June 30, 2014

Marilyn Tavenner  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1448-P  
Room 445-G  
Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, D.C. 20201

Re: CMS-1608-P: Medicare Program; Inpatient Rehabilitation Facility  
26308 (May 7, 2014).

Dear Administrator Tavenner:

On behalf of the Association of Rehabilitation Nurses (ARN) – representing nearly 12,000  
rehabilitation nurses 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 proposed rule  
implementing the Inpatient Rehabilitation Facility (IRF) prospective payment system (PPS) for  
fiscal year (FY) 2015.

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.  
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  
rehabilitation facilities, hospitals, long-term subacute care facilities/skilled nursing facilities,
long-term acute care facilities, comprehensive outpatient rehabilitation facilities, home health, and private practices, just to name a few.

ARN supports efforts to ensure people with physical disability and chronic illness have access to comprehensive quality care in whichever care setting is more appropriate for them. Specifically, as a part of its missions, 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.

**Proposed Changes to the IRF-PAI**

ARN is supportive of data collection and the use of a common assessment tool, but is opposed to adding additional burdens to facilities and staff by requiring the collection information that is not needed. The draft IRF-PAI reflecting the proposed changes in the FY 2015 IRF PPS Proposed Rule includes items 25A (height on admission) and 26A (weight on admission) which is routine information already collected by nursing staff upon admission and there is no need to have this information on the IRF PAI.

There are also discrepancies involving item 15A (admit from). The item includes codes for both hospice at home and hospice at an institutional facility. The Medicare Benefits Policy Manual states that the medical necessity criteria for IRFs require that patients must need an intensive level of rehabilitation services and have the ability to actively participate in an intensive rehabilitation therapy program. Specifically, the Medicare Benefits Policy Manual states “The inpatient rehabilitation facility (IRF) benefit is designed to provide intensive rehabilitation therapy in a resource intensive inpatient hospital environment for patients who, due to the complexity of their nursing, medical management, and rehabilitation needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care.” It is highly unlikely that a hospice patient would meet all the criteria stipulated in the Benefits Manual. Item 15A also includes two codes for home (01 and 06). If a patient is being admitted from home then there should only be a need for one code. It would be very difficult for IRFs to verify if a patient is admitted from home with or without home health services.

The suggested changes to the IRF-PAI also do not coincide with existing data and forms utilized for follow-up. While ARN understands that follow-up is not a part of the IRF PPS, many IRFs collect follow-up data on such things as FIM scores and readmissions to track the durability of outcomes as well as required by voluntary accreditation and certification standards. The Commission on Accreditation of Rehabilitation Facilities requires that facilities collect data at the beginning of services, appropriate intervals during service, the end of services, and point(s)
in time following services. By changing destination codes and demographic information there will be conflicts with existing structures and forms used in follow-up. Finally, we oppose item 44C (was the patient discharged alive) because there is no information capturing what happens to the rehabilitation patient who dies/expires on the rehabilitation unit.

VII. Proposed Refinements to the Presumptive Compliance Methodology

ARN believes that the recovery from an acute episode of illness or injury depends on adequate medical treatment and early identification of needs for rehabilitation care; and that IRFs are a 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 needs to restore and improve their function and health status. A patient’s admission to an IRF should not be based on their diagnosis alone, but on their health and rehabilitative needs.

ARN is opposed to the removal of several codes from the Impairment Group Codes That Meet Presumptive Compliance Criteria. IRFs utilize these criteria to assure compliance with the “60 Percent Rule.” Removal of these codes would restrict access to medically necessary services because it would essentially be granting Centers for Medicare and Medicaid Services (CMS) the discretion to modify or limit those conditions that count towards the 60 percent threshold. Additionally, ARN is opposed to the “75 Percent Rule” because the level of rehabilitation care an individual requires cannot be determined based on diagnoses alone. In testimony before the Ways & Means Health Subcommittee earlier this year, senior officials from CMS and MedPAC have characterized the Rule as “arbitrary.”

VIII. Proposed Data Collection of the Amount and Mode (Individual, Group, and Co-Treatment) of Therapy Provided in IRFs According Occupational, Speech, and Physical Therapy Disciplines

ARN understands the importance of the collection of data on the amount and types of therapy provided in an IRF as that is the distinguishable characteristic between IRFs and other post-acute care providers. However, ARN is concerned with the increased burden on rehabilitation nurses and other rehabilitation personnel who will be asked to collect data on the amount and mode of therapy provided. Additionally, we are concerned with the groupings of the different modes of therapy as one-to-one therapy is vastly different than a group therapy session. Existing Medicare criteria for IRFs are in place that stipulates the majority of rehabilitation must be 1:1 therapy; therefore the need to collect and report this on the IRF-PAI is both unnecessary and burdensome.

XI. Proposed Revisions and Updates to the Quality Reporting Program for IRFs
B. Quality Measures Previously Finalized for and Currently Used in the IRF Quality Reporting Program


In the FY 2012 IRF PPS, CMS adopted the National Quality Forum’s (NQF’s) measure #0138 as part of the QRP. The FY 2013 Medicare outpatient PPS final rule refined this measure. In the FY 2014 final rule, CMS indicated that it intended to make no further refinements to this quality measure.

The statute mandates that CMS must include certain data reporting measures for IRF, but allows the Secretary the discretion to choose which quality measures to include in the program. ARN respectfully urges CMS to consider removing the current CAUTI measure due to the infinitesimal number of CAUTIs found in rehabilitation hospitals. A recent study by Meddings et al. examined over 767,000 adult discharges from Michigan hospitals and found that only 2.6 percent of all hospital-acquired UTIs were coded in claims as being catheter-associated. Given Medicare’s rules related to non-payment for healthcare-acquired conditions, CAUTIs reduced Medicare spending by only 0.003 percent for all hospitalizations. ii

2. Percent of Residents with Pressure Ulcers That Are New or Worsened (Short-Stay) (NQF #0678)

The FY 2014 final rule adopted NQF measure #0678, which reports the number of Stage 2-4 pressure ulcers that are new or have worsened since the last assessment. ARN is committed to ensuring that our patients receive high-quality care and recognize that the prevalence of pressure ulcers can be an indication of poor health care quality. However, IRF patients have a very low incidence of pressure ulcers and we believe that this collection of data is burdensome and does not measure quality.

3. Percentage of Residents or Patients Who were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay) (NQF #0680)

The rule was adopted in the FY 2014 IRF PPS Final Rule (78 FR 47905 through 47906), reporting on the number of short-stay patients or residents who receive a seasonal influenza vaccine. This quality measure has been endorsed by the NQF as measure #0680. The final rule clarifies that the influenza season typically runs from October 1 to March 31 of each year.

ARN opposes this measure and urges CMS not to retain in FY 2015. While ARN is committed to ensuring that our patients receive the highest quality health care possible, we are concerned that overutilization of quality measures – while well intentioned – may have the unintended
consequence of impeding health care quality. The purpose of rehabilitative care is to promote functional recovery and achievement of goals by patients so that they are able to function to their maximum potential in the least restrictive environment. The proposed measure is not related to the specific rehabilitative care provided to the patient and/or resident of an IRF and thus should not be included in the IRF QRP. Numerous opportunities exist in other health care settings to receive immunizations, prior to an individual’s admission to the IRF.

C. Proposed New IRF QRP Quality Measures Affecting the FY 2017 Adjustments to the IRF PPS Annual Increase Factor and Beyond General Considerations Used for Selection of Quality Measures for the IRF QRP

ARN commends CMS for its desire and work to increase the quality of care of patients in the post-acute care setting through the use of NQF endorsed measures, but does not believe that the following proposed quality measures accurately reflect quality improvement or quality of care provided. ARN does not support the National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (NQF #1716) and the National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset Clostridium difficile Infection (CDI) Outcome Measure (NQF #1717). The purpose of rehabilitation is to promote functional recovery and achievement of goals by patients so that they may function to their maximal potential in the least restrictive environment. These measures do not represent the quality or outcomes of rehabilitation programs. Furthermore, the incidence of these conditions occurring in rehabilitation is extremely rare. If a patient in rehabilitation has either condition, generally it is something that is present on admission from transfer from acute care. The inclusion of these indicators as so called “quality measures” may cause rehabilitation facilities to inappropriately screen for these conditions.

Additionally, ARN believes that the quality indicator, All Cause Unplanned Readmissions within 30 days of discharge from an IRF is not appropriate for IRFs because it is not NQF endorsed and it fails to exclude readmissions unrelated to the initial reason for admission. According to a 2013 Office of Inspector General report, of the 3.3 million Medicare residents who stayed in nursing homes for at least 1 day in FY 2011, 825,765 (24.8 percent) experienced hospitalizations. That number is compared to the 9.4% readmission rate of IRFs in FY 2011. IRFs provide unique clinical value for patients who require hospital-level care and intensive rehabilitation after an illness, injury or surgery and should not be penalized for conditions not associated with the patient’s initial reason for admission.

ARN also requests that correct and cross-cutting terminology is utilized with respect to patients. Inpatient rehabilitation patients are referred to as patients – not residents.

D. IRF QRP Quality Measures and Concepts Under Consideration for Future Years
ARN agrees that the Inpatient Rehabilitation Facility Quality Reporting System could be greatly enhanced by further developing and expanding core measures such as mobility and self-care and is pleased to see them included for consideration for future years. ARN supports these indicators with the caveat that they are risk-adjusted and diagnosis/impairment group specific with definitive inclusion/exclusion criteria.

Conclusion

ARN very much appreciates the opportunity to provide comments to CMS regarding the proposed rule implementing the IRF PPS for FY 2015. 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,

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President