June 2, 2023

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

SUBJECT: CMS-1781-P, Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2024 and Updates to the IRF Quality Reporting Program; Proposed Rule, Federal Register (Vol. 88, No. 67), April 7, 2023

Dear Administrator Brooks-LaSure:

On behalf of our more than 400 member hospitals and health systems, including approximately 90 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) 2024.

California's hospitals, including its inpatient rehabilitation hospitals, continue to face unprecedented financial pressure as a result of COVID-19's impact on the labor market and the health care supply chain. From 2019 to 2022, costs per adjusted discharge rose 25%[1] (driven by increases in salary costs +22%, supply expenses +18%, and pharmaceuticals +19%). However, base payment rates for Medicare have failed to keep pace with input price inflation.

CHA is concerned the proposed 2024 IRF rule will only exacerbate these challenging circumstances for inpatient rehabilitation facilities and the patients they serve. The proposed net market basket update of +3.0% is inadequate relative to the input price inflation faced by IRFs and continues CMS' historic trend of proposing woefully inadequate payment updates. For example, in 2022 CMS finalized an unadjusted market basket update of 2.6%. However, the actual data used by CMS to set the market basket update for IRFs show that costs actually increased by 5.3% (a difference of 2.7% from the final market basket update), resulting in a significant underpayment to IRFs in 2022. To ensure continued broad access to inpatient rehabilitation services for Medicare patients, CHA offers the following comments on the 2024 IRF PPS proposed rule:

[1] https://www.kaufmanhall.com/insights/research-report/california-hospital-financial-impact-report-april-2023-update

499 So. Capitol Street SW, Suite 410, Washington, DC 20003 ▪ Office: (202) 488-3740 ▪ FAX: (202) 488-4418

1215 K Street, Suite 700, Sacramento, CA 95814 ▪ Office: (916) 443-7401 ▪ www.calhospital.org

- *Provide an Adequate Market Basket Update*: CHA respectfully asks that CMS use data that better reflect the input price inflation that IRFs have experienced and are projected to experience in 2024. Further, CHA respectfully asks that CMS make a one-time "forecast error adjustment" to account for prior year underestimation of the IRF market basket update. Finally, as in prior years, CHA respectfully asks CMS to use its exceptions and adjustments authority to eliminate the unjustified reduction to the market basket update as a result of the Affordable Care Act (ACA)-mandated productivity adjustment for any year covered under the COVID-19 public health emergency.
- *Revise Methodology Used to Calculate the Labor-Related Share*: CHA is concerned that the methodology CMS uses to rebase and revise the labor-related share of Medicare inpatient payments for hospitals with a wage index of 1 or greater is premised on the flawed assumption that some categories of labor costs are not subject to geographic variation. CHA asks that CMS revise its methodology for rebasing the labor-related share to account for the geography wage variation inherent in all home office and non-clinical professional services costs.
- *Conduct Additional Testing on Cross-Setting Discharge Function Score Measure*: CHA urges CMS to conduct additional testing on the proposed Discharge Function score measure to ensure it does not disincentivize facilities from taking on complex patients, and delay adoption of the measure in the IRF quality reporting program (QRP) until it has been endorsed by the consensus-based entity (CBE).

Below, please find CHA's specific comments on these issues.

Market Basket Update

CMS proposes a market basket increase for FFY 2024 of 3.2%. This is then reduced by the negative 0.2 percentage-point "productivity adjustment" required under the ACA. The resulting proposed IRF market basket update equals 3.0% (3.2% minus 0.2 percentage points for productivity reduction).

CHA is deeply disappointed in the net proposed 3.0% market basket update, as it is wholly inadequate relative to the input cost inflation experienced by IRFs. In light of this, we ask CMS to:

1. Recalculate the market basket update using data that more accurately reflects the growth in input prices
2. Provide a one-time "forecast error adjustment" that accounts for CMS' underpayment of IRFs since 2020
3. Use its exceptions and adjustments authority to provide a one-time increase in funding to account for the ill-conceived ACA productivity adjustment during the COVID-19 public health emergency (PHE)

First, 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. As discussed above, California's per discharge costs have increased 25% from 2019 to 2022. However, over the same period, the market basket update has only increased per unit payments 6.95%.[2]

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[2] CHA analysis of CMS market basket data.

Even before the application of the productivity adjustment (discussed further below), the methodology — based on IHS Global Insight (IGI) data — failed to keep up with cost growth year-over-year. 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 better reflects 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.

Second, in prior comment letters, CHA, along with other stakeholders, expressed its concern that the market basket update proposed (and subsequently finalized) in a given year was inadequate relative to input price inflation. Unfortunately, that concern has been realized. Based on files recently released by CMS, the actual market basket update for FFY 2022 should have been 5.3%. Instead, CMS finalized a market basket update of 2.6%, resulting in IRFs being underpaid relative to inflation by 2.7 percentage points.

In both the skilled-nursing facility PPS and for the capital input price index (CIPI) used to update capital IPPS payments, CMS makes "forecast error adjustments" when it underestimates the market basket update. As an example, in this year's SNF PPS rule, CMS proposes a 3.6 percentage point forecast error adjustment. In FY 2022, the SNF market basket update was 2.7%. The actual increase for FY 2022 is 6.3%, resulting in the actual increase being 3.6 percentage points higher than the estimated increase in the 2022 SNF PPS final rule. Therefore, CMS proposes that the FFY 2024 market basket percentage increase of 2.7% would be adjusted upward to account for the forecast error adjustment of 3.6 percentage points, resulting in a SNF market basket percentage increase of 6.3%. **Similarly, CHA asks that CMS apply a one-time 2.7 percentage point "forecast error adjustment" to the proposed FFY 2024 IRF market basket update of 3.2% for a 5.7% update, net of the .2% ACA productivity adjustment. This will account for the significant underpayment that occurred in FFY 2022.**

While stakeholders asked CMS to provide a forecast error adjustment in response to the inadequate payment update in the FFY 2023 IRF proposed rule, CMS declined to do so. The agency responded that:

> *Section 1886(j)(3) of the Act requires that the Secretary shall determine a prospective payment rate*[3] *for IRFs and establish an increase factor based on an appropriate percentage increase in a market basket of goods and services, which means that the update relies on a mix of both historical data for part of the period for which the update is calculated and forecasted data for the remainder. For instance, the FY 2023 market basket update in this final rule reflects historical data through the first quarter of CY 2022 and forecasted data through the third quarter of CY 2023. While there is currently no mechanism to adjust for market basket forecast error in the IRF payment update,*[4] *the forecast error for a market basket update is calculated as the actual market basket increase for a given year less the forecasted market basket increase.*

[3] Emphasis added.
[4] Emphasis added.

CMS is correct in that the agency has not previously provided a forecast error adjustment in the IRF PPS. However, nothing in Section 1886(j)(3) specifically precludes the use of a forecast error adjustment. Section 1886(j)(3)(C)(i), which describes the IRF increase factors, states:

> *(i) IN GENERAL.—For purposes of this subsection for payment units in each fiscal year (beginning with fiscal year 2001), the Secretary shall establish an increase factor subject to clauses (ii) and (iii). Such factor shall be based on an appropriate percentage increase[5] in a market basket of goods and services comprising services for which payment is made under this subsection, which may be the market basket percentage increase described in subsection (b)(3)(B)(iii)[6]. The increase factor to be applied under this subparagraph for each of fiscal years 2008 and 2009 shall be 0 percent.[792]*

CHA notes that the word "prospective" is not used in Section 1886(j)(3)(C)(i) to describe or modify the IRF "increase factor." Further, we note that the section requires that the factor be based on an "appropriate percentage increase."

For FFY 2022 the actual (appropriate) market basket update was 2.7 percentage points higher than the final rule (projected) market basket update. This resulted in payments that were inappropriate relative to the increase in the market basket of goods and services comprising the services for which payment is made to IRFs. Therefore, we believe that CMS should make a one-time adjustment to account for this significant underpayment.

Finally, as in prior years, CHA believes the assumptions underpinning the ACA-mandated productivity adjustment are fundamentally flawed. As such, we respectfully disagree with the continuation of this policy — particularly during any fiscal year impacted by 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 — 74.1% — implies in the FFY 2024 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 COVID-19 PHE, productivity fell[7] as a result of having to use temporary staffing because of high turnover rates of employed staff due to COVID-19 and the accompanying labor shortage.

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 exceptions and adjustments authority found in Section 1886(j)(3)(A)(v) to remove the productivity adjustment for any fiscal year that was

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[5] Emphasis added.
[6] (b)(3)(B)(ii)(VIII): Subsequent fiscal years is the market basket percentage increase.
[7] https://www0.gsb.columbia.edu/faculty/abartel/papers/human_capital.pdf

covered under PHE determination, i.e., 2020 (.4%), 2021 (.0%), 2022 (.7%), and 2023 (.3%), from the calculation of market basket for FFY 2024 and any year thereafter.

Area Wage Index – Labor-Related Share Rebasing

CMS' proposed total labor-related share of 74.1% for FFY 2024 is 1.2 percentage points higher than the FFY 2023 labor share of 72.9% . The higher labor-related share is due to the incorporation of the 2021 Medicare cost report data, which increased the compensation cost weight by approximately 0.8 percentage points compared to the 2016-based IRF market basket. **CHA appreciates CMS' proposal to increase the labor-related share based on data that better reflect increased labor costs as a percentage of IRF's overall cost structure.**

CMS proposes to continue to classify a cost category as labor-related if the costs are labor intensive and vary with the local labor market. Similar to the 2016-based IRF market basket (and in other PPS payment systems that incorporate a labor-related share), the proposed 2021-based IRF market basket includes two cost categories for nonmedical Professional Fees (including, but not limited to, expenses for legal, accounting, and engineering services). These are Professional Fees: Labor-Related and Professional Fees: Nonlabor-Related. **As it has in responses to CMS' labor-related share rebasing proposals in other payment systems, CHA continues to respectfully disagree with CMS' assertion that some portion of professional contract labor costs and home office costs are not subject to geographic variation in labor costs. We ask that in the final rule, CMS allocate all 9.4 percentage points[8] for professional services and home office costs to the Professional Services: Labor-Related Category.**

For the proposed 2021-based IRF market basket, CMS proposes to estimate the labor-related percentage of non-medical professional fees (and assign these expenses to the Professional Fees: Labor-Related services cost category) based on the same method used to determine the labor-related percentage of professional fees in the 2016-based IRF market basket.

As it has during prior rebasing of the labor-related share, CMS proposes to determine the proportion of legal, accounting and auditing, engineering, and management consulting services that meet its definition of labor-related services based on a survey of hospitals conducted in 2008. Based on these results, CMS proposes to apportion approximately 2.6 percentage points of the 4.0 percentage point figure into the Professional Fees: Labor-Related share cost category and designate *the remaining 1.4 percentage points into the Professional Fees: Nonlabor-Related cost category*[9].

CHA questions the validity of CMS' assumption that fees for services provided by firms located outside of a hospital's CBSA do not vary based on geography. The implied underpinning of this assumption is that national and regional professional services firms do not compete with local professional services firms based in a hospital's core-based statistical area (CBSA). However, this is an erroneous assumption. When hospitals seek professional services, the services they are seeking are not so unique (e.g., accounting, engineering, management consulting) that they could only be provided by regional or national firms. CMS' own survey data support this conclusion, as approximately 65% of these services are sourced from

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[8] 4 percentage points related to Accounting & Auditing, Legal, Engineering, and Management Consulting Services plus 5.4 percentage points related to Home Office labor costs
[9] Emphasis added.

firms in the local market. Therefore, hospitals solicit proposals for "professional services" from local, regional, and national firms.

When competing with local firms for a given contract or project, regional and national firms have every incentive to adjust their pricing in response to local labor market conditions. If the local labor market has lower wages than the national average — which will influence the pricing of a local firm's response to a request for proposal from a hospital — regional and national firms must reduce the offered price of their services to be competitive with local firms that offer the same services. Conversely, if the local labor market has higher wages than the national average, regional and national firms have every incentive to price accordingly to increase their profit margins on a given contract. Therefore, pricing for services offered by regional and national firms to hospitals in differing CBSAs will vary significantly based on local rates due to these firms competing with local firms that provide the same service.

CHA respectfully asks CMS to offer evidence that pricing for professional services provided by regional and national firms to hospitals is offered in a national market that is not subject to geographic cost variation. Unless the agency can produce strong evidence that prices for professional services provided by firms outside of a hospital's local labor market are homogenous — that an IRF in Sault Ste. Marie, Mich., is charged the same hourly rates for audit services by the same national accounting firm as a hospital in Sacramento, Calif. — CHA respectfully asks CMS to restore the 1.4 percentage points it proposes to reclassify to Professional Services: Nonlabor-Related to the Professional Services: Labor-Related category. In the absence of data that prove standardized pricing by regional and national professional services firms, CHA believes the Professional Services: Labor-Related category cost weight should be 4.0 percentage points.

CMS also asserts, without providing additional evidence, that because a hospital's home office costs are outside of its local market, these labor costs do not vary due to differences in cost of living. Based on this unsupported assertion, the agency proposes to classify a portion of these expenses as labor-related and nonlabor-related. Based on analysis of cost report data, CMS proposes allocating 2.4 percentage points of the Home Office/Related Organization Contract Labor cost weight (5.4% times 45%) to the Professional Fees: Labor-related cost weight and *3.0 percentage points of the Home Office/Related Organization Contract Labor cost weight to the Professional Fees: Nonlabor-related cost weight*[10] (5.4% times 55%). **CHA strongly disagrees with the assertion Home Office/Related Organization compensation costs that occur outside of a hospital's labor market are not subject to geographic wage variation. As such, we do not believe the proposed reclassification to the Professional Fees: Nonlabor-Related cost category is justified.**

CHA replicated CMS' Home Office/Related Organization analysis. We identified approximately 809 hospitals (37% of hospitals with home office data) that were not in the same labor market as their home office. Of these hospitals, 202 were in labor markets with a wage index greater than 1. While these hospitals account for only 25% of hospitals with home offices outside of their labor markets, their salary, wage, and benefit costs are approximately 34% of the salary, wage, and benefit costs for hospitals with home offices outside their labor market.

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[10] Emphasis added.

Further, the analysis indicates that the home office/related party average hourly salary, wage, and benefit costs for hospitals with home offices outside of their labor market is $54.82. However, for the 202 hospitals in a labor market with a wage index greater than 1, the average hourly home office wage is $57.74 (5% higher than average). By contrast, the average hourly home office wage for the 607 hospitals in a labor market with a wage index of 1 or less is $53.43 (3% lower than average).

Analysis of Home Office Costs for Hospitals with Home Offices Outside Their Labor Market

	Hospital Count	% of Total Hospital Count	Home Office/Related Party Salary, Wage, and Benefit Cost	% Total Wage Related Costs	Home Office/Related Party Hours	Home Office Average Hourly Wage	% Difference from Total Average Hourly Wage
Hospitals with Wage Index Values <=1	607	75%	$ 7,886,217,045	66%	147,609,035	$ 53.43	-2.54%
Hospitals with Wage Index Values >1	202	25%	$ 4,068,762,125	34%	70,462,064	$ 57.74	5.33%
Total	809	100%	$ 11,954,979,170	100%	218,071,100	$ 54.82	0.00%

These data indicate that — contrary to CMS' unsupported assertion — home office salary, wage, and benefit costs for hospitals with home offices outside of their labor market are subject to geographic wage variation. Hospitals in labor markets with wage indexes greater than 1 on average have higher home office wage-related costs than hospitals with wage indexes of 1 or less. **Given this evidence of geographic wage variation in home office costs for hospitals that are not located in the same labor market as their home office, CHA respectfully asks CMS to withdraw its proposal to reclassify 3.0 percentage points of the Home Office/Related Organization cost weight to the Professional Fees: Nonlabor-Related cost category. Instead, we ask the agency to allocate the full 5.4 percentage points of the Home Office/Related Organization cost weight to the Professional Fees: Labor-Related cost category.**

Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)

CMS proposes several changes to the IRF QRP, including two new cross-setting measures, the removal of overlapping discharge function measures, and a modification to the existing COVID-19 Vaccination Coverage among Health Care Personnel (HCP) measure.

Proposed Modification to the COVID-19 Vaccination Coverage Among HCP Measure

CMS proposes to modify the current HCP COVID-19 vaccination measure beginning with the FFY 2025 IRF QRP, consistent with proposals across all Medicare QRPs. Specifically, CMS would replace the definition of "complete vaccination course" with a definition of "up to date" for Centers for Disease Control and Prevention (CDC)-recommended COVID-19 vaccines. The agency proposes this modification to incorporate evolving CDC guidance related to booster doses and their associated time frames.

While the denominator of the current measure would not change — and is reflective of all HCP eligible who work in the facility for at least one day during the reporting period — the numerator of the measure would be changed. It would be changed to be the cumulative number of HCP in the denominator population who are considered up to date with the recommended COVID-19 vaccines as defined by the

CDC[11] on the first day of the quarter. Compliance with the FFY 2025 IRF QRP requirements would be based on reporting of eligible HCP who are up to date beginning with quarter four of calendar year 2023. Beginning with the FFY 2026 IRF QRP, IRFs would be required to submit data for the entire calendar year.

CMS does not propose any changes to the data submission or reporting processes for the measure, and IRFs would continue to be required to collect data for at least one self-selected week during each month of the reporting quarter and submit that data to the CDC National Healthcare Safety Network (NHSN) prior to the quarterly deadline.

CHA strongly supports ongoing efforts to maintain high levels of up-to-date vaccination for COVID-19 among both HCPs and the communities they serve. However, as we exit the PHE and enter an endemic phase of the disease, we are concerned that the data reporting requirements associated with the measure will divert already stretched resources from patient care to administrative processes. The CDC's definition of "up to date," can change every quarter, and it is challenging for IRFs to collect and continuously assess the vaccination status of every single employee who works in the facility for a given reporting period. Further, the requirement that IRFs collect and report on this data for at least one week each month has strained the already stressed workforce.

In developing the measure, CMS relied heavily on the specifications and experience with the Influenza Vaccination Among HCP Measure. The flu vaccine measure assesses vaccinations during "flu season" — which is defined as October through March — and is reported annually. While there are still questions about the seasonality of COVID-19, future vaccination schedules, and how often new versions of a COVID-19 vaccine will be available, an annual data collection and reporting process is significantly less burdensome than reporting data for one week out of each month of the year. **We urge CMS to consider limiting the reporting requirements to at least one week for each quarter and work with the CDC to move toward a version of the measure that could be reported annually.**

In addition, we continue to have concerns that the lag in timeline between reporting the data to NHSN and public reporting of the measure results in publicly reported data that are outdated and inconsistent with the public's understanding of vaccination rates in a given facility. As proposed, data for quarter four of 2023 would not be publicly reported until September 2024, at which point it is likely that the definition of "up to date" could be significantly different than when the data was collected, due to changes in recommended vaccination schedules or updated boosters. Finally, we remain concerned that the measure has not undergone rigorous reliability and validity testing and has not been endorsed by the consensus-based entity (CBE).

Proposed Adoption of Discharge Function Score Measure and Removal of Overlapping Discharge Measures
Beginning with the FFY 2025 IRF QRP, CMS proposes to adopt a new assessment-based outcome measure that estimates the percentage of IRF patients who meet or exceed an expected discharge score during the reporting period. In conjunction with this proposal, CMS would remove three current IRF QRP functional status measures that would overlap with the newly proposed measure.

[11] https://www.cdc.gov/nhsn/pdfs/hps/covidvax/uptodateguidance-508.pdf

The proposed discharge function score measure includes an observed discharge function score that is calculated by summing individual function item values from the IRF Patient Assessment Instrument (IRF-PAI) at discharge. The expected discharge function score is calculated by risk-adjusting the observed score to control for patient characteristics, including age, admission function score, and clinical conditions to establish how much functional improvement would be expected after their IRF stay. The measure uses a statistical imputation approach to account for missing IRF-PAI elements when codes demonstrate that an "activity was not attempted (ANA)." In the event that an IRF-PAI item is coded as ANA, the imputation method inserts variables based on the values of other, non-missing items that are similar to the missing item to make assumptions about what the patient would have scored on that item if it had been attempted.

CHA strongly supports the inclusion of functional status measures in the IRF QRP and across the post-acute care settings. We appreciate the resources CMS has invested in developing this cross-setting measure, including the technical expert panel that was convened in 2021 and 2022. We also appreciate that CMS will not increase reporting burdens by using established GG items from the IRF-PAI and by proposing to remove overlapping measures in conjunction with the adoption of the proposed measure. However, we urge the agency to delay finalizing the measure across the QRPs until it has received endorsement from the CBE, and we offer several comments on considerations for possible refinements to the measure over time.

For example, we understand that the statistical imputation approach to addressing items coded as ANA was endorsed by the technical expert panel as the method most likely to produce an unbiased estimate of the patient's function had the item been attempted. However, it is a very complex calculation and may be difficult to understand how performance is impacted by both IRFs and the public. We urge CMS to continuously evaluate this method, particularly to identify if it has differential impacts across the post-acute care settings. In addition, we urge CMS to provide additional coding guidance for ANA use for the GG items in order to better standardize and reduce the use of ANA codes.

We also urge CMS to consider additional factors for risk adjustment in the future to help ensure that the measure does not disincentivize IRFs from taking on more complex patients. CHA members have reported that post-acute care patients with significant comorbidities such as a diagnosis or history of COVID-19 or Long COVID can take much longer to recover than other patients, and this could be a factor that may impact a patient's expected function score. Under the hospital readmissions reduction program and the hospital value-based purchasing program clinical outcomes domain, CMS includes a covariate risk adjustment on measures for patient history of COVID-19 within 12 months of admission. While it may be too early to understand the impact of COVID-19 on functional outcomes, we urge CMS to monitor its data for future measure refinements. In addition, we urge the agency to consider how it could address the impact of social determinants of health (SDOH) on functional outcomes, including how data from the new SDOH elements in the IRF-PAI 4.0 could contribute to this work.

Proposed Adoption of Percent of Patients/Residents who are Up to Date with COVID-19 Vaccination Measure

CMS proposes to adopt an assessment-based process measure that reports the percent of stays in which patients in an IRF are up to date on their COVID-19 vaccinations per the CDC's latest guidance,

beginning with the FFY 2026 IRF QRP. The data would be collected via a yes/no question on the IRF-PAI, and the measure has no denominator exclusions and is not risk-adjusted.

CHA strongly supports COVID-19 vaccination and we do not oppose the concept of a patient or resident vaccination measure. However, as noted in our comments on the HCP vaccination measure, much remains unknown about the seasonality of COVID-19, future vaccination schedules, and how often new versions of a COVID-19 vaccine will be available. It is unclear that most patients would have an understanding of the CDC's specific definition of "up to date" when answering a yes/no question for the patient assessment, leading to potentially inaccurate data. Further, we are concerned that the publicly reported data will not be reflective of any actionable activity by the facility, given the limited role of IRFs in vaccination efforts.

We note that during the pre-rulemaking process, the Measures Application Partnership (MAP) Coordinating Committee did not support the adoption of the measure, and urged CMS to reconsider exclusions for medical contraindications, complete reliability, and validity measure testing, and seek endorsement by the CBE. We urge CMS to follow the recommendations of the MAP Coordinating Committee, and delay adoption of such a measure until it has been thoroughly tested and endorsed by the CBE.

Modification of Regulation for Excluded IRFs Paid Under the PPS
CMS proposes to revise regulations to establish a uniform rule for status changes for IRF units that would permit the status of an IRF unit to be changed from not excluded to excluded (or excluded to non-excluded) at any time during a cost period. CMS notes that the existing policy was implemented before the establishment of IRF PPS and was created to address the administrative complexity associated with cost-based reimbursement. CMS concludes that the requirement that status changes occur at the beginning of a cost reporting period only is no longer necessary, creates an unnecessary burden, and does not take into account the challenges that hospitals may face in completing construction projects. CHA appreciates CMS' recognition of the need to update this regulation, and strongly supports this change. CHA also requests that CMS clarify that this change is applicable to free-standing IRF hospitals, as well as distinct part units of general acute care hospitals.

CHA appreciates the opportunity to comment on the FFY 2024 IRF PPS 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