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Francis J. Crosson, M.D., Chairman  
Jon B. Christianson, Ph.D., Vice Chairman  
Mark E. Miller, Ph.D., Executive Director

May 27, 2015

Andy Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Room 445-G, Hubert H. Humphrey Building  
200 Independence Avenue SW  
Washington, DC 20201

**RE: File Code CMS-1624-P**

Dear Mr. Slavitt:

The Medicare Payment Advisory Commission (MedPAC) appreciates the opportunity to submit comments on the Centers for Medicare & Medicaid Services (CMS) proposed rule entitled Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2016; Proposed Rule, *Federal Register* 80, no. 80, 23332-23399 (April 27, 2015). We appreciate your staff's continuous efforts to administer and improve the Medicare payment system for inpatient rehabilitation facilities (IRFs), particularly given the competing demands on the agency.

This rule proposes a payment update for IRFs in fiscal year (FY) 2016 and details a number of additional proposals. We focus our comments on the payment update and proposed updates to the IRF Quality Reporting Program (IRFQRP).

**Proposed FY 2016 update to payment rates for IRFs**

CMS proposes a 1.9 percent increase to the IRF payment rate. CMS obtained this result by following the statutory formula of starting with a 2.7 percent market basket increase and subtracting a productivity estimate of 0.6 percentage points and an additional deduction of 0.2 percentage points; both are required by the Patient Protection and Affordable Care Act of 2010 (PPACA).

*Comments*

We understand that CMS is required to implement this statutory update. However, we note that after reviewing many factors—including indicators of beneficiary access to rehabilitative services,

the supply of providers, and Medicare margins—the Commission determined that Medicare’s current payment rates for IRFs appear to be adequate and therefore recommended no update to IRF payment rates for FY 2016. We appreciate that CMS cited our recommendation, even while noting that the Secretary does not have the authority to deviate from statutorily mandated updates.

### **Proposed revisions and updates to the IRF Quality Reporting Program**

CMS is required in FY 2014 and each subsequent year to reduce the annual market basket update by 2 percentage points for any IRF that fails to successfully report on a specified set of quality measures. In addition, The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) requires the Secretary to implement quality measures and resource use and other measures that are standardized and interoperable across PAC settings. The IMPACT Act also requires IRFs, long-term care hospitals (LTCHs), skilled nursing facilities (SNFs), and home health agencies (HHAs) to report standardized patient assessment data.

Seven quality measures have previously been finalized for use in the IRFQRP:

- Rates of catheter-associated urinary tract infection;
- Percent of patients with new or worsened pressure ulcers;
- Influenza vaccination coverage among health care personnel;
- Percent of patients who were assessed and appropriately given the seasonal influenza vaccine;
- All-cause unplanned readmissions for 30-days post-discharge from the IRF;
- Methicillin-resistant staphylococcus aureus (MRSA) events; and
- Clostridium difficile infection (CDI) events.

The April 27, 2015 rule proposes to add six new measures to the IRFQRP for FY 2018:

- Rates of patients experiencing one or more falls with major injury;
- Rates of patients with admission and discharge functional assessment and a care plan that addresses function
- Change in self-care score;
- Change in mobility score;
- Discharge self-care score; and
- Discharge mobility score.

As required by the IMPACT Act, several of these proposed measures would correspond with measures already in use in other settings. The falls with major injuries measure corresponds with one used for long-stay residents in nursing facilities. The admission and discharge functional assessment and care plan measure corresponds with one that will be used in LTCHs beginning in FY 2018. The change in self-care score measure will be calculated using data elements developed for the Continuity Assessment Record and Evaluation (CARE) tool used in CMS’s Post-Acute

Care Payment Reform and Demonstration (PAC-PRD), a standardized tool designed for use in IRFs, LTCHs, SNFs, and HHAs.

CMS also proposes replacing two previously finalized measures (all-cause unplanned readmissions for 30-days post-discharge and percent of residents with new or worsened pressure ulcers) with similar measures already in use in other Medicare QRPs.

### *Comments*

For many years, the Commission has supported the development and implementation of outcome measures that can be compared across post-acute care settings so that policy makers and patients can evaluate and compare differences in the quality of care providers furnish and the outcomes patients achieve. Implementation of a common patient assessment tool will allow the comparison of costs, quality of care, and patient outcomes across all post-acute settings, while controlling for differences in patient condition and other characteristics that affect the cost of care or the patient's capacity to benefit from care. Those comparisons, in turn, would allow us to know what Medicare is buying in each setting and assess the value of the services furnished.

The Commission has also urged CMS to move away from clinical process measures in Medicare's QRPs and toward the use of outcome measures such as avoiding preventable readmissions and hospital-acquired infections. Outcomes are more meaningful to patients, and focusing on outcomes rather than process measures can have a greater impact on provider behavior.

The IMPACT Act requires Medicare to implement a quality measure addressing the domain of "functional status, cognitive function, and changes in function and cognitive function." To meet this requirement, CMS proposes to use a process measure in which each PAC provider would report the percentage of its patients for whom it performed a functional assessment at admission and discharge, and developed a care plan that addresses at least one functional goal. The Commission notes that CMS already requires IRFs to perform a functional assessment at admission and discharge for all Medicare patients. The Commission does not support the addition of this process measure to the IRFQRP. We urge the agency to use instead an outcome measure that reports actual changes in PAC patients' physical and cognitive functioning while they are under a provider's care, as envisioned in the IMPACT Act. In addition, as in previous years, we encourage CMS to drop process measures already included in the IRFQRP, such as assessment of influenza vaccination, which might deflect providers' attention and resources from more productive quality improvement activities.

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 IRFQRP 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 required process measures that minimally advance or may actually reduce the overall quality of beneficiary care.

Andy Slavitt  
Acting Administrator  
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## **Conclusion**

MedPAC appreciates your consideration of these issues. The Commission values the ongoing collaboration between CMS and MedPAC staff on IRF policy, and we look forward to continuing this relationship.

If you have any questions regarding our comments, please do not hesitate to contact Mark Miller, MedPAC's Executive Director, at 202-220-3700.

Sincerely,

A handwritten signature in black ink that reads "Francis J. Crosson M.D." in a cursive script.

Francis J. Crosson, M.D.  
Chairman

FJC/dkk