CALIFORNIA HOSPITAL ASSOCIATION
Providing Leadership in Health Policy and Advocacy

June 7, 2021

Chiquita Brooks La-Sure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

SUBJECT: CMS-1748-P, Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2022 and Updates to the IRF Quality Reporting Program; Proposed Rule, Federal Register (Vol. 86, No. 68), April 12, 2021

Dear Administrator Brooks-LaSure:

On behalf of our more than 400 member hospitals and health systems, including approximately 80 inpatient rehabilitation facilities (IRFs), the California Hospital Association (CHA) is pleased to submit comments on the Centers for Medicare & Medicaid Services (CMS) IRF prospective payment system (PPS) proposed rule for federal fiscal year (FFY) 2022.

California's IRFs have been significantly impacted by the COVID-19 public health emergency (PHE), and we appreciate CMS' efforts to address that impact in its payment and quality programs, as well as its strong commitment to improving health equity. CHA offers the following comments on specific proposals.

UPDATE TO PAYMENTS FOR HIGH-COST OUTLIERS AND CASE MIX GROUP WEIGHTS

CMS proposes to use FFY 2020 claims data to calculate the fixed loss outlier threshold and Case Mix Group (CMG) weights for FFY 2022. As a result of using FFY 2020 data, CMS proposes to increase the fixed loss outlier threshold from $7,906 for FFY 2021 to $9,192 for FFY 2022 to maintain estimated outlier payments at approximately 3% of total estimated aggregate IRF payments for FFY 2022. While the proposed rule states the agency considered using FFY 2019 claims data to mitigate the effects of COVID-19, it ultimately did not, as this would be contrary to CMS' long-standing practice to use the most recent vintage of available claims data. Additionally, the FFY 2019 data do not reflect any of the changes to the CMG definitions or the data used to classify IRF patients into CMGs that became effective in FFY 2020.

However, in the proposed rule CMS does not provide adequate support for its assertion that it is appropriate to use the FFY 2020 data to establish CMG weights and the outlier threshold. The proposed rule provides no commentary on whether the patient mix or utilization trends in the FFY 2020 IRF claims data have been impacted by the COVID-19 pandemic or are comparable to utilization patterns in the FFY 2019 data — and, therefore, more likely to approximate "normal" utilization as is anticipated

in FFY 2022. CHA assumes that IRF utilization, as in other settings, would be aberrant relative to normal conditions, given the national moratorium on non-emergent services in March and April, local moratoriums throughout the year in COVID-19 "hot spots," and a general decline in acute inpatient admissions for non-COVID-19-related care.

Therefore, using FFY 2020 claims data will inappropriately skew both the CMG weights and the calculation of the outlier threshold to reflect utilization trends that the agency does not believe will exist in FFY 2020. This assumption is supported by commentary in the FFY 2022 inpatient prospective payment system (IPPS) proposed rule. To support its use of FFY 2019 data, the agency states:

> *With respect to inpatient utilization in FY 2020, we believe that COVID-19 and the risk of disease were drivers of the different utilization patterns observed. Therefore, the continuing rapid increase in vaccinations coupled with the overall effectiveness of the vaccines leads us to conclude based on the information available to us at this time that there will be significantly lower risk of COVID-19 in FY 2022 and fewer hospitalizations for COVID-19 for Medicare beneficiaries in FY 2022 than there were in FY 2020. This calls into question the applicability of inpatient data from FY 2020 to the FY 2022 time period for hospitals paid under the IPPS and LTCH PPS.*

Abnormal utilization and case mix trends, as a result of COVID-19, have been observed in other settings, leading CMS ultimately to choose to use FFY 2019 claims data, instead of aberrant FFY 2020 data, to determine key aspects of the FFY 2022 payment updates in the IPPS, inpatient psychiatric facility (IPF) PPS, and skilled-nursing facility (SNF) PPS proposed rules. Given that inpatient hospitalizations are a precursor to IRF admissions, like SNFs, it is unlikely that utilization trends in IRFs were different from other settings in FFY 2020.

CHA estimates that the combined impact of using potentially aberrant FFY 2020 data to calculate the CMG weights and outlier thresholds will inappropriately reduce payments to California IRFs by $1.1 million and $4.5 million, respectively (total estimated impact, $5.6 million). This is illustrated conceptually in the tables below, reproduced from the proposed rule, showing a reduction in payments to IRFs in the Pacific Region Urban and Pacific Region Rural by 1.3 and 2.7 percentage points, respectively.

Proposed Rule Table 17 (2020 Claims Data) Compared to Table 22 (2019 Claims Data)
Impact Analysis – Pacific Region Urban IRFs

	Outlier	FY 2022 WI and Labor Share	CMG Weights	Total Percentage Change
2020 Claims Data	(0.70)	0.60	(0.20)	1.90
2019 Claims Data	0.30	0.60	-	3.20
Impact	(1.00)	-	(0.20)	(1.30)

Proposed Rule Table 17 (2020 Claims Data) Compared to Table 22 (2019 Claims Data)
Impact Analysis – Pacific Region Rural IRFs

	Outlier	FY 2022 WI and Labor Share	CMG Weights	Total Percentage Change
2020 Claims Data	(1.40)	0.30	(0.60)	0.40
2019 Claims Data	0.70	0.30	-	3.10
Impact	(2.10)	-	(0.60)	(2.70)

CHA strongly agrees with CMS' assertion in the FFY 2022 IPPS proposed rule that patient utilization and case mix trends across all settings of care in FFY 2022 will more closely resemble those in FFY 2019, not FFY 2020. Therefore, we strongly encourage CMS not to use the FFY 2020 IRF claims data to calculate the FFY 2022 IRF CMG weights and fixed loss outlier threshold.

If CMS persists in using data from FFY 2020, it must provide evidence in the final rule that — unlike other care settings — IRFs did not experience aberrant trends in utilization and case mix in FFY 2020 as a result of COVID-19 pandemic. Specifically, CHA believes CMS must provide insight into the year-to-year changes in the percentages of dually eligible patients, those with end-stage renal disease, stays resulting from falls with major injury, and other indicators of changes in patient severity and utilization trends to support its assertion that FFY 2020 claims data are appropriate to use for fixed loss outlier threshold and CMG weight setting in FFY 2022. **However, if FFY 2020 claims data have been materially impacted by the COVID-19 pandemic, we believe CMS must use the 2019 claims data to establish both the IRF fixed loss outlier threshold and CMG weights for FFY 2022.**

Proposed COVID-19 Vaccination Coverage Among Health Care Personnel Measure

CMS proposes to add a new process measure to the IRF Quality Reporting Program (QRP), beginning with FFY 2023, to track the percentage of health care personnel who receive a complete COVID-19 vaccination course. CMS proposes an initial data submission period of October 1 through December 31, 2021, for use in the FFY 2023 IRF QRP Program, with data reported for at least one week of every month in the reporting period using the Centers for Disease Control and Prevention (CDC) National Health Safety Network (NHSN) web-based surveillance system. For FFY 2024 and subsequent years, CMS proposes a full calendar year reporting period. CMS proposes to publicly report the CDC's quarterly summary of the COVID-19 health care personnel vaccination measure.

California's hospitals strongly support the nation's COVID-19 vaccination efforts and have been leaders in vaccinating their communities. **Hospitals remain committed to achieving high levels of vaccination among their employees; however, we are concerned that the adoption of a measure to assess COVID-19 vaccination rates among IRF staff is premature for FFY 2023 with reporting beginning October 1.**

The first COVID-19 vaccine was approved by the Food and Drug Administration (FDA) under emergency use authorization (EUA) on December 11, 2020. EUAs have subsequently been issued for two additional COVID-19 vaccines, and the early evidence has been promising both in terms of vaccine safety and efficacy. Despite increasing levels of COVID-19 vaccination, a degree of vaccine hesitancy remains among the general population as well as hospital staff. Given the recent availability of vaccines (barely six months), misinformation, and because the vaccines are currently authorized for emergency use — rather than FDA approved — many facilities have encouraged vaccination among their staff but have not established vaccination as a condition of employment and do not control the vaccination status of their employees. As accurate information about the vaccines dispels myths and vaccines receive full FDA approval (as opposed to EUA), we are hopeful more health care personnel will become vaccinated.

The measure will also increase data collection and reporting burdens on IRFs that do not provide COVID-19 vaccinations directly to their employees and staff. While CMS says that it has modeled this measure after previously required measures to assess influenza vaccination rates among health care personnel, there are key differences between COVID-19 and flu vaccination administration and data collection among staff. Whereas it is common, and in fact state laws like in California require, that health care facilities provide influenza vaccination for their employees on an annual basis, COVID-19 vaccination administration has been much more fragmented.

All Californians receive their COVID-19 vaccinations through providers that have been selected by the state's third-party administrator (TPA) as part of the state's vaccination network, or through pharmacies participating in the Federal Pharmacy Partnership. While some general acute care hospitals, including many that operate IRFs, participate in the state's TPA network, participation is not universal or consistent, and many hospitals do not have access to vaccine doses and administration.

Though early COVID-19 vaccination efforts prioritized certain health care personnel — some of whom were vaccinated within their facilities or health systems — the measure includes a very broad definition of health care personnel, which would include many employees, independent contractors, and volunteers who would have been vaccinated in the community. **This measure will place additional burden on IRFs to seek and verify complete vaccination status from their employees whose vaccine may have been provided in settings outside of the facility, such as a local pharmacy or county mass vaccination clinic. IRFs will need to devote significant resources to developing systems to track employee vaccination, including which vaccines and how many doses are required for complete vaccination.**

CHA is also concerned that the definition of the measure numerator could be significantly impacted by the potential need for booster shots. Currently, the numerator would assess the cumulative number of health care personnel eligible to work in the hospital or facility for at least one day during the reporting period and who received a complete vaccination course against SARS-CoV-2. Unlike the influenza vaccination — which requires an annual course of vaccination — much remains unknown about the long-term efficacy of the existing COVID-19 vaccines, and a requirement for a booster shot could modify the definition of a "complete vaccination course." **CHA urges CMS to consider delaying adoption of such a measure until more is known about the long-term efficacy, final FDA approval, and vaccination schedule for COVID-19 vaccines.**

In addition, currently IRFs can voluntarily report COVID-19 vaccination rates for health care personnel to the Department of Health and Human Services (HHS) through weekly COVID-19 Hospital Data Reporting via the TeleTracking portal. The proposed NHSN fields to capture health care personnel vaccination data will require additional information that is more detailed than what is submitted via the TeleTracking portal and will require even more time and effort to collect. We urge CMS to consider the significant burden imposed on IRFs in reporting increasingly detailed health care personnel vaccination data in addition to reporting duplicate data to different portals for various purposes. We believe a voluntary approach is more appropriate given these challenges.

CHA is also concerned that the vaccination rates for this measure could vary significantly form the time of data submission to public reporting. CMS proposes to begin public reporting of the measure on *Care Compare* in September 2022 for the data submitted during the fourth quarter of 2021. We are concerned that the significant lag time between data submission and reporting will not provide patients with accurate data on the vaccination status of health care personnel in a specific facility. In addition, should a booster shot be required for any of the currently available vaccines, the definition of a fully vaccinated individual could change between the data submission and public reporting of the data, providing an even more incomplete window into health care personnel vaccination rates.

Finally, the measure proposed by CMS has not been fully specified, tested, or endorsed by the National Quality Forum (NQF). While CHA understands the immediate challenges posed by the COVID-19 pandemic and the benefits of understanding health care personnel vaccination rates, we do not support the inclusion of measures that have not been thoroughly tested and are not endorsed by the NQF in the Medicare quality reporting programs. **We urge the agency to fully develop and test the measure for reliability and validity — and seek NQF endorsement — prior to adopting it as a required measure in the IRF QRP. CHA urges CMS not to adopt a COVID-19 health care personnel vaccination measure beginning with FFY 2023.**

RFI – Closing the Health care Equity Gap in Post-Acute Care Quality Reporting Programs

California hospitals are committed to improving health equity and eliminating disparities in health care outcomes. Unequal access to health care and health resources due to race, socioeconomic status, and other social determinants of health has long been of concern to our members — and the COVID-19 pandemic has further demonstrated racial and ethnic health disparities that can no longer be ignored. The reasons for health equity disparity are multi-faceted, and answers to the problem are just as complex. Overcoming these obstacles will require a long-term, systemic approach with collaboration across all levels of government and institutions.

CHA applauds the administration for its strong commitment to addressing health equity, as evidenced by several of President Biden's executive orders. We appreciate that as an early step, CMS is seeking comments on how it can leverage Medicare quality reporting programs to make reporting of health disparities based on social risk factors and race and ethnicity more comprehensive and actionable for facilities, providers, and patients. Hospitals are uniquely positioned to help advance health equity and reduce disparities, and many of our members have already invested in efforts to improve data collection on race, ethnicity, language preference, and other sociodemographic data. As the agency considers its future steps, we offer the following high-level principles on improving demographic data collection, stratification of quality measure results, and future measures to assess health equity.

Improving Demographic Data Collection

The collection of standardized, comprehensive, and accurate data is essential to assessing disparities that exist in our health care system. Hospitals have invested significant resources in collecting these data from their patients; however, the data are not always captured in a consistent manner and format. For example, it is common for race and ethnicity information to be collected at registration, but other social demographic factors, such as access to transportation or food insecurity, may be captured as part of discharge planning or case management services. The data may also be maintained across separate systems and departments. **CMS should engage stakeholders to understand the current practices for demographic data collection and provide education to promote best practices that ensure consistency in these efforts.**

CHA also urges CMS to assess current efforts to collect demographic data beyond race and ethnicity, such as the standardized patient assessment data elements (SPADEs) required for post-acute care (PAC) settings and International Classification of Diseases, Tenth Revision (ICD-10) z-codes. CHA notes that, while CMS expanded the SPADEs to include a new category for social determinants of health, data collection has been delayed due to the COVID-19 PHE. **CMS should implement and learn from the experience of PAC providers collecting the existing SPADEs before expanding to other settings or adding additional data elements. We also urge CMS to engage stakeholders to understand how z-codes are currently used and consider how to better standardize and incentivize this coding.**

Stratification of Quality Measure Results

CMS says that it is considering providing facilities with reports that would stratify quality measure results by race and ethnicity, similar to its current approach to provide hospitals with confidential hospital-specific reports (HSRs) for several condition- and procedure-specific readmissions measures strategies for dual-eligibility status in the Hospital Readmissions Reduction Program. **CHA supports providing hospitals with confidential HSRs stratified by race and ethnicity in order to provide hospitals with information that could expose significant disparities. However, we believe that understanding the underlying causes of disparities — such as housing instability, access to healthy foods, and community violence — requires a more granular level of data collection.** While dual eligibility status and race or ethnicity have been shown to be accurate proxies for social risk, those characteristics intersect with other systemic factors that result in inequities in our health care system. We encourage CMS to continue to explore how it could provide hospitals with actionable data that allow them to work with community partners in advancing health equity in their communities.

Future Measures to Assess Health Equity

In the IPPS and IPF PPS proposed rule RFIs, CMS discusses the possible creation of a Hospital and Facility Equity Score that would synthesize results across multiple social risk factors and disparity measures. **CHA is concerned that a measure that would require a complex aggregation methodology is unlikely to produce results that are actionable to the facility for quality improvement purposes.** We urge CMS to rethink the development of an aggregate Hospital or Facility Equity Score and instead focus its resources on improving and standardizing data collection and reporting of social demographic data in such a way that provides facilities with accurate and specific data on disparities within and across their facilities.

CHA appreciates the opportunity to comment on the FFY 2022 IRF PPS proposed rule. If you have any questions, please contact me at mhoward@calhospital.org or (202) 488-3742, or Pat Blaisdell, vice president, continuum of care, at pblaisdell@calhospital.org or (916) 552-7553.

Sincerely,
/s/

Megan Howard
Vice President, Federal Policy