

March 25, 2019

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: Inpatient Rehabilitation Facility (IRF) Case Mix Groupings Methodology and Considerations for Upcoming Fiscal Year Proposed Rules

Dear Ms. Verma:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including 1,272 inpatient rehabilitation facilities (IRFs), and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) urges the Centers for Medicare & Medicaid Services to use its upcoming proposed rules for IRFs and other post-acute care providers to address several issues related to the implementation of the revised case-mix grouping (CMG) policies.

IRFs are required to conduct a patient assessment upon admission and discharge for every beneficiary admitted under Medicare fee-for-service or Medicare Advantage; these data are used to classify patients into CMGs based on clinical characteristics and resource needs. Providers also use these data to monitor the quality of care furnished. In the fiscal year (FY) 2019 IRF prospective payment system (PPS) final rule, CMS finalized its proposal to reform the current IRF patient assessment process and case-mix system starting FY 2020. Under this change, CMGs would be informed by data already collected through the IRF patient assessment instrument (PAI) instead of the Functional Independence Measure (FIM™) Instrument, which has been used to assign patients to CMGs for more than 30 years.

The AHA requests transparency from CMS in the decision-making process behind functional status assessment and subsequent CMG policies, as well as additional issues we hope to see addressed in the forthcoming rules.



REQUEST FOR TRANSPARENCY IN RULEMAKING

The AHA appreciates the enormous amount of work that goes into the rulemaking process. It is tremendously helpful to the field to have a window into this work. **As such, we request that CMS provide as much transparency as is feasible in the proposed rules in order to offer insight into the policy decisions made.** It is vital that we and our members understand how and why CMS reaches the conclusions that drive the programmatic choices proposed so that we understand how changes will affect patient care.

For example, when constructing the motor score calculation using the IRF-PAI Section GG items, CMS selected only certain items from the larger set. These items do not precisely match those used to determine similar composite scores used in the IRF Quality Reporting Program (QRP). Yet, CMS has not provided information on why and how the agency and its contractors made its selection decisions or chose the weights for those items. We generally favor alignment across patient assessment mechanisms that evaluate the same or similar outcomes, and believe that CMS also seeks to align various reporting requirements. The field would benefit from knowing why CMS makes these policy choices and the extent to which they are based upon clinical evidence.

As another example, in response to public comments that the functional assessment data elements in the IRF-PAI do not accurately capture patient severity, CMS stated “We disagree...We believe that the six level scale utilized for the data items located in the Quality Indicators section of the IRF-PAI better distinguishes change at the highest and lowest levels of patient function by documenting minimal change from no change at the low end of the scale.”¹ However, the analysis done by Uniform Data System for Medical Rehabilitation (UDSMR) (and cited in our FY 2019 IRF PPS proposed rule [comment letter](#)) using FY 2017 IRF discharges found that many of the IRF-PAI indicators show very different levels of function from their counterparts in the FIM™. Even if CMS’s conclusion is data driven, there is a clear discrepancy between the conclusions reached by CMS and those by external analysts. As such, additional background from CMS on how the agency reached its determination would help clarify this incongruity.

We again urge CMS to perform analyses on how patients would be affected by the new CMGs. CMS has proposed some new indicators – for example, stairs, rolling-over indicators and the phase-out of the wheelchair, which appear to lower the standards used for CMG assignment. This has the effect of assigning patients a higher functional level (which reduces the need for IRF services), relative to the corresponding FIM™ items. Using the wheelchair item as an example, CMS’s rationale for making this change was mentioned in only a few sentences in the rule’s companion technical report, which leaves the field uninformed about the need for and impact of this proposed

¹ Centers for Medicare & Medicaid Services, Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2019 Final Rule, 83 Fed. Reg. 38541 (August 6, 2018)

change. It would be helpful if the agency shared both the clinical rationale and relative change in R^2 for each of the proposed new items that will be used to assign patients to a CMG. **We request CMS provide the clinical reasons a patient would receive a certain score and how that score would compare between the new item and the item previously used.**

Finally, CMS also finalized its proposal to decrease the number of CMGs for stroke from 10 to six, which reduces the specificity of patient categorization and reduces payment for the most complex patients. However, CMS did not share with stakeholders the algorithms and regression trees used to design the proposed refinements that led to these and other changes. These same analyses were used to construct the new CMG framework and definitions, including the corresponding relative weights and average length of stay values. The lack of transparency on these critical analyses has rendered providers unable to fully evaluate or replicate CMS's policy development process or outcomes.

CONCERNS REGARDING FUNCTIONAL ASSESSMENT DATA ELEMENTS

As we have voiced before, the AHA has concerns regarding the reliance upon data elements developed in the Post-Acute Care Payment Reform Demonstration (PAC PRD); specifically, we question whether the Section GG items are suitable for use in determining payments through informing CMGs. While we understand that CMS has finalized the replacement of the FIM™ items with the Section GG items for the IRF PPS, we would like to reiterate our apprehension as CMS moves forward with payment reforms in other post-acute settings that also use these patient assessment elements.

As detailed in a 2017 Dobson DaVanzo [report](#) critiquing the prototype Medicare payment system for post-acute care in the past, we have strong concerns regarding any reliance on the PAC PRD analysis, especially for use in payment determinations. The data used in that analysis are out-of-date, were limited in scope, and do not reflect the current state of the PAC field in terms of patient volume or distribution across the four PAC settings. For example, the provider sample used in the PAC PRD accounted for just 0.4 percent of PAC providers and 0.1 percent of PAC stays across the four settings in 2013, with skilled nursing and home health providers and stays being under represented. If a PAC PPS were to base payments on case-mix groups informed by data elements developed decades ago using outdated data, it certainly would be not only misaligned, but also bad policy.

Further, we remain concerned about the accuracy of the section GG patient assessment data elements. First, the elements, which emerged from the CARE tool, have been criticized for their inability to capture the full resource needs of high-acuity PAC patients. In addition, while CMS contends that “elements in the CARE tool include proven predictors of health care costs and utilization,” in actuality, it does not. CMS demonstrated only interrater reliability and validity, and only for the entire tool in

estimating clinical functional status – a proxy for testing the validity of individual data elements. As a result, policymakers and stakeholders possess little information on the construct validity of each of the Section GG functional status data elements in predicting costs and utilization. In fact, we lack any validation of the predictive power of each section GG item. Given this fundamental limitation, we urge CMS to use instead patient assessment data elements that have either been more recently developed and tested for validity in predicting costs and utilization, or existing elements for which updated testing – with more recent data – has been performed.

We also remain concerned that new Section GG items fail to accurately assess cognitive impairment. As finalized in the FY 2019 IRF PPS rule, this functional impairment is assessed using the Brief Interview for Mental Status (BIMS). However, BIMS assesses simple memory recall rather than actual cognitive impairment; as such, it does not appear to be predictive of resource use. We recognize that there is currently not a good alternative already included in the IRF-PAI, but also know that CMS contractors RAND and Abt Associates recently completed a national beta test on potential new standardized patient assessment data elements (SPADEs) that include items on cognitive status.

These newly tested elements could be more appropriate for use in assigning patients for CMGs; however, according to RAND and Abt's general evaluation of candidate SPADEs – the teams' qualitative assessment of each data element evaluated in the national beta test – only one of those items was positively viewed as having potential utility to describe case mix. In addition, the contractors only provided information on the elements' feasibility and interrater reliability, not the construct validity of the elements and their ability to predict resource use. Thus, we ask CMS to consider whether the functional status items currently used in Section GG and those being developed for potential use across post-acute settings accurately capture patient functional status specifically for use in payment determinations. If there is not statistically significant support that these elements accurately reflect predicted costs, we urge CMS not to use them for that purpose.

IMPLICATIONS FOR FUTURE POST-ACUTE ALIGNMENT

Finally, we ask CMS to provide insight on how the recently finalized changes to the IRF PPS and any proposed updates in the forthcoming fiscal year rules will affect the future alignment across post-acute care settings. We understand that CMS is statutorily required to implement standardized and interoperable quality measures and patient assessment data elements and to develop a unified post-acute care PPS model as part of the Improving Post-Acute Care Transformation Act. Because each setting currently uses the functional status indicators in Section GG that now inform IRF CMGs, we question how the payment determinations for other PPSs will be affected in the future. We also urge CMS to consider the concerns raised in response to the changes to the IRF CMGs (e.g., how they reflect patient severity, whether the items used to assign to

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CMGs align with items used for similar assessments in related quality measures, etc.) and address them preemptively in any proposed changes for other post-acute settings.

Thank you for the opportunity to share our views. If you have any questions concerning our comments, please contact me or have a member of your team contact Caitlin Gillooley, senior associate director of policy, at cgillooley@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President
American Hospital Association