AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

November 30, 2023

SUBMITTED ELECTRONICALLY

Mr. Ben Harder
Managing Editor and Chief of Health Analysis
U.S. News & World Report

Ms. Sarah Lessem
Project Director
Best Hospitals Project
RTI International

Re: U.S. News 2023-2024 Rehabilitation Hospital Ranking Methodology

Dear Mr. Harder and Ms. Lessem,

On behalf of the American Medical Rehabilitation Providers Association (AMRPA), we appreciate the opportunity to provide comments and recommendations to U.S. News and World Report (USNWR) and RTI International regarding the USNWR 2024-2025 rehabilitation hospital rankings. AMRPA is the national voluntary trade association representing more than 700 inpatient rehabilitation hospitals and unit members (referred to by policymakers as inpatient rehabilitation facilities, or IRFs). Given our members' specialized focus on complex conditions such as stroke, traumatic brain injury, and traumatic spinal cord injury (among others), AMRPA believes that an effective rankings system provides a vital resource to patients and their caregivers when making post-acute care decisions. For those reasons, AMRPA appreciates our longstanding engagement with the USNWR and RTI teams to refine and continually modernize the rehabilitation rankings system, and we strongly support your efforts to incorporate more objective data into the hospital rankings methodology as part of this undertaking.

This year, our comments are particularly focused on ways to ensure that the methodology reflects the specialized services provided by our IRF members, including with respect to the way that patient outcomes, services, and expert opinion are accounted for in the rankings formula. While we urge USNWR and RTI International to incorporate most of our recommendations in next year's rankings formula, other suggested refinements will likely require longer-term collaboration between rehabilitation stakeholders and your team (e.g., the potential development of a more representative expert opinion survey). We look forward to continued engagement on both the near-term and longer-term refinements to the rehabilitation rankings methodology to ensure this tool provides the most relevant information for patients and providers alike. Our key recommendations follow:

- We applaud USNWR for its responsiveness to past AMRPA recommendations to decrease the weight accorded to expert opinion rankings, including a significant drop (from 50% to 30%) in the most recent rankings year. Given the impact of this year-to-year change, we encourage USNWR to either hold this measure at 30% or, at most, provide a more modest reduction in the

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next rankings year to allow stakeholders to fully assess the impact of the current measure weight.

- At the same time, we encourage USNWR to consider changes to the way in which expert opinion is captured. As a long-term recommendation, we encourage USNWR to work with rehabilitation stakeholders (such as AMRPA and/or the American Academy of Physical Medicine and Rehabilitation) to develop a survey that is more accessible and representative of rehabilitation physicians with knowledge of high-quality IRF providers. As another consideration, AMRPA asks USNWR to only consider survey responses with those physicians whose specialty is most aligned with the care provided at most inpatient rehabilitation hospitals and who can meaningfully assess quality across IRFs' care and outcomes.
- Furthermore, we urge USNWR to ensure that the expert opinion survey represents a statistically valid sample of physician surveyors. AMRPA continues to have concern about number of physicians who take part in the survey (relative to the field at large), and we ask USNWR to find ways to increase the survey completion rates and establish a minimum threshold for respondents. In the interest of transparency, we also ask USNWR to publish the number of surveys on which the expert opinion is based.
- AMRPA strongly supports USNWR's recent decision to add three conditions to those that count toward the volume measure (with non-traumatic brain injury, non-traumatic spinal cord injury, and neurologic), and urges USNWR to increase the weight of this measure to accord appropriate weights to each of the six conditions.
- AMRPA is concerned that the outcomes measures are not representative of IRFs' current performance by the time they are utilized for the rankings. While we recognize the limitations of the publicly reported claims-based measures, we encourage USNWR to identify other outcome measures that are based upon periods of time that are more concurrent with the rankings year or are consistent in timing with the other measures utilized in the rankings. As we detail below, we also encourage USNWR to ensure that any current and new measures in the outcomes domain are appropriately risk adjusted to account for the IRF patient population, as well as the COVID-era data that will be reflected in upcoming rankings years.
- AMRPA reiterates our past recommendation that USNWR increase the weight accorded to the accreditation and model systems measures, and consider a broader range of accreditation metrics (e.g., accreditation for specialty programs).
- AMRPA reiterates our past opposition to the 5% weight currently accorded to the influenza healthcare personnel vaccination measure. While we continue to believe that this measure does not meaningfully reflect the quality of a rehabilitation hospital, we also urge USNWR to be particularly mindful of the challenges that providers in certain states face with respect to staff-focused vaccination requirements. As an alternative, we encourage USNWR to consider measures that more effectively capture a rehabilitation hospital's patient safety-focused performance, such as hospital-acquired infection rates, rates of pressure ulcers, and the number of patients who experience one or more falls with major injury during their IRF stay.
- Finally, AMRPA would like to engage with USNWR and policymakers in the future to find ways to better incorporate patients' social determinants of health and hospitals' commitment to health equity into the methodology. Such measures could include, for example, total charity beds, Medicaid mix, and measures reflecting patients' access to food and transportation. In the future, USNWR could also consider ways to capture IRF programs that integrate patients back into their communities, such as adaptive sports programs.

We offer our more detailed recommended refinements below:

Expert Opinion – Weight & Survey Representativeness
AMRPA continues to support USNWR's efforts to incorporate more objective and hospital-reported data into its methodology and move away from its approach of basing a hospital's score fully on its reputational measure. We also appreciated USNWR's responsiveness to past AMRPA recommendations regarding the need for a gradual transition away from the 100% expert opinion weight in order to ensure that the new objective measures and weights did not produce skewed or unintended consequences. For those reasons, AMRPA supported USNWR's decision to weigh expert opinion at 50% of a hospital's score during the early methodology transition period, and its most recent decision to weigh expert opinion at 30% during the current ranking year.

We understand that USNWR ultimately aims to reduce the expert opinion weight for inpatient rehabilitation providers to the same level as similar providers, such as cardiology and neurology (approximately 12-15%). While AMRPA supports that goal in the long term, we encourage USNWR to maintain the expert opinion weight for the next rankings year. Given the significant one-year change in this weight (a 20% reduction), we believe that holding the opinion at its current weight (or, at most, a more modest year-to-year reduction) will give both USNWR and IRF stakeholders the chance to fully assess the impact of this change and identify the most appropriate measures that should receive a correspondingly greater weight.

In addition, we believe a more moderate weight change will allow USNWR to make necessary refinements to the way in which it collects this data. First, we recommend that the future iterations of the survey be more limited with respect to the respondents, with appropriate emphasis on physical medicine and rehabilitation physicians. We encourage USNWR (as well as Doximity) to explore more nuanced ways of identifying other appropriately surveyed physicians, such as those physicians who focus on adaptive sports after catastrophic injury. Our recommendation – which we assume aligns with USNWR's goal - is to ensure that any surveyed physician can meaningfully attest to the care and quality provided at IRFs across the nation. We would appreciate the chance to discuss this recommendation in greater depth.

AMRPA members have also raised concerns related to the transparency and representativeness of the survey. In the most recent methodology document, it was noted that the overall survey response rate for Rehabilitation was 10.0%, with response rate by region higher for Northeast (13.8%) and Midwest (12.0%) and lower for West (8.3%) and South (7.2%). Having the expert opinion as a prominent measure of the USNWR Rehabilitation rankings should require that results are based upon a statistically valid and representative sample of responses to remove any perceived bias from the limited responses. AMRPA therefore recommends that USNWR require a minimal threshold of responses for each region and an overall completion threshold (such as 25%). We also encourage USNWR to publish more detailed data about how many physicians participate and the hospitals with which they are affiliated.

Lastly, AMRPA would like to repeat our past recommendation that USNWR work with AMRPA and other stakeholders to develop an alternative survey mechanism (for example, initiating a new type of collaborative surveying effort between U.S. News and the American Academy of Physical Medicine and Rehabilitation (AAPM&R)). We believe that this type of effort could result in both a higher

volume of surveyed physicians and a more representative population for the IRF-specific rankings methodology.

In sum, AMRPA recommends that (1) USNWR maintain (or, at most, more moderately reduce) the expert opinion measure in next year's methodology; (2) ensure that only physicians who can meaningfully attest to the care and quality of hospital providers in the IRF field be counted as surveyors; and (3) as a precursor to any significant reduction in the expert opinion weight in the future, USNWR should improve transparency regarding the survey respondents and undertake efforts to ensure that the respondent pool is higher volume and has a sufficient response rate.

Patient Volume

AMRPA continues to support patient volume as an important component of USNWR's ranking methodology. We particularly appreciate USNWR's partnership with both AMRPA and eRehabData® as part of the effort to capture all-payer data for certain conditions. As AMRPA has discussed with USNWR in the past, we believe that all-payer data sharing provides a more comprehensive assessment of a hospital's experience and expertise in treating certain conditions, especially those conditions with considerable rates of non-Medicare patients (e.g., traumatic brain injury).

AMRPA also appreciates that USNWR added non-traumatic brain injury, non-traumatic spinal cord injury, and neurological conditions to the rankings, consistent with our past recommendations. We believe the six different condition groupings of patients now show the broad scope of underlying conditions for which IRF providers deliver exceptional outcomes for patients. Given these improvements to the volume measure, AMRPA and its members would like to see the weight for patient volume increase overall (particularly as the expert opinion weight drops), and equal weight accorded to each condition.

Outcomes Data

AMRPA appreciates the increased weight accorded to outcomes measures. AMRPA strongly believes that the strong outcome data affiliated with IRFs are representative of the physician-led, hospital-level, interdisciplinary care and intensive therapy of inpatient rehabilitation, and distinguishes IRFs from other post-acute care settings. While AMRPA supports increasing the weight of outcomes in the USNWR Rehabilitation rankings for these reasons, we are concerned that the existing outcome measures are not capturing IRFs' recent performance or improvements (relative to the rankings year). The three measures currently included in the USNWR Rehabilitation rankings are claims-based measures, which utilize two years of claims data from a time period ending over a year and a half prior to the publication of the rankings. Both the two-year period and the outdated nature of these measures allow little opportunity to show meaningful improvements. For these reasons, AMRPA encourages USNWR to identify other outcome measures that are based upon periods of time that are more current or are consistent in timing with the other measures utilized in the rankings. We urge USNWR to consider increasing the weight for this measure once more current performance metrics are identified and such measures are determined to be appropriately risk-adjusted. Quality leaders from within the Association stand ready to assist USNWR as it considers its approach to risk adjustment in both the IRF and other specialty rankings systems.

We also reiterate our past suggestion that USNWR be mindful of the different datasets that apply to IRFs and long-term care hospitals (LTCHs) for the current outcome measures on Care Compare, and ensure that each type of hospital is fairly and equally compared among peers if they continue to be included in the same methodology.

Finally, we encourage USNWR to ensure that any current and new measures in the outcomes domain are appropriately risk-adjusted to account for the IRF patient population. We also ask the USNWR team to take appropriate steps to account for the COVID-era impacts that will be reflected in Care Compare data for the 2024-2025 rankings year (when providers were still adjusting to shifts in referrals and patient acuity stemming from the public health emergency).

Accreditation-Focused Measures
AMRPA supports CARF International accreditation as a measure that should continue to be part of USNWR's ranking methodology, and we believe it should be given more weight as other measures are scaled back. AMRPA would welcome the opportunity to discuss how to expand the accreditation measure if USNWR increases its weight, such as through the incorporation of condition-specific accreditation programs.

As a procedural matter, we urge U.S. News to capture this data from CARF International itself, rather than through an intermediary source (as U.S. News currently does through the AHA Annual Survey data). AMRPA is aware that CARF International has questioned the accuracy of how this data is reported on AHA Annual Surveys, and AMRPA would be willing to work with U.S. News to provide the most accurate and current information for both CARF accreditation and any specialty accreditations added to this measure.

Model System Measure
Similar to the accreditation measure, AMRPA strongly supports the inclusion of a Model System Centers-focused measure in the IRF ranking methodology. As USNWR evaluates modifications to the weights for accreditation measures, we believe that the Model System Center measure also deserves equal or enhanced representation in the weighting.

Vaccination Measures
AMRPA reiterates our past recommendation that USNWR fully remove the influenza vaccination from its ranking methodology. We believe that the current measure receives a disproportionately high weight (5%) given that the measure does not meaningfully distinguish providers, nor does it provide patients with particularly relevant information when selecting an IRF. We believe the weight accorded to this measure would be far more appropriately assigned to the measures addressed above. In the alternative, AMRPA believes there are numerous measures that more meaningfully reflect a hospital's commitment to patient safety (which is how the influenza measure is categorized in the methodology). These measures may include, for example, hospital-acquired infection rates and the number of patients who experience one or more falls with major injury during their IRF stay, as well as other relevant data (such as rates of pressure ulcers) reported on Care Compare.

Potential Future Refinements to the Methodology
AMRPA supports USNWR's commitment to continually refining the methodology to reflect the most important measures for IRF patients and providers. As part of this effort, AMRPA would like to

engage with USNWR and policymakers in the future to find ways to better incorporate patients' social determinants of health (SDOH) and hospitals' commitment to health equity into the methodology, such as exploring ways to capture charity beds, Medicaid mix, and measures reflecting patients' access to food and transportation. CMS has initiated the data collection, reporting, and analysis of some SDOH measures, and AMRPA believes that USNWR should look at enhancing the rankings with factors related to health equity. In the future, USNWR could also consider ways to capture IRF programs that integrate patients back into their communities, such as adaptive sports programs.

We would welcome the opportunity to discuss these concepts with USWNR as part of our continued partnership and shared interest in modernizing the inpatient rehabilitation hospital and unit ranking methodology.

Process-Related Recommendations
AMRPA members recommend that they be able to see their ranking/performance scores prior to the final release, such as at the quarterly or midyear mark. Given the increasing sophistication and complexity of USNWR's scoring, members would appreciate the chance to verify their scores and have more time to potentially improve their performance during the ranking year.

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AMRPA greatly appreciates the opportunity to provide input on U.S. News' methodology for 2024-2025, and also looks forward to serving as a resource as U.S. News contemplates further changes in future performance years. If you have any questions, please do not hesitate to reach out to Kate Beller, AMRPA Executive Vice President for Policy Development and Government Relations, at kbeller@amrpa.org and Troy Hillman, AMRPA Director of Quality and Health Policy, at thillman@amrpa.org.

Sincerely,

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