Submitted Electronically

June 22, 2015

Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1624-P
P.O. Box 8013
Baltimore, MD 21244-1850

RE: CMS 1624-P, Proposed Fiscal Year 2016 Payment and Policy Changes for Medicare Inpatient Rehabilitation Facilities (CMS-1624-P)

Dear Mr. Slavitt:

On behalf of our over 200 member hospitals and health systems, including numerous inpatient rehabilitation facilities (IRFs), the Florida Hospital Association (FHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2016 proposed rule for the IRF prospective payment system (PPS). This letter focuses on concerns related to the proposed change to an IRF-specific market basket and proposed additions to the IRF quality reporting program (QRP).

Proposed IRF-Specific Market Basket

The FHA urges CMS to postpone implementation of a new IRF-specific market basket until the agency can ensure it accurately reflects costs for freestanding and hospital-based IRFs. When CMS initially implemented the IRF PPS in FY2003, it used the inpatient PPS market basket to calculate the mandatory annual inflationary update for the IRF payment system. In FY2006, the agency began using the rehabilitation, psychiatric and long-term care (RPL) market basket, which is based on cost data for freestanding IRFs, inpatient psychiatric facilities and long-term care hospitals. For FY2016, CMS proposes to use an IRF-specific market basket, which would be based on cost data for both freestanding and hospital-based IRFs. Therefore, this market basket requires a reliable method to disentangle the costs of hospital-based IRF units from those of their host hospital as cost data for hospital-based IRFs are embedded within the host hospital's Medicare cost report.

Dobson Davanzo & Associates replicated CMS's calculation of the proposed IRF-specific market basket and has identified concerns that are shared by the FHA. Until these concerns are addressed and corrected by CMS, we recommend that the implementation of an IRF-specific market basket be postponed. It is important to note that 78 percent of IRF providers are hospital-based units and, as the Dobson report observes, "we estimate that 67 percent of the expenditure weights will be based on data for hospital-based IRF units. Thus, using potentially unreliable allocated data that will account for more than two-thirds of the market basket information could be problematic and perhaps introduce error into the IRF-specific market basket."

Proposed Changes to the IRF QRP

The FHA is concerned that the proposed Continuity Assessment and Record Evaluation (CARE) tool functional status measure data would be collected in addition to the 28 functional independence measure (FIM) items IRFs are required to report on the inpatient rehabilitation facility-patient assessment instrument (IRF-PAI) for payment purposes. In contrast to the six-level rating scale used in the proposed CARE tool measures, the FIM uses a seven-level rating scale. IRFs have historically used FIM measures (as submitted on the IRF-PAI) for both quality purposes and Medicare reimbursement. In the proposed rule, CMS is now proposing to require IRFs to instead use CARE functional items for quality data while retaining the FIM measures for reimbursement. The FHA agrees that standardizing data collection across post-acute care providers is a laudable goal. But requiring IRFs to collect simultaneously two different sets of functional status data would simply increase provider burden and create confusion. Using both the CARE tool and the FIM will create additional work, but not add additional information or value.

Instead of implementing duplicative reporting tools that may lead to confusion and safety risks, the FHA recommends that CMS consider calculating functional status measures using the FIM data that IRFs already collect for payment purposes. This approach could be coupled with the development of a transition plan to revise the existing FIM functional status items so they are more consistent with data collected in other post-acute care facilities. This approach would allow the agency to meet the requirement that IRFs report functional status data, while laying the groundwork for a measure that is more "standardized" and "interoperable" across post-acute care settings as called for in the IMPACT Act of 2014.

Thank you for the opportunity to comment. If you have any questions, please do not hesitate to contact me at (407) 841-6230 or via email at kathyr@fha.org.

Sincerely,

Kathy Reep

Kathy Reep
Vice President/Financial Services