GUNDERSEN
HEALTH SYSTEM®

April 4, 2022

Centers for Medicare & Medicaid Services,
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Attention: CMS–10036
7500 Security Boulevard
Baltimore, MD 21244–8016.

Re: Comments in response to CMS–10036: Proposed Collection; Comment Request Regarding Inpatient Rehabilitation Facility Quality Reporting Program Requirements

Dear Administrator Brooks-LaSure:

On behalf of Gundersen Health System, we are writing in response to the request for comments on the Inpatient Rehabilitation Facility Quality Reporting Program and Requirements that are set to begin this year. We appreciate the administration's commitment to reducing regulatory barriers to providing patient and community care and are looking forward to sharing our comments and outlook on CMS's proposals.

Gundersen Health System is an integrated health system providing services throughout nineteen counties in western Wisconsin, southeastern Minnesota, and northeastern Iowa. Our system includes a primary hospital in La Crosse, six critical access hospitals, and over 70 clinics. With over 8,000 employees, we are the largest employer in the region. We are committed to supporting public policy that helps to enrich every life through improved community health, outstanding experience of care, and decreased cost burden. We believe public policy should be a contributor to improving population health.

We are pleased to offer additional comments for the IRF QRP and SPADES measures detailed in the following section.

Revised Compliance Date for Certain Reporting Requirements Adopted for Inpatient Rehabilitation Facility (IRF) QRP

CMS finalized measures for the IRF-PAI and SPADES measures to go into effect in FY 2021. However, due to the PHE, they were postponed until one year after the PHE ended. In the Home Health proposed rule, CMS is revising this stance to move the compliance date to October 1, 2022.

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Comments

The adoption of the IRF-PAI v 4.0 and reporting date for new SPADEs and TOH measures should continue to be delayed until October 1, 2023, or one full fiscal year after the PHE ends. We do not agree with CMS's reasoning that IRFs are prepared to undergo the necessary training and implementation steps to adopt these new standards.

Unfortunately, due to the COVID-19 pandemic, healthcare providers are facing staffing shortages at all levels of care creating severe limitations in moving patients from Acute Hospitals to all PAC settings. There are staff shortages in Nursing, Nursing Assistants, Housekeeping, Dietary, Information Systems, and many more departments all impacting direct patient care.

In a multitude of healthcare systems, there is a severe Information Systems backlog of work in addition to staff shortages. Precipitated by the PHE, it was essential for Gundersen's Information Systems Department to divert routine work to rapidly adjust to meet patient care needs virtually and develop new and improved virtual platforms. This serves to backlog other routine work which is unfortunate, but necessary. The IS department is likewise burdened with staff shortages further exacerbating the challenges the healthcare system is facing. The implementation of the IRF PAI 4.0 will be a burdensome and time-consuming process and would pull critical IS staffing away from other essential work impacting direct patient care needs.

As CMS suggests, training and education of clinical staff will be necessary for the implementation of the IRF PAI 4.0 and ensuring staff can understand, assess, and document multiple added areas that are expected to be completed. As we mentioned, Gundersen and other healthcare providers are facing significant staffing shortages. We find it unrealistic for CMS to expect that we can pull staff away from direct patient care shifts for training and education to new elements of the IRF PAI. Additionally, we have yet to see education and training materials on the IRF PAI to be released. There are several new areas and if there is not standardized training and education to staff there will be wide variation on how that data is collected.

Training of staff needs to be completed well in advance of October 1st as implementation of the tool is set to be for *Discharges* on or after October 1, 2022. Documentation and data collection will need to be implemented well in advance of that date for patients that may have a longer length of stay, such as 6 weeks or longer prior to the October 1st date.

With the unpredictability of COVID-19 and the variant strains, we need to ensure that all staff are available for any upcoming surges. Staff are currently suffering from the ongoing trauma of dealing with a pandemic that has created an exodus of staff leaving the healthcare field altogether, further exacerbating workforce shortages. CMS must minimize administrative and reporting requirements to the greatest extent possible until providers are able to recover from the pandemic's effects.

Lastly, we do not believe that implementing this assessment would encourage patient-centered care. The assessment details more of a blanket requirement for all patients regardless of medical,

physical, cognitive, or social needs. The unintended consequence of this "check-the-box" provision of care is that it takes away time from more individualized care needs. Therefore, many of the provisions would be meaningless for the patient and their needs. Several data points are required at both admission and discharge even if only a few days apart and some data is unlikely to change from one point in time to another given shorter lengths of stay. Yet completing this assessment takes valuable time away from more pressing care needs. This is especially true as Post-Acute Care settings can vary in the structure of care and care provisions. Therefore, requiring the same onerous data collection for a patient in an IRF *and* a long-term care patient living in a skilled nursing facility is often redundant and does not produce the same need or quality of data.

Overall, we do not have the administrative capacity to incorporate updated assessments at this time and disagree with CMS's determination that this is feasible. We implore CMS to make improvements to the IRF PAI assessment instrument to reduce the burden on providers once it does take effect. Below we have provided several recommendations for consideration:

- We recommend CMS provide IRF's flexibility in SPADE collection to reduce reporting burden and regulatory duplication.
- We ask that CMS find alternative routes of gathering data such as in IRF PAI Sections N Medications and Section O Special Treatments, Procedures, and Programs. CMS should already have access to this data by way of Coding/Billing without burdening direct patient care staff with duplicating this information to complete the IRF PAI.
- We ask that CMS remove the expectation for re-assessing items at discharge when the likelihood of the information changing during a short hospital stay is unlikely. Areas included in this could include Transportation, Health Literacy, BIMS, CAM, PHQ, Special Treatments, Procedures, and Programs.
- We ask CMS how this data will be used to improve the quality of care. Will it contribute to establishing a payment methodology or provide opportunity for marked improvement in care?
- The blanket approach to data collection across all PAC settings, does little to support a patient-centered care approach. A blanket approach means you are either over-assessing or under-assessing at any given circumstance. Over or under generalizing what is important or relevant for a patient's care needs is neither patient-centered nor efficient and increases the cost of care by applying non-relevant measures in a blanket approach when it should not be applicable. Providing the flexibility to apply measures that are relevant to a patient's individual care, not arbitrarily, would be a much more meaningful approach to Quality Care.

Conclusion

On behalf of Gundersen Health System, we appreciate the opportunity to comment on this proposed rule. We strongly support an improved value-based healthcare delivery system and appreciate efforts by CMS to achieve these goals. Please consider our comments as we work together to improve healthcare delivery in a thoughtful and evidence-based manner. If we can provide any other assistance, or if you have any questions, please feel free to contact us anytime.

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Sincerely,

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