June 25, 2013

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


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) 2014.

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.

XIII. Proposed Revisions and Updates to the Quality Reporting Program for IRFs

ARN appreciates the opportunity to comment on changes to the Quality Reporting Program (QRP) for
FY 2014 and subsequent years. We believe that accurate reporting of relevant data can be useful to
measuring whether patients are receiving the high-quality health care to which they are entitled. To that
depth, ARN believes the QRP could be greatly enhanced by further developing and expanding core
measures such as mobility and self-care – relevant measures specifically related to rehabilitative services.
These measures should be appropriately risk-adjusted and specific to a diagnosis and/or impairment
group. Finally, it is imperative that all quality measures contain clearly defined inclusion and exclusion
criteria.

As nurses, we are committed to ensuring that our patients receive the highest-quality care possible,
regardless of the practice setting. However, we are concerned that measurement for the sake of
measurement and reporting for the sake of reporting impedes our members’ ability to provide high-quality
care to their patients. In his testimony before the House Ways and Means Health Subcommittee, Dr.
Mark Miller, Executive Director of MedPAC, stated “The Commission has also discussed the need for a
limited set of measures to simplify the myriad of metrics providers and MA (Medicare Advantage) plans
are required to report.” ARN does not support measures that are not clinically relevant or representative
for a given setting or patient population. In order to be useful, measures must be meaningful.

To that end, while not specifically mentioned in the proposed rule, ARN wanted to raise our concern with
measure #3035 – Reliability Adjusted Central-Line Associated Blood Stream Infection (CLABSI), which
was included in the Measure Applications Partnership (MAP) February 2013 report. This measure has
not been endorsed by the National Quality Forum (NQF). ARN does not support this indicator and
explicitly voiced our dissatisfaction and lack of support to the MAP as part of the public comment period.
The incidence of CLABSI in rehabilitation facilities is an extremely rare occurrence. As such, if this
measure were included in the IRF QRP, facilities would be required to obtain cultures for no reason other
than to document on admission that the CLABSI was or was not noted on admission. Because of the
infrequency and unintended consequences, despite its inclusion in the MAP, we urge CMS not to consider
this indicator in the futures for IRFs.

We strongly urge CMS to thoughtfully analyze the impact of data reporting requirements on the day-to-
day operations of nurses and all health care providers. Indeed, the October 2014 Inpatient Rehabilitation
Facility Patient Assessment Instrument (IRF-PAI) is nine pages in length and will require additional time
to be able to appropriately complete – this is time that is not spent on direct patient care.

ARN stands ready to work with CMS and other stakeholders to engage in a thoughtful dialogue about the
specific data that are necessary to collect for quality reporting purposes and improving health care quality.
We also look forward to an opportunity to discuss what other data reporting may no longer be necessary.

1 MedPAC Testimony to the House Ways and Means Health Subcommittee, Medicare Post-Acute care Reforms, Dr.
Considerations by HHS, Final Report (Feb. 2013), available at
B. Quality Measures Previously Finalized and Currently in Use for the IRF Quality Reporting Program

2. Previously Finalized IRF QRP Quality Measures
   i. National Healthcare Safety Network (NHSN) Catheter Associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138)

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 current proposed rule, CMS indicated that it intends 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.\(^3\)

C. Proposed New IRF QRP Quality Measures Affecting the FY 2016 and FY 2017 IRF PPS Annual Increase Factor, and Subsequent Year Increase Factor

2. Quality Measures Proposed for Quality Data Reporting Affecting the FY 2017 IRF PPS Annual Increase Factor and Subsequent Years
   ii. Proposed IRF QRP Measure #2: Percentage of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay) (NQF #0680)

The proposed rule seeks to adopt a quality measure to the IRF QRP, 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 proposed rule clarifies that the influenza season typically runs from October 1 to March 31 of each year.

ARN opposes the adoption of this measure and urges CMS to refrain from its adoption. 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.

iii. Proposed IRF QRP Measure #3: Percentage of Residents or Patients With Pressure Ulcers That are New or Worsened (Short-Stay) (NQF #0678) – Proposal To Adopt the NQF Endorsed Version of This Measure

The proposed rule seeks to adopt 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, we are concerned that the adoption of this NQF measure may be too premature. As you know, on June 13, 2013, the technical experts panel (TEP) met to develop a common pressure ulcer quality tool across the minimum data set (MDS), patient assessment instrument (PAO), and outcome assessment information set (OASIS). ARN urges CMS to refrain from adding the proposed quality measure until the TEP has finalized its quality tool in order to minimize the potential number of changes to the reporting measure.

D. Proposed New IRF-PAI That Are Related to the IRF Quality Reporting Program

3. Proposed Revision to the IRF-PAI To Add Mandatory Risk Assessment Data Items for NQF #0678 Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay)

CMS proposes to update the current IRF-PAI to include certain data elements that CMS believes is necessary to risk adjust the NQF-endorsed measure relating to pressure ulcers. Specifically, CMS would include new indicator boxes as part of the IRF-PAI admissions assessment related to: Peripheral Vascular Disease (PVD), Peripheral Arterial Disease (PAD), and diabetes. CMS also proposes to correct a previous oversight and add height and weight to the IRF-PAI.

ARN supports the inclusion of the height and weight information to the IRF-PAI. As CMS correctly points out in the preamble to the proposed rule, height and weight are a necessary diagnostic tool.

However, ARN is concerned with CMS’ proposal to include information related to prevalence of PVD, PAD, and diabetes as part of a pressure ulcer quality measure. None of these conditions are recognized as conditions that are risk factors for pressure ulcers. As CMS is aware, PVD is a risk factor for statis or venous ulcers and PAD is a risk for arterial ulcers. While diabetes mellitus and diabetic neuropathy are risk factors for diabetic ulcers, diabetic ulcers are not the same as pressure ulcers. CMS could consider including a question related to diabetes or circulation as an indicator for poorer healing potential or delayed healing, but neither diabetes nor circulation are risk factors for pressure ulcers.

Therefore, ARN urges CMS to eliminate this data collection as part of the NQF-endorsed measure on pressure ulcers. While ARN supports quality initiatives, as discussed in greater detail above, ARN is concerned that over-collection of data can unnecessarily impede the ability of health care providers to provide high-quality health care to their patients.

4. Proposed Revision to the IRF-PAI To Add Voluntary Data Items Related to NQF #0678 Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay)
CMS proposes to make some additional changes to the IRF-PAI, including the ability of providers to better document all relevant categories of pressure ulcers. In addition, CMS proposes to attempt to capture information on the unstageable pressure ulcers due to a non-moveable device or dressing.

ARN appreciates CMS’ willingness to respond to stakeholder input. However, we are concerned that the policy as currently proposed may be misguided. While we appreciate the need to document and code pressure ulcers, we are concerned that the proposed measure simply documents the presence of a pressure ulcer and does not take into account the extent to which the pressure ulcer has healed. For example, a patient is admitted with a stage 3 pressure ulcer that is properly treated such that the wound is reduced in size by more than 50 percent at the point of discharge. Under the proposed measure, the wound’s improvement would not be appropriately captured in the data collection and the facility would be assessed the same as if they hadn’t intervened to reduce the size of the patient’s wound.

Moreover, with lengths of stay decreasing, many patients’ wounds do not fully heal until after they have been discharged from the facility. Thus, ARN encourages CMS to revise its quality measure to account for significant improvements in pressure ulcers, which we believe is a more accurate quality reporting measure than simply the number and severity of pressure ulcers.

In addition, ARN is concerned with CMS’ proposal to report on the unstageable pressure ulcers due to non-removable devices or dressings. ARN questions how health care providers would be able to assess the presence of a pressure ulcer at the point of admission if the patient has a non-removable device or dressing. For example, consider a common instance in which a patient is admitted to an IRF with a cast, which is removed within 10 days of admission, at which the presence of a pressure ulcer is detected. Once the cast has been removed, it is possible to categorize and begin addressing the pressure ulcer; however, what may not be ascertainable is when the pressure ulcer developed – did it develop during the patient’s care at the IRF, or was it present on admission? In most cases, it may not be possible to truly known when the wound began. The IRF may not be responsible for the development of the pressure ulcer and thus should not be penalized for discovering the wound. Thus, ARN would encourage CMS from requiring pressure ulcer data to be reported for individuals who are admitted with a non-removable device or dressing.

**Conclusion**

ARN very much appreciates the opportunity to provide comments to CMS regarding the proposed rule implementing the IRF PPS for FY 2014. 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](mailto: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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