

June 20, 2016

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

***RE: CMS-1647-P, Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2017.***

Dear Mr. Slavitt:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including 1,115 inpatient rehabilitation facilities (IRFs), the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2017 proposed rule for the IRF prospective payment systems (PPS). This letter addresses our concerns related to the coding guidelines for the IRF "60% Rule" presumptive compliance test and quality-reporting provisions in the proposed rule. Specifically, we are seeking the inclusion of selected ICD-10-CM codes, which, under ICD-9-CM, qualified toward presumptive compliance. In addition, we urge CMS to make several improvements to the measures proposed for the FY 2018 and FY 2020 IRF Quality Reporting Program prior to their implementation.

#### **REDUCTION 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. 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.



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. **Although CMS did not specifically propose any changes to the 60% Rule methodology for FY 2017, we restate our prior request for CMS to address the omission of 60% Rule presumptive test qualifying codes, which we believe are related to the conversion to ICD-10-CM.** Specifically, below we identify many of the conditions that were compliant under ICD-9-CM, but, since June 1, 2016, have been excluded from the list of compliant codes, the Presumptive Compliance List 2 (CMS file 508\_Compliant\_Version\_Presumptive Compliance-2). These errors may have resulted from certain diagnosis codes inadvertently being omitted as counting towards the 60% Rule or changes in codes as a result of the conversion to ICD-10-CM. **Since CMS did not intend for these patients to be excluded from the presumptive test under ICD-9-CM, the agency should include them under ICD-10-CM.**

Hip Fractures. Under ICD-9-CM, cases reported with the etiological diagnosis code of 820.8, Unspecified part of neck of femur, closed, would have counted toward 60% Rule compliance under Impairment Group Code (IGC) 08.11 (Orthopedic Disorders – Status Post Unilateral Hip Fracture). However, CMS is not allowing the equivalent ICD-10-CM codes to count toward 60% Rule compliance. **The rehabilitation treatment plan for a 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 been challenging, as radiologists feel that specifying “femoral neck” in the x-ray impression is sufficient and have been either unable or unwilling to be more specific.** Although the descriptor for these codes includes the term “unspecified,” the codes are in fact specific to the neck of the femur and should not be treated like other codes where the condition is not specified. Specifically, the codes below with the 7<sup>th</sup> characters for initial and subsequent encounters should be added:

- S72.001- Fracture of unspecified part of neck of right femur
- S72.002- Fracture of unspecified part of neck of left femur

Multiple Trauma. The General Equivalence Mappings (GEMs) incorrectly map 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. 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, codes for the specific bones fractured should be reported. The mapping error has resulted in patients with multiple fractures no longer counting toward 60% Rule compliance.

AHA has submitted a request to correct the ICD-9-CM to ICD-10-CM mapping error to CMS and the Centers for Disease Control and Prevention (CDC). **In the interim, any combination of two fractures represented by the ICD-10-CM categories listed below should be included in the list of 60% Rule presumptive codes.** These codes should include initial and subsequent encounters.

- Category S22, Fracture of rib(s), sternum and thoracic spine
- Category S42, Fracture of shoulder and upper arm
- Category S52, Fracture of forearm
- Category S62, Fracture at wrist and hand level
- Category S72, Fracture of femur
- Category S82, Fracture of lower leg, including ankle
- Category S92, Fracture of foot and toe, except ankle

Traumatic Brain Injury. As of FY 2016, CMS no longer counts codes for traumatic brain injury with either unspecified or no loss of consciousness (LOC) toward 60% Rule compliance.

**However, we strongly urge CMS to include all codes for traumatic brain injuries in the 60% Rule, regardless of whether there is LOC and whether the length of time of the LOC is specified or not.** For example, ICD-10-CM diagnosis code S06.5X0A, Traumatic subdural hemorrhage without loss of consciousness, initial encounter, reported as the etiological diagnosis and paired with either IGC 02.21 (Brain Dysfunction - Traumatic, Open Injury) or IGC 02.22 (Brain Dysfunction - 0002.22 Traumatic, Closed Injury) fails the CMS 13 presumptive compliance. 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 if the patient did lose consciousness, for how long. Inconsistently, when the same code for traumatic brain injury without loss of consciousness is used as secondary diagnosis code (rather than as the etiological diagnosis), the case is compliant.

Traumatic Injuries. Most ICD-10-CM code categories for chapter 19 (Injury, poisoning, and certain other consequences of external causes) require a 7<sup>th</sup> character for initial encounter (A), subsequent encounter (D) and sequela (S). Categories for traumatic fractures have additional 7<sup>th</sup> character values. However, it has come to our attention that only the 7<sup>th</sup> 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 CDC as the ICD-10-CM code set maintainers) has provided several examples of the correct application of the 7<sup>th</sup> character. These examples demonstrate that “subsequent encounter” is the correct option for rehabilitation services and **we urge CMS to include the applicable 7<sup>th</sup> characters for “subsequent encounter” in the Presumptive Compliance List 2.** The following example was published in the Fourth Quarter 2013 issue:

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.

As this example indicates, the correct 7<sup>th</sup> character for rehabilitation facilities is “D” for subsequent encounters.

## **IRF AREA WAGE INDEX**

**CMS should align the inpatient PPS data used to calculate the IRF, long-term care hospital (LTCH), and skilled nursing facility (SNF) PPS area wage index (AWI) values for FY 2017.** Currently, the AWIs for the IRF PPS and the other post-acute settings are based on inpatient PPS wage data, without taking into account geographic reclassification. However, the inpatient PPS data used to calculate the IRF AWI is different from those used to calculate the LTCH and SNF AWI values for the same fiscal year. Specifically, the proposed FY 2017 IRF AWI is calculated using the inpatient PPS cost reports that began during FY 2012. In contrast, the inpatient PPS, LTCH PPS, and SNF PPS AWI values proposed for FY 2017 were calculated using inpatient PPS cost reports that began during FY 2013. It is unclear why the IRF AWI calculation is based on older data, relative to the data used for the other payment systems. As the healthcare system moves toward alternative payment models based on longer episodes that cover services provided by more than on care setting, it would be appropriate for CMS to align the AWI methodologies used across the hospital and post-acute payment systems by using the same, most recent inpatient PPS data.

## **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 percentage point reduction to the IRF’s annual market-basket update.

CMS proposes a total of five new measures for the IRF QRP, four of which are proposed to meet the requirements of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014. Four of the measures would be added to the FY 2018 IRF QRP, while one would be added for the FY 2020 program. The IMPACT Act is intended to foster greater standardization and alignment of measures across CMS’s post-acute care quality reporting programs, including the IRF QRP.

## **FY 2018 MEASUREMENT PROPOSALS**

CMS proposes four new measures for the FY 2018 IRF QRP – Medicare spending per beneficiary, discharge to community, potentially preventable readmissions, and a “within stay” IRF readmission measure. All four measures are calculated using Medicare claims data, and do

not require the submission of additional data by IRFs. **While the AHA appreciates that CMS is proposing most of these measures to fulfill its statutory requirements under the IMPACT Act, we believe all four measures need significant improvement prior to their implementation.** We first comment on several issues pertaining to all four measures, then provide measure-specific comments.

#### Overarching Measure Issues.

*Measure Testing.* **The AHA strongly urges that all four measures be tested for reliability and validity, and that full information about measure testing be made publicly available prior to implementation. Furthermore, we urge that the measures undergo field testing with providers – prior to implementation.** The draft measure documents provided on CMS’s website provide a variety of information about the measure cohorts, exclusions and risk adjustment variables that are proposed for the measures. However, the draft specifications provide very limited data that would enable the field to evaluate measure design decisions. For example, there are few descriptive statistics showing the distribution of performance by characteristics like bed size or urban/rural status. There also is a lack of information on the level of statistical significance of the variables chosen for most of the risk adjustment models.

**Given that the measures will be publicly reported, it is imperative that they provide an accurate portrayal of provider performance.** For this reason, CMS must ensure that each measure is fully tested, and that the results of that testing are fully transparent so that all stakeholders have an opportunity to suggest meaningful improvements to the measure. Indeed, these data also would be expected to be submitted as part of the National Quality Forum (NQF) endorsement process, and the AHA strongly recommends that all measures in CMS programs receive NQF endorsement prior to implementation.

**In addition, we recommend CMS conduct a “dry run” in which all IRFs providers are given confidential preview reports of their performance prior to publicly reporting the measure.** CMS has used dry runs in the past – including in its post-acute care quality reporting programs – for new measures so that providers can become familiar with the methodology, understand the measure results, know how well they are performing, and have an opportunity to give CMS feedback on potential technical issues with the measures. Given the relative novelty of all four measures, we believe a dry run would be a crucially important step to enhancing the understanding and credibility of the measures.

*Socioeconomic Adjustment.* **The AHA believes IRF performance on all four measures may be impacted by socioeconomic factors. We strongly urge CMS to assess each measure for the impact of such factors, and incorporate socioeconomic adjustment where necessary.** For example, in submitting the proposed measures for NQF endorsement, the agency could take advantage of the NQF’s socioeconomic adjustment “trial period.” As part of the trial period, NQF is asking for measure developers to conduct a conceptual and empirical analysis of the impact of socioeconomic status on measure performance when measures are submitted for NQF review.

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. For example, in January 2016, the National Academy of Medicine (NAM) released the first in a planned series of reports that identifies “social risk factors” affecting the health outcomes of Medicare beneficiaries and methods to account for these factors in Medicare payment programs. Through a comprehensive review of available literature, the NAM’s expert panel found evidence that a wide variety of social risk factors may influence performance on certain health care outcome measures, such as readmissions, costs and patient experience of care. These community issues are reflected in readily available proxy data on socioeconomic status, such as U.S. Census-derived data on income and education level, and claims-derived data on the proportion of patients dually eligible for Medicare and Medicaid. The agency also recently adopted a policy to provide an “interim” adjustment for sociodemographic factors for several measures in the Medicare Advantage Star Rating program. Yet, to date, CMS has resisted calls to incorporate sociodemographic adjustment into the quality measurement programs for IRFs, hospitals and other providers.

We are concerned that without socioeconomic adjustment, providers caring for poorer and sicker patients will appear to perform worse on some outcome measures than others treating a different patient population. Indeed, measures that fail to adjust for sociodemographic factors when there is a conceptual and empirical relationship between those factors and the measure outcome lack credibility, unfairly portray the performance of providers caring for more complex and challenging patient populations, and may serve to exacerbate health care disparities.

*More Frequent Measure Data.* **We encourage CMS to consider providing measure data to IRFs on a more frequent basis, such as quarterly. We also urge that data be provided at the patient level, as is done with hospital quality reporting programs.** For most of the claims-based measures used in CMS’s programs, the agency gives providers performance data on an annual basis. However, to make effective use of the measures to improve performance, IRFs and other providers need timelier data to understand whether interventions are having an effect. Thus, we encourage the agency to explore the feasibility of more frequent performance reports on all four measures.

Medicare Spending per Beneficiary for IRFs (MSPB-IRF). **The AHA strongly urges CMS to carefully evaluate the MSPB-IRF measure’s clinical risk adjustment approach.** In particular, we are concerned that the measure does not adjust for patient functional status. We believe patient functional status is an important determinant of patient outcomes. 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 on providers to incorporate information from these assessments into the risk model.

**As an interim step to improving risk adjustment, CMS could consider using case mix groups (CMGs) in the risk adjustment model.** The proposed measure uses rehabilitation impairment codes, which are rollups of specific CMGs. However, CMGs provide more granular information about the patient because they are based in part on the clinical characteristics of a

patient. In fact, the CMGs reflect information on patient functional status collected from the IRF-patient assessment instrument (IRF-PAI). We believe the CMGs may provide a more robust way to account for patient characteristics that influence the Medicare spending assessed by the measure.

Lastly, we urge CMS to examine the inclusion of short-stay (i.e., three days or fewer) IRF patients, and determine whether any additional exclusions are warranted. In some cases, the condition of a patient admitted to the IRF may deteriorate quickly as a result of disease progression, and it may be necessary to readmit the patient to a hospital. Under existing CMS rules, IRFs have a three-day period to determine whether patients are appropriate for IRF care. Yet, as currently designed, the measure would include short stay patients. Thus, it may be problematic to attribute the episode costs of those patients to IRFs.

**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 re-hospitalizations 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 the Medicare Payment Advisory Commission 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 should test the measure to ensure it provides an accurate portrayal of performance.

**Potentially Preventable Readmissions (PPRs).** CMS proposes two PPR measures for the FY 2018 IRF QRP – a post-discharge PPR measure, and a “within stay” PPR measure. **The AHA is concerned by the overlap of the proposed post-discharge PPR measure with the existing IRF QRP all-cause readmission measure. We believe using two distinct readmission measures – with results that are likely to differ – will make it confusing for IRFs to track and improve their performance. We urge the agency to implement a single readmission measure in the IRF QRP.** The proposed post-discharge PPR measure assesses the risk-adjusted rate of unplanned PPRs to short-stay acute care hospitals and IRFs in the 30 days after IRF discharge. The measure includes only those patients whose IRF stay was preceded by a “prior proximal” acute care hospital stay in the 30 days prior to IRF admission. However, the proposed measure differs from the all-cause, unplanned readmission previously added to the IRF QRP in that it includes only those readmissions considered to be potentially preventable.

The AHA has long urged that readmissions measurement focus on those readmissions that are truly preventable, and we appreciate the overall intent of the measure. Over time, the PPR measure may prove to be superior to the all-cause readmission measure. However, we urge continued evaluation of the 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 “potential preventable.” However, we encourage CMS to undertake ongoing empirical testing to ensure there is evidence that the codes actually are associated with the identified categories.

**The AHA opposes the adoption of the “within stay” PPR measure for the IRF QRP.** The construction of the measure is similar to the post-discharge PPR measure, except that it assesses PPRs during IRF stays. In the proposed rule, CMS states its belief that using the two proposed PPR measures in tandem is appropriate because it enables the agency “to assess different aspects of care and care coordination.” Whereas the within-stay PPR measure focuses on care provided during the IRF stay, the post-discharge PPR measure “focuses on transitions from the IRF into less intensive settings.” Nevertheless, we are concerned that using multiple readmission measures will lead to confusion, and make it more challenging to track and improve performance. We also note that the measure is not required by the IMPACT Act.

**Lastly, the AHA urges CMS to review the various readmission measures used across its post-acute measurement programs to ensure they create consistent improvement incentives across the system.** We note that the QRPs for IRFs, long-term care hospitals (LTCHs) and home health agencies, as well as the skilled-nursing facility (SNF) value-based purchasing (VBP) and SNF QRP programs, all include finalized or proposed readmission measures. While the basic construction of the measures is similar, there are some important differences. For example, while CMS has proposed post-discharge PPR measures for IRFs, LTCHs and SNFs, the agency uses a readmission measure in the SNF VBP that assesses readmissions in the 30 days following acute care hospital discharge. As stated previously, the agency also has proposed a “within stay” readmission measure for IRFs. Yet to date, there has not been an assessment of whether the differences in measurement across these providers facilitate readmission reduction efforts. Given the value and importance of readmission reduction, we encourage CMS to work with post-acute care providers, hospitals and other stakeholders to evaluate whether the readmission measurement is being structured in a way that helps, and not hinders, effective collaboration.

## **FY 2020 MEASUREMENT PROPOSAL**

Drug Regimen Review with Follow up on Clinically Significant Issues. **The AHA urges CMS to provide a more specific definition of “clinically significant issues” in the drug regimen review measure. We are concerned that a lack of this specific definition will make it challenging to collect reliable and accurate measure data.** The proposed measure assesses the percentage of IRF stays for which all of the following things are true:

- Drug regimen review was conducted at the time of admission;
- *For clinically significant issues identified at admission*, the IRF contacted a physician (or physician-designee) by midnight of the next calendar day and completed prescribed/recommended actions in response to the identified issues; and
- *For other issues identified during IRF stay*, the facility contacted a physician (or physician-designee) and completed prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified.



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To report the measure, IRFs would be expected to complete three items on the IRF-PAI that reflect the above activities. However, the items themselves provide no specific indication of what issues may be considered clinically significant. The measure specifications provided by CMS also do not concretely define a “clinically significant” drug issue. Without these definitions, there are likely to be variations in measure performance that are not based on differences in care, but rather on differences in data collection.

We thank you for the opportunity to comment on this proposed rule. If you have any questions concerning our comments, please feel free to contact Rochelle Archuleta, director for policy, at [rarchuleta@aha.org](mailto:rarchuleta@aha.org), regarding the 60% Rule comments, or Akin Demehin, senior associate director, regarding the quality-related comments, at [ademehin@aha.org](mailto:ademehin@aha.org).

Sincerely,

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Executive Vice President