AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

March 9, 2021

The Honorable Chiquita Brooks-LaSure
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-10036
P.O. Box 8016
Baltimore, MD 21244-8016

Delivered Electronically

RE: Agency Information Collection Activities: Proposed Collection; Comment Request [CMS-10036]

Dear Administrator Brooks-LaSure:

On behalf of the American Medical Rehabilitation Providers Association (AMRPA), we appreciate the opportunity to provide further comments on implementation of the IRF-PAI version 4.0. AMRPA is the national trade association representing more than 700 inpatient rehabilitation hospitals and units (referred to by policymakers as inpatient rehabilitation facilities (IRFs)), which focus on the care and functional recovery of some the most vulnerable Medicare beneficiaries – such as traumatic brain injury, stroke, spinal cord injury, and COVID-19 patients. The vast majority of our members are Medicare participating providers, and according to the Medicare Payment Advisory Commission (MedPAC), IRFs served 363,000 Medicare beneficiaries with more than 409,000 IRF stays in 2019.

Since the start of the pandemic in early 2020, AMRPA has appreciated CMS' actions that have allowed inpatient rehabilitation hospitals and units to play a pivotal role in the nation's response to the COVID-19 public health emergency (PHE). Many of the flexibilities granted to IRFs at the start of the pandemic, including those related to the IRF Quality Reporting Program (QRP) were and continue to be essential for IRFs as they care for both traditional rehabilitation patients, as well as address acute-care surge needs. The initial delay of the IRF-PAI v 4.0 was a critical flexibility that ensured rehabilitation hospital/unit staff were able to devote their time and resources to direct patient care, rather than the enactment of new regulatory requirements.

While the surges of new COVID-19 infections have generally abated from their summer 2021 and December 2021-January 2022 peaks, the lingering impacts from each of those and prior waves have compounded on one another and created an onerous landscape for IRFs – particularly in regards to staffing. IRFs have been especially challenged by workforce shortages impacting nurses, therapists, and other clinical team members that are responsible for completing the rigorous Medicare reporting requirements for IRFs. For these reasons, we believe this is a particularly inappropriate time to implement new regulatory requirements – especially requirements that nearly double the length from current requirements. AMRPA appreciated CMS' initial PHE-related delay for adoption of the IRF-PAI v 4.0 and compliance date for reporting requirement for some standardized patient assessment data elements

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(SPADEs) and quality measures through an interim final rule with comment period (IFC)[1]. **AMRPA requests CMS continue to delay adoption of the IRF-PAI v 4.0 and reporting dates for associated SPADEs and quality measures. This delay should remain in place until there is consensus across the IRF field that staffing levels have returned to an adequate level which would allow for implementation. AMRPA also requests that CMS include reimplementing the IRF-PAI v 4.0 delay in the upcoming FY 2023 Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) proposed rule.**

A summary of AMRPA's recommendations is below, with full details following:

1. **The delay of the IRF-PAI v 4.0 and reporting date for new SPADEs and Transfer of Health Information (TOH) measures should be extended until there is measurable evidence that the IRF workforce challenges have improved.**
2. **AMRPA reiterates our FY 2020 comments that CMS should reduce the data completeness threshold for the IRF QRP to be in line with other PAC QRPs. At minimum, the threshold should be lowered for the first year of reporting the new SPADEs.**
3. **AMRPA urges CMS to utilize future rulemaking to address reimbursement policies that likely fail to account for increased resource use related to issues identified via the IRF-PAI v 4.0.**
4. **AMRPA urges CMS to solicit stakeholder comments on the IRF-PAI v 4.0 in the FY 2023 IRF PPS proposed rule.**

I. Staffing and Administrative Challenges Have not Resolved Despite a Decline in COVID-19 Incidence

When the IFC delaying adoption of the IRF-PAI v 4.0 and reporting dates for a number of SPADEs and the TOH measures was initially released, CMS stated the purpose of the delay was because the agency "wanted[ed] to provide maximum flexibilities for [IRFs] to respond to the public health threats posed by the COVID-19 PHE, and to reduce the burden in administrative efforts associated with attending training, training their staffs and working with their vendors to incorporate the updated assessment instruments into their operations." In this payment year's home health (HH) proposed rule, CMS stated that IRFs "now have the administrative capacity" to conduct the necessary processes to implement the regulatory requirements.

AMRPA continues to disagree with the agency's assertions. While the nation has made significant progress in developing effective treatment protocols and vaccinated a significant portion of the population and new COVID-19 cases have declined from their 2021 peaks, administrative issues have only increased. In fact, our members report staffing shortages are more significant in February 2022 that they were in even two or three months ago. IRFs face residual effects of the earlier pandemic phases (e.g., significantly backlogged information systems (IS) departments) and new and evolving impacts (e.g. increasing staffing shortages) compound one another. The prior two years have made evident that the COVID-19 pandemic is a constantly shifting emergency. It is critical the agency not take steps that would further disrupt or adversely impact providers' ability to prioritize patient care.

[1] 85 FR 27550

a. Healthcare Staffing Shortages Have Only Accelerated in Early 2022

Staffing shortages are not only impacting acute-care hospitals. Providers across the entire health care system are competing with one another to procure clinical and administrative staff. AMRPA members within larger health systems report having inpatient rehabilitation unit nurses diverted to other areas of their hospital to respond to ongoing acute-care demands. These challenges are widespread and not limited to COVID-19 hotspots. Numerous members report currently utilizing charge nurses for direct patient care and holding their census in order to maintain appropriate nurse:patient ratios. Many members also reported widespread staffing shortages in other areas such as dietary services, leading to a ripple effect for nursing staff. Further, some members described the loss of their PPS/IRF-PAI coordinators – the staff member tasked with conducting training to staff on IRF-PAI requirements and data submission – and the challenges in filling such a highly-skilled and technical position. Nearly every AMRPA member surveyed described being unable to fill approved open positions due to a lack of applicants, both for FTE and contract positions.

Implementing the IRF-PAI v 4.0 and reporting the SPADEs and TOH measures is a significant undertaking for IRFs. Implementation requires significant amount of training from clinical staff, such as nurses and others involved in assessment, to the more administrative roles such as information systems (IS) staff. Collectively, these workforce issues clearly demonstrate the need for timely and comprehensive reporting relief wherever possible, including with respect to the IRF PAI v. 4.0.

b. CMS Has Provided Insufficient Time for Training on the IRF-PAI v 4.0

When CMS finalized the IRF-PAI v 4.0 implementation date for October 1, 2022, the agency stated that training materials and final specifications would be released in "early 2022" in the form of "online learning modules, tip sheets, question and answer documents, and/or recorded webinars and videos." At the time of this comment letter – nearly into Q2 2022 - the agency has yet to announce or release any stakeholder training materials, nor has the manual for version 4.0 been released. Given the aforementioned significant staffing shortages across the field, it is critical that IRFs be given numerous trainings with advance notice. Failure to provide these training materials in a timely manner prevents IRFs from being able to not only training clinical staff charged with assessment, but also inhibits IS staff from being able to build the necessary technology infrastructure. With CMS unable to release training opportunities in early 2022 as it asserted it would, AMRPA urges the agency to reconsider the October 1, 2022 implementation date.

c. IRF Information System Departments Have not Been Granted Adequate Time to Update to IRF-PAI v 4.0

Staffing challenges and increased demand are not limited to nursing teams. In order to adopt the IRF-PAI v 4.0, along with associated SPADEs and the TOH measures, IRF information system (IS) departments must ensure Electronic Health Record (EHR) platforms are up to date. Some AMRPA members report that certain EHRs are not assisting with updating to the IRF-PAI v 4.0, instead tasking local hospital staff with building the appropriate platform. Additionally, many smaller rehabilitation units take lower priority in IS updates compared to acute-care needs. These challenges necessitate a long runway for implementing the IRF-PAI v 4.0.

Further, this proposal comes at a time when IRF IS departments are significantly backlogged as a result of implementing mandatory and time-sensitive COVID-19-related tracking platforms. Many AMRPA members report their IS departments are also still working to implement 2020 and 2021 "maintenance releases" that were delayed due to the pandemic and also facing staffing shortages. To now require IRFs to adopt a new version of the IRF-PAI along with new measures and SPADEs that will require a significant level of staff training and resources, when CMS was unable to provide training materials in a timely manner as it asserted it would do upon finalizing the implementation date is inappropriate.

We also note that CMS proposed the October 1, 2022 IRF PAI v. 4.0 implementation date in the course of its CY 2022 home health rulemaking. We believe this may have limited the extent of IRF PAI-specific feedback that CMS received given that this important provision was included in a separate payment rule. This makes it all the more important that CMS allow IRF stakeholders to meaningfully review and comment on a workable implementation date in the upcoming payment rule.

In sum, it is vital that CMS minimize administrative and reporting requirements to the greatest extent practical. The factors compelling the initial IRF-PAI v. 4.0 delay are in some ways even more severe than they were at the start of the pandemic. Reimplementing a delay of the IRF-PAI v. 4.0 would be prudent step towards ensuring that IRFs can continue to maximize staff time and resources to prioritize direct patient care. **AMRPA therefore urges to CMS reimplement a delay of the IRF-PAI v 4.0 in the upcoming FY 2023 IRF PPS proposed rule.**

II. Recommendations Related to the IRF-PAI v 4.0

Reimplementing a delay of v 4.0 would also provide CMS with an opportunity to refine the IRF-PAI. AMRPA continues to recommend CMS implement quality measures and assessment data collection requirements of the IMPACT Act in a practical and minimally burdensome way, ensuring that PAC providers, patients, and caregivers have access to the most meaningful information.

At the time the SPADEs and TOH measures were proposed for inclusion in a new IRF-PAI, AMRPA raised concern that CMS' burden estimation was not representative of the true administrative burden IRFs would face. AMRPA maintains this position. It should be noted that the IRF-PAI v 4.0 will be substantially longer than the current version. Such a significant change, as previously noted, will have a ripple-effect throughout IRFs and will require a significant amount of time and resources to incorporate.

In AMRPA's FY 2020 IRF PPS proposed rule comment letter, we requested that CMS address disparities in PAC QRP completion thresholds to account for the increased burden on providers with the new version of the IRF-PAI. While AMRPA firmly believes reimplementing a delay for the IRF-PAI v 4.0 (and associated SPADEs and TOH measures) is crucial, we reiterate our request that CMS consider an IRF QRP completion threshold that is alignment with other PAC QRPs (i.e., 80 percent versus the current 95 percent). At minimum, the completion threshold for the IRF QRP should be lowered for the first reporting year of the new SPADEs.

AMRPA also continues to recommend CMS provide IRFs flexibility in SPADE collection in order to reduce reporting burden and regulatory duplication. We again request that CMS revise the requirements for the Social Determinants of Health (SDOH) SPADEs to be assessed *at some point* during the IRF stay, rather than within the admission assessment timeframe, and not require the collection of any SDOH SPADEs on the discharge assessment as these data elements are unlikely to change throughout the course of an IRF stay.

Lastly, AMRPA requests CMS utilize future rulemaking to account for the likely increase in resource utilization resulting from the collection of new SPADEs. AMRPA supports the assertion that SDOH can have a significant impact on rehabilitation patients. However, AMRPA has concerns that the SPADEs included in the IRF-PAI v 4.0 will identify problems that require intensive resources to address or remedy, but that CMS has failed to account for in reimbursement policies. For example, one of the new SDOH SPADEs asks the patient if "lack of transportation [has] kept you from medical appointments, meetings, work or from getting things needed for daily living." If a patient responds with yes, the IRF is likely to devote resources to addressing the transportation difficulties, yet non-emergent transportation benefits are not included in Medicare fee-for-service. **We therefore request that CMS continue to assess the adequacy of payment policies and ensure that potentially concealed costs related to adoption of the IRF-PAI v 4.0 are accounted for.**

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AMRPA appreciates the opportunity to submit comments on the IRF-PAI. We look forward to continuing to work with CMS on policies impacting the Quality Reporting Program and the IRF field. If you have any questions, please do not hesitate to reach out to Kate Beller, AMRPA Executive Vice President for Policy Development and Government Relations (202-207- 1132, kbeller@amrpa.org).

Sincerely,

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