March 14, 2014

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services (CMS)
200 Independence Avenue
Washington, DC 20201

Re: Functional Status Quality Measures for Inpatient Rehabilitation Facilities (IRFs) and Long Term Care Hospitals (LTCHs)

Dear Administrator Tavenner:

The American Academy of Physical Medicine and Rehabilitation (AAPM&R) appreciates the opportunity to comment on the current proposed functional status quality measures. Thank you for the invitation to assist CMS to improve the sustainability of the Medicare program and to develop alternative models for healthcare delivery and reimbursement, rewarding high quality, cost effective care. The AAPM&R supports reforms to the post-acute care (PAC) system provided the reforms follow fundamental principles that put patients first, maintain access to medical and other rehabilitation services and programs at the appropriate level of intensity, consistent with the needs of beneficiaries, and that allow physicians and their rehabilitation teams to provide patient-centered care in the most efficient and effective setting.

The AAPM&R is the national medical society representing more than 8,000 physiatrists, physicians who are specialists in the field of physical medicine and rehabilitation (physiatry). Physiatrists treat adults and children with acute and chronic pain, persons who have experienced catastrophic events from trauma or diseases, such as strokes, brain injuries, spinal cord injuries, limb amputations, and with impairment and disability due to rheumatologic conditions, musculoskeletal injuries, and other disorders or disease processes that result in impairment and/or disability. Physiatrists treat patients across PAC settings, including inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs), and long term acute care hospitals (LTACHs). With appropriate medical rehabilitation and rehabilitation services and programs across the care continuum, most patients can regain significant function, and many can return to live fulfilling and productive lives in their homes and communities.

Functional Status and Community Support, Integration, and Participation
According to Chapter 110 (Inpatient Rehabilitation Facility Services) of the Medicare Hospital Manual, there are two important characteristics of inpatient
rehabilitation: 1) "The patient can reasonably be expected to make measurable improvement (that will be of practical value to improve the patient’s functional capacity or adaptation to impairments) as a result of the rehabilitation treatment..." and 2) "In most instances the goal of an IRF stay is to enable a patient’s safe return to the home or community-based environment upon discharge...."

While the quality measures address functional improvement, they 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. In fact, the AAPM&R 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.

Integration of CARE Items into Current Systems
The Academy would like to note that the items in the CARE tool 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 the CARE tool would thus require a separate data collection system to report the quality measures and a different collection system for payment. The Academy is concerned that this will be a major obstacle for IRFs to operationalize without any benefit at the patient level.

Risk Adjustment
With regard to the risk adjustment variables, the Academy recommends that sophisticated risk adjustment models should include patient characteristics, including more specifically-measured co-morbid conditions that link with physician, nursing, psychological, therapeutic, and other resource requirements for clearly identified subpopulations. The age stratification of less than 65 does not have enough discrimination and should include more discrete age groupings. Age clusters across the lifespan should be more clearly delineated so that the tool can be studied in younger populations as well as those in the typical Medicare age groups.
The grouping of all neurologic conditions in the primary rehabilitation diagnosis section does not appear to adequately discriminate between acute and chronic or deteriorating conditions. Nor does the risk adjustment model take into account levels of severity for different conditions. Populations such as patients with the most severe disabilities (such as those due to spinal cord injury, moderate to severe brain injury, or other conditions with intense medical and rehabilitation nursing needs, and psychological, and behavioral services and whose functional gains measured by the CARE tool may be limited) should be considered separately in the analysis of data and the creation of payment models, with consideration of different thresholds for meaningful change for these complex patients. The Academy suggests that prognostic groupings should also be considered in the models that take into account the diversity of the populations served in PAC.

**Recommendations for Future Iterations**

The Academy feels strongly that once the instrument has been implemented, it should continue to undergo validity and reliability testing, with reference to individual patient subpopulations. Additionally, research studies should be conducted to:

- Compare the CARE tool 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 tool or to replace it with other measures for the measurement of functional status across the continuum of care.
- 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.

In sum, The Academy is in full support of measurement instruments that can transcend and ultimately break down the silos that currently exist in the PAC sector. In order for such 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,
The American Academy of Physical Medicine and Rehabilitation thanks CMS for the opportunity to share its thoughts on the current proposed functional status quality measures. We hope these comments provide a meaningful perspective in your efforts to reform the post-acute care (PAC) system. We remain committed to being part of the solution in any way we can. If there are questions concerning the Academy’s comments, please contact Christina Hielsberg (chielsberg@aapmr.org) 847-737-6088.

Sincerely,

Elliot J. Roth, MD
Chair, AAPM&R Evidence-Based Practice Committee