American Hospital Association

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

July 1, 2013

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

RE: CMS-1448-P, Medicare Program; Inpatient Rehabilitation Facility Prospective Payment Systems for Federal Fiscal Year 2014 (Vol. 78, No. 891), May 8, 2013

Dear Ms. Tavenner:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 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 (FY) 2014. While we support many of the proposed changes in the rule, we are deeply concerned about the proposed narrowing of the cases that count toward the "60% Rule" policy and the quality provisions in the rule.

PROPOSED NARROWING OF 60% RULE CODES

The IRF 60% Rule requires that 60 percent of an IRF's cases for a prior 12-month period fall within 13 qualifying conditions or have qualifying comorbidities. Compliance with the 60% Rule is assessed through a two-step process. The first step is the presumptive assessment, which is a software audit by a CMS contractor that assesses ICD-9-CM diagnosis codes submitted for each patient. IRFs that fail to demonstrate 60% Rule compliance using this presumptive test may then elect a second step involving a comprehensive assessment in which a contractor audits a sample of the facility's medical records to assess compliance with this policy.

The proposed rule notes that CMS has studied the codes that currently count toward 60% Rule compliance. Through this examination, the agency found changes and variation over the years in hospital coding, clinical practice, condition frequencies and 60% Rule enforcement by CMS contractors. Based on this finding, CMS is proposing to remove 331 codes from the list of

qualifying codes that count toward the 60% Rule – CMS's first ever material modification of the 60% Rule qualifying codes. **The AHA is concerned that several of the proposed coding changes are unwarranted and inappropriate. Specifically, we are concerned that they are clinically irrelevant, administratively unrealistic, and do not further CMS's ability to ensure that IRFs are treating medically appropriate patients. These changes will have the immediate effect of decreasing the compliance rate for many IRFs, reducing IRFs' ability to admit diagnoses outside of the 60% Rule qualifying conditions, and potentially decreasing access to IRF services for patients that would benefit from these specialized services.**

The 60% Rule is intended to ensure that IRFs concentrate on treating a patient population that is distinct from that treated in other post-acute settings. However, this goal has already been met through a variety of regulatory interventions by CMS. First, the long-standing requirement that IRF patients require and receive at least three hours of therapy a day results in an IRF patient mix that, as a whole, is unlike the mix treated in other settings. In addition, the agency's substantial redesign of the 75% Rule (now the 60% Rule) in 2004 initiated a period of major volume reduction for the IRF field – a drop of more than 123,000 cases from 2004 through 2011. Further, CMS implemented new regulatory requirements in January 2010 that required IRF physicians to apply even more stringent admission criteria when considering whether a patient was medically necessary for the IRF setting. **Collectively, these regulatory actions have resulted in a substantial reduction in IRF utilization and an IRF case mix that is, on average, more acute than in prior years.[1] Given these changes, the proposed narrowing of 60% Rule eligible codes is inappropriate, and we are concerned they would reduce access to IRF services for patients who would otherwise meet IRF admissions criteria.** This is especially worrisome since, as noted below, CMS has not provided a sound clinical rationale to support removing some of the codes.

We also ask CMS to clarify for all stakeholders, including Medicare auditors, that any changes to 60% Rule coding guidelines in the final rule will take effect on a *prospective* basis for 12-month 60% Rule audit cycles reviewing services provided in FY 2014 and beyond.

Non-specific Diagnosis Codes

CMS proposes to remove non-specific codes whenever more specific codes are available from those that count toward 60% Rule compliance. The AHA agrees that whenever possible, IRFs should use the most specific code possible to describe a medical disease, condition or injury on the inpatient rehabilitation facility patient assessment instrument (IRF-PAI). **However, we strongly object to the blanket approach taken in this proposed rule of uniformly removing non-specific codes whenever more specific codes are available.**

First, the ability of IRFs to obtain more specific codes from the referring hospital, instead of using non-specific codes, is often administratively unrealistic. IRFs have to rely on the documentation provided by the referring general acute care hospital when assigning certain

[1] MedPAC Report to Congress. March 2013. Pages 224-225.

codes to describe the patient's status. It is both difficult and burdensome to attempt to obtain detailed medical documentation from the transferring facility, especially when the transferring facility itself may not have the level of specificity required by the proposed changes. The difficulty is compounded when the IRF admission is further removed from the patient's treatment in the general acute care hospital, such as when a patient is discharged from a general acute care hospital, then treated in a long-term care hospital, and then transferred to an IRF.

In addition, while many hospitals are working with their physicians to improve the quality and specificity of their medical documentation in preparation of ICD-10-CM and ICD-10-PCS implementation and to mitigate the risk of payment denials due to audits by Medicare contractors, improvements in the specificity of the documentation will take time. It is therefore, again, administratively unfeasible to require IRFs to obtain the more specific codes.

Finally, there is no clinical rationale for excluding the hip fracture, stroke, or traumatic brain injury codes, nor the other unspecified codes proposed for elimination from 60% Rule qualification. It is incorrect for CMS to assume that unspecified codes reflect either poor documentation or poor coding. **We urge the agency not to finalize its proposals for any of the non-specific codes and we present specific examples below that illustrate how CMS's proposals do not further ensure that IRFs are concentrated on treating medically appropriate patients.**

Hip Fracture. CMS proposes to eliminate codes 820.00, 820.10, 820.30, 820.8 and 820.9 from the list of 60% Rule qualifying codes. However, there is no clinical rationale for this elimination, as these codes already specify the fracture as being of the "neck of femur." It is unlikely that the physician documentation would reflect anything more specific without a copy of the x-ray report, yet the x-ray may have been taken in an emergency department, at the general acute care hospital, in the nursing home, or some other location, and therefore not available as part of the IRF record. Further, the additional specificity of which portion of the neck of the femur is affected does not impact the type or intensity of rehabilitation services the patient requires and therefore does not further CMS's ability to ensure IRFs are treating medically appropriate patients.

Stroke. CMS proposes to eliminate codes 433.91 and 434.91, which specify whether the occlusion of a cerebral infarction was of a cerebral artery or precerebral artery, from the list of 60% Rule qualifying codes. The related, more specific, codes CMS would require instead identify whether the cerebral artery infarction was due to thrombosis or embolism or which precerebral artery (e.g., basilar, carotid, vertebral or other) was affected. However, generally, thrombotic and embolic strokes are very similar with the same symptoms, causes and treatments. Therefore, there is no basis for CMS to require IRFs to provide this additional level of specificity. Providers determine the need for acute rehabilitation services based on the degree of neurological deficits and functional impairment – not on whether the stroke was thrombotic or embolic, or which precerebral artery was involved.

Traumatic Brain Injuries. CMS proposes to remove approximately 120 codes for traumatic brain injuries from the list of 60% Rule qualifying codes, including codes for skull fractures, cerebral lacerations and concussions, seemingly because the more specific codes identify the duration of the patient's loss of consciousness (LOC). However, the elimination of these codes is administratively unrealistic. For example, when the LOC is of short duration, the information may be typically recorded, at the scene of the injury, by the emergency medical technician or the ambulance driver, and often is not available to the receiving IRF.

As another example, a patient may sustain a fall at home. This patient's family may notice that the patient doesn't appear "right" and mobility is declining, prompting a visit to the emergency department where a diagnosis of subdural hematoma is made. The patient is then transferred to the IRF to address mobility issues associated with a traumatic brain injury. In this example, the family has no information to share with the receiving IRF regarding potential LOC. Yet, despite the absence of this information, the patient is clinically appropriate for hospital-level care and intensive therapy.

Arthritis Codes

Unlike many other diagnoses, the degree of severity of arthritis is an important factor in determining whether a patient is clinically appropriate for IRF care. However, this information is not captured in the arthritis ICD-9-CM codes. Therefore, the agency believes, and we concur, that medical review should be used to establish whether a patient with arthritis should be included in the IRF's presumptive compliance percentage. Under this new arrangement, in which arthritis cases are not counted in the 60% Rule presumptive test, we expect that the arthritis cases would be pulled from both the numerator and the denominator of the presumptive test's compliance calculation.

As noted above, CMS contractors determine compliance with the 60% Rule through a two-step process – a presumptive assessment, and then, if that is failed, a comprehensive assessment. **We recommend that CMS incorporate the unique nature of the arthritis codes into this process by creating a new, three-step approach to assess 60% Rule compliance**:

- Step 1: Assess 60% Rule compliance using the presumptive test;
- New Optional Step 2: Allow IRFs failing Step 1 to undergo an audit of only the facility's arthritis cases for the 12-month period under review. The result of this arthritis-only audit would be added to the results of the presumptive test in Step 1, using a methodology that weights the findings of both the presumptive test and the arthritis-only chart audit; and
- Step 3: Assess 60% Rule compliance using a comprehensive assessment for IRFs failing Step 1 and, if appropriate, Step 2.

Congenital Anomalies

CMS proposes to remove selected congenital anomaly diagnosis codes from the list of 60% Rule qualifying codes because the agency believes that patients with these conditions would be

unlikely to meet the IRF admissions criterion for intensive therapy. **We concur with CMS that these are rare cases and have no objection to the removal of those codes.**

Unilateral Upper Extremity Amputations

CMS proposes to remove all of the codes for unilateral upper extremity amputation from the list of 60% Rule qualifying codes because the agency believes that the sole presence of these codes does not reflect the patient's need for intensive rehabilitation services provided in an IRF. **We agree with this proposal, as the patient's need for IRF care typically depends on other conditions.**

Miscellaneous Diagnosis Codes

CMS proposes to remove certain miscellaneous diagnosis codes from the list of 60% Rule qualifying codes because they do not represent a significant number of IRF patients. **We do not object to this proposal.** However, while IRFs do not treat a significant number of patients with the codes identified for tuberculosis (abscess, meningitis, encephalitis or myelitis) and tuberculoma (of the meninges, brain or spinal cord), we reiterate our strong objection to making blanket decisions to remove codes simply because they are "unspecified" codes. For example, CMS recommends the codes for tuberculosis be removed because they do not identify the type of test used to make the diagnosis. However, the entire methodology for classifying tuberculosis based on how the diagnosis was made is outdated and such a structure has been entirely removed from ICD-10-CM. Therefore, it would be inappropriate for CMS to require more specific codes that necessitate such additional testing.

PROPOSED FACILITY-LEVEL ADJUSTMENTS

The proposed rule modifies the methodology for calculating the IRF PPS rural, low-income patient (LIP) and teaching status adjustments and updates the amounts of these adjustments accordingly. Specifically, the agency states that it is concerned that variation in costs between freestanding IRFs, and IRF units in general acute hospitals and critical access hospitals (CAH) is reducing the accuracy of the facility adjustments. Therefore, CMS proposes to add a new control variable to distinguish freestanding IRFs from IRF units in the regression analysis it uses to update the adjustments. With this change, CMS would be able to control for cost structure differences between freestanding IRFs and IRF units, thereby removing their influence from the calculation of the facility adjustment factors.

To help mitigate year-to-year fluctuations, the current methodology to calculate facility adjustments uses a three-year rolling average of data in calculating the size of these adjustments. Accordingly, CMS proposes to base the FY 2014 adjustments on a three-year average of claims data (FYs 2010, 2011 and 2012), with the addition of the new control variable discussed above. However, in the past, the rolling-average approach has not adequately stabilized the adjustments – in FYs 2012 and 2013, CMS instead had to freeze them at FY 2011 levels. This trend of large fluctuations continues in FY 2014 – CMS proposes the following FY 2014 facility adjustments, which, if implemented, would yield sizeable changes from current levels:

- Rural Adjustment: 14.28 percent (compared to 18.4 percent for FY 2013);
- LIP Adjustment Factor: 0.3158 (compared to 0.4613 for FY 2013); and
- Teaching Adjustment Factor: 0.9859 (compared to 0.6876 for FY 2013).

We are very concerned about the magnitude of the differences between the FY 2013 and the proposed FY 2014 facility adjustments. We also are concerned that the rule does not fully explain the regressions that CMS proposes to use to calculate the FY 2014 adjustments or share the data needed to replicate the agency's analysis. **Therefore, the AHA urges CMS to delay updating the IRF facility adjustments until a viable alternative to the current approach is identified.** We also request that CMS release the full set of data and specifications of its regression models to allow providers to fully analyze the agency's proposal.

IRF QUALITY REPORTING PROGRAM

The Patient Protection and Affordable Care Act (ACA) mandated the establishment of a quality reporting program (QRP) for IRFs paid under the IRF PPS. Failure to meet the data submission requirements and deadlines of the program subjects IRFs to a 2-percent reduction to their annual market-basket update, beginning in FY 2014. CMS proposes no new measures for the FY 2014 or FY 2015 program, but does make proposals for FY 2016 and FY 2017.

FY 2016 Proposed Measure

CMS proposes to add the same influenza vaccination coverage among health care personnel measure that is currently reported in other federal programs, including the inpatient quality reporting (IQR) program. CMS proposes to collect this measure using the Centers for Disease Control and Prevention's National Health Safety Network (NHSN), the same mechanism used to collect the measure in other programs. The measure is endorsed by the National Quality Forum (NQF), and was supported for inclusion in the IRF QRP by the Measure Applications Partnership (MAP). The MAP is a multi-stakeholder board charged with making annual recommendations to the Secretary of Health and Human Services (HHS) regarding which measures should be included in national quality reporting programs.

The AHA supports the inclusion of the health care personnel influenza vaccination measure in the IRF QRP. However, we also ask CMS to clarify how the measure will be reported for IRF units physically located within acute care hospitals. The proposed rule does not specifically address this situation, but existing guidance suggests that separate collection and reporting of this measure for IRF units physically located within acute care hospitals may be redundant. According to existing Frequently Asked Questions (FAQ) guidance on the NHSN website, acute care hospitals are expected to collect the measure for "all units that are physically considered a part of the inpatient acute care facility site, regardless of the size or type of unit." The FAQ also notes that if the specific unit is "staffed by acute care facility workers, follows the acute care infection control policies, and answers to the acute care administration, then the workers in that location should be included for the acute care influenza

vaccination coverage."[1] Based on this guidance, we believe that the intention of the measure is to encourage personnel in a patient care facility managed by a common entity—and any units located within that facility—to receive flu vaccination. Many AHA members have IRF units that share management, infection control policies and personnel with the acute care facility. Those same members also have noted that their IRF unit health care personnel flu vaccination rates are already part of the acute care hospital's quality reporting program.

We urge CMS to allow IRF units within acute care hospitals to attest that their health care personnel flu vaccination reporting is completed through the acute care hospital's quality reporting program, thereby receiving credit for reporting in the IRF QRP. Given that the proposed data reporting periods and submission deadlines for the measure are the same as those for other federal quality programs, we believe attestation would promote alignment across programs, and avoid unnecessary burden for IRF units.

FY 2017 Proposed Measures
The agency proposes two new measures and updates one existing measure for the FY 2017 IRF QRP.

Unplanned All-Cause, All Condition Readmissions. The proposed claims-based measure assesses readmissions to short-stay acute care hospitals and long-term care hospitals within 30 days of a discharge from an IRF. The measure uses the same basic approach as the Hospital Wide All-Cause Unplanned Readmission measure currently in the hospital inpatient quality reporting program (IQR). The measure also employs a risk-adjustment methodology to adjust for patient factors such as demographic characteristics (e.g., age, gender), principal diagnosis and co-morbid conditions.

The AHA does not support the inclusion of the proposed readmissions measure in the IRF QRP. The measure has yet to undergo NQF review. Thus, we urge CMS to seek NQF endorsement of the measure, and to subsequently seek a MAP review of the endorsed measure. CMS could then re-propose an NQF-endorsed measure in a future rule. We believe an NQF review would allow the field to more fully examine the measure specifications, as well as any testing data.

Moreover, we believe that the focus of readmission reduction efforts should be on preventable readmissions. Additional research and analysis is necessary to understand what proportion of readmissions following IRF discharges can be prevented, as well as what specific strategies can be employed within IRFs to reduce the likelihood of preventable readmissions. The overarching goal of readmission reduction efforts is to improve patient outcomes. In some cases, better outcomes can be achieved if patients are kept out of the hospital. In other cases, however, a readmission is a medically necessary part of achieving the best outcome for patients. Many IRF patients are medically complex, and have needs that cannot be adequately managed by physicians, home health agencies and other post-discharge

[1] This frequently asked question can be found at the following link: http://www.cdc.gov/nhsn/faqs/FAQ-Influenza-Vaccination-Summary-Reporting.html#Quest9jan13

caregivers. Efforts to characterize higher readmissions rates following IRF discharge as "worse than expected" are premature without a better understanding of how many of those readmissions are actually avoidable.

The AHA continues to be very concerned that CMS's existing readmission measure construct, and therefore the proposed IRF readmission measure, do not adequately focus on assessing preventable readmissions. Namely, the proposed IRF measure fails to exclude readmissions unrelated to the initial reason for admission, and does not adjust for socioeconomic factors. CMS must address these issues not only for the proposed IRF readmission measure, but for all readmissions measures used in reporting and payment programs.

The measure should exclude readmissions unrelated to the initial reason for IRF admission because such readmissions are not indicative of the quality of care provided during hospitalization. Under the proposed construction of the readmissions measure, if a patient was treated at an IRF for a hip fracture, and that patient was readmitted to an acute care hospital 15 days after IRF discharge with a severe burn, the readmission for the burn would be counted towards the hospital's total number of readmissions. While re-hospitalization is obviously necessary in this instance, we do not believe that readmission is indicative of the quality of care that patient received at the IRF for the hip fracture.

We have urged the agency to incorporate appropriate exclusions for unrelated readmissions since the measures were introduced into the IQR program. We believe exclusions for unrelated readmissions also are needed for any readmissions following IRF discharges. We urge CMS to actively engage the IRF community to ensure that any exclusions for unrelated readmissions reflect the way IRFs provide care. Indeed, "unrelated" readmissions following IRF discharges may be distinct from unrelated readmissions following discharge from acute care hospitals and/or long-term care hospitals.

The AHA also continues to urge CMS to incorporate an adjustment for socioeconomic factors into all of its readmissions measures. All hospitals and IRFs, regardless of the circumstances they face, aim to provide the highest quality of care to the patients and families that rely on them. Applying an appropriate adjustment for socioeconomic factors would acknowledge the reality that hospitals and IRFs cannot always control or change structural barriers to accessing resources that can help prevent readmissions.

Indeed, experience with preventing hospital readmissions has shown that readmissions are affected by a variety of factors, many of which are beyond the control of hospitals. The health care infrastructure of a community greatly impacts readmissions rates. A lack of access to primary care, mental health services, physical therapy and other rehabilitative support can increase the likelihood of readmissions. Our members have noted that IRF patients often require ongoing supportive therapy after discharge. Other factors can include lack of public transportation (which can affect access to medical care), and inconsistent access to appropriate foods to aid in patient recovery. While hospitals and IRFs should do all within their power to

care for and assist the patients in challenging circumstances, they should not suffer reputational harm from unfavorable readmissions scores due to community issues.

Dual-eligible status is a powerful predictor of readmission risk to acute care hospitals and is a factor that is readily available to CMS. CMS should explore its use as an adjustment factor for the IRF readmissions measure to account for socioeconomic differences. It reflects the hospital's share of impoverished Medicare patients, and since the readmission measures only include Medicare beneficiaries, an adjustment based on a hospital's proportion of dual-eligible beneficiaries is appropriate and would enable fairer comparisons of performance among hospitals.

In reporting performance on the readmissions measure, CMS could separate IRFs into quartiles based on the proportion of their patients that are dual eligible. Once all eligible IRFs are divided into quartiles based on the proportion of dual-eligible patients, CMS could then determine the average readmissions rate within each quartile. Finally, CMS could calculate an excess readmissions ratio for IRFs using the existing readmissions measures. However, those measures would use each quartile's average readmissions rate, rather than the average readmissions rate of all IRFs in the program. Thus, the readmissions score reported would then be dependent on how an IRF performs compared to other IRFs with a similar proportion of duals. We believe adjusting the measures in this fashion may facilitate a much fairer comparison of IRF readmissions rates.

Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-stay). CMS proposes to collect the data for this measure through the addition of data items to the Quality Indicator section of the IRF-PAI, which will be used beginning on Oct. 1, 2014.

The AHA does not support the inclusion of this measure in the IRF QRP program because this measure may not be appropriate for the IRF setting. We agree that prevention of influenza through vaccination keeps patients healthier, and reduces the spread of influenza. However, short-stay post-acute patients have access to influenza vaccination in multiple settings prior to arrival at an IRF. Indeed, patient flu vaccination is a requirement of the IQR program and approximately 95 percent of IRF patients are admitted directly from acute care hospitals. While acute care hospitals have been focused on improving discharge communications to other care providers, it can be difficult for IRFs to obtain an accurate vaccination history. In some cases, patients have actually received flu vaccination through their primary care physician, or may simply not know or remember their vaccination status. While we believe that the intention of including this measure is good, we are concerned that patients may receive unnecessary vaccinations. We are not confident that the benefits of implementing this measure are fully offset by the resources needed to collect and report it.

Update to Percent of Residents with New or Worsened Pressure Ulcers. CMS previously finalized this measure for the FY 2014 IRF QRP as a non-risk adjusted measure. With the

updates to the Quality Indicator section of the IRF-PAI, CMS proposes to use a risk-adjusted version of the measure for FY 2017 payment determination. **The AHA supports this proposal.**

FY 2016 and FY 2017 Data Submission Proposals

Measures Reported through the IRF-PAI. With the implementation of the revised IRF-PAI planned for Oct. 1, 2014, CMS proposes to collect only three quarters of data for the FY 2016 program (Jan. 1, 2014 – Sep. 30, 2014). CMS would then use the new IRF-PAI for the entire FY 2017 program, collecting data beginning Oct. 1, 2014. **The AHA supports these proposals for previously finalized measures in the program. However, we do not support the proposal for the patient influenza vaccination measure because we do not support the inclusion of the measure in the program.**

Infection Measures Reported through NHSN. For FYs 2016 and 2017, CMS proposes to use the quarterly submission deadlines for the catheter-associated urinary tract infection (CAUTI) measures that are aligned with those for the hospital IQR program, as well as the long-term care hospital quality reporting (LTCHQR) program. Similarly, the agency proposes to collect the health care provider influenza vaccination measure using the same timeframe as the IQR and LTCHQR. **The AHA supports these proposals. However, as noted above, we also urge CMS to allow IRF units within acute care hospitals to attest that their health care personnel flu vaccination measure is reported through the acute care hospital's reporting, thereby receiving credit for reporting in the IRF QRP.**

Disaster/Extenuating Circumstances Waiver. **The AHA supports CMS's proposed disaster and extenuating circumstances waiver process for the IRF QRP, and applauds the agency for recognizing the impact of natural disasters and other extenuating circumstances on the ability of IRFs to collect and report quality data.** CMS proposes a waiver process for IRFs participating in the IRF QRP. IRFs seeking a temporary pause in quality reporting would submit a waiver request to CMS within 30 days of the occurrence of the extraordinary circumstance, providing evidence of the impact of the extraordinary circumstance, and an estimated date when reporting would be able to resume. CMS also states it has the authority to grant waivers or extensions to a region or locale without IRFs specifically requesting them.

Reconsiderations and Appeals Process. **The AHA supports the agency's proposed reconsideration and appeals process for the IRFs.** Each year, the agency proposes to notify any IRFs found to be non-compliant with IRF QRP requirements that they are potentially subject to a reduction in their annual payment update. IRFs would be given an opportunity to file a reconsideration request with CMS. In the request, an IRF would need to provide either a justifiable reason for non-compliance, or evidence that the IRF is actually in compliance. CMS proposes that an IRF could reverse its finding of non-compliance if the hospital provides sufficient evidence that it complied with the requirements, or has a justifiable reason why it could not comply.

Thank you again for the opportunity to comment. If you have any questions, please feel free to contact me or Rochelle Archuleta, senior associate director of policy, at (202) 626-2320 or rarchuleta@aha.org.

Sincerely,

/s/

Rick Pollack
Executive Vice President