June 13, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1677-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

**Re: CMS-1677-P: Medicare Program: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices**

Dear Administrator Verma,

On behalf of the Association of Rehabilitation Nurses (ARN) – representing more than 5,400 rehabilitation nurses and more than 13,000 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 Hospital Inpatient Prospective Payment Systems (PPS) for Acute Care Hospitals and the Long-Term Care Hospital (LTCH) PPS for Fiscal Year (FY) 2018.

The proposed rule contains a wide-range of policy changes; given the expertise and experience of rehabilitation nurses, we generally will be focusing our comments on section VIII of the rule – Proposed Changes to the Long-Term Care Hospital Prospective Payment System (LTCH PPS) for FY 2018, section IX of the rule which contains the LTCH Quality Reporting Program (LTCH QRP), and the components of the rule that pertain to the implementation of the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act)

**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, and spiritual needs. We begin to work with individuals and their families soon after the onset of a disabling injury or chronic illness and continue to provide support and care, including patient and family education, which empowers these individuals when they return home, to work, or to school. Rehabilitation nurses also often teach patients and their caregivers how to access systems and resources.

ARN supports efforts to ensure individuals with physical disability and chronic illness have access to comprehensive quality care in whichever care setting is most appropriate for them. 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 individuals living with physical disability and/or chronic illness.

**Proposed Changes to the LTCH PPS for FY 2018**

ARN commends the agency for seeking to "pay each LTCH an appropriate amount for the efficient delivery of medical care to Medicare patients … [and] account adequately for each LTCH's case-mix in order to ensure both fair distribution of Medicare payments and access to adequate care for those Medicare patients whose care is more costly." To that end, ARN does not inherently oppose site-neutral payments so long as such payments are adequate to ensure the resources necessary to care for each individual patient and their respective medical and nursing care needs. ARN members believe there should be more equitable payment across settings and that if the goal is to move toward a more unified PAC payment system, then certain regulatory requirements, such as the 25 percent rule (see additional comments below) should be lifted.

***Short-Stay Outline Policy***

The rule includes a proposal to change the Short-Stay Outlier (SSO) policy which would utilize a blended per diem payment rate that would "results in paying LTCH cases with a very short length of stay more like an IPPS case, and LTCH cases with relatively longer lengths-of-say more like a non-short-stay LTCH PPS standard Federal payment rate case." We understand that the agency is proposed to codify the change to the SSO policy and in doing so "remove the incentive to delay patient discharges for payment reasons." ARN supports this change as it is patient-

centered and outcomes-focused, while also ensuring appropriate allocation of scarce federal resources.

***Moratorium and Proposed Regulatory Delay of the Full Implementation of the "25-Percent Threshold Policy Adjustment"***

ARN has grave concerns about the "25-percent threshold policy" and supports delaying its implementation. This policy, which is a per discharge payment adjustment in the LTCH PPS that is applied to payments for Medicare patient discharges when the number of such patients originating from any single referring hospital is in excess of the applicable threshold for a given cost reporting period, typically set at 25 percent. A patient's admission to an LTCH should not be based on referral source, but on their health and rehabilitative needs.

Given our concerns about the impact of the policy on patient access to quality LTCH care at the facilities patients and their family members wish to utilize, we fully support the agency's proposed regulatory moratorium on the implementation of the 25-percent threshold policy until the agency "can examine data under the application of the site neutral payment rate to further evaluate, when more data are available, whether the policy is in fact still necessary." We commend the agency for recognizing the need to examine the data and study whether this policy is necessary. We fully support the 1-year moratorium and urge the agency to formalize this change in the final rule for FY 2018.

**Long-Term Care Hospital Quality Reporting Program (LTCH QRP)**

ARN members are committed to providing the highest quality, state-of-the-art care to Medicare beneficiaries across all care settings. As part of this dedication to patient care, we support the agency's efforts to improve quality and outcomes for Medicare beneficiaries. We stand ready to work with the agency on the following and other issues to ensure that the LTCH QRP meets the needs of Medicare beneficiaries, holds providers appropriately accountable for quality and outcomes, and does not unduly burden providers in implementation and compliance.

***Accounting for Social Risk Factors in the LTCH QRP***

We support the agency's efforts to improve outcomes and reduce health disparities and to "ensure that the quality of care furnished by providers and suppliers is assessed as fairly as possible … while ensuring that beneficiaries have adequate access to excellent care." To that end, we very much appreciate that the agency has concerns about "holding providers to different standards for the outcomes of their patients with social risk factors because we do not want to mask potential disparities or minimize incentives to improve the outcomes for disadvantaged populations." We thank the agency for seeking public comment on "which social risk factors might be most appropriate for reporting stratified measure scores and/or potential risk adjustment of a particular measure."

We previously have submitted comments to the agency about the need to utilize socioeconomic and demographic factors in risk adjustment for the proposed resource use measures. We understand the agency is considering factors such as dual eligibility for Medicare and

Medicaid/low-income subsidy, race, and ethnicity. We agree with those factors and would like to take this opportunity to reiterate our previous comments to the agency about further expanding the list of socioeconomic and demographic factors that are utilized in risk adjustment, with a focus on those that affect both discharge to community and 30-day readmissions measures, including:

1. Age;
2. Presence of support system (spouse, partner, children, and/or parents who are able to learn and are willing to participate in learning care and providing care);
3. Finances (does the individual qualify for aid or have private funds to assist with care or is there a family/caregiver with the ability to stay home with the individual; how will the individual obtain equipment not covered under Medicare);
4. Education and healthcare literacy (the ability to understand the medical diagnoses and the care that is needed);
5. Physical ability of the caregiver (e.g. age of caregiver, presence of impairments in caregiver, weight and medical condition of caregiver);
6. Living conditions and home access;
7. Community resources available for respite; and
8. Presence of pre-morbid assistance with self-care.

In addition to utilizing these factors to make appropriate adjustments in the ARP, ARN believes that utilizing the above factors during the assessment of patients would enable providers, in collaboration with the patient/caregiver, to develop a more comprehensive treatment and intervention plan that addresses these concerns, improves outcomes, and helps to prevent avoidable readmissions.

As CMS continues to develop and refine existing and planned LTCH QRP measures, ARN encourages CMS to consider the following features of care furnished in a LTCH:

- Assessment of family members and caregivers' capacity to assume patient care post-discharge;
- Coordination and collaboration on patient, family, and medical goals of care when patients' goals are to return to their home- or community-based setting; and
- Ethical considerations regarding ongoing care and family support for continuing or terminating complex medical care and the addition of language related to initiating and/or introducing palliative care.

***Proposed Collection of Standardized Patient Assessment Data Under the LTCH QRP***

We understand the agency is proposing to define "standardized patient assessment data" as "patient assessment questions and response options that are identical in all four PAC assessment instruments, and to which identical standards and definitions apply." ARN represents rehabilitation nurses that work in all four PAC settings – LTCH, skilled nursing facilities (SNFs), home health agencies (HHAs), and inpatient rehabilitation facilities (IRFs) – and as such, we support standardizing the definition as well as the implementation of this data collection effort. Further, we support the agency's goal of standardizing the questions and responses across all

PAC settings to help "enable the data to be interoperable, allowing it to be shared electronically, or otherwise between PAC provider types."

***Policy for Retaining LTCH QRP Measures and Proposal to Apply That Policy to Standardized Patient Assessment Data***

ARN understands and supports the current CMS policy that allows any quality measure adopted for use in the LTCH QRP to "remain in effect until the measure is removed, suspended, or replaced" and agrees that this policy should be applied to the standardized patient assessment data that will be adopted by the agency for the LTCH QRP.

***Policy for Adopting Changes to LTCH QRP Measures and Proposal to Apply That Policy to Standardized Patient Assessment Data***

ARN understands that CMS adopted a subregulatory process to "incorporate updates to LTCH quality measure specifications that do not substantively change the nature of the measure" and that substantive changes to measures are undertaken through formal rulemaking. ARN agrees with the agency that this approach be applied in the same manner to the standardized patient assessment data being adopted for the LTCH QRP.

***Quality Measures Previously Finalized for the LTCH QRP***

***Potentially Preventable 30-Day Post-Discharge Readmission Measure for Long-Term Care Hospital Quality Reporting Program***

While ARN is generally supportive of the potentially preventable readmissions measure, we have several concerns. ARN believes PAC facilities should not be penalized for conditions that prompt readmission which are unrelated to the patient's initial reason for admission to the LTCH. For example, hospitalization can change the condition of a patient, increasing the likelihood of an unplanned readmission, which is outside the control of the PAC provider. Additionally, we believe CMS should account for differences in each LTCH's mix of low-income patients when calculating readmission rates.

***Medicare Spending Per Beneficiary- Post-Acute Care (PAC) LTCH QRP***

ARN appreciates CMS's efforts to create a continuum of accountability between providers and improve post-treatment care planning and coordination. We understand, and appreciate, the intent of the MSPB-PAC resource use measures is to ensure patients receive high quality care and address geographic variations in Medicare PAC spending. However, assessing providers' efficiency based solely on the MSPB-PAC measures is inappropriate, given that some post-acute providers may treat a greater number of medically complex patients who require multi-faceted, highly skilled rehabilitation and treatment than other providers of the same type.

ARN believes the MSPB-PAC resource use measures may unintentionally encourage facilities to selectively admit or refuse patients based on the type and complexity of their conditions. It is vitally important that individuals with chronic and disabling conditions are served in a PAC

setting that includes the provision of services that will optimize health outcomes and quality of life. The MSPB-PAC resource use measures, which evaluate PAC providers' efficiency relative to the efficiency of the national median PAC provider of the same type, fail to take into consideration the health needs and desired outcomes of each patient. ARN has concerns that PAC providers will be assessed based solely on costs per patient, without accounting for the superior patient outcomes facilitated by PAC providers.

***Discharge to Community-PAC LTCH QRP***

ARN believes that patients who have been discharged to the community and die within the post-discharge window should not be included within the quality measure, given the variation in patient characteristics across the four settings. For example, as compared to all Medicare beneficiaries, the LTCH patient population represents the most disabled, elderly, and frail beneficiaries. The Medicare Payment Advisory Commission's (MedPAC) March 2015 Report to Congress noted that compared with other beneficiaries, those admitted to LTCHs are "disproportionately disabled (under age 65), over age 85, or diagnosed with end-stage renal disease."[i] ARN urges CMS to exclude from the quality measure those patients that die within the post-discharge window after being discharged to the community, as the types of patients treated in each setting greatly varies and can lead to an inaccurate reflection of the quality of care.

ARN is pleased that CMS has acknowledged that return to the community is an important outcome for many patients; however, we have concerns that the term "community" is defined as home/self-care, with or without home health services, based on Patient Discharge Status Codes 01, 06, 81, and 86 on the Medicare Fee-for-Service (FFS) claim. CMS's proposed discharge to community measure fails to consider when a patient's "home" is a custodial nursing facility and the patient's post-acute episode involves a discharge back to his or her "home." In such circumstances, including the final post-acute provider in the discharge to community measure when a patient is discharged to the originating level of care, but in essence, is returning home, may distort the findings of the quality measure. We encourage CMS to design a quality measure that is capable of capturing the difference between a patient's return to his or her home and a patient's post-acute episode that involves transfer to the same level of care.

***LTCH QRP Quality Measures and Measure Concepts Under Consideration for Future Years***

ARN appreciates the agencies ongoing effort to improve the quality of care and ensure appropriate resource allocation among PAC settings, including LTCHs. We understand the agency is proposing new measures for implementation beginning in FY 2020 and, that as part of this expansion, the agency is proposing to remove the current pressure ulcer measure and replace it with a modified version entitled Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury and adopt two new measures related to ventilator weaning. Overall, ARN believes that the proposed changes are appropriate in reducing regulatory burden while maintaining measures to promote quality care for patients.

***Proposed Mechanical Ventilation Process Quality Measure: Compliance with Spontaneous Breathing Trail (SBT) by Day 2 of the LTCH Stay***

ARN has concerns regarding the agency's proposal to implement a new measure related to SBT by Day 2 of the LTCH stay. A number of our members noted that the proposal seems to conflict with the requirement for 96 hours of ventilator dependence while in the LTCH in order to get the full LTCH payment and not be a site neutral payment. Other members also expressed concern about whether this is a safe and feasible practice for their patients. ARN appreciates the desire to increase the number of LTCH patients who are weaned as soon as clinically appropriate from mechanical ventilation and supports this goal. However, we urge the agency to provide additional clarification regarding how this measure would interact with other regulatory requirements and practices. As such, we do not recommend this measure be finalized or adopted as currently proposed, until further clarification and information can be provided to ensure alignment with all federal policies as well as ensuring patient safety.

***Proposed Removal of the All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from LTCHs From the LTCH QRP***

ARN supports efforts to ensure harmonious and equal measures across the post-acute care continuum and therefore agrees with the proposed removal of the readmission measure.

**IMPACT Act Measure – Possible Future Update to Measure Specifications**

As we have previously commented to the agency, ARN supports efforts to ensure harmonious and equal measures across the PAC continuum.

We appreciate the agency has acknowledged in the proposed rule that the measures under development are: Transfer of Information at PAC Admission, Start or Resumption of Care from other Providers/Settings; and Transfer of Information at PAC Discharge, and End of Care to other Providers/Settings and that the agency intends to propose to specify these measures no later than October 1, 2018 and adopt them for FY 2021, with data collection beginning on or about April 1, 2019. We wish to comment at this time on measure under consideration #321 and measure under consideration #327 that the unique goals, preferences, and needs of the
patient should be considered in transferring patient information either at the initiation of services or at the completion of those services. As care transitions are a confusing time for the patient and family/caregiver, we urge modification of the measures so as to require facilities to communicate the capabilities and limitations of PAC facilities to ensure a patient's clinically assessed needs match the level of care determined by relevant decision-makers (which includes the patient and family/caregiver).

***Change in the pressure ulcer to skin integrity***
ARN supports the replacement of the current pressure ulcer measure, Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678) with a modified version of that measure, Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury.

***Cognitive Function and Mental Status Data***

***Brief Interview for Mental Status (BIMS)***

ARN supports the utilization of the BIMS in evaluating a patient's cognitive status and believes it is valid and reliable in its assessment. Given the relatively low burden of administering the assessment and its ability to generally predict a cognitive impairment, we believe clinicians should be encouraged to administer the assessment on a regular basis as a means to evaluate whether there are changes in the patient's cognition.

However, ARN has concerns regarding the BIMS' limitations. The BIMS has been shown to be unable to differentiate between patients with a mild cognitive impairment and those with no cognitive impairment; further, it cannot provide a completely clear picture of a patient's cognitive status. We urge CMS and RAND to clarify what, if any, additional tools will be used to detect potential cognitive impairment or dementia, such as collecting information from the patient's family or caregivers to confirm or provide supplemental data.

***Behavioral Signs and Symptoms***

Behavioral signs and symptoms could indicate a patient has a cognitive dysfunction or is uncomfortable and needs assistance. The development of an individualized, person-centered care plan depends on accurate assessment and preventative methods. As members of interdisciplinary teams, nurses collaborate with physicians, social workers, psychologists, therapists, and case managers. Because of these relationships and interactions, nurses are well-equipped to identify and respond to patients with potential behavioral issues.

ARN recognizes the need to monitor and assess behavioral signs and symptoms in an effort to better inform a patient's treatment plan. We have concerns, however, that the scope of the Behavioral Signs and Symptoms assessment is limited and may be ineffective for increasing quality of care and improving patient outcomes. The assessment does not capture subtle signs or symptoms, such as agitation or anxiety, which could indicate a cognitive impairment. If a patient exhibits such symptoms, it is unlikely to be referenced in the assessment, which could lead to the development of a care plan that does not fully reflect the patient's condition. Specific questions that help the clinician/assessor identify subtle behavioral signs or symptoms should be included in this assessment to assist in the development of a patient's care plan.

***Patient Health Questionnaire-2***

ARN is supportive of the PHQ and believes the PHQ-2 and PHQ-9 are useful, valid clinical tools. Both questionnaires assist clinicians in determining the severity of symptoms upon admission and throughout the delivery of care in the PAC setting. ARN recommends that the PHQ should initially be presented to patients in the most basic form (PHQ-2), and then administered in its more thorough form if these initial screening questions are positive. Upon admission into a PAC facility, patients are overwhelmed, creating a situation in which some individuals may not feel comfortable with a more invasive mental health screening. Utilizing a shorter form will reduce the burden experienced by clinicians in collecting assessment data.

While we appreciate CMS's efforts to limit the administrative burden on patients and providers by proposing to utilize the PHQ-2 as an initial screen for depression, potentially eliminating the

need for conducting the PHQ-9 in some circumstances, we have concerns the PHQ-2 is unable to identify the more subtle signs and symptoms of depression. Should CMS move forward with adopting the PHQ-2 as a gateway tool for the PHQ-9 across PAC settings, we recommend CMS utilize a low threshold level for the PHQ-2, to ensure clinicians do not miss those patients who require further evaluation.

***Special Services, Treatments, and Interventions Data***

ARN is committed to providing our patients with the highest quality of health care, but we are concerned that the collection of additional data points will create an unnecessary burden on rehabilitation nurses. ARN understands the need for data to be used for risk adjustment, but the same interventions should be applied across PAC settings.

**Conclusion**

ARN very much appreciates the opportunity to provide comments to CMS regarding the proposed rule implementing the LTCH PPS for FY 2018. 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 have your staff contact our Health Policy Associate, Jeremy Scott (jeremy.scott@dbr.com or 202-230-5197). We thank you for your consideration of our concerns, recommendations, and requests.

Sincerely,

Stephanie Vaughn

Stephanie Vaughn, PhD RN CRRN FAHA
President

[i] Medicare Payment Advisory Commission (2013). *Report to the Congress: Medicare and the health care delivery system*. Retrieved from http://medpac.gov.