May 31, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

SUBJECT: CMS-1767-P, Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2023 and Updates to the IRF Quality Reporting Program, Proposed Rule, Federal Register (Vol. 87, No. 66), April 6, 2022

Dear Administrator Brooks-LaSure:

On behalf of our more than 400 member hospitals and health systems, including 75 inpatient rehabilitation facilities (IRFs), the California Hospital Association (CHA) is pleased to submit comments on the Centers for Medicare & Medicaid Services (CMS) inpatient rehabilitation facility (IRF) prospective payment system (PPS) proposed rule for federal fiscal year (FFY) 2023.

California's IRFs have been significantly impacted by the COVID-19 public health emergency (PHE). We are deeply concerned that the proposed market basket update is inadequate relative to the input cost inflation — in large part due to labor market dislocations as a result of COVID-19 — IRFs are facing. To preserve access to this setting of care for all Medicare beneficiaries, we ask CMS to develop a methodology to calculate the market basket update that accurately reflects the recent (and anticipated continued) rapid input price inflation. Further, we are concerned that the significant increase in the IRF outlier threshold will hold IRF payments below CMS' targeted level. We are also deeply concerned about any future proposal to include discharges to home health agencies in the IRF transfer policy.

Despite these concerns, CHA appreciates CMS' request for information (RFI) related to improving the IRF PPS payment adjusters. We also support CMS' strong commitment to reducing the conditions that result in inequitable health outcomes, as demonstrated by the request for information on measuring health care quality disparities. CHA offers the following comments on specific proposals.

Market Basket Update

CMS proposes a market basket increase for FFY 2023 of 3.2%. This is then reduced by the negative 0.4percentage-point "productivity adjustment" required under the Affordable Care Act (ACA). The

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resulting proposed IRF market basket update equals 2.8% (3.2% minus 0.4 percentage points for productivity reduction).

CHA is deeply disappointed in the proposed 2.8% market basket update, as it is wholly inadequate relative to the input cost inflation experienced by IRFs. Labor related costs — based on CMS' own forecast of the labor related share in Table 4 of the proposed rule — will make up 73.2% of IRF expenses in FFY 2023.

While CHA appreciates that CMS will refresh the market basket update in the final rule with more recent data, we are deeply concerned that the revised update will still be insufficient relative to input cost inflation — particularly for labor.

Even before the application of the productivity adjustment (discussed further below), the methodology — based on IHS Global Insight (IGI) data — has failed to keep up with cost growth year-over-year. Inflation has reached levels not seen in 40 years,[1] which predates the implementation of the inpatient prospective payment system (IPPS) in October of 1983, on which the IRF PPS market basket update is modeled. It is clear, based in particular on rapidly rising labor costs, that CMS' current methodology for updating the market basket is ill-suited to a highly inflationary environment. **Therefore, we ask CMS to consider other methods and data sources to calculate the final rule "base" (before additional adjustments) market basket update that would better reflect the rapidly increasing input prices facing IRFs.** If CMS fails to provide an adequate market basket update, CHA is deeply concerned about access to inpatient rehabilitation services for Medicare beneficiaries.

Market Basket Update — Productivity Adjustment

The productivity adjustment required under the ACA is estimated to be negative 0.4 percentage points. CMS uses the total factor productivity (TFP) adjustment as calculated by the Bureau of Labor Statistics. The adjustment is calculated, as it has been in the past, as the 10-year moving average of changes in multifactor productivity for the period ending September 30, 2023, based on IGI's fourth quarter 2021 forecast.

CHA believes the assumptions underpinning the productivity adjustment are fundamentally flawed. As such, we strongly disagree with the continuation of this punitive policy — particularly during the PHE. The productivity adjustment to the market basket update assumes that IRFs can increase overall productivity — producing more goods with the same or fewer units of labor input — at the same rate as increases in the broader economy. However, providing care to patients in IRFs is highly labor intensive, as CMS' projection of the labor related portion of the federal rate — 73.2% — implies in the FFY 2023 proposed rule.

This level of care must be provided on-site and has a high "hands-on" component. Therefore, IRFs cannot improve productivity using strategies like offshoring or automation that are commonly deployed in other sectors of the economy that produce goods (auto manufacturing) or services (restaurants that use automated ordering systems to reduce overall staffing count). Further, CHA notes that during the PHE, productivity fell[2] as a result of having to use temporary staffing due to COVID-19-related turnover and

[1] https://www.npr.org/2022/02/10/1079260860/january-inflation-consumer-prices-cpi-economy-federal-reserve
[2] https://www0.gsb.columbia.edu/faculty/abartel/papers/human_capital.pdf

the accompanying labor shortage. Temporary staff are not accustomed to a specific IRF's workflow, which reduces the number of patients they can care for in a regular shift.

Given that CMS is required by statute to implement a productivity adjustment to the market basket update, CHA asks the agency to work with Congress to permanently eliminate this unjustified reduction to hospital payments. Further, we ask CMS to use its section 1135 waiver authority to remove the productivity adjustment for any fiscal year that was covered under public health emergency determination (e.g., 2020, 2021, and 2022) from the calculation of market basket for FFY 2023 and any year thereafter.

IRF PPS Outliers

For FFY 2023, CMS is proposing to continue to set the fixed-loss threshold amount so that outlier payments account for 3% of total payments made under the IRF PPS. For FFY 2023, as it has in the past, CMS will use the latest available claims data — in this case, FFY 2021 — to set the fixed-loss threshold. Based on an analysis of FFY 2021 IRF claims and the FFY 2022 rate increases, CMS estimates that for FFY 2022 IRF outlier payments will be 3.8% of total payments, or 0.8 percentage points higher than the target of 3%. For this reason, CMS believes it is necessary to raise the fixed-loss threshold to better target 3% of IRF payments as outliers. For FFY 2023, CMS proposes to increase the fixed-loss threshold from $9,491 in FFY 2022 to $13,038 in FFY 2023. CHA notes that the fixed-loss outlier threshold in the IRF PPS is 37% greater than it was in FFY 2022.

CHA is deeply concerned that CMS has overestimated the impact of COVID-19 on the IRF PPS outlier threshold. This will have the effect of depressing additional, necessary payments to IRFs to compensate them for the additional cost incurred when treating high-cost Medicare beneficiaries. We ask CMS to calculate the IRF PPS outlier threshold using the charge inflation factor from FFY 2018 to FFY 2019 (instead of using the charge inflation factor from FFY 2020 and 2021). Further, we also ask CMS to adjust the cost-to-charge ratios (CCRs) used in the IRF fixed-loss outlier threshold by comparing the percentage change in the national average case-weighted CCRs between the March 2019 and March 2020 updates to the Provider Specific File (PSF). This is the last update of the PSF prior to the PHE. **CHA notes that CMS used both of these approaches to normalize the impact of COVID-19 on the fixed loss outlier threshold in the IPPS proposed rule. We believe a similar approach would be appropriate in the IRF PPS.**

Adding Home Health to the IRF Transfer Policy

CMS requests comments from stakeholders regarding the IRF transfer payment policy. Specifically, CMS notes that IRF discharges to home health (HH) services are not currently included in the transfer policy, which reduces payments for IRF stays that are less than the average length for the applicable case mix group and are transferred to another institutional site, including another IRF, an inpatient hospital, a skilled-nursing facility, or a long-term care hospital. CMS notes that HH was not initially included in the transfer policy due to limited availability of HH claims data, and that the Office of the Inspector General estimates that including HH services in the transfer policy would result in significant cost savings. CMS now poses several questions to IRF providers, hoping to use information from stakeholders in conjunction with its analysis for potential rulemaking in the future.

California's hospitals are strongly opposed to the inclusion of HH services in the IRF transfer policy, due to the unique role of HH in providing support for a safe, effective, and sustained return to home and community. Most individuals cared for in inpatient rehabilitation facilities have experienced the recent onset of significant disability, and while the intensive inpatient interdisciplinary care provided in an IRF is essential to a patient's recovery, it is most accurately viewed as the beginning — not the end — of a patient's journey and successful return to home and community. Most patients who are discharged from an IRF have continued medical and functional needs. While IRF care will have allowed them to progress to the point that they can reside in their homes, they will continue to have significant functional limitations and ongoing medical management needs. In this context, HH services provide an essential support to a patient's transition from institutional care to home and community. IRF care and HH care are not duplicative or redundant. Rather, they are complementary components of a system of care that addresses different stages of the patient's recovery.

CHA member hospitals provided responses to the questions CMS advanced on this topic.

1. *Beyond the existing Medicare claims data, under what circumstances, and for what types of patients (in terms of clinical, demographic, and geographic characteristics) do IRFs currently transfer patients to home health?*
   CHA member IRFs reported a wide range of clinical or other conditions that require a referral to HH services, including continued therapy and medical care needs, and lack of access to services outside the home. A primary goal of the IRF-to-HH transition is to ensure the patient's continued recovery and the effective carryover of training received in the IRF to the home setting. Most patients leaving an IRF, regardless of diagnosis, continue to have significant functional limitations and therapy needs, and HH therapy services provide an essential resource to assess home safety and to provide ongoing therapy and caregiver training. Many post-IRF patients also have specific medical conditions requiring in-home nursing care such as IV antibiotic or wound care. Finally, our member IRFs report that many patients are unable to access outpatient therapy services, either because the necessary outpatient services are not available in their region or their disability limits their ability to travel outside their home.

2. *Should CMS consider a policy similar to the IPPS transfer payment policy?*
   CHA members are strongly opposed to a change to the IRF transfer payment policy to align with the IPPS transfer policy.

3. *What impact, if any, do stakeholders believe this proposed policy change could have on patient access to appropriate post-acute care services?*
   California IRF providers refer many patients to HH care upon discharge. In a recent survey of member IRFs, nearly two-thirds of the respondents indicated that they recommend HH agency services for at least 50% of their Medicare patients who are returning home. California IRFs are concerned that including transfers to HH in the IRF transfer policy would result in reduced access to medically necessary and cost-effective nursing and therapy services, and ultimately compromise patient outcomes. As one CHA member said, *"If the goal is to get a patient back into their home, why is there a penalty for achieving that goal?"*

   Limiting or discouraging HH utilization would undoubtedly result in increased rates of readmissions if or when patients don't adapt well to the home setting when left to do it on their

own. Access to HH will provide continued medically necessary care and monitoring as well as training to support safety in the home setting.

Additionally, if unable to refer to the HH setting, IRFs may find it necessary to hold patients for an extended time in the IRF setting. As IRF patients recover, many — likely most — will get to a point that they no longer require the intensive program provided in the IRF setting (i.e., no longer meet medical necessity criteria for IRF care), but are not ready to return home without additional support. Such patients may have to remain in IRF beds for extra days or weeks even though they no longer need that level of care. Alternatively, a patient who is not "ready" to go home independently after completion of an IRF stay may end up being transferred to a skilled-nursing facility. The unintended consequences of limiting access to HH care post-IRF will be to increase overall costs and undermine the goal of maximizing patient outcomes and return to their communities.

CHA urges CMS to reject consideration of adding home health to the IRF transfer policy in order to ensure that Medicare beneficiaries continue to have access to the continuum of care that best meets their needs throughout their recovery.

Solicitation of Comments Regarding the Facility-Level Adjustment Factor Methodology

CMS currently adjusts the payment amount associated with a case mix group (CMG) to account for facility-level characteristics such as a facility's percentage of low-income patients, teaching status, and location in a rural area. It also adjusts whether the IRF is freestanding or hospital-based. Each of these factors is calculated based on a regression analysis. CMS has observed relatively large fluctuations in these factors from year-to-year, and since 2015 it has maintained the same facility-level adjustment factors calculated in 2014. In the proposed rule, CMS seeks comment from stakeholders on the methodology used to determine the facility-level adjustment factors and suggestions for possible updates and refinements to this methodology.

CHA appreciates the cautious approach that CMS is taking as it considers approaches to updating the IRF PPS facility-level adjusters. **Given the potential negative impact to IRF access that a sudden reduction to Medicare payments could create for beneficiaries, CHA asks CMS to phase-in any change to the IRF adjustment factors over multiple years as it has done with other changes of this magnitude.** To the extent possible, this will allow facilities that are negatively impacted by reduced Medicare payments the opportunity to adjust their cost structures.

Proposed All-Payer IRF QRP Reporting Requirement

CMS proposes to require that an inpatient rehabilitation facility patient assessment instrument (IRF-PAI) be completed for each patient cared for in an IRF, regardless of payer. CMS proposes that this new policy would begin with the IRF PPS FFY 2025 payment year, requiring that facilities would need to begin data collection regardless of payer source on Oct. 1, 2023.

CHA supports the goal of standardizing the collection and reporting of patient assessment data and quality reporting measures across post-acute care settings. CHA member IRFs also recognize the value of collecting and reporting data on patients regardless of payer type. In fact, most California IRFs report that they currently complete IRF-PAIs on all admissions, rather than limiting completion to Medicare beneficiaries only. However, CHA is concerned that the proposed timeline for implementation of all-payer

reporting places significant burden on IRFs and does not allow sufficient time for necessary preparation, particularly in the consideration of the upcoming implementation of the IRF-PAI 4.0 on Oct. 1, 2022.

The start date for the IRF-PAI 4.0, originally scheduled for October 2019, was delayed due to the PHE. The updated IRF-PAI includes several new required data elements, including new standardized patient assessment data elements, resulting in a much longer form. The new IRF-PAI is 30 pages long (increased from the current 16-page form) and, according to CMS' own estimates, will require nearly 23% more time to complete (105.8 minutes, up from 86 minutes). Additional time will be needed for staff training and the development and implementation of new operational policies and procedures.

Based on these factors, the successful implementation of the IRF-PAI 4.0 will be a complex challenge. Over the next year to 18 months, IRFs will be challenged to allocate sufficient staff time to address the increase in time required for completion. In this context, an imminent requirement to complete for all payers will exacerbate these demands and will limit the ability to modify or improve the new form and implementation.

CHA urges CMS to delay the requirement for implementation of the updated IRF-PAI for all payers until at least Oct. 1, 2024, to allow for the opportunity to review the first year of IRF-PAI 4.0 use and develop a clearer understanding of the necessary time commitment and operational considerations. In addition, as CMS expands the scope of data collection to include all patients, we urge the agency to reduce the IRF-PAI completeness threshold to align with other post-acute settings. Currently, the IRF-PAI threshold is set at 95%, while the skilled-nursing facility (SNF) minimum data set (MDS) assessment instrument completeness threshold is 80%. When these thresholds were established, the IRF-PAI was significantly shorter than the MDS. However, the IRF-PAI 4.0 will be similar in length to the SNF MDS, and the completion thresholds should be aligned.

Potential Future Inclusion of an Electronic Health Record-Driven Digital National Healthcare Safety Network (NHSN) Measure

CMS seeks comments on the future inclusion of a measure for the IRF QRP that would use data from the electronic health record (EHR) that would assess rates of IRF-onset *Clostridiodes difficile* infection (CDI). Specifically, CMS is considering eventually replacing the current NHSN Healthcare-Associated CDI (HA-CDI) outcome measure with a newly developed version that would use EHR-derived data to define CDI, using both a positive microbiological test for CDI and evidence of treatment.

CHA shares CMS' goals of utilizing technology to improve and align quality measurement across the public and private sectors. However, as CMS acknowledges in the proposed rule, some IRFs do not utilize certified EHR technology, as post-acute care providers were not eligible for the EHR incentive programs authorized by the Health Information Technology for Economic and Clinical Health Act of 2009. For many IRFs — particularly freestanding IRFs that cannot leverage a hospital system's EHR — reporting of the digital version of the HA-CDI outcome measure would require significant investments in both technical infrastructure and staff training. Should CMS move forward with the adoption of the digital version of the measure, a significant transition period will be necessary to ensure IRFs can participate. At minimum, providers that already use an EHR generally need 18 to 24 months of lead time for vendors to incorporate new measures and for providers to update workflow and train staff on new requirements. For IRFs with less experience using EHRs, additional periods of voluntary reporting, along with technical support and education from CMS, would be necessary.

CHA appreciates the opportunity to comment on the FFY 2023 IRF proposed rule. If you have any questions, please contact me at cmulvany@calhospital.org or (202) 270-2143, or Megan Howard, vice president of federal policy, at mhoward@calhospital.org or (202) 488-3742.

Sincerely,

/s/
Chad Mulvany
Vice President, Federal Policy