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

RE: CMS-1671-P, Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2018.

Dear Ms. Verma:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including 1,272 inpatient rehabilitation facilities (IRFs), and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2018 proposed rule for the IRF prospective payment system (PPS). Our comments address concerns related to the coding guidelines for the IRF "60% Rule" presumptive compliance test and quality-reporting provisions in the proposed rule. **Specifically, while we support several of the proposed coding changes, we have concerns with others, as well as the rule's lack of transparency on the rationale supporting some of these changes, as discussed below. We also have concerns about the 60% Rule policy. In addition, the AHA urges CMS to reconsider changes made to one measure in the IRF quality reporting program (QRP), and delay the implementation of new standardized patient assessment data elements into the IRF Patient Assessment Instrument (PAI).**

REFINEMENT OF CODES FROM THE 60% RULE PRESUMPTIVE TEST

The IRF 60% Rule requires that 60 percent of an IRF's cases for a prior 12-month period fall within 13 qualifying conditions ("CMS 13") or have qualifying comorbidities. Compliance with the 60% Rule is assessed through a two-step process. The first step is the presumptive assessment – a software audit by a CMS contractor that analyzes diagnosis codes submitted for each patient searching for the CMS 13 or comorbidities. IRFs that fail to demonstrate 60%

Rule compliance using this initial 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. We note that the CMS 13, implemented in 2004, may no longer align with current medical practice.

Since FY 2016, health care facilities have migrated from ICD-9-CM to ICD-10-CM diagnosis codes in compliance with the HIPAA code set standards. We support CMS efforts to correct errors that occurred in the application of the presumptive test related to the conversion to ICD-10. These errors resulted in certain diagnosis codes inadvertently omitted from counting towards the 60% Rule or changes in codes because of the conversion to ICD-10-CM. However, there are additional areas for improvement as noted below.

Transparency. The AHA notes that some of the proposed changes to this set of codes, as well as changes in prior years, are supported with only a limited clinical and/or policy rationale. The absence of a detailed policy rationale results in a seemingly arbitrary proposal. As a result, it is difficult to determine whether the changes are based on purely the annual ICD-10-CM code changes, clinical reasons, policy changes or a combination of different reasons. In addition, it is nearly impossible to analyze and plan for the potential impact to provider's operations. **With regard to the current proposed coding changes, and those in future rules, we urge CMS to provide greater transparency by sharing a comprehensive policy rationale, with supporting data, for each proposed coding change.**

Furthermore, many of the proposed changes to the conditions that count presumptively toward the 60% Rule are difficult to identify because of the format in which they are presented in the proposed rule. Specifically, the proposed rule points to the CMS website for the list of current ICD-10-CM codes used to perform the presumptive methodology and then a separate list for those codes used in the future. This format requires commenters to review thousands of diagnosis codes to compare the current list against the future list to identify the differences between the two. CMS does not identify specific proposed changes without specific rationales. As a comparison, inpatient PPS coding changes are presented with separate tables identifying additions and deletions to the Complications/Comorbidities (CC) and Major Complications/Comorbidities (MCC) as Table 6I.1- Proposed Additions to MCC List; Table 6I.2- Proposed Deletions to MCC List; Table 6J.1- Proposed Additions to CC List; and Table 6J.2- Proposed Deletions to CC List.

In addition, the inpatient PPS proposed rule typically provides narrative descriptions and supporting data when conditions (and their corresponding ICD-10-CM/ICD-10-PCS codes) are moved from one MS-DRG to another. **In the future, we urge CMS to provide separate tables in proposed and final rules for "additions" and "deletions" of ICD-10-CM codes, as well as a discussion of the rationale for the changes. Displaying separate tables will allow IRF providers to clearly identify the changes, analyze them and use the explanation to help educate patients and staff.**

Traumatic Brain Injury. We are pleased that CMS agrees with our previous comments pertaining to the 60% Rule to restore many of the ICD-10-CM codes for traumatic brain injury with either unspecified or no loss of consciousness (LOC). The lack of specificity regarding the length of LOC does not automatically equate to poor documentation. There are many instances where the information is administratively and/or clinically unavailable. Hospitals should not be penalized for patients that have suffered traumatic brain injuries where it is not possible to determine if the patient lost consciousness or not, or if the patient did lose consciousness, for how long.

We urge CMS to reconsider clinically similar codes for fracture of the base of the skull with cerebral laceration or contusion. These codes were inexplicably excluded from Impairment Group Code (IGC) Brain Dysfunction - 0002.22, Traumatic, Closed Injury. The excluded etiology and IGC pairing list completely excludes the case from qualifying. In addition, it is the first step used to determine if a case is compliant and whether it excludes ICD-10-CM codes for fractures of the base of skull codes (choice A) ***if*** paired with a code from (choice B). The specific code pairs are shown in the table below.

ICD-10 Code	Choice	Code Title
S02.101A	A	Fracture of base of skull, right side, initial encounter for closed fracture
S02.102A	A	Fracture of base of skull, left side, initial encounter for closed fracture
S06.330A	B	Contusion and laceration of cerebrum, unspecified, without loss of consciousness, initial encounter
S02.101A	A	Fracture of base of skull, right side, initial encounter for closed fracture
S02.102A	A	Fracture of base of skull, left side, initial encounter for closed fracture
S06.360A	B	Traumatic hemorrhage of cerebrum, unspecified, without loss of consciousness, initial encounter
S02.101A	A	Fracture of base of skull, right side, initial encounter for closed fracture
S02.102A	A	Fracture of base of skull, left side, initial encounter for closed fracture
S06.9X9A	B	Unspecified intracranial injury with loss of consciousness of unspecified duration, initial encounter
S02.91XA	A	Unspecified fracture of skull, initial encounter for closed fracture
S06.330A	B	Contusion and laceration of cerebrum, unspecified, without loss of consciousness, initial encounter
S02.91XA	A	Unspecified fracture of skull, initial encounter for closed fracture
S06.360A	B	Traumatic hemorrhage of cerebrum, unspecified, without loss of consciousness, initial encounter
S02.91XA	A	Unspecified fracture of skull, initial encounter for closed fracture
S06.9X9A	B	Unspecified intracranial injury with loss of consciousness of unspecified duration, initial encounter

The exclusion of the above code pairs does not make sense either clinically or from a coding perspective. ICD-10-CM category, “S02, Fracture of skull and facial bones,” has an instructional note to “Code also any associated intracranial injury (S06.-).”

Hip Fractures. We are pleased that CMS is proposing to allow ICD-10-CM codes for fractures of "unspecified part of the neck of the femur" which counted towards 60% Rule compliance under ICD-9-CM. The rehabilitation treatment plan for femoral neck fracture is the same whether specified to a specific part of the femur or not. Attempts to obtain more specificity from radiologists have not been successful as radiologists have been either unable or unwilling to be more specific in the X-ray impression for "femoral neck."

Multiple Trauma. The General Equivalence Mappings (GEMs) incorrectly mapped ICD-9-CM diagnosis code 828.0, Multiple *fractures* involving both lower limbs, lower with upper limb, and lower limb (s) with rib (s) and sternum, to ICD-10-CM code T07, Unspecified multiple injuries. As we noted in last year's comments, hospitals would be violating ICD-10-CM coding rules if they were to report ICD-10-CM code T07 for patients with multiple fractures. Instead, hospitals should report codes for the specific bones fractured. **We agree with CMS's proposal to correct this error by counting IRF-PAIs that contain two or more of the ICD-10-CM codes from three major multiple trauma lists in specified combinations.**

Traumatic Injuries. Most ICD-10-CM code categories for chapter 19 (Injury, poisoning, and certain other consequences of external causes) require a 7th character for initial encounter (A), subsequent encounter (D) and sequela (S). Categories for traumatic fractures have additional 7th character values. However, only the 7th characters for "initial encounter" and "sequela" have been included in the Presumptive Compliance List 2. The *Coding Clinic for ICD-10-CM and ICD-10-PCS* Editorial Advisory Board (which has representation from CMS and the Centers for Disease Control and Prevention as the ICD-10 code set maintainers) has provided several examples of the correct application of the 7th character. These examples demonstrate that "subsequent encounter" is the correct option for rehabilitation services, and **we urge CMS to include the applicable 7th character for "subsequent encounter" in the Presumptive Compliance List 2. IRF providers should follow all official ICD-10-CM coding rules regardless of the payer. This approach eliminates the need to keep up with different sets of coding rules.**

The following example published in the fourth quarter 2013 issue of *Coding Clinic* demonstrates the correct usage of the 7th character in the IRF setting:

> Question:
> The patient was admitted to the inpatient rehabilitation facility (IRF) following an acute care hospitalization for surgical treatment of a displaced fracture of the right intertrochanteric femur. The patient was admitted to the IRF for rehabilitative services, including physical and occupational therapy as well as fracture aftercare. What are the appropriate diagnosis codes for the IRF stay?

Answer:
Assign code S72.141D, Displaced intertrochanteric fracture of right femur, subsequent encounter, for the closed fracture with routine healing, as the principal diagnosis for the IRF stay.

ICD-10-CM Code G72.89, Other Specified Myopathies. CMS is proposing to remove code G72.89 citing inconsistent use of this code among IRFs, including representing patients with generalized weakness who do not meet the requirements of the 60% Rule. We agree that code G72.89 is not the correct code for generalized weakness or general debility. **ICD-10-CM code G72.89 should be retained on the Presumptive Compliance List because it is the appropriate code for a variety of specified myopathies, such as neuromuscular disorders, that fall into one of the CMS 13 conditions that satisfy the 60% Rule.**

We recommend CMS provide education on the appropriate use of this code, monitor its usage, and then reevaluate the utilization of this code. We are concerned that eliminating the code would inappropriately disqualify true myopathy cases.

Subregulatory Process for Updates to Presumptive Methodology Diagnosis Code Lists. CMS is proposing a subregulatory process for non-substantive updates to the ICD-10-CM Presumptive Methodology Code List. Notice-and-comment rulemaking would be reserved for substantive changes. CMS appears to consider annual changes to the medical code sets made by the ICD-10 Coordination and Maintenance Committee the type of changes to be addressed through a subregulatory process. CMS would apply all relevant changes to the list of codes used in the presumptive compliance methodology so that the codes on that list would be consistent with the most recent ICD-10 medical code set. CMS says that it would apply the changes without regard to any policy judgments about use of the codes for the presumptive compliance methodology. Substantive changes, such as removal of codes from the list, would occur through the notice-and-comment rulemaking process. Under the proposal, each year's updated lists of ICD-10-CM codes for the presumptive compliance methodology would be available on the IRF PPS website prior to the effective date of the changes in the ICD-10 medical code data set.

We recommend that rather than relying on a subregulatory process, CMS use formal rulemaking to identify both the additions and deletions to the presumptive methodology diagnosis code lists and allow providers the opportunity to review the accuracy of the codes. This process is similar to the process followed by CMS in the hospital inpatient PPS where CMS publishes tables for proposed additions, deletions, revisions to the principal diagnosis, secondary diagnosis and complication/comorbidities/major complication comorbidities lists.

Implementation Timeline. CMS does not clearly state when it will implement the rule's proposed changes. We recommend a two-step implementation:

- **Effective Immediately:** Retroactively implement changes related to correcting ICD-10-CM errors (e.g., multiple fractures and traumatic brain injuries) by restoring the

codes to the Presumptive Compliance List. Furthermore, the codes should be removed as excluded etiologic diagnoses on the list of Impairment Group Codes That Meet Presumptive Compliance Criteria. Since such changes are in essence corrections of errors resulting from the transition from ICD-9-CM, the proposed changes should be made effective retroactively for compliance review periods beginning on or after Oct. 1, 2015, or alternatively effective for discharges on or after Oct. 1, 2017.

- **Delayed Implementation: We strongly urge CMS to delay implementation of any final restrictive changes such as the proposed removal of codes and IGC/code pairings from the 60% Rule's presumptive testing methodology by at least one year.** The effective date should be for cost report periods beginning on or after Oct. 1, 2018. The change should be scheduled to apply to an IRF at the beginning of its compliance review period. Implementing the proposed modifications any earlier is inequitable and impermissible retroactive rulemaking.

  A delayed implementation will allow all IRFs undergoing presumptive testing to be reviewed based upon a compliance period that is comprised of at least 12 months of data reflecting the effects of any modifications to the codes and IGC/code pairings that may be implemented in the final rule. IRFs require at least one year to implement the more challenging changes related to compliance with the 60% Rule (e.g., removing conditions from IGCs). In general, it is easier for providers to implement additions than deletions to the 60% Rule. Deletions require a significant amount of time and effort to change processes related to patient admission, documentation and to educate and train staff and clinicians.

60% RULE POLICY

The AHA urges CMS to reevaluate the 60% Rule facility criterion in recognition of the policy's limitations, most notably its arbitrary access restrictions for patients with diagnoses outside of the CMS 13 qualifying conditions. In particular, the policy's outdated set of qualifying conditions warrants close examination and modernization. An updated set of conditions would allow IRFs to optimize their unmatched clinical services for patients needing hospital-level care in combination with intensive rehabilitation. We ask CMS to consider these concerns when analyzing the 60% Rule's current role in reducing access to care:

- As stated in prior comments to CMS, the AHA does not support a diagnosis-based test for IRFs, which, by definition, denies access to patients who meet IRF medical necessity standards but do not comply with the 60% Rule. Such denials of access for patients with a condition beyond the 13 qualifying conditions highlight the irrational and harmful nature of the policy.
- The 60% Rule qualifying conditions, originally designated in the mid-1970s, were updated in 2004 with the implementation of the CMS 13, which narrowed the cases that count toward compliance with the policy. Given the absence of a material review

and recalibration of the conditions during the last decade – while significant medical and delivery system innovations were occurring – a reconciliation of these factors is now warranted. Without such a realignment, we will continue to see a mismatch between the 60% Rule and current medical practice, which will sustain the pattern of medically necessary patients being denied IRF access solely due to their non-compliance with the policy.

- The current IRF classification criteria, stringent admissions criteria and medical necessity audits already provide rigorous standards for IRF access; another policy barrier is not needed. Collectively, these policies provide assurance that IRFs are treating patients who require this unique setting.
- The development of new payment models such as accountable care organizations and bundled payment, especially those models targeting orthopedic conditions, is yielding new clinical pathways for episodes of care that include traditional and new uses of IRF services. The 13-year old 60% Rule framework is prohibiting the full innovation of IRF services within these new treatment patterns. Instead, CMS should support elevating the role of IRFs for patients who meet the already strict admissions criteria for this clinically valuable and unique setting.
- Since the unique IRF coding protocols do not fully align with ICD-10-CM official coding guidelines, CMS designed a two-tiered compliance process (presumptive compliance review and medical record review) that is highly burdensome and driving CMS and IRF costs, while yielding no benefit to Medicare or providers, and actually harming beneficiaries. CMS would benefit both the agency, patients and providers by addressing this misguided, time-consuming and costly compliance process.
- A modernized 60% Rule could serve as a constructive bridge to a future post-acute care PPS, which is being developed under a mandate of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014. This new PPS is being designed for implementation without an arbitrary element such as the 60% Rule.
- The statute allows for the policy threshold to be set at "up to 60 percent," which gives CMS great latitude to address this policy's weaknesses.

IRF QUALITY REPORTING PROGRAM (IRF QRP)

The Affordable Care Act mandated that reporting of quality measures for IRFs begin no later than FY 2014. Failure to comply with IRF QRP requirements will result in a 2.0 percentage point reduction to the IRF's annual market-basket update. Currently, CMS requires the reporting of 18 quality measures by IRFs. CMS proposes two new measures and the replacement of one measure for the FY 2020 IRF QRP. In addition, CMS would require IRFs to collect certain standardized patient assessment data beginning with IRF admissions on or after Oct. 1, 2018 to meet additional requirements mandated by the IMPACT Act.

While the AHA appreciates that the proposed measures are intended to address significant patient health outcomes, all three of them need significant improvement before they would be suitable for use in the IRF QRP. Furthermore, CMS's proposal to

report standardized patient assessment data is too much, too soon, and we believe the data elements require further testing prior to implementation. Therefore, we urge CMS to delay its proposal to report standardized patient assessment data for at least one year.

FY2020 MEASUREMENT PROPOSALS

Changes in Skin Integrity Post-acute Care (PAC): Pressure Ulcer/Injury. **The AHA urges CMS not to adopt this measure for the IRF QRP until it has conducted further testing around the inclusion of unstageable pressure ulcers and deep tissue injuries (DTIs) in the measure calculation.** The IRF QRP already includes a measure examining the percentage of patients that have new or worsened pressure ulcers. Yet CMS would replace this measure with one that asks IRFs to capture data on both "stageable" pressure ulcers (i.e., those that can be assigned a numerical score of 1 to 4), and unstageable pressure ulcers, including DTIs, assessing which ones at each stage are unhealed. CMS suggests this change is appropriate because it would capture a fuller range of skin integrity issues. CMS further posits that this measure would help the agency meet its IMPACT Act mandate to implement "interoperable measures" across PAC settings because this same measure is proposed for other post-acute settings.

However, the AHA is concerned that the definition of pressure ulcers included in the measure is too subjective to collect reliable, accurate measure data across IRFs and other PAC providers. As a result, the measure could provide misleading portrayals of IRF performance. As CMS admits in the proposed rule, there are few studies that provide information regarding the incidence of unstageable ulcers in PAC settings. In addition, there is no universally accepted definition for DTIs; in fact, studies have shown that a significant proportion of DTIs are initially misdiagnosed as stage 1 ulcers or other dermatological diagnoses with similar symptoms that are not intended to be captured by this measure. As a result, the measure may be subject to surveillance bias in which providers have higher rates of DTIs because their surveillance systems are more sensitive to capturing them.

Furthermore, the AHA also is concerned that the measure change would result in artificial distinctions between IRFs that are attributed solely to the way injuries are counted, not in the quality of care provided. CMS believes one of the benefits of implementing this revised measure is that it would increase the variation in measure scores across providers, "thereby improving the ability to discriminate among poor- and high-performing IRFs." However, the purpose of changing a measure is not to create performance variation. It is especially troubling when one considers that this increased variation may not stem from differences in quality, but rather from differences in the interpretation of the definitions and differences in the rigor in counting. Any measure changes should be rooted in evidence that specifications are inconsistent with current science, or that specifications need further clarity to ensure consistent data collection across providers.

The AHA strongly urges CMS to undertake additional testing of the measure to ensure it consistently collects accurate data. We believe this testing should assess whether the measure is subject to surveillance bias and other unintended consequences that could affect how IRF performance is reported.

The AHA also urges CMS to make substantive plans around its promised "additional training opportunities and educational materials" prior to implementation. CMS is proposing significant changes to the measure data collection approach. Rather than assessing the number of new or worsened pressure ulcers at each stage (as in the current measure), CMS would ask IRFs to count the number of unhealed pressure ulcers at each stage and subtract the number present upon admission. We believe excluding those pressure ulcers that are present on admission is an appropriate improvement to the measure, but it adds complexity in coding that will be essential to explain to IRFs. Furthermore, IRF performance on the revised measure is likely to look quite different from the current measure. Thus, CMS should prepare consumer-facing educational materials explaining why IRF performance is different.

All-cause Unplanned Readmission Measure for 30 Days Post-Discharge from IRFs. **The AHA is pleased with CMS's proposal to remove this duplicative and confusing measure from the IRF QRP and supports its removal.** We continue to urge CMS to review the remaining readmission measures used across its post-acute quality programs to ensure that they create consistent improvement incentives across the system.

STANDARDIZED PATIENT ASSESSMENT DATA REPORTING

In addition to requiring standardization and alignment of quality measures, the IMPACT Act also requires the collection of standardized patient assessment data. The reporting of these data is a requirement of the PAC quality reporting programs; as a result, failure to comply with the requirements would result in a 2.0 percentage payment reduction. In an attempt to facilitate data sharing and comparisons across PAC settings, CMS proposes to introduce the required reporting of standardized data elements into each setting's respective assessment tools. For the IRF setting, this would entail the addition of several new data elements to the IRF-PAI. Specifically, the agency would require IRFs to collect data on functional status, cognitive function, medical conditions, impairments, and several types of special treatments and services. While PAC providers would fulfill the FY 2019 requirement by reporting data elements already implemented in the various quality reporting programs (namely, those used to calculate the Percent of Residents or Patients with Pressure Ulcers that are New or Worsened, Short Stay), IRFs would be required to report data based on several new elements beginning Oct. 1, 2018.

The AHA believes the implementation of these data elements is too much, too soon. We urge CMS to delay the reporting of the data elements by at least one year. This approach would allow the reporting of elements associated with the Pressure Ulcer measure to fulfill the

FY 2019 and 2020 requirements. **We also urge the agency to carefully assess whether all of these data elements are necessary to meet the IMPACT Act mandate.**

Validity and Reliability of Elements. Of the proposed 23 data elements, only five are currently reported in the IRF-PAI. The other 18 are used in other post-acute setting tools, mainly the Minimum Data Set (MDS) 3.0 used in skilled nursing facilities (SNFs). CMS purports that the use of these elements in the MDS and the testing in the Post-Acute Care Payment Reform Demonstration (PAC PRD) are sufficient to show that collection of these elements in the IRF setting is feasible and that the elements will result in valid and reliable data. Unfortunately, the PAC PRD results were significantly affected by small sample sizes, and the reliability of many data elements was poor. Thus, it is unwise to depend on the PAC PRD results to judge the integrity of the proposed IRF-PAI data elements. In addition, for several of the elements, the precise items CMS proposes to add have not been tested in the PAC PRD or another PAC setting; rather a similar or related item was deemed close enough and thus appropriate for implementation.

Considering that providers are asked to report on these 23 data elements for admissions and discharges beginning in little over a year and that failure to report would result in a significant decrease in their market basket update, **we believe that CMS lacks sufficient evidence that these data elements are ready for inclusion in the IRF QRP.**

Burden on Providers. As mentioned previously, CMS's proposal would add 18 new data elements to the already lengthy IRF-PAI. **Because many of these elements have multiple parts (i.e., a principal element and two to seven sub-elements or questions), this could result in 50 additional tasks for a provider.** While any one task may not take a long time to complete, the addition of all of these elements at once would change a IRF provider's workflow considerably.

In fact, CMS is currently engaged in multiple contracts to develop several additional standardized patient assessment data elements for future years in PAC QRPs. Unless CMS plans to significantly reduce the current reporting burdens on PAC providers, it is unrealistic to mandate that providers comply with an exponentially growing list of reporting requirements. We also are deeply concerned about IRF providers' ability to reconfigure their databases and electronic health records by October 2018 to comply with these reporting requirements. Therefore, we strongly urge CMS to delay implementation of these new data elements. Because the IMPACT Act requires the collection of standardized patient assessment data for FY 2019 and each subsequent year, CMS could consider data already reported in a standardized manner across the various PAC settings to be sufficient for FY 2019 and FY 2020. CMS proposes that reporting of the elements used to calculate the Pressure Ulcer measure, which is implemented in all four PAC settings, would satisfy the statutory requirement; AHA suggests continuing this approach for an additional year to allow for further consideration of the additional data elements.

IRF QRP PUBLIC REPORTING FOR CY 2018

CMS proposes to publicly report data in calendar year (CY) 2018 for three assessment-based measures and three claims-based measures. The claims-based measures were those adopted in the FY 2017 inpatient PPS and IRF final rules, and include:

- Medicare Spending Per Beneficiary;
- Discharge to Community; and
- Potentially Preventable 30-Day Post-Discharge Readmissions.

The AHA voiced several concerns regarding these measures when they were first proposed, some of which were addressed in final rulemaking. Some issues remain, and given that the measures will be publicly reported next year, it is imperative that these measures present an accurate portrayal of provider performance. For this reason, we encourage CMS to continue considering the following recommendations.

Sociodemographic Adjustment. The AHA believes IRF performance on all three measures may be affected by sociodemographic factors. We urge CMS to assess each measure for the impact of such factors and incorporate sociodemographic adjustment where necessary. The evidence continues to mount that sociodemographic factors beyond providers' control – such as the availability of primary care, physical therapy, easy access to medications and appropriate food, and other supportive services – influence performance on outcome measures. Most recently, this connection was clearly shown in a report to Congress from the Office of the Assistant Secretary for Planning and Evaluation and in the National Academy of Medicine's series of reports on accounting for social risk factors in Medicare programs. The reports provide evidence-based confirmation of what hospitals and other providers have long known: patients' sociodemographic and other social risk factors matter greatly when trying to assess the quality of health care providers. As a result, CMS has proposed to implement sociodemographic adjustment in the Hospital Readmission Reduction Program—an important first step to improving the fairness of the program.

Yet, to date, CMS has resisted calls to incorporate sociodemographic adjustment into the quality measurement programs for IRFs and other PAC providers. Failing to adjust measures for sociodemographic factors when necessary and appropriate can adversely affect patients and worsen health care disparities because the penalties divert resources away from hospitals and other providers treating large proportions of vulnerable patients. It also can mislead and confuse patients, payers and policy makers by shielding them from important community factors that contribute to worse outcomes. Thus, **we urge CMS to incorporate sociodemographic risk adjustment for these outcomes measures.**

Medicare Spending per Beneficiary for IRFs (MSPB-IRF). The AHA urges CMS to carefully evaluate the MSPB measure's clinical risk adjustment approach. We encourage the agency to work with providers to explore the feasibility of incorporating an adjustment for patient functional status. We believe patient functional status is an important determinant of patient

outcomes. CMS could examine whether reliable information on functional status could be collected from claims data. In addition, given that IRFs and other post-acute care providers are required by CMS to collect information on functional status as part of patient assessments, CMS should explore whether it is feasible and not overly burdensome to providers to incorporate information from these assessments into the risk model.

Discharge to Community. The AHA urges CMS to carefully assess the reliability and validity of patient discharge codes used to calculate the discharge to community measure. The measure assesses the percentage of Medicare fee-for-service (FFS) patients discharged from IRFs to home or home health care (i.e., "community discharges") with no unplanned rehospitalizations or deaths within 31 days of discharge. CMS would identify community discharges using patient discharge status codes recorded on Medicare FFS claims. However, as noted by MedPAC and in other published studies, patient status discharge codes often lack reliability. Given that they are so integral to the calculation of the discharge to community measure, CMS must test the measure to ensure it provides an accurate portrayal of performance.

Potentially Preventable Readmissions (PPRs). The AHA has long urged that readmission measurement focus on those readmissions that are truly preventable, so we applaud CMS for proposing to remove the duplicative all-cause unplanned readmissions measure from the IRF QRP. However, we urge continued evaluation of the PPR measure. In particular, the categories and lists of "potentially preventable readmissions" should be based on careful evaluation by clinical experts and detailed testing. We appreciate that a technical expert panel was consulted on the list of categories and codes of readmissions considered "potentially preventable." However, we strongly encourage CMS to undertake additional empirical testing to ensure there is evidence that the codes actually are associated with the identified categories.

FUTURE CONSIDERATIONS FOR THE IRF QRP

In addition to proposing changes to the IRF QRP for proximal program years, CMS also invited public comment on the importance, relevance, appropriateness and applicability of quality measures for future years in the IRF QRP. We appreciate the opportunity to provide input on these longer term proposals, and hope that CMS incorporates our and others' comments thoughtfully as the agency further develops the IRF QRP.

Development of Experience of Care Survey-based Measures. **The AHA has long favored the use of patient experience surveys as tools to help providers improve the engagement and satisfaction of patients and their families. However, the proliferation of questions on such surveys has resulted in substantial costs to providers to collect the data as well as a significant burden to patients.** Indeed, many patients have expressed frustration to our members about the length of surveys and the amount of time it takes to complete them. It is critical that surveys include a parsimonious set of questions so that valuable patient time and finite provider resources are used efficiently and effectively.

We urge that any patient experience of care survey for IRFs be carefully aligned with other surveys to reduce duplicative collection activities. A patient's course of care often crosses multiple care settings and providers within a given time period, and the Consumer Assessment of Providers and Systems (CAHPS) program has surveys for nearly every setting. Indeed, CAHPS includes surveys for physicians, hospitals, nursing homes, dialysis facilities and home health agencies. Patients who receive care in two or more of these settings could receive multiple surveys. Typically, surveys are not distributed until days or weeks after a patient has received their care. This may create confusion about which provider or facility is actually being assessed. A patient may inadvertently attribute a positive or negative experience to the wrong provider.

The AHA also strongly recommends that CMS explore the development of more economical survey administration approaches for patient experience surveys, such as emailed or web-based surveys. While we appreciate the value of assessing the patient experience across the care continuum, the use of multiple surveys means more time spent by patients to answer surveys and more resources expended by providers to administer them. Moreover, for the purposes of CMS reporting programs using CAHPS tools, providers are permitted to use only two survey administration modes – mailed surveys and telephone surveys. Mailed surveys are relatively inexpensive to administer, but often suffer from low response rates and a significant time lag. Telephonic surveys typically yield a higher response rate and provide more timely results, but are much more expensive to administer.

Modification of Discharge to Community Measure. **The AHA supports the modification to this measure, which would exclude baseline nursing facility residents from the calculation.** As CMS notes, these residents did not live in the community prior to their IRF stay and thus would not necessarily be expected to return "successfully" to the community following discharge as specified in the measure. This modification would more accurately portray the quality of care provided by IRFs while controlling for factors outside of the IRF's control.

IMPACT Act Measures on Transfer of Information. **The AHA urges CMS to be cautious in its development of these Transfer of Information measures, and only adopt the measures that are endorsed by the National Quality Forum (NQF).** The measures under development include "Transfer of Information at Post-Acute Care Admission, Start or Resumption of Care from Other Providers/Settings" and "Transfer of Information at Post-Acute Care Discharge to Other Providers/Settings and End of Care." We agree that the transfer of information between and among post-acute care settings is vital to ensuring safe and high-quality patient care; however, these measures are still in the early stages of development.

When they were considered by the NQF's Measure Application Partnership (MAP) in January, the public comment period had closed only a month earlier. The specifications of the

measure lacked information on the modes of information transfer and failed to take pre-admission screening requirements that are already in place for IRFs into account. The MAP voiced concerns that the measures did not ensure that the information being transferred was standardized or provided in a sufficient manner to benefit the patient's care, and many MAP participants worried that this process measure would not yield any useful information that would result in improvements in care or patient outcomes.

As noted in the proposed rule, CMS intends to specify these measures no later than Oct. 1, 2018 and begin data collection on or about April 1, 2019. If these measures cannot pass the NQF endorsement process prior to those dates, **we urge CMS to delay implementation of these measures until they receive endorsement.**

We thank you for the opportunity to comment on this proposed rule. Please contact me if you have questions or feel free to have a member of your team contact Nelly Leon-Chisen, director for coding and classification, at nleon@aha.org, regarding coding, Rochelle Archuleta, director of policy, at rarchuleta@aha.org, regarding the payment provisions, or Caitlin Gillooley, associate director of policy, at cgillooley@aha.org, pertaining to the quality-reporting provisions.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President
Government Relations and Public Policy