November 16, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

Re: Draft Measure Specifications for Potentially Preventable Hospital Readmission Measures for Post-Acute Care

Dear Acting Administrator Slavitt:

On behalf of the Association of Rehabilitation Nurses (ARN) – representing more than 5,300 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 draft measure specifications for potentially preventable hospital readmission measures for post-acute care (PAC).

Rehabilitation nurses take a holistic approach to meeting patients’ nursing and medical, vocational, educational, environmental, and spiritual needs. Rehabilitation nurses begin to work with individuals and their families soon after the onset of a disabling injury or chronic illness. We continue to provide support and care, including patient and family education, which empowers these individuals when they return home, or to work, or school. Rehabilitation nurses often teach patients and their caregivers how to access systems and resources.

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 inpatient rehabilitation facilities (IRFs), hospitals, long-term subacute care facilities/skilled nursing facilities (SNFs), long-term acute care facilities, comprehensive outpatient rehabilitation facilities (CORFs), home health, and private practices.

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, particularly among the Medicare population.

**Measure Exclusions**

ARN is pleased the Centers for Medicare and Medicaid Services (CMS) has proposed discharge measure exclusions; however, we disagree with the proposed exclusion criteria of patients less than 18 years old. Many IRFs treat patients younger than 21 when necessary, which is reflected by the Functional Independence Measure (FIM) and IRF-Patient Assessment Instrument (PAI), both of which are used to assess patients age seven or older. ARN encourages CMS not to exclude patients under 18 years old from the discharge measures.

While the time frame for the initial data collection for the project varied from one year (SNFs), two years (IRFs and LTCHs), and three years (HH) the reporting time frame for this indicator must be the same for all PAC settings. Reporting can be based on either one year of data, two years of data, etc. but it cannot vary among settings. This must be addressed by CMS and the subcontractors.

ARN questions the rationale behind the exclusion for SNF stays where the patient had one or more intervening PAC admissions which occurred either between the prior proximal hospital discharge and SNF admission or after the SNF discharge, within the 30-day risk window as well as SNF admissions where the patient had multiple SNF admissions after the prior proximal hospitalization, within the 30-day risk window. The rationale states that “when patients have multiple PAC admissions, evaluating quality of care coordination is confounded and even controversial in terms of attributing responsibility for a readmission among multiple PAC providers. Similarly, assigning responsibility for a readmission for patients who have multiple SNF admissions subsequent to their prior proximal hospitalization is also controversial.” ARN believes that this rationale could apply to any PAC setting and therefore, disagrees with having this as an exclusion from the SNF denominator.

ARN also has serious concerns with the exclusion criteria of SNF stays with a gap of greater than one day between discharge from the prior proximal hospitalization and admission to a SNF. The exclusion criteria fail to consider a medically complex patient that is treated in an IRF and subsequently readmitted within 30 days for an issue that may have been treated as a comorbidity. Given that a prior proximal hospitalization is defined as an inpatient admission to an acute care hospital, critical access hospital (CAH), or a psychiatric hospital, and IRFs are licensed as hospitals, we believe that admission to an IRF should be considered a proximal hospitalization and disagree that patients who are clinically different should be excluded.

In regards to the within-stay criteria, IRFs have been seeing a rise in the number of patients who must return to the acute inpatient care setting within 48-72 hours of admission due to the disparity between the level of care which their condition (can either be a co-morbidity or
complication secondary to the presenting diagnosis) requires and the level of care which an IRF is able to provide. To this end, ARN disagrees with the within-stay criteria delineated for ARNs and believes that in these instances, re-admissions are a necessity for patient safety, and not necessarily preventable.

**Measure Specifications**

While ARN is generally supportive of the potentially preventable readmissions measure specifications, we have several concerns. As ARN has stated in previous comment letters, the IRF measure is based on 24 months of data while the SNF measure is based on 12 months of data. PAC facilities should not be penalized for conditions that prompt readmission which are unrelated to the patient’s initial reason for admission. We also oppose CMS’s proposal to require PAC providers to utilize 30-day readmission claims data to determine their readmission rates. Using claims data to calculate readmission rates will be difficult for IRFs and other PAC settings, as claims data are cumbersome to use and access. Employing a 30-day readmission rate measure will not provide meaningful insight or have an impact on quality improvement efforts if the PAC settings do not have unrestricted access to the data.

**Conclusion**

ARN very much appreciates the opportunity to provide comments to CMS regarding the Draft Measure Specifications for Potentially Preventable Hospital Readmission Measures for PAC. 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.

Respectfully submitted,

Cheryl Lehman, PhD RN CNS-BS RN-BC CRRN
President