



**American Hospital
Association**

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June 18, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1624-P
P.O. Box 8013
Baltimore, MD 21244-1850

Re: CMS 1624-P, Proposed Fiscal Year 2016 Payment and Policy Changes for Medicare Inpatient Rehabilitation Facilities (CMS-1624-P)

Dear Mr. Slavitt:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including 286 inpatient rehabilitation facilities (IRFs), the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2016 proposed rule for the IRF prospective payment system (PPS). This letter focuses on our concerns related to the proposed change to an IRF-specific market basket and proposed additions to the IRF quality reporting program (QRP).

PROPOSED IRF-SPECIFIC MARKET BASKET

The AHA urges CMS to postpone implementation of a new IRF-specific market basket until the agency can ensure it accurately reflects costs for freestanding and hospital-based IRFs. When CMS initially implemented the IRF PPS in FY 2003, it used the inpatient PPS market basket to calculate the mandatory annual inflationary update for the IRF payment system. In FY 2006, the agency began using the rehabilitation, psychiatric and long-term care (RPL) market basket, which is based on cost data for freestanding IRFs, inpatient psychiatric facilities and long-term care hospitals. For FY 2016, CMS proposes to use an IRF-specific market basket, which would be based on cost data for both freestanding and hospital-based IRFs. Therefore, this market basket requires a reliable method to disentangle the costs of hospital-based IRF units



from those of their host hospital. Specifically, cost data for hospital-based IRFs are embedded within the host hospital's Medicare cost report, from which they must be withdrawn for use in the calculation of the proposed IRF-specific market basket.

Dobson Davanzo & Associates replicated CMS's calculation of the proposed IRF-specific market basket and has identified concerns that are shared by the AHA. **Until these concerns, which are discussed below, are addressed and corrected by CMS, we recommend that the implementation of an IRF-specific market basket be postponed. We also ask that the IRF field be provided an opportunity to analyze and comment on the re-calculated proposal prior to its implementation.**

First, we are concerned that CMS is using a flawed methodology for allocating overhead costs to hospital-based IRF units. Specifically, CMS states that the wages and salaries cost weight for the proposed market basket is about 2 percentage points lower than for the current RPL market basket, primarily due to the proposed inclusion of hospital-based IRF data. However, this conclusion is inconsistent with conventional wisdom that salary costs for hospital-based IRFs are actually higher than for freestanding IRFs. Upon further examination, it appears that CMS allocated overhead wages and salaries to the "routine cost" portion of the IRF unit but, in contrast to other cost weights, did not make a similar allocation to the "ancillary cost" portion of the IRF unit. As a result, the wages and salaries cost weight is understated. Dobson re-ran the market-basket calculation incorporating all wages and salaries costs and found that the IRF-unit wages and salaries cost weight increased by more than 5 percentage points, which, in turn, increased the overall wages and salaries cost weight by 4 percentage points.

Second, an additional concern is the number of IRF cost reports that lacked data needed to calculate reliable employee benefits and contract labor cost weights. Specifically, Dobson found that, in the FY 2012 IRF cost reports, the same reports used by CMS to calculate the IRF-specific market basket, only 96 of 217 freestanding IRFs (44 percent) and 268 of 819 units (33 percent) provided employee benefits data on their cost reports. Further, only 79 of 217 freestanding IRFs (36 percent) and 131 of 819 units (16 percent) provided contract labor cost data on their cost reports. Rather than proceeding with these incomplete data, CMS should, for any future IRF market basket that replaces the RPL, consider using inpatient PPS cost report data as a proxy for these specific data elements, as is done for the RPL market basket.

PROPOSED CHANGES TO THE IRF QRP

Since FY 2014 IRFs have been required to submit QRP data by specified deadlines. Failure to comply subjects IRFs to a 2 percentage point reduction to their annual market-basket update. For the FY 2018 IRF QRP, the agency proposes seven measures – one of which was previously finalized for the IRF QRP – to satisfy the requirements of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014. The IMPACT Act is intended to foster greater alignment of measures across CMS's post-acute care quality reporting programs, including the

IRF QRP. The agency also re-proposes its previously finalized all-cause readmission measure so it reflects the version of the measure recently endorsed by the National Quality Forum (NQF).

We first offer general comments on CMS's implementation approach for the IMPACT Act, then address CMS's specific proposals.

GENERAL CONSIDERATIONS FOR IMPLEMENTING THE IMPACT ACT

The AHA strongly encourages CMS to develop and make publicly available a comprehensive plan describing how it will implement the provisions of the IMPACT Act in all of its post-acute care quality programs. The IMPACT Act is a multi-faceted law that will have significant operational impacts for IRFs, long-term care hospitals (LTCHs), skilled nursing facilities (SNFs) and home health (HH) agencies. The law's requirements will involve changes to quality measures and the patient assessment tools used for each care setting. A comprehensive plan would enable all stakeholders to understand whether CMS's approach works in a concerted fashion across its programs. It also would give all of the affected post-acute care providers an opportunity to plan for the potential impacts to their operations.

The AHA urges CMS to adhere to the four principles outlined below in implementing the provisions of the IMPACT Act:

- **Communicate estimated implementation timelines for all data collection and reporting requirements as early as possible.** We appreciate that CMS used the proposed rule to indicate that IMPACT Act quality measure requirements would generally be tied to payment in the fiscal year that begins two years after they are adopted in rulemaking. We encourage the agency to use its plan to identify the estimated implementation dates for specific measures and patient assessment data.
- **Use reliable, accurate, feasible and care-setting appropriate measures that are both endorsed by the NQF, and reviewed by the multi-stakeholder Measure Applications Partnership (MAP).** The IMPACT Act strongly encourages the use of NQF-endorsed measures, as well as the MAP review process. We applaud CMS for engaging the MAP in an *ad hoc* review earlier this year. However, as described in greater detail below, we are concerned that several of the measures proposed for FY 2018 lack NQF endorsement.
- **Foster as much standardization of measures and data collection across post-acute care settings as possible, while recognizing that limited variations may still be necessary.** The IMPACT Act requires that CMS adopt the same measurement domains for all post-acute care QRPs, and that the measures be "standardized and interoperable" across post-acute care facilities. However, the statute does not provide specific operational definitions of these two terms. We believe how CMS interprets these terms will have significant implications for post-acute providers.

The AHA cautions that “complete” standardization and interoperability of measures – i.e., using the exact same measure specifications, data definitions and data collection tools across all post-acute care settings – may not always be possible. The agency may not have NQF-endorsed measures shown to work across all four settings. Similarly, CMS may need to alter measures so they work with the data collection mechanisms of a particular care setting, or so that they focus on collecting the data most relevant to a particular patient population. In such instances, CMS could instead focus on achieving “topical” standardization in which all four post-acute care provider types report on the same measure topics, but using data collection instruments and definitions (e.g., rating scales) that may vary. To fulfill the requirement of “interoperability,” CMS could develop mechanisms to ensure the data are routinely shared across post-acute settings with crosswalks or other explanations of how the data from each setting are defined. In those instances where the agency can achieve “topical” standardization only, the agency should undertake additional measurement development activities to determine whether greater standardization is possible.

- **Minimize the burden of collection and reporting requirements.** IRFs and other post-acute care providers must balance numerous reporting requirements from CMS, private payers and others. CMS should ensure any new requirements add value and are not unnecessarily duplicative with existing reporting requirements.

PROPOSED MEASURES FOR FY 2018

The IMPACT Act mandates that CMS adopt measures addressing several measure “domains” for all of its post-acute care quality reporting programs. To address the domains of skin integrity, major falls and functional status, CMS proposes seven measures – one previously adopted measure, and six new measures. These proposed measures would be collected using the CMS-mandated IRF Patient Assessment Instrument (IRF-PAI), and submitted using CMS’s Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. CMS proposes significant modifications to the quality indicators section of the IRF-PAI to capture new measure data and promote greater standardization of collected data elements across post-acute care providers.

Pressure Ulcers. **The AHA supports CMS’s proposal to use the IRF QRP’s previously finalized pressure ulcer measure to satisfy the requirements of the IMPACT Act.** The measure assesses the percentage of patients with stage 2 to stage 4 pressure ulcers that are new or worsened since a prior assessment. This measure is endorsed by the NQF and was supported by the MAP for use in the IRF QRP.

To collect the measure, CMS proposes a number of seemingly minor modifications to questions in the IRF-PAI. While we do not object to these changes, we ask CMS to use the final rule and sub-regulatory mechanisms (e.g., the IRF-PAI Training Manual) to clarify a couple of aspects of data collection. For example, CMS proposes to change one IRF-PAI pressure ulcer item that currently reads “unstageable due to a non-removable dressing *and device*” to “unstageable due to

a non-removable dressing” (emphasis added). If CMS intends to exclude devices from the assessment of unstageable pressure ulcers, it should clearly communicate this change. If not, the agency should consider adding the words “...and device” back into the IRF-PAI.

Falls with Major Injury. The AHA believes the proposed fall with major injury measure could be an appropriate addition to the IRF QRP. However, before adopting the measure, we urge CMS to ensure the measure has been adequately tested on IRF patients, and to develop a risk-adjustment approach. The measure assesses the percentage of residents that experience one or more falls with major injury. The measure is used in the LTCH QRP and was recently proposed for the SNF QRP. While the measure is NQF-endorsed, the measure specifications and testing data used to obtain NQF endorsement are specific to long-stay (i.e., more than 100 days) nursing home residents. As a result, it is not specifically endorsed for use in IRFs. Nevertheless, CMS proposes to continue using this measure because the agency believes it meets the IMPACT Act’s requirement that measures be “interoperable” across care settings. We do not believe implementing a measure whose reliability and validity is unknown outside of the long-stay nursing home setting fosters an effective use of falls data across post-acute care settings. In fact, it may instead lead to the sharing of inaccurate and misleading data.

In addition, we urge CMS to incorporate risk adjustment into the measure. A patient’s propensity for falls is determined not only by the quality of care, but also a variety of other clinical factors beyond the control of providers, including co-morbid conditions and baseline level of functioning. Furthermore, the IMPACT Act requires that measures include risk adjustment where necessary and appropriate. In the context of quality measurement, risk adjustment is a widely accepted approach to account for some of the factors outside the control of providers when one is seeking to isolate and compare the quality of care provided by various entities. Risk adjustment is meant to create a “level playing field” that allows fairer comparisons of whether providers are doing all they can to ensure the quality of care.

Functional Status. While the AHA agrees that functional status is a vitally important measurement area for IRFs and other post-acute care providers, we do not support the functional status measures CMS proposes for the FY 2018 IRF QRP. We are concerned that the measures lack NQF endorsement, duplicate existing IRF QRP reporting requirements and fail to capture important functional changes in the IRF patient population.

In general, functional status measures assess the extent to which patients regain the ability to perform activities (or “functions”) essential to daily living, such as self-care and mobility. CMS proposes a total of five functional status measures:

- One measure assessing the percentage of IRF patients who have functional status assessments completed at both admission and discharge and who have a care plan that addresses function through the inclusion of a numerical functional goal score at the time of admission;

- Two risk-adjusted “functional outcome” measures assessing the extent to which the self-care (e.g., personal hygiene, eating) and mobility (e.g., ability to walk a certain distance with or without assistance) functions of an IRF’s patient population changes between admission and discharge; and
- Two risk-adjusted “functional outcome” measures determining the percentage of IRF patients whose self-care and mobility functional status at the time of discharge meet or exceed “expected” levels.

To calculate these measures, CMS proposes to add 92 new items to the quality indicators section of the IRF-PAI; IRFs would complete these items for each patient at admission and discharge. Twenty-eight of these new items ask IRFs to provide a numerical score (using a six-level scale) of the level of independence patients demonstrate on self-care and mobility functional assessment items. The remaining 64 items ask about issues such as mobility prior to IRF admission, cognition and bladder continence. CMS would use this information as part of the risk adjustment approach for the functional outcome measures. The proposed items and rating scale are derived from the Continuity Assessment Record and Evaluation (CARE) tool developed as part of the Post-Acute Care Payment Reform Demonstration (PAC-PRD) project.

The AHA is concerned the proposed CARE tool functional status measure data would be collected *in addition to* the 28 Functional Independence Measure (FIM) items IRFs are required to report on the IRF-PAI for payment purposes. In contrast to the six-level rating scale used in the proposed CARE tool measures, the FIM uses a seven-level rating scale. The FIM items address most of the same topics as the proposed functional status measures, despite CMS’s assertion that the “proposed function items...do not duplicate existing items” on the IRF-PAI. CMS seems to believe that differences in “the data collection and associated data collection instructions...the rating scales used to score a patient’s level of independence...and the item definitions” make the measures different from the functional status measures, but we believe that CMS has focused on the wrong question. The relevant question is not whether the two approaches to measuring functional status have differences. Of course they do. The relevant question is whether the CARE tool and the FIM are two ways of measuring the same thing – like meters and feet are two ways of measuring length. Using both does not provide any additional information or help to achieve any goal, but could create confusion. Similarly, using both the CARE tool and the FIM will create additional work, but not add additional information or value. In fact, there are reasons to believe that the CARE tool is an inferior way to collect important data, as explained further below.

The AHA agrees that standardizing data collection across post-acute care providers is a laudable goal. But requiring IRFs to collect simultaneously two different sets of functional status data would simply increase provider burden and create confusion. The restoration of function is a central goal to the care delivered in IRFs. For this reason, it is critical for IRF providers to have accurate and consistent signals on changes in function. Yet, CMS’s proposal could make these signals far more ambiguous. For example, both the FIM and the CARE tool measures assess the extent to which patients need assistance when being transferred from a bed

to a chair. But if a patient needed only a moderate amount of assistance, their scores on the existing FIM tool and the proposed measure would vary. For example, they could score as a level 4 on the FIM scale (Minimal Contact Assistance (patient can perform 75 percent or more of task), but a level 3 on the CARE measure's scale (Partial/moderate assistance – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort). The existence of these two inconsistent data points in the medical record would make it much more challenging for clinicians to understand a patient's course of care.

Furthermore, many of our IRF members have expressed concern that the rating scale used in the CARE tool-derived measures is not sensitive enough to changes in patient functional status. In some cases, patients with significant recovery in function receive the same scores at admission and discharge, thereby understating the extent of their improvement. For example, a patient who enters an IRF only able to wash his right arm but is discharged able to wash his entire upper body would rate as a level 2 on the CARE item set (i.e., requiring substantial/maximal assistance) at both admission and discharge.

Even more concerning, however, is that the CARE tool-derived rating scale may inadvertently overstate a patient's level of function, leading to potential patient safety risks. For example, in contrast to the existing FIM scale, patients can receive the highest score (Level 6) on the mobility items on the CARE data set regardless of whether they can walk independently or with assistive equipment (e.g., a walker or a cane). Yet, patients who use assistive devices have a higher risk of falling than other patients, making it a central part of an IRF's care coordination activities. For example, an IRF may choose to transfer a patient to a SNF because a patient's home is not accessible to patients needing assistive devices. Or the IRF may provide a discharge referral to HH services to reduce the dependence on a walker.

Instead of implementing duplicative reporting tools that may lead to confusion and safety risks, the AHA recommends that CMS consider calculating functional status measures using the FIM data that IRFs already collect for payment purposes. This approach could be coupled with the development of a transition plan to revise the existing FIM functional status items so they are more consistent with data collected in other post-acute care facilities. This approach would allow the agency to meet the requirement that IRFs report functional status data, while laying the groundwork for a measure that is more "standardized" and "interoperable" across post-acute care settings. Any transition would require considerable analysis and input from the field to ensure there are not negative unintended consequences for IRF reimbursement. Any changes also should be tested in IRFs to ensure the revised instrument collects accurate, reliable and meaningful data.

Readmissions Measure. The AHA urges CMS to adjust the IRF QRP's readmission measure for sociodemographic factors before implementing it in the program. For FY 2018, CMS proposes to re-adopt the version of the measure endorsed by the NQF in December 2014. This measure assesses the risk-adjusted rate of unplanned readmissions to short-stay acute care hospitals and LTCHs within 30 days of discharge from an IRF. The measure is calculated using Medicare fee-for-service (FFS) claims data, and captures returns of Medicare patients within 30

days of IRF discharge from the community or another care setting of lesser intensity (e.g., SNFs, home health) to a short-stay acute care hospital or LTCH.

Unfortunately, the IRF readmission measure, like CMS's other readmission measures, fails to adjust for sociodemographic factors outside the control of the IRF – such as the availability of primary care, mental health services, easy access to medications and appropriate food. Mounting evidence shows that socioeconomic factors significantly influence the likelihood of a patient's health improving after discharge or whether a readmission may be necessary. These community issues are reflected in readily available proxy data on sociodemographic status, such as Census-derived data on income and education level, and claims-derived data on the proportion of patients dually eligible for Medicare and Medicaid. We urge CMS to consider using these data to apply sociodemographic adjustment to the IRF readmission measure.

IRF QRP PUBLIC REPORTING

The AHA supports CMS's proposal to publicly report some IRF QRP data beginning in the fall of 2016, and applauds the agency's intent to give IRFs a 30-day period to preview their data. However, we strongly urge CMS to allow IRFs to submit data corrections during this preview period. CMS proposes to report data on catheter-associated urinary tract infections (CAUTI), pressure ulcers and readmissions. Similar to other CMS quality reporting programs, the agency proposes to give IRFs a 30-day period to preview their performance. However, this 30-day period would not provide an opportunity to submit corrections to the data. Instead, CMS states that the existing data submission period of 4.5 months following the end of a quarter for IRF data will give IRFs sufficient opportunity to review and submit corrections to their data.

However, with nearly all of its other quality reporting programs, CMS allows providers to submit data corrections in conjunction with the data preview period. This is appropriate because the process of collecting and reporting quality measure data is time and resource intensive. By combining the data submission and review/corrections periods, CMS would effectively abridge the allotted time that IRFs have to collect and submit their data.

The AHA also urges CMS to develop a plan to communicate how changes in measure specifications may affect IRF performance levels. For example, the IRF pressure ulcer measure will undergo some changes for data collected on or after Oct. 1, 2016. Similarly, infection measures like CAUTI undergo periodic updates to the underlying measure definitions and performance benchmarks. Given that the public will use data to assess IRF quality, it is important that CMS provide appropriate context for meaningful changes in measure performance.

Andy Slavitt
June 18, 2015
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Thank you for the opportunity to comment. If you have any questions about our comments, feel free to contact me or Rochelle Archuleta, director of policy, at (202) 626-2320 or rarchuleta@aha.org.

Sincerely,

/S/

Rick Pollack
Executive Vice President