June 26, 2017

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1671-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CMS-1671-P: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2018, 82 Fed. Reg. 20690 (May 3, 2017).

Dear Administrator Verma:

On behalf of the Association of Rehabilitation Nurses (ARN) – representing more than 5,000 rehabilitation nurses and more than 13,000 Certified Registered Rehabilitation Nurses (CRRN) that work to enhance the quality of life for those affected by physical disability and/or chronic illness – we appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed rule implementing the Inpatient Rehabilitation Facility (IRF) prospective payment system (PPS) for fiscal year (FY) 2018.

Overview of Rehabilitation Nursing

Rehabilitation nursing is a philosophy of care, not a work setting or a phase of treatment. We base our practice on rehabilitative and restorative principles by: (1) managing complex medical issues; (2) collaborating with other specialists; (3) providing ongoing patient/caregiver education; (4) setting goals for maximum independence; and (5) establishing plans of care to maintain optimal wellness. Rehabilitation nurses practice in all settings, including freestanding rehabilitation facilities, hospitals, long-term subacute care facilities/skilled nursing facilities (SNFs), long-term acute care facilities, comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHAs), and private practices.

Rehabilitation nurses take a holistic approach to meeting patients' nursing and medical, vocational, educational, environmental, and spiritual needs. We begin to work with individuals and their families soon after the onset of a disabling injury or chronic illness and continue to provide support and care, including patient and family education, which empowers these

individuals when they return home, to work, or to school. Rehabilitation nurses also often teach patients and their caregivers how to access systems and resources.

ARN supports efforts to ensure people with physical disability and chronic illness have access to comprehensive quality care in whichever care setting is most appropriate for them. Specifically, as a part of its mission, ARN stands ready to work with policymakers at the local, state, and federal levels to advance policies and programs that promote maximum independence for people living with physical disability and/or chronic illness.

Proposed Changes to the IRF PPS for FY 2018

ARN members are committed to providing the highest quality, state-of-the-art care to Medicare beneficiaries across all care settings, especially in IRFs. As part of this dedication to patient care, we support the agency's efforts to improve quality and outcomes for Medicare beneficiaries and promote higher quality and more efficient health care for Medicare beneficiaries, specifically in IRFs. Linking a portion of Medicare payments to quality measures will assist in transforming Medicare from the current fee-for- service (FFS) model to a model based on quality and value. We stand ready to work with the agency on the following and other issues to ensure that the IRF QRP meets the needs of Medicare beneficiaries, holds providers appropriately accountable for quality and outcomes, and does not unduly burden providers in implementation and compliance.

Solicitation of Comments Regarding the Criteria Used to Classify Facilities for Payment Under the IRF PPS

The level of rehabilitation care an individual requires cannot be determined based on diagnoses alone. ARN believes that recovery from an acute episode of illness or injury depends on adequate medical treatment and early identification of functional needs for rehabilitation care and for that reason continues to oppose the 60 percent rule.

IRFs are a critical part of the quality care continuum. The physician and rehabilitation team, including a rehabilitation nurse, should determine the type, duration, and intensity of rehabilitative care each patient requires to restore or improve their function and health status. In Analysis of the Classification Criteria for Inpatient Rehabilitation Facilities, CMS concluded that Medicare policies should ensure the availability of IRF services to beneficiaries whose intensive rehabilitation needs cannot be adequately served in other settings. ARN agrees with this finding and notes that limiting IRFs to 13 conditions in order to evaluate compliance with the 60 percent rule is inadequate.

Additionally, per the CMS 2010 guidelines, all admission require a pre-admission screen, documentation by a rehabilitation physician that he/she has reviewed and concurs with the findings of the pre-admission screen, an order to admit, a post-admission physician evaluation, and an overall plan of care all within 72 hours of admission. This documentation demonstrates medical and functional necessity for IRF level care. Rehabilitation experts should determine the need for admission based on functional needs not on diagnosis alone. ARN advocates for the elimination of the 13 conditions and replacing them with functional and medical criteria for IRF admission.

Proposed Subregulatory Process for Certain Updates to Presumptive Methodology Diagnosis Code Lists

ARN supports CMS's proposal to establish a formal process to distinguish between non-substantive and substantive updates to the ICD-10-CM codes.

Proposed Revisions and Updates to the IRF Quality Reporting Program (QRP)

ARN is supportive of the *Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act)*, as the collection of standardized, post-acute care (PAC) assessment data will be greatly beneficial to ensuring individuals receive the right care in the most appropriate PAC setting. The *IMPACT Act* "requires the development and reporting of measures pertaining to resource use, hospitalization, and discharge to the community. Through the use of standardized quality measures and standardized data, the intent of the [IMPACT] Act, among other obligations, is to enable interoperability and access to longitudinal information for such providers to facilitate coordinated care, improved outcomes, and overall quality comparisons."[1]

To ensure the transfer of health information and care preferences of a patient are accurately communicated, ARN recommends that CMS adopt a more direct approach for engaging the patient in order to gain insight and feedback on quality of care. Many other organizations have prioritized patient involvement, including the Patient Centered Outcomes Research Institute (PCORI), which actively seeks to engage patients to determine what is meaningful and important to them in terms of research questions. Moreover, the Nursing Alliance for Quality of Care has defined patient and family engagement in decisions regarding care as "essential to improving quality."[2] Additionally, the National Quality Strategy has identified three aims for the health care system, one of which directly relates to patient involvement, and suggests that to improve the overall quality of care, health care must be more patient-centered, reliable, accessible, and safe.[3]

ARN also believes the IRF QRP could be greatly enhanced by further developing and expanding core measures such as mobility and self-care. ARN supports these indicators with the caveat that they be risk-adjusted and diagnosis/impairment group-specific with definitive inclusion/exclusion criteria.

ARN's white paper, *The Essential Role of the Rehabilitation Nurse in Facilitating Care Transitions*, emphasizes the current lack of care coordination in practice during transitions of care[4]. Our paper

[1] CMS PAC Quality Initiatives - IMPACT Act of 2014 & Cross Setting Measures. Retrieved from: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014-and-Cross-Setting-Measures.html
[2] Nursing Alliance for Quality of Care. (2013). Fostering Successful Patient and Family Engagement. Retrieved from www.naqc.org
[3] U.S. Department of Health and Human Services. (2012). Annual Progress Report to Congress: National Strategy for Quality Improvement in Health Care. Retrieved from www.ahrq.gov
[4] The Essential Role of the Rehabilitation Nurse in Facilitating Care Transitions. Retrieved from: http://www.rehabnurse.org/uploads/files/healthpolicy/ARN_Care_Transitions_White_Paper_Journal_Copy_FINAL.pdf

discusses how the provision of care is fragmented, disorganized, and guided by factors unrelated to the quality of care or patient outcomes and how decision-makers often lack adequate information to make the best decision during care transition planning. Rehabilitation professionals have identified the importance of including the patient and their family members in the decision-making process regarding the most appropriate location for PAC. ARN has specifically emphasized that the measures should include both the receipt of information needed to coordinate care and the transmittal of information.

Measuring and Accounting for Social Risk Factors in the IRF QRP

ARN maintains a steadfast commitment to supporting the agency's objective "to improve beneficiary outcomes including reducing health disparities, and we want to ensure that all beneficiaries, including those with social risk factors, receive high quality care." We support the agency's efforts to improve outcomes and reduce health disparities and to "ensure that the quality of care furnished by providers and suppliers is assessed as fairly as possible … while ensuring that beneficiaries have adequate access to excellent care." To that end, we very much appreciate that the agency has concerns about "holding providers to different standards for the outcomes of their patients with social risk factors because we do not want to mask potential disparities or minimize incentives to improve the outcomes for disadvantaged populations." We thank the agency for seeking public comment on "which social risk factors might be most appropriate for reporting stratified measure scores and/or potential risk adjustment of a particular measure."

We previously have submitted comments to the agency about the need to utilize socioeconomic and demographic factors in risk adjustment for the proposed resource use measures. We understand the agency is considering factors such as dual eligibility for Medicare and Medicaid/low-income subsidy, race, and ethnicity. We agree with those factors and would like to take this opportunity to reiterate our previous comments to the agency about further expanding the list of socioeconomic and demographic factors that are utilized in risk adjustment, with a focus on those that affect both discharge to community and 30-day readmissions measures, including:

1. Age;
2. Presence of support system (spouse, partner, children, and/or parents who are able to learn and are willing to participate in learning care and providing care);
3. Finances (does the individual qualify for aid such as low-income subsidy or have private funds to assist with care or is there a family/caregiver with the ability to stay home with the individual; how will the individual obtain equipment not covered under Medicare);
4. Education and healthcare literacy (the ability to understand the medical diagnoses and the care that is needed);
5. Physical ability of the caregiver (e.g. age of caregiver, presence of impairments in caregiver, weight and medical condition of caregiver);
6. Living conditions and home access;
7. Community resources available for respite;
8. Race and ethnicity;
9. Geographic area of residence;

10. Dual eligibility for Medicare and Medicaid;
11. Cognition; and
12. Presence of pre-morbid assistance with self-care.

In addition to utilizing these factors to make appropriate adjustments in the IRF QRP, ARN believes that utilizing the above factors during the assessment of patients would enable providers, in collaboration with the patient/caregiver, to develop a more comprehensive treatment and intervention plan that addresses these concerns, improves outcomes, and helps to prevent avoidable readmissions.

As CMS continues to develop and refine existing and planned IRF QRP measures, ARN encourages CMS to consider the following features of care furnished in an IRF:

- Assessment of family members and caregivers' capacity to assume patient care post-discharge;
- Coordination and collaboration on patient, family, and medical goals of care when patients' goals are to return to their home- or community-based setting; and
- Ethical considerations regarding ongoing care and family support for continuing or terminating complex medical care and the addition of language related to initiating and/or introducing palliative care.

Proposed Collection of Standardized Patient Assessment Data Under the IRF QRP

ARN strongly supports the *IMPACT Act*, and believes that valid, reliable, and relevant measures are fundamental to the effectiveness of the IRF QRP. As part of the *IMPACT Act* implementation, we understand the agency is proposing to define "standardized patient assessment data" as "patient assessment questions and response options that are identical in all four PAC assessment instruments, and to which identical standards and definitions apply." ARN represents rehabilitation nurses that work in all four PAC settings – IRFS, Long Term Acute Care Hospitals (LTCH), home health agencies (HHAs), and skilled nursing facilities (SNFs) – and as such, we support standardizing the definition as well as the implementation of this data collection effort. Further, we support the agency's goal of collecting standardized patient assessment data "to drive improvement in health care quality across" the four PACS settings.

We share the agency's concerns that the "assessment questions and response options in the four PAC assessment instruments are not currently standardized with each other [and] as a result, questions and response options … cannot be readily compared." We support the agency's effort to standardize the questions and responses across all PAC settings to help "enable the data to be interoperable, allowing it to be shared electronically, or otherwise between PAC provider types."

We wish to note a concern with respect to the proposed change from multiple assessments to one assessment performed on admission and one on discharge. At present, the current MDS assessment schedule, along with change of therapy (COT), end of therapy (EOT), start of therapy (SOT), help to track resident progress, decline, or maintenance of function and provide essential clinical data to support patient-centered care. We have concerns that this change might have an adverse impact on patients.

Policy for Retaining IRF QRP Measures and Proposal to Apply That Policy to Standardized Patient Assessment Data

ARN understands and supports the current CMS policy that allows any quality measure adopted for use in the IRF QRP to "remain in effect until the measure is removed, suspended, or replaced" and agrees that this policy should be applied to the standardized patient assessment data that will be adopted by the agency for the SNF QRP.

Policy for Adopting Changes to IRF QRP Measures and Proposal to Apply That Policy to Standardized Patient Assessment Data

ARN understands that CMS adopted a subregulatory process to "incorporate updates to IRF quality measure specifications that do not substantively change the nature of the measure" and that substantive changes to measures are undertaken through formal rulemaking. ARN agrees with the agency that this approach be applied in the same manner to the standardized patient assessment data being adopted for the IRF QRP.

Quality Measures Currently Adopted for the IRF QRP

Total Estimated Medicare Spending Per Beneficiary (MSPB)–Post-Acute Care (PAC) SNF QRP

ARN appreciates CMS's efforts to advance care management and improve the efficiency and coordination of care provided to patients in PAC settings by developing measures that allow for meaningful comparisons between providers in the same PAC setting. As we have previously commented to the agency, ARN urges CMS to clarify how the information collected by the MSPB-PAC SNF episode-based measure will be communicated to patients and providers, as we expect the efficiency of SNFs may be difficult to convey to beneficiaries in a meaningful manner. We have concerns the information made available to the public could unfairly be interpreted as a measurement of the PAC provider's quality of care, rather than an indicator of the facility's relative efficiency.

We understand and appreciate the intent of the MSPB-PAC IRF QRP measure is to ensure patients receive high quality care and address geographic variations in IRF spending. However, assessing IRF providers' efficiency based solely on the MSPB-PAC IRF QRP measure is inappropriate, given that some post-acute providers may treat a greater number of medically complex patients who require multi-faceted, highly skilled rehabilitation and treatment than other providers of the same type. ARN believes the MSPB-PAC measure may unintentionally encourage IRFs to selectively admit or refuse patients based on the type and complexity of their conditions.

It is vitally important that individuals with chronic and disabling conditions are served in a setting that includes the provision of services that will optimize health outcomes and quality of life. The MSPB-PAC measure, which evaluates IRF providers' efficiency relative to the efficiency of the national median provider of the same type, fails to take into consideration the health needs and desired outcomes of each patient. We are concerned that IRFs will be assessed based solely on cost per patient, without accounting for the superior patient outcomes facilitated by IRFs.

While ARN supports CMS's efforts to align the MSPB-PAC measures with the hospital MSPB measure, stipulated by the *IMPACT Act*, as the development of the MSPB-PAC resource measures continues, we encourage CMS to take into consideration the possible financial incentives for hospitals to prematurely discharge patients to PAC facilities. A recent study, published in the journal *Medical Care*, suggests that some hospitals may prematurely discharge patients to post-acute settings as a substitute for prolonged inpatient care, thus inflating PAC facilities' costs, increasing hospital readmission rates, and distorting measurement.[5]

Discharge to Community

ARN has concerns with the proposed exclusion of post-acute stays that end in discharge to the same level of care, as we believe CMS's proposed exclusion criteria fails to consider when a patient's "home" is a custodial nursing facility and the patient's post-acute episode involves a discharge back to his or her "home." In such circumstances, including the final post-acute provider in the discharge to community measure when a patient is discharged to the originating level of care, but in essence, is returning home, may distort the findings of the quality measure. We encourage CMS to design a quality measure that is capable of capturing the difference between a patient's return to his or her home and a patient's post-acute episode that involves transfer to the same level of care.

ARN also believes that patients who have been discharged to the community and expire within the post-discharge window should not be excluded from the discharge to community quality measure, given the variation in characteristics of IRF patients. We encourage CMS to exclude patients from the Discharge to Community-PAC IRF QRP who pass away within the post-discharge window after being discharged to the community, as the types of patients treated in IRFs greatly varies and can lead to an inaccurate reflection of the quality of care.[6]

Potentially Preventable 30-Day Post-Discharge Readmission Measure for IRF QRP

While ARN is generally supportive of the potentially preventable readmissions measure, we believe PAC facilities should not be penalized for conditions that prompt readmission which are unrelated to the patient's initial reason for admission to the IRF. For example, hospitalization can change the condition of a patient, increasing the likelihood of an unplanned readmission, which is outside the control of the PAC provider. Additionally, ARN recommends that CMS account for differences in each IRF's mix of low-income patients when calculating readmission rates.

Drug Regimen Review Conducted with Follow-up for Identified Issues-PAC IRF QRP

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[5] Sacks, G. D., Lawson, E. H., Dawes, A. J., Weiss, R. E., Russell, M. M., Brook, R. H., Zingmond, D. S., Ko, C. Y. "Variation in Hospital Use of Postacute Care After Surgery and the Association With Care Quality." *Medical Care* 54.2 (2016): 172-179.

[6] Proposed Measure Specifications for Measures Proposed in the FY 2017 IRF QRP NPRM (April 2016). Retrieved from: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/Proposed-Measure-Specifications-for-FY17-IRF-QRP-NPRM.pdf

ARN supports the Medicare Payment Advisory Commission's (MedPAC) recent comments[7] on the drug regimen review measure. We concur with MedPAC that CMS should consider the development of a measure that evaluates how PAC providers are supporting medication reconciliation throughout the care continuum and whether a PAC provider is sending medication lists to either the next PAC provider, or if being discharged home, to the patient's primary care provider. It is imperative that all health care professionals responsible for the patient's care are aware of the patient's prescribed medications. Requiring providers to transmit medication lists to relevant providers may enhance adherence and improve monitoring of the patient's condition, which may help to prevent avoidable readmissions and unintended medical harm.

IRF QRP Quality Measures Proposed Beginning With the FY 2020 IRF QRP

ARN appreciates the agencies ongoing effort to improve the quality of care and ensure appropriate resource allocation among PAC settings, including IRFs. We understand the agency is proposing new measures for implementation beginning in FY 2020. Overall, ARN believes the expansion of core measures to include National Quality Forum (NQF) IRF measures is appropriate. Measures should be clinically relevant or representative for a given setting or patient population and measures must be meaningful in order to be useful. Patient-reported outcomes and measures that are meaningful to patients and families also should be included. Most importantly, the underlying theme (and the intent of the *IMPACT Act*) is that measures must be harmonious across settings.

Proposed Modifications to Potentially Preventable 30-Days Post-Discharge Readmission Measures for IRF QRP

ARN supports efforts to ensure harmonious and equal measures across the post-acute care continuum and therefore agrees with the proposed removal of the readmission measure.

Proposed Standardized Resident Assessment Data Reporting for the FY 2019 IRF QRP

Change in the pressure ulcer to skin integrity

ARN supports the replacement of the current pressure ulcer measure, Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678) with a modified version of that measure, Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury.

Proposed Standardized Resident Assessment Data Reporting for the FY 2020 IRF QRP

Cognitive Function and Mental Status Data

Brief Interview for Mental Status (BIMS)

[7] MedPAC March 25, 2016 Comment Letter. Retrieved from: http://medpac.gov/documents/comment-letters/medpac-comment-on-cms's-post-acute-care-quality-measures.pdf?sfvrsn=0

ARN supports the utilization of the BIMS in evaluating a patient's cognitive status and believes it is valid and reliable in its assessment. Given the relatively low burden of administering the assessment and its ability to generally predict a cognitive impairment, we believe clinicians should be encouraged to administer the assessment on a regular basis as a means to evaluate whether there are changes in the patient's cognition.

However, ARN has concerns regarding the BIMS' limitations. The BIMS has been shown to be unable to differentiate between patients with a mild cognitive impairment and those with no cognitive impairment; further, it cannot provide a completely clear picture of a patient's cognitive status. We urge CMS and RAND to clarify what, if any, additional tools will be used to detect potential cognitive impairment or dementia, such as collecting information from the patient's family or caregivers to confirm or provide supplemental data.

Behavioral Signs and Symptoms

Behavioral signs and symptoms could indicate a patient has a cognitive dysfunction or is uncomfortable and needs assistance. The development of an individualized, person-centered care plan depends on accurate assessment and preventative methods. As members of interdisciplinary teams, nurses collaborate with physicians, social workers, psychologists, therapists, and case managers. Because of these relationships and interactions, nurses are well-equipped to identify and respond to patients with potential behavioral issues.

ARN recognizes the need to monitor and assess behavioral signs and symptoms in an effort to better inform a patient's treatment plan. We have concerns, however, that the scope of the Behavioral Signs and Symptoms assessment is limited and may be ineffective for increasing quality of care and improving patient outcomes. The assessment does not capture subtle signs or symptoms, such as agitation or anxiety, which could indicate a cognitive impairment. If a patient exhibits such symptoms, it is unlikely to be referenced in the assessment, which could lead to the development of a care plan that does not fully reflect the patient's condition. Specific questions that help the clinician/assessor identify subtle behavioral signs or symptoms should be included in this assessment to assist in the development of a patient's care plan.

Patient Health Questionnaire-2

ARN is supportive of the PHQ and believes the PHQ-2 and PHQ-9 are useful, valid clinical tools. Both questionnaires assist clinicians in determining the severity of symptoms upon admission and throughout the delivery of care in the PAC setting. ARN recommends that the PHQ should initially be presented to patients in the most basic form (PHQ-2), and then administered in its more thorough form if these initial screening questions are positive. Upon admission into a PAC facility, patients are overwhelmed, creating a situation in which some individuals may not feel comfortable with a more invasive mental health screening. Utilizing a shorter form will reduce the burden experienced by clinicians in collecting assessment data.

While we appreciate CMS's efforts to limit the administrative burden on patients and providers by proposing to utilize the PHQ-2 as an initial screen for depression, potentially eliminating the need for conducting the PHQ-9 in some circumstances, we have concerns the PHQ-2 is unable to

identify the more subtle signs and symptoms of depression. Should CMS move forward with adopting the PHQ-2 as a gateway tool for the PHQ-9 across PAC settings, we recommend CMS utilize a low threshold level for the PHQ-2, to ensure clinicians do not miss those patients who require further evaluation.

Special Services, Treatments, and Interventions Data

ARN is committed to providing our patients with the highest quality of health care, but we are concerned that the collection of additional data points will create an unnecessary burden on rehabilitation nurses. ARN understands the need for data to be used for risk adjustment, but the same interventions should be applied across PAC settings.

Conclusion

ARN very much appreciates the opportunity to provide comments to CMS regarding the proposed rule implementing the FY 2018 IRF PPS. We are available to work with you, your colleagues, the rehabilitation community, and other stakeholders to develop and implement payment policy changes that ensure access to quality care for Medicare beneficiaries with physical disabilities and/or chronic disease. If you have any questions, please contact me or have your staff contact our Health Policy Associate, Jeremy Scott (jeremy.scott@dbr.com or 202-230-5197). We thank you for your consideration of our concerns, recommendations, and requests.

Sincerely,

Stephanie Vaughn

Stephanie Vaughn, PhD RN CRRN FAHA
President