August 22, 2017

The Honorable Pat Tiberi, Chair
Ways and Means Health Subcommittee
United States House of Representatives
Washington, D.C.

RE: Comments for Provider Statutory & Regulatory Relief Initiative

Dear Chairman Tiberi:

On behalf of the Association of Rehabilitation Nurses (ARN), representing more than 5,000 rehabilitation nurses and more than 13,000 certified rehabilitation registered 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 provide comments to the House Ways and Means Health Subcommittee on the Provider Statutory & Regulatory Relief Initiative.

ARN supports efforts to ensure people with physical disability and chronic illness have access to comprehensive, quality care in whichever care setting is most appropriate for them. Rehabilitation nurses take a holistic approach to meeting patients' nursing and medical, vocational, educational, environmental, and spiritual needs. Rehabilitation nurses begin to work with individuals and their families soon after the onset of a disabling injury or chronic illness. We continue to provide support and care throughout the continuum of care by including patient and family education, which empowers these individuals when they return home, to work, or to school. Rehabilitation nurses often teach patients and their caregivers to navigate various heath care systems and access resources.

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 and 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 inpatient rehabilitation facilities (IRFs), hospitals, long-term subacute care facilities and skilled nursing facilities, long-term acute care facilities, comprehensive outpatient rehabilitation facilities, home health, and private practices.

1. **How Congress can deliver statutory relief from the mandates established in law through our legislative authority.**

Scope of Practice

Changes in health care are influencing the conversion of many positions in nursing to advanced practice positions due to the complexity of providing and managing care for clients and families. Position titles and responsibilities will continue to change and evolve to meet the needs of society and the healthcare delivery system. Clients with chronic illness and disability will continue to require access to highly skilled rehabilitation professionals for their continued healthcare needs. Supported by the Institute of Medicine (IOM) report *The Future of Nursing*, nurses must be allowed and supported to practice to the full extent of their education and training by removing scope of practice barriers. ARN recommends that Congress amend the Medicare program to authorize advanced practice registered nurses to perform admission assessments, as well as certification of patients for home health care services and for admission to hospice and skilled nursing facilities.

Social Security Act Sec. 1802. [42 U.S.C. 1395a]

Communication also is a key component of care delivery. Hospital staff must effectively communicate discharge instructions to patients and/or their caregivers and be available to discuss and answer patients and their caregivers' questions about post-discharge obligations. To do so, hospitals should communicate the capabilities and limitations of PAC facilities so that a patient's clinically assessed needs match the level of care determined by decision-makers, which include the patient and family member or caregiver. According to a recent study published in Health Affairs, hospital staff members provided little guidance to patients when they were selecting a facility for PAC. The study found that hospital discharge planners offered patients lists of SNFs containing names and addresses but little else. Hospital staff members indicated in the study that they believe that they can supply only lists of SNFs to patients having been instructed that patient choice statutes preclude them from providing any other information. ARN is very concerned that the current misinterpretation of patient choice is precluding providers from utilizing the quality data that are available to make an informed choice of skilled nursing facilities. ARN recommends that this statute be clarified to ensure that patients have the data necessary to make an informed choice about their next setting of care.

2. **How Congress can work with Health and Human Services Secretary Tom Price, M.D., and Centers for Medicare and Medicaid Services Administrator Seema Verma to deliver regulatory relief through Administrative action.**

Quality Measures and Data Collection

Across the health care continuum there is redundancy in the quality measures required by prospective payment systems that need to be streamlined and structured to provide more meaningful data on patient outcomes. In the post-acute care (PAC) setting alone, the same measure can be comprised of different inclusion /exclusion criteria and have different criteria depending on the setting in which the measure applies. Quality measures should be meaningful

and useful and force change and improvement in patient care. The more measurement requirements put into place, the farther from the bedside we drive nurses and other healthcare professionals.

The ways in which data on quality measures is collected also creates a barrier to improvement in patient care. Use of the Continuity Assessment Record and Evaluation (CARE) tool to collect PAC data has not demonstrated being effective, efficient or leading to increased quality/ decreased costs. The CARE tool has added an additional data collection burden which is also driving nurses and healthcare professionals away from the bedside. At this time, there is no standardized hospital discharge tool. However, the Department of Health and Human Services (HHS) has developed a standardized patient assessment tool to capture clinical and demographic characteristics of patients across post-acute care settings. This tool exists in two forms – the CARE Tool and the B-CARE tool. However, these two tools do not identify the best next setting for patients being discharged from general acute-care hospitals, and providers report both tools are burdensome and lack the ability to capture the full spectrum of a patient's medical complexity to determine post-hospital care needs.[1]

The following lessons can serve as guiding principles in developing future discharge planning or patient assessment tools:

1. Post-hospitalization placements must first and foremost be based on patients' clinical needs. Clinical decision making, as reflected in any hospital discharge planning process or collection of standard metrics, must be considered an essential element in the design of future payment models.
2. Discharge planning tools must be designed to incorporate the medical judgment of treating physicians and other clinicians.
3. Discharge planning tools must be administratively feasible and not add to current administrative burden.
4. Discharge planning tools should provide information that helps clinicians optimize patient health during the hospital stay to help return the patient to as full function as possible and reduce the overall need for post-hospitalization services.
5. Standard information about the patient can be collected by tools with different design structures, reduce variation in post-acute placement, and assist in reducing readmissions.

The CARE Tool does not identify the appropriate care setting following discharge from a hospital or post-acute care provider, rather it facilitates care planning by assessing a patient at a particular point in time. CMS remains committed to a standardized patient assessment tool and continues to support the CARE Tool, as indicated by the use of the tool to collect post-aucte care quality data. The agency's sustained interest in expanding the use of the CARE Tool is evidenced by its recent hosting of expert panels to evaluate whether the tool could be used, in lieu of the existing post-acute care patient instruments, to collect the data needed to calculate payment through the current post-acute care prospective payment systems.
Many providers in the Post-Acute Care Payment Reform Demonstration (PAC-PRD) found that excessive time and resources were required to complete the instrument. Further, concerns were raised about the tool's ability to capture the health status of high-acuity patients. As a result,

[1] American Heart Association. (2015). *Private-sector hospital discharge tools*. Retrieved from www.heart.org.

there has been little interest in the CARE Tool from the provider community. Even a shortened version used by Bundled Payment for Care Improvement (BPCI) initiative participants to monitor the patient-level effects of care redesign – referred to as the B-CARE Tool – has been considered too lengthy and burdensome to complete and does not offer any "added advantage" toward improving the care of patients. The CARE Tool's shortcomings combined with its inability to guide placement in the next setting has led some hospitals to develop customized discharge planning tools.

Conditions of Participation

Care transitions to PAC settings remain a confusing time for patients and their families and can result in both overuse and underuse of PAC services and suboptimal quality of care and clinical outcomes. The Conditions of Participation for PAC settings should be clarified in such a way that the consumer fully understands the differences between settings. For instance, in order to be called a rehabilitation facility or have rehabilitation in the name of a facility, that facility should be licensed as a hospital (which IRFs are).

Skilled Nursing Facility (SNF) Three-Day Rule

ARN appreciated CMS' attempt to clarify the general rule in the regulations with respect to short inpatient hospital stays and the SNF three-day rule in the Calendar Year 2016 Hospital Outpatient Prospective Payment System. Classification as an inpatient versus outpatient has multiple implications for post-acute care. The Medicare Payment Advisory Commission (MedPAC) recently examined this issue and found that in 2012, 100,000 hospital stays were for three days and included time in observation. Thus, such stays would not be considered qualifying hospital stays for SNF coverage. Within this group, approximately 11,000 hospital stays ended with a non-covered discharge to a SNF.[i] Such patients were admitted to the hospital and sometimes/often unknowingly placed in "observation status." Following the short inpatient stay, such patients attempted to receive short-term rehabilitation services in a SNF, only to find the services were not covered under Medicare Part A because they had not received inpatient care for the requisite three days prior to admission to the SNF. The confusion surrounding patient status has led to a breakdown in patient care and the inability of patients to receive or pay for necessary services. ARN believes that the two-midnight rule is excessive and does nothing to facilitate quality care. We believe that a physician/clinician should be able to determine within 24 hours whether a patient will need to be admitted and recommends that this policy be removed.

Face-to-Face Encounter Requirement for Certification of Eligibility for Medicare Home Health Services

Section 6407 of the Patient Protection and Affordable Care Act of 2010 (PPACA) established a face-to-face encounter (f2f) requirement for certification of eligibility for Medicare home health services, by requiring the certifying physician to document that he or she, or a non-physician practitioner working with the physician, has seen the patient. The encounter must occur within 90 days prior to the start of care, or within 30 days after the start of care. At issue is that the PPACA never created a standardized f2f documentation form and payments to home health agencies (HHA) are being denied because Medicare Auditors are determining that physicians are not completing the f2f documentation as required by Medicare. HHAs are requesting physicians

to redo a f2f in order to include as much information as possible, but there is no way of requiring or enforcing that a physician do so. There are many cases where the patient is clearly homebound and unable to see their primary physician within the 30 day period but failure to comply with this mandate results in either discharging the patient (which could increase risk for readmission) or not receiving reimbursement for services. ARN recommends the following courses of action:

1. Revise the f2f requirements to eliminate or significantly modify the physician documentation requirements as set out in the Medicare rule to eliminate the need for a physician to spell out why the patient's clinical condition requires Medicare covered home health services.
2. Allow a non-physician practitioner to perform the encounter, certify that the encounter occurred, and compose all necessary documentation of the findings from the encounter.
3. Revise Medicare telehealth coverage requirements to include a patient's home as an originating site.

Denial of Home Health Payments When Required Patient Assessment Is Not Received

Change Request 9585 put into effect April 1, 2017 automated denial of home health prospective payment system (HH PPS) claims when the condition of payment for submitting patient assessment data has not been met. The policy specifically states that:

> OASIS reporting regulations at 42 CFR 484.20(a) require the OASIS to be transmitted within 30 days of completing the assessment of the beneficiary. In most cases, this 30 day period will have elapsed by the time a 60 day episode of HH services is completed and the final claim for that episode is submitted to Medicare. If the OASIS assessment is not found in the QIES system upon receipt of a final claim for an HH episode and the receipt date of the claim is more than 30 days after the assessment completion date, Medicare systems will deny the HH claim.

ARN acknowledges the need to have timely submission, but penalizing HHAs for the entire episode of care does not incentivize HHAs to continue to provide the care. ARN recommends reducing the penalty for late submission of OASIS data.

Anti-Kickback Statute

For individuals with chronic and disabling conditions it is critical that they are served in a PAC setting that includes the provision of services that will optimize health outcomes and quality of life. Individuals accessing PAC services are often some of the frailest and most vulnerable individuals who are living longer in their disease trajectories. Patients' clinically assessed needs often do not match the level of care determined by decision makers because optimal patient outcomes may not be the primary factor considered. Competing factors include proximity of providers, relationships between providers of care, payer source, and variation in the interpretations of regulations regarding PAC. The current CMS discharge planning regulations preclude a hospital from offering advice to a patient on the selection of a provider for post-hospital care or suggesting a specific facility and not designed for the collaborative relationships essential to providing the greatest value to the patients, their families, and the healthcare delivery system. ARN recommends that Congress work with the Agency to amend the Anti-Kickback

Statute so that hospitals are able to freely communicate the capabilities and limitations of PAC facilities to ensure that a patients' clinically assessed needs match the level of care determined by decision makers which should include the patient and family/caregiver.

Conclusion

ARN very much appreciates the opportunity to provide comments to the House Ways and Means Subcommittee on Health regarding ways to deliver relief from the regulations and mandates that impede innovation, drive up costs, and ultimately stand in the way of delivering better care for Medicare beneficiaries. We are available to work with you, your colleagues, the rehabilitation community, and other stakeholders to develop and implement changes to the Medicare program 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, PhD RN CRRN FAHA
President

[i] MedPAC Public Meeting Transcript, Page 64, http://medpac.gov/documents/november-2014-meeting-transcript.pdf?sfvrsn=0 (November 6, 2014).