AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

May 31, 2024

Submitted electronically via [2024-Measure-Set-Review-Measures-for-Public-Comment website]

Re: Partnership for Quality Measurement (PQM) Measure Set Review (MSR) Public Comment opportunity to consider measures for removal from Centers for Medicare & Medicaid Services (CMS) quality programs.

The American Medical Rehabilitation Providers Association (AMRPA) appreciates the opportunity to submit comments on the **PQM MSR list of measures under consideration for removal from CMS quality programs**. AMRPA is the national trade association representing more than 700 freestanding inpatient rehabilitation facilities and rehabilitation units of acute-care general hospitals (IRFs).[1] The vast majority of our members are Medicare participating providers with quality measure information publicly reported on the CMS Care Compare website. AMRPA has always looked to be a partner to regulating agencies and other key quality stakeholders in promoting meaningful and effective quality reporting in the IRF program, and we look forward to continuing this type of partnership with Battelle and the PQM moving forward.

AMRPA recognizes the importance of a consensus-based entity (CBE) and the processes "to inform the selection and removal of health care quality and efficiency measures, respectively, for use in the Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS) Medicare quality programs". AMRPA believes that the PQM MSR process is essential and must facilitate an effective identification and removal of quality measures that are administratively burdensome, do not distinguish high-quality care in and among IRFs, or do not result in better patient outcomes. AMRPA stands ready to work with the PQM in the next PQM MSR cycle and ensure that the PQM has sufficient information to remove existing IRF QRP measures that create unnecessary administrative burden for IRFs and their patients without delivering meaningful information to patients or policymakers.

AMRPA offers the following comments on the list of measures up for removal and provide suggestions for alternative/replacement measures listed in the 2024 Measure Set Review List.

[1] Inpatient rehabilitation facilities (IRFs) – both freestanding and units located within acute-care hospitals – are fully licensed hospitals that must meet Medicare Hospital Conditions of Participation (COPs) and provide hospital-level care to high acuity patients. IRFs' physician-led care, competencies, equipment and infection control protocols are just some of the features that distinguish the hospital-level care provided by IRFs from most other PAC providers.

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1. **PQM Should Finalize the MSR List with the Two Current 2 IRF QRP Measures**

The initial MSR list of measures up for removal includes 34 measures. There are two measures from the IRF QRP that are currently included on this list:

- *29. (00575-01-C-IRFQR) Potentially Preventable 30-Day Post-Discharge Readmission Measure for Inpatient Rehabilitation Facility Quality Reporting Program*

- *30. (00576-01-C-IRFQR) Potentially Preventable Within Stay Readmission Measure for Inpatient Rehabilitation Facility Quality Reporting Program*

AMRPA supports the inclusion of these measures in the initial list of measures up for removal from the IRF QRP. While AMRPA members support the need for readmission measures as part of measuring the quality of care provided by IRFs, these two existing measures of readmission have been identified by AMRPA members as having the following issues that support their removal from the IRF QRP:

A. The measure is not timely or representative of the quality of care currently provided by IRFs.

When these measures are publicly reported, the information included in the measure is from a period of time that is 2-4 years old. For instance, the March 2024 update of Care Compare for these measures included data on discharges between October 1, 2020 through September 30, 2022. This period of time includes the COVID-19 Public Health Emergency (PHE), where healthcare services and practices were significantly altered and potentially produced performance on these quality measures that is not representative of current practices post-PHE. Consumers of this information (such as patients, caregivers, providers, and payers) should be provided with as close to real-time information as possible as they evaluate and coordinate care for themselves or their loved ones. Because of the delay of reporting information and the fact that this data does not represent the current quality of care provided at IRFs, these measures should be considered for removal from the IRF QRP.

B. The 2-year period of data limits the opportunities for IRFs to report changes in performance.

Not only is the information for these measures not timely, but the amount of data included in these measures limits the ability to display changes in performance (both positive and negative). Because these measures include 2-years of data, IRFs may not see any significant changes in performance for quite some time. Any change in quarterly performance can be mitigated by the performance from the prior 7 quarters of information, and even a year of improved performance may be offset by the prior year of lower performance. These measures need to allow the ability to display changes in performance to allow patients, caregivers,

providers, and payers the opportunity to effectively evaluate and coordinate care. Performance over a 2-year period limits the ability to evaluate more recent performance and make informed decisions on care based on such performance changes, and these measures should be removed in favor of measures that accurately represent changes in performance.

C. IRFs are unable to obtain the information necessary to manage performance.

CMS does not provide IRFs with patient-level data on these measures, limiting the opportunity to identify factors impacting performance or refute the values that are being publicly reported. How can an IRF change their performance on these measures when they are not provided any information on which patients were readmitted nor any additional information about the readmission? Quality measures are intended to allow for the ability to improve performance resulting in better patient outcomes; however, without any information on these measures, IRFs cannot initiate performance improvement plans or identify risk-factors for potential readmission. Unless or until CMS can provide patient-level information on these measures, we believe these measures should be removed from the IRF QRP.

D. The public reporting of these measures can lead to negative unintended consequences other than patient harm.

As noted previously, quality measure information is publicly reported and used by patients, caregivers, providers, and payers when making care decisions. Because these measures do not provide current performance, limit the ability to show changes in performance, and do not provide IRFs with information to improve performance, the values publicly displayed on Care Compare can negatively influence care decisions - especially if these measures are used in discharge planning processes, referrals, or prior authorization determinations. These circumstances negatively impact all interested parties who may utilize these quality measures for making care determinations, and should result in these measures being removed from the IRF QRP.

AMRPA urges PQM to ensure that these measures remain on the MSR list of measures considered for removal from the IRF QRP, and that each of the factors for removal we have noted in our comments are included in the discussion and ultimate rationale for removal.

2. **PQM Should Consider Additional IRF QRP Measures on the MSR List of Measures to be Considered for Removal.**

As part of the AMRPA Policy Priorities for 2024, the AMRPA Quality of Care Committee was tasked with seeking to alleviate administrative burden through the review and removal of existing IRF QRP measures. As part of this effort, we recently conducted a survey of AMRPA Quality of Care Committee members to identify measures they believe should be removed from the IRF QRP, as well as providing one or more of the CMS-specified reasons for measure removal (as defined at 42 CFR § 412.634(b)(2)) for any measure suggested for removal. The results of this survey unanimously identified two measures for removal, and we would like to include these two measures for consideration of inclusion on the MSR list.

A. COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date [CMIT Measure ID #01699 (not endorsed)]

This measure is not currently implemented as data collection will begin October 1, 2024. Once implemented, this measure will be displayed on Care Compare as the facility-level observed percentage of patients recorded on the IRF-PAI as being identified as up to date with their COVID-19 vaccinations. No risk-adjustment methodology is included with this measure.

The AMRPA Quality of Care Committee survey identified three CMS-specified reasons for measure removal:

a. <u>Performance or improvement on a measure does not result in better patient outcomes</u>.

While AMRPA supports COVID-19 vaccinations for patients at risk of severe illness, hospitalization and death from COVID-19, no research or studies are available to suggest that a higher percentage of vaccinated patients results in better patient outcomes, or conversely that a lower percentage of vaccinated patients results in worse patient outcomes. Vaccination rates for both COVID-19 and Influenza vary significantly across the country and have not been shown to correlate with any other IRF quality measures attributable to patient outcomes. Accordingly, we believe that this measure should be removed from the IRF QRP.

b. <u>The costs associated with a measure outweigh the benefit of its continued use in the program</u>.

The administrative burden for IRFs to capture this information for every patient can be significant, as an IRF patient may not know what the current up-to-date status for this vaccination is, nor be able to recall when their last vaccination occurred. This information is not currently required

as part of any pre-admission screening and may not be a part of any required transfer of information from one provider to the next. For patients unable to respond, the efforts to obtain this information from alternative sources could require a significant amount of time and resources. Additionally, the reliability and validity of this measure could be questioned without any validation of the patient response against actual CDC vaccination records. With little to no benefit associated with the performance of this measure, the costs and administrative burden are unnecessary and should result in this measure being removed from the IRF QRP.

c. A measure does not align with current clinical guidelines or practice.

Once the COVID-19 PHE ended, numerous employment and related requirements for COVID-19 vaccination ended. Additionally, some states legislatively removed the requirement for patients to report their vaccination status or for any reporting of COVID-19 vaccinations. Because of the variations in state-level requirements and clinical practices, the measure should not be utilized to measure the quality of care and should not be included in the IRF QRP.

For the reasons noted, we respectfully ask that PQM consider adding the COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date [CMIT Measure ID #01699 (not endorsed)] to the MSR list for consideration of removal from the IRF QRP.

B. COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) [CMIT Measure ID #00180 (not endorsed)]

This measure identifies the percentage of HCP eligible to work in the IRF setting for at least one day during the reporting period, excluding HCP with contraindications to the COVID-19 vaccine, who are considered up to date, regardless of clinical responsibility or patient contact.

Like the COVID-19 Vaccination Status measure for patients, the AMRPA Quality of Care Committee survey identified the same three CMS-specified reasons for measure removal:

a. Performance or improvement on a measure does not result in better patient outcomes.

While AMRPA supports COVID-19 vaccinations for HCP at risk of severe illness, hospitalization and death from COVID-19, no research or studies are available to suggest that a higher percentage of vaccinated HCP results in better patient outcomes, or conversely that a lower

percentage of vaccinated HCP results in worse patient outcomes. Vaccination rates for both COVID-19 and Influenza vary significantly across the country and have not been shown to correlate with any other quality measures attributable to patient outcomes. Accordingly, we believe that this measure should be removed from the IRF QRP.

b. The costs associated with a measure outweigh the benefit of its continued use in the program.

The administrative burden for IRFs to capture this information for every HCP is significant. First, IRFs need to make sure to collect and report information for any HCP that may be present for at least one day in the IRF. This would include non-clinical staff, contract workers and consultants. This requires a significant amount of administrative burden also can impact staffing determinations. Second, IRFs must stay informed of the current requirements for the up-to-date status for this vaccination, and update vaccination information for each HCP when the requirements change. The need to continually evaluate all the HCP against updated requirements makes the monthly reporting requiring increasingly burdensome – particularly given staffing turnover and increased use of contract labor within IRFs and across the healthcare system. Finally, the CDC NHSN reporting system has been significantly challenging and has resulted in 2% payment penalties for some IRFs who have had technical issues with the system or infection control staffing turnover. The CDC NHSN system also provides very limited information to verify that the information has been entered correctly and attributed to the proper facility, often requiring IRFs to go through a reconsideration process to avoid a 2% payment penalty. With little to no benefit associated with the performance of this measure, the costs and administrative burden are unnecessary and should result in this measure being removed from the IRF QRP.

c. A measure does not align with current clinical guidelines or practice.

As stated with the patient measure, once the COVID-19 PHE ended, numerous employment and related requirements for COVID-19 vaccination ended. Additionally, some states legislatively removed the requirement for patients to report their vaccination status or for any reporting of COVID-19 vaccinations. Because of the variations in state-level requirements and clinical practices, the measure should not be utilized to measure the quality of care and should not be included in the IRF QRP.

For the reasons noted, we respectfully ask that PQM consider adding the COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) [CMIT Measure ID

#00180 (not endorsed)] to the MSR list for consideration of removal from the IRF QRP.

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AMRPA thanks Battelle and the PQM for allowing us the opportunity to provide feedback on the Partnership for Quality Measurement (PQM) Measure Set Review (MSR) list of measures under consideration for removal from the CMS QRPs. In sum, AMRPA supports the PQM MSR process and urges PQM to include the IRF QRP measures currently identified in the MSR list as well as the additional ones we have included in our comments. AMRPA stands ready to work with Battelle and the PQM to help ensure meaningful quality measures continue to be considered for use in CMS quality programs.

Should you wish to discuss these comments further, please contact Troy Hillman, AMRPA Director of Quality and Health Policy (thillman@amrpa.org / (202) 207-1129) or Kate Beller, JD, AMRPA President (kbeller@amrpa.org / 202-207-1132).

Sincerely,

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