AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

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Submitted electronically via PQM Guidebook of Policies and Procedures for PRMR and MSR website

Re: Partnership for Quality Measurement (PQM) Guidebook of Policies and Procedures for Pre-Rulemaking Measure Review (PRMR) and Measure Set Review (MSR)

The American Medical Rehabilitation Providers Association (AMRPA) appreciates the opportunity to submit comments on the **PQM Guidebook of Policies and Procedures for PRMR and MSR**. AMRPA is the national trade association representing more than 700 freestanding inpatient rehabilitation facilities and rehabilitation units of acute-care general hospitals (IRFs).[1] The vast majority of our members are Medicare participating providers. In 2021, IRFs served 335,000 Medicare Fee-for-service (FFS) beneficiaries with more than 379,000 IRF stays among 1,181 IRFs.[2] AMRPA has always looked to be a partner to regulating agencies and other key quality stakeholders in promoting meaningful and effective quality reporting in the IRF program, and we look forward to continuing this type of partnership with Battelle and the PQM moving forward

AMRPA recognizes the importance of a consensus-based entity (CBE) and the processes "to inform the selection and removal of health care quality and efficiency measures, respectively, for use in the Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS) Medicare quality programs". AMRPA believes that the PQM PRMR and MSR processes are essential and must include the careful consideration of quality measures to ensure that they distinguish high-quality care in and among IRFs and other post-acute care providers. AMRPA is hopeful that the new PQM PRMR and MSR processes will improve upon some of the issues of the National Quality Forum (NQF) Measure Applications Partnership (MAP) that have been experienced over the past few years and have impacted IRFs and their patients.

While AMRPA supports the PQM PRMR and MSR concepts, our review of the Guidebook has identified a few concerns related to committee structure, consensus agreement threshold, voting procedures and consideration of non-endorsed measures. We note that many of these recommendations complement the separate comments we provided on the PQM E&M Guidebook and urge Battelle to incorporate these refinements across both documents. We offer our recommendations in the following sections.

[1] Inpatient rehabilitation facilities (IRFs) – both freestanding and units located within acute-care hospitals – are fully licensed hospitals that must meet Medicare Hospital Conditions of Participation (COPs) and provide hospital-level care to high acuity patients. IRFs' physician-led care, competencies, equipment and infection control protocols are just some of the features that distinguish the hospital-level care provided by IRFs from most other PAC providers.
[2] Medicare Payment Advisory Committee (MedPAC) March 2023 Report to the Congress – Medicare Payment Policy, Chapter 9. Pages 263 and 266.

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1. **IRFs and their patients may be underrepresented or misrepresented in the PQM PRMR and MSR processes**

While AMRPA appreciates the PQM efforts to consolidate some of the former NQF MAP committees as well as maintaining a separate and distinct Post-Acute Care (PAC)/Long Term Care (LTC) Committee, we are concerned that the Guidebook does not explicitly identify a targeted number of individuals from IRFs or with experience in IRF care. While we recognize that there are a number of opportunities for representatives from IRFs to be included on these committees, we believe that PQM should specifically target an equal number of individuals from each of the PAC/LTC settings identified in the Guidebook (i.e, Home Health, Hospice, IRF, Long-Term Care Hospital (LTCH), and Skilled Nursing Facility). Targeting equal representation would ensure that each setting-specific measure considered for PRMR and MSR would be given equal opportunity to receive input and feedback on the potential impact the measure may have on that setting.

While having an equal amount of IRF representatives on the PRMR and MSR committees would be a positive step, AMRPA remains concerned at the potential of IRF representatives being assigned to the Advisory (Delphi) Group and not the Recommendations (Nominal) Group. In this scenario, their involvement is procedurally limited to only review, rating, and written recommendation. There is no guarantee that the information provided by a member of the Advisory (Delphi) Group is discussed during the Recommendations (Nominal) Group endorsement meeting, suggesting that it is possible for measures impacting IRFs and their patients to be considered without adequate representation.

For these reasons, AMRPA encourages PQM to ensure that IRFs and their patients are adequately represented in the PRMR and MSR processes and committees. We ask PQM to consider targeting an equal number of individuals from each of the PAC/LTC settings to each of the Groups/Committees to ensure that IRFs and their patients are not underrepresented or misrepresented during consideration of measures.

2. **Recommendation of a measure should require complete or 100% agreement**

AMRPA members are concerned that quality measures impacting IRFs and their patients have the opportunity to be recommended for use in CMS quality programs regardless of the recommendation or consideration from IRF representatives. Historically, quality measures impacting IRFs have been recommended for use without the support of IRF representatives. In turn, this results in increased administrative burden to support data collection and management of quality measures that lack value for IRFs and their patients. Perhaps most concerningly, these types of measures fail to differentiate performance among providers that would promote desired outcomes and help patients determine the most appropriate provider for their care. While we recognize that consensus is defined as having general agreement, we believe that the recommendations for setting specific quality measures should not proceed without complete agreement from those representatives the measure may impact. In other words, recommendation of a quality measure that is applicable to IRFs should not proceed if the IRF representative(s)

is/are not in agreement, regardless of whether 75% or more of the remaining committee members are in agreement.

AMRPA recommends that PQM consider 100% agreement for recommendation of a measure for use in a CMS quality program, or at a minimum that 100% agreement is achieved from setting-specific representatives for any setting-specific measures. This will ensure that the recommendations from the PRMR and MSR processes are supported and applicable to those impacted by the measure.

3. **PQM should not allow for voting to be completed off-line in instances where a voting quorum is not present**

AMRPA is concerned that when a voting quorum is not present for voting on recommendation decisions, the Guidebook provides that "those members not present at the meeting for voting will have until 48 hours (2 business days) after the meeting to vote offline." Given the critical nature of recommendation decisions, we believe that voting should be done only when a voting quorum is present and should be done live. Allowing those not present the opportunity to vote off-line within 48 hours following the live voting presents the potential for biased or skewed voting results, where those not present may not have heard or been involved in the preceding discussion of the measure and may instead vote based upon feedback from those present for the discussion and live vote.

AMRPA recommends that PQM remove the opportunity to allow voting to be performed off-line within 48 hours after the recommendation meeting, and instead require that voting is done live during the meeting when a voting quorum is present.

4. **PQM should not allow for the consideration of measures that have not been endorsed through the Endorsement and Maintenance (E&M) process**

AMRPA and our members are concerned about the continued consideration of measures for use in CMS quality programs that have not been reviewed and endorsed by a CBE E&M process. As noted in the E&M Guidebook, the amount of scientific rigor, public input, and committee consideration that is dedicated to every measure in the E&M process is critical to ensuring that measures are safe, effective, and promote the likelihood of desired outcomes. PQM is improving the E&M process to make the consideration of measures for endorsement more timely and streamlined. Bypassing the E&M process creates a significant amount of uncertainty among providers and patients and questions the reliability and validity of the measure and its intended use. Because of the quicker turnaround time for endorsement, and the critical nature of the E&M process, we believe that every measure placed in the PRMR and MSR process should be endorsed.

Additionally, requiring that measures in the PRMR and MSR processes are endorsed will eliminate some the of potential issues and shortcomings from the prior NQF MAP process. A significant number of measures that have been through the NQF MAP process were not endorsed measures, and most if not all of these measures would receive a recommendation of conditional

support with the condition being that the measure obtain endorsement. Some of these measures eventually went back through the NQF endorsement process, but others have not been through a formal endorsement process. This questions the integrity of the recommendations from the NQF MAP process as well as the measure itself.

Measures that have been implemented prior to any endorsement review have been subject to ongoing changes to measure criteria, calculations, and requirements, causing significant amounts of unnecessary administrative burden to providers and confusion among patients, caregivers and payers regarding the measure values that are publicly displayed. In these instances, providers and their patients essentially become test subjects while CMS and their measure developers continue to tweak measures to fit their intended need or use. The E&M process would require that testing already have been done and completed and meet all of the "scientific acceptability, feasibility, usability, and use for the target population and entities of the program under consideration".

AMRPA recommends that PQM remove the consideration for measures that have not been endorsed by a CBE, and require that all measures intended for use in in CMS quality programs complete the PQM E&M process for endorsement. This would make the E&M process considerably more transparent and collaborative and lead to direct improvements in quality reporting across the Medicare program.

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AMRPA thanks Battelle and the PQM for allowing us the opportunity to provide feedback on the Partnership for Quality Measurement (PQM) Guidebook of Policies and Procedures for Pre-Rulemaking Measure Review (PRMR) and Measure Set Review (MSR). In sum, AMRPA supports the PQM PRMR and MSR processes but urges PQM to do more to include IRF representation, ensure that setting-specific measures obtain complete agreement from setting-specific representatives, mandate that voting be performed live when a voting quorum is present following a full discussion of each measure, and require that any measure considered is endorsed through the PQM E&M process. AMRPA stands ready to work with Battelle and the PQM to help ensure meaningful quality measures continue to be considered for use in CMS quality programs. Should you wish to discuss these comments further, please contact Troy Hillman, AMRPA Director of Quality and Health Policy (thillman@amrpa.org / (202) 207-1129) or Kate Beller, JD, AMRPA Executive Vice President for Government Relations and Policy Development (kbeller@amrpa.org / 202-207-1132).

Sincerely,

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