May 31, 2022

SUBMITTED ELECTRONICALLY VIA www.regulations.gov

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS-1767-P: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Fiscal Year 2023 Proposed Rule

Dear Administrator Books-LaSure:

On behalf of the Association of Rehabilitation Nurses (ARN) – representing approximately 4,500 rehabilitation nurses and more than 14,000 Certified Registered Rehabilitation Nurses (CRRN) that work to enhance the quality of life for those affected by physical disability and/or chronic illness – we appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed rule implementing the Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) for Fiscal Year (FY) 2023.

Overview of Rehabilitation Nursing

Rehabilitation nursing is a philosophy of care, not a work setting or a phase of treatment. We base our practice on rehabilitative and restorative principles by: (1) managing complex medical issues; (2) collaborating with other specialists; (3) providing ongoing patient/caregiver education; (4) setting goals for maximum independence; and (5) establishing plans of care to maintain optimal wellness. Rehabilitation nurses practice in all settings, including freestanding rehabilitation facilities, hospitals, long-term subacute care facilities/skilled nursing facilities (SNFs), long-term acute care facilities, comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHAs), and private practices.

Rehabilitation nurses take a holistic approach to meeting patients' nursing and medical, vocational, educational, environmental, social, spiritual, and safety needs. We lead and coordinate rehabilitation, restorative care, and community reintegration for populations across all age groups and ethnicities across the care continuum, from ambulatory care to hospice. Rehabilitation nurses begin to provide care to individuals, their families, and caregivers soon after the onset of a disabling injury or chronic illness and continue to provide specialty care, patient and family education, and care transition planning that empowers these individuals to return home, work, and/or school. Rehabilitation nurses, in collaboration with interdisciplinary teams, provide comprehensive, population-specific care management to access health care services, adaptive technology and equipment, and community resources.

ARN supports efforts to ensure persons with disabilities and chronic illnesses have access to the appropriate level of rehabilitation services to maximize functional outcomes, independence, and quality of

life. Specifically, as a part of its mission, ARN stands ready to work with policymakers at the local, state, and federal levels to advance policies and programs that promote maximum independence for all persons in need of rehabilitation.

Solicitation of Comments Regarding the Potential Expansion of the IRF Transfer Payment Policy to Include Home Health Services

ARN opposes any future expansion of the IRF transfer policy to include discharges for a patient discharged home under the care of home health. As CMS is aware, patients admitted to an IRF need both sophisticated medical care and intensive and highly coordinated rehabilitation services. Given the complexity of the primary conditions treated by IRFs, the treatment to restore patients' functional and cognitive skills can often extend well beyond a patient's IRF stay. When the patient needs these services in the home and is unable to access these services in an outpatient setting, the use of home health is certainly appropriate and does not represent a failure of the IRF to provide optimal care and treatment.

For more than two decades, the IRF PPS has allowed medically complex patients to return home in as safe and timely a manner as possible, with home health often facilitating the transition to home. ARN would argue a return to home is the most preferable outcome for all rehabilitation cases, and IRFs should not be disincentivized from facilitating these outcomes. Patients should be discharged to home when the patient has achieved their individualized rehabilitation goals regardless of the case mix group (CMG) average length of stay (ALOS). Discharge to home prior to the ALOS should be celebrated as a great achievement, even if the patient requires further assistance of home health agencies, as this assistance is in their home, which is the most healing and the least costly setting.

ARN understands that the proposal to expand the transfer policy to include home health comes from the HHS Office of Inspector General (OIG) report in December 2021. The OIG specifically examined the FY 2017 and FY 2018 IRF claims that would have triggered a payment reduction under the transfer policy if home health had been a covered site.[1] The OIG also assessed the reduced payments under the transfer policy and then compared to the IRFs' costs of care for the patients in the sample. The OIG concluded that the Medicare program would have realized a significant savings of approximately $1 billion for those payment years had the IRF transfer policy been expanded to include home health services. The OIG therefore recommended that CMS implement an IRF payment policy for early discharges to home health care.

ARN is very concerned with both the OIG's analysis and ultimate recommendation. We believe that the OIG did not meaningfully address in their report the fact that the IRF PPS bases payments on patients' ALOS, which in turn has implications for patient stays with discharges before and after the ALOS. While IRFs may receive payment more than their costs for certain patients that are able to be safely discharged to home in advance of the ALOS for their CMG, there are correspondingly patients who must stay beyond the ALOS and for whom IRFs incur costs in excess of their ALOS-based CMG payment. If this were to be implemented, IRF's will be paid the per-diem rate for the CMG instead of the full rate. For example, CMG X – ALOS is 10 days, reimbursement $10,000. If the patient is discharged home on day 6 without home health, the IRF would be paid $10,000. If the patient is discharged on day 6 with home health, they would receive $1,000/day ($ reimbursement/ALOS). Thus, the IRF would be paid $1,000 per day plus an additional ½ day payment for the first day for a total of $5,500. Implementing a policy that focuses only on those home health discharges that occur before the ALOS would create an immediate distortion unless a corresponding adjustment was provided for patients with stays that exceed the ALOS. ARN believes that any policy change should be patient focused. The patient should be discharged to home when their

[1] Claims were counted when the LOS was more than 3 days but less than the average CMS LOS, and that HH services began within 3 days of the IRF discharge date.

goals are met, regardless of the need for home health and the IRF should not be financially penalized for this.

While ARN appreciates CMS' commitment to reducing the overall cost to the Medicare system, we don't believe expanding the transfer policy to include home health services is right for the patients we serve. Furthermore, this proposed policy runs counter to the Administration's stated goals of improving access to home health services. Rehabilitation nurses help patients restore their functional ability to the point of being able to return home safely in the most expedient timeframe. Expanding the transfer policy to include home health services essentially penalizes IRFs for ensuring appropriate continuity of care beyond IRF discharge. ***We urge CMS not to expand the IRF transfer policy to include home health services in future payment rules.***

Proposal to Require Quality Data Reporting on all IRF Patients

ARN is concerned with CMS's proposal to begin collecting IRF-PAI assessments on all patients receiving care within an IRF regardless of the patient's payer. While we have been on record in the past as being generally supportive of standardize data collection and quality improvement initiatives, we cannot support this proposal absent key information from CMS regarding how it plans to implement the strategy and use the data it captures.

As you know, effective October 1, 2022, the IRF-PAI version 4.0 will increase the data collection burden by over 100 data points. The increased burden is not insignificant in this time of unprecedented staffing shortages, rising costs and lingering impacts of the COVID-19 pandemic. This staffing concern was also echoed in a recent report by the HHS Assistant Secretary for Planning and Evaluation. The report suggested that the healthcare workforce shortages will continue to persist and significantly worsen by 2030.[2] Aside from staffing shortages, IRFs are facing increased costs to retain staff and procure necessary supplies. To add the need to collect IRF-PAI's on all patients would only further compound this burden.

CMS says that all-payer data collection would not be included in payment updates for IRFs despite the increased costs IRFs will have to shoulder in conducting additional data collection. Clarification on how exactly CMS will use this additional data is needed.

ARN does support the idea of wanting more data in the aggregate to bolster the Care Compare website, as in its current state Care Compare does not accurately reflect the work that rehabilitation providers do. CMS must consider how any data from non-Medicare sources is publicly reported on Care Compare. There are distinct differences between patients of various payment sources, and it is necessary for CMS to appropriately risk-adjust and display those differences.

ARN encourages CMS to provide more details around the data collection and how the data will be used, and to consider the burden reporting on an already depleted workforce and the issues around the data reported on Care Compare. ***We believe these issues must be addressed before moving forward with an all-payer IRF-PAI implementation.***

Inclusion of National Healthcare Safety Network Healthcare-Associated Clostridioides Difficile Infection Outcome Measure in the IRF QRP

ARN appreciates the seriousness of healthcare acquired Clostridioides Difficile Infections (CDI) for our patients and understands why CMS wants to improve upon this outcome measure. CMS purports that

[2] *Impact of the COVID-19 pandemic on the hospital and outpatient clinician workforce: Challenges and policy responses*. ASPE. (n.d.). Retrieved May 6, 2022, from https://aspe.hhs.gov/reports/covid-19-health-care-workforce

using data from electronic health records (EHR) for the CDI measure it would both increase the accuracy of the measure and reduce the reporting burden, as it would negate manual entry of information into the NHSN reporting platform. We agree that electronic transmission would decrease reporting burden. However, we are concerned that IRF's are not prepared to do this electronically and this would require potentially costly changes to the EHR which could not be completed quickly. As this data is reported currently, NHSN data shows that CDI is only present in 1% of IRF patients. Continued reporting of this measure, as it effects so few patients, is unwarranted and ARN questions if it is worth the cost to IRF's to make the necessary changes to the EHR when all other costs of business (supplies, staff, medications) are at an all time high. Another concern is that this measure includes a 14 day look back. Many patients are not in the acute care setting for 14 days and obtaining this data could prove challenging to the IRF.

If CMS proceeds with transitioning to a CDI digital quality measure, ARN would like to know the agencies plan for how IRFs would operationalize a 14 day look back. Additionally, if CMS moves forward, ***ARN would urge CMS to provide enough time for IRFs to build out the EHR in order to implement the new CDI digital quality measure.***

Overarching Principles for Measuring Equity and Healthcare Quality Disparities Across CMS Quality Programs

ARN applauds CMS' continued commitment to addressing inequities in health care. Our members stand ready to assist with efforts to ensure that patients of all backgrounds have access to needed rehabilitation care. We are committed to achieving equity in health care outcomes for our patients by supporting quality improvement activities, research and by enabling patients to make more informed care decisions. ARN has long sought to reflect and represent all nurses pursuing excellence in rehabilitation practice, in turn, reflecting and representing our diverse patient populations and allowing for the highest level of cultural humility. We are strengthened by our support of members inclusive of race, ethnicity, gender, gender identity, sexual orientation, religion, age, disability, and life experiences, which benefits our patients. Through these values and beliefs, ARN fosters and respects the diverse ideas, opinions, and thoughts that will ensure our community continues to excel, innovate, and encourage learning and leadership. Furthermore, ARN recognizes the significance of the contributions that a diverse community of nurses can make to the field of rehabilitation and our patients.

ARN contends that adding additional quality measures only further increases the IRFs reporting burden, which doesn't always equate to better outcomes for patients. As Dr. Lisa Rosenbaum wrote in her recent article in the New England Journal of Medicine on *Reassessing Quality Assessment—The Flawed System for Fixing a Flawed System*, "…as we shift toward value-based payment, invest heavily in an improvement infrastructure that isn't clearly working, and navigate an epidemic of burnout and workforce demoralization," we seem to inch further away from quality patient outcomes.[3] When considering the cost of care, what we have seen is that quality measures don't always reduce the cost of care.

We do agree with AMRPAs belief that any health equity measures should also include disability status. Unfortunately, what we do know is that disability status data is inconsistently collected across federal data efforts. This leads to significant gaps in the availability of this information and thus, an inability to fully understand how disability status intersects with and compounds demographic factors, social determinants of health, and other characteristics. ***ARN would welcome the opportunity to work with AMRPA and***

[3] Rosenbaum, Lisa. *Reassessing Quality Assessment—The Flawed System for Fixing a Flawed System.* The New England Journal of Medicine. April 14, 2022.

CMS on defining and measuring disability so that we can better understand how disability affects a patients access and experience with rehabilitation care.

Conclusion

ARN appreciates the opportunity to provide comments to CMS regarding the proposed rule implementing the FY 2023 IRF PPS. We are available to work with you, your colleagues, the rehabilitation community, and other stakeholders to develop and implement payment policy changes that ensure access to quality care for Medicare beneficiaries with physical disabilities and/or chronic disease. If you have any questions, please contact me or ARN's Health Policy Associate, Jeremy Scott (jscott@dc-crd.com or 202-484-1100). We thank you for your consideration of our comments.

Sincerely,

Jill Rye, DNP RN CRRN CNL FARN
President