American Hospital Association

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Kerry N. Weems
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: (CMS–1554–P) Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2009. (Vol. 73, No. 81), April 25, 2008.

Dear Mr. Weems:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 37,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed changes to the inpatient rehabilitation facility (IRF) prospective payment system (PPS) for fiscal year 2009. This proposed rule implements the IRF PPS provisions in the 2007 *Medicare, Medicaid, and S-CHIP Extension Act* (MMSEA) that permanently lower the 75% Rule to a 60 percent threshold and permanently expand the rule to include cases with qualifying comorbidities. The proposed rule also implements an 18-month payment freeze authorized by MMSEA and other standard annual updates. Our comments address CMS' request for input on value-based purchasing, hospital-acquired conditions and the current demonstration on hospital discharges to post-acute care.

VALUE-BASED PURCHASING

The AHA and hospital leaders believe that the concept of rewarding performance excellence holds merit. Hospitals are committed to improving the quality and safety of the care that they provide every day. They are committed to providing safe, effective, patient-centered, timely, efficient and equitable care to all patients. However, as noted in AHA's June 9 comment letter on CMS' inpatient proposed rule, we have concerns about the agency's plans to significantly expand the number of quality measures used for inpatient PPS payment determination.

CMS requested input from the IRF field on how the inpatient value-based purchasing system would work for the IRF PPS and other payment systems. We urge CMS to first study the operation and impact of this policy as it applies to the inpatient PPS before determining whether to proceed with a parallel plan for any other payment systems. We encourage CMS to work closely with the affected providers up front to build broad support, reduce confusion and coordinate any such effort with providers' independent quality improvement initiatives. To meaningfully impact quality of care at the patient level, it is critical that selected measures represent a consensus among affected stakeholders and that they first undergo rigorous validation for accuracy and reliability. An advisory panel of clinicians and scientists would provide the agency with guidance on which IRF conditions are appropriate for inclusion under this policy. In addition, a two-phase rollout of a value-based payment system similar to the process used for the inpatient PPS would be appropriate for the IRF PPS, with pay-for-reporting first, followed by pay-for-outcomes.

HOSPITAL-ACQUIRED CONDITIONS

Under the hospital-acquired conditions policy to be implemented for the inpatient PPS in 2009, CMS has adopted eight conditions and proposed nine additional conditions for which it would no longer pay a higher diagnosis-related group rate if the conditions occur while a patient is under a hospital's care. If CMS expands the hospital-acquired conditions payment approach to the IRF PPS or other payment systems, it is essential that the conditions selected be:

- reasonably preventable;
- conducive to identifying whether they are present on admission; and
- be suitable for risk adjustment to capture acuity variation by hospital.

These points and concerns are discussed extensively in the AHA's June 9 inpatient PPS comment letter and prior comments to CMS on the inpatient PPS hospital-acquired conditions policy and are equally important for the IRF PPS. We believe that these key considerations have not been adequately addressed for 13 of the 17 conditions.

Congress has granted CMS the authority to apply the hospital-acquired conditions policy exclusively to the inpatient PPS diagnosis-related groups. CMS should not extend the hospital-acquired conditions policy to other payment systems. Detailed clinical information is needed to determine if the presence of a hospital-acquired condition should limit payment, and that is best determined by the IRF.

HOSPITAL DISCHARGE TO POST-ACUTE CARE DEMONSTRATION

In the proposed rule, CMS calls for input on its current demonstration involving a standardized assessment of Medicare beneficiaries being discharged from inpatient hospitals to post-acute settings. Specifically, CMS is seeking input on how this

demonstration on a common patient assessment instrument – called the Continuity Assessment Record and Evaluation (CARE) tool – "might advance the use of health information technology in automating the process for collecting and submitting quality data." While we see the long-term potential for the common use of a patient assessment instrument – such as the CARE tool – to facilitate the efficient flow of electronic, secure patient information, it is too early to draw any conclusions. The CARE demonstration is in the beginning stages and electronic information has yet to be transmitted between participating organizations. It is unclear whether the demonstration will be able to test Web-based, inter-organization transfer of patient information. Therefore, because it is too premature to know how successfully hospitals can implement the CARE tool, it is impossible to predict whether the tool would be effective for collecting and submitting quality data.

If you have any questions about these comments, please feel free to contact me or Rochelle Archuleta, senior associate director for policy, at (202) 626-2320 or rarchuleta@aha.org.

Sincerely,

Rick Pollack
Executive Vice President