
American Music Therapy Association
American Occupational Therapy Association
American Speech-Language-Hearing Association
American Therapeutic Recreation Association
Amputee Coalition
The Arc of the United States
Association of Academic Physiatrists
Association of University Centers on Disabilities
Autistic Self Advocacy Network
Blue Ridge Independent Living Center
Brain Injury Association of America
California Foundation for Independent Living Center
Center for Independence of the Disabled, NY
Center for Medicare Advocacy
Child Neurology Foundation
Christopher and Dana Reeve Foundation
Coalition for Barrier Free Living
Disability Rights Education and Defense Fund
Disabled Resource Services
Easter Seals
Epilepsy Foundation
Falling Forward Foundation
Finger Lakes Independence Center
The Freedom Center, Inc.
Lakeshore Foundation
National Association for the Advancement of Orthotics and Prosthetics
National Association of State Head Injury Administrators
National Multiple Sclerosis Society
National Stroke Association
New Yorkers for Accessible Health Coverage
Paralyzed Veterans of America
Uniform Data System for Medical Rehabilitation
United Cerebral Palsy
United Spinal Association
Westchester Disabled On the Move, Inc.