May 28, 2024

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

***SUBJECT: CMS-1804-P, Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for FFY 2025 and Updates to the IRF Quality Reporting Program; Proposed Rule, Federal Register (Vol. 89, No. 62), March 29, 2024***

Dear Administrator Brooks-LaSure:

On behalf of 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) 2025.

California's hospitals, including its inpatient rehabilitation hospitals, continue to face unprecedented financial pressure. From 2019 to 2023, costs per adjusted discharge rose 25%[1] (driven by increases in salary costs +33%, supply expenses +18%, and pharmaceuticals +19%). However, base payment rates for Medicare have failed to keep pace with input price inflation.

There is widespread concern that the proposed 2025 IRF rule will only exacerbate these challenging circumstances for inpatient rehabilitation facilities and the patients they serve. The proposed net market basket update (MBU) of +2.8% is inadequate relative to the input price inflation faced by IRFs. It continues CMS' historic trend of proposing woefully inadequate payment updates. In 2022, CMS finalized an unadjusted MBU of 2.6%. However, the actual data used by CMS to set the MBU for IRFs show that costs actually increased by 5.3% (a difference of 2.7% from the final MBU), resulting in a significant underpayment to IRFs in 2022. Further, in 2023, CMS finalized a MBU of 4.2%. Again, the actual data used by CMS to set the MBU for IRFs show that costs actually increased by 4.8% (a difference of 0.6% from the final MBU), resulting in a continued, compounding underpayment to IRFs in 2023 as well. It is anticipated a similar result will have occurred when the 2024 final data is available. To ensure continued broad access to inpatient rehabilitation, CMS is respectfully asked to use data that better reflects the

[1] Current State of California Hospital Finances, Kaufman Hall, May 2024

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input price inflation that IRFs have experienced and are projected to experience in 2025. Further, CMS must make a one-time "forecast error adjustment" to account for prior years' underestimation of the IRF MBU. Below, please find specific comments on these issues.

## Market Basket Update

CMS proposes a market basket increase for FFY 2025 of 3.2%. This is then reduced by the negative 0.4 percentage-point "productivity adjustment" required under the ACA. The resulting proposed IRF MBU equals 2.8% (3.2% minus 0.4 percentage points for productivity reduction).

**IRFs are deeply disappointed in the net proposed 2.8% MBU, as it is wholly inadequate relative to the input cost inflation experienced by IRFs.** In light of this, CMS is asked to:

1. Recalculate the MBU using data that more accurately reflects the growth in input prices.
2. Provide a one-time "forecast error adjustment" that accounts for CMS' gross underpayment of IRFs since 2021.

While it is understood that CMS will refresh the MBU in the final rule with more recent data, concerns remain on whether the revised update will still be insufficient relative to input cost inflation (as has been the case in prior years). As discussed above, California's per discharge costs have increased 25% from 2019 to 2023. However, over the same period, the MBU has only increased per unit payments 11.45%.[2]

Even before the application of the productivity adjustment, the methodology — based on IHS Global Insight (IGI) data — fails to keep up with cost growth year-over-year. It is clear, based in particular on sustained elevated labor costs and increased utilization of contract labor in response to nursing shortages, that CMS' current methodology for updating the market basket is ill-suited to the current environment as it does not properly account for the growth in costs associated with contract labor. **Therefore, CMS is asked to consider other methods and data sources to calculate the final rule "base" (before additional adjustments) MBU that better reflects the rapidly increasing input prices facing IRFs.**

Specifically, CMS is asked to consider using the average growth rate in allowable Medicare costs per risk adjusted discharge[3] for IRF hospitals for FFY 2022 to calculate the FFY 2025 final rule MBU from IRF cost reports (both freestanding and sub-providers of an acute care hospital). This growth rate will capture the increased cost of contract labor, unlike the proxy for labor cost growth currently used in the proposed MBU. Based on analysis, this would yield an unadjusted MBU of 4.08%. A net MBU of 3.68%[4] for FFY 2025 better reflects the actual input price inflation California's hospitals anticipate facing in the coming year, rather than the 2.8% net MBU proposed by CMS.

The Medicare cost report data capture all allowable costs, including personnel costs (and excluding non-operating costs) that comprise inpatient rehabilitation services. ***Given that these data comprise all the costs — on a volume and risk-adjusted basis — necessary to provide inpatient rehabilitation, they represent appropriately weighted indicators of changes in wages and prices which are representative of the mix of goods and services necessary to provide inpatient rehabilitation services to Medicare beneficiaries***. While these data are a measure of historical cost growth, they reflect the payment

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[2] CHA analysis of CMS market basket data.
[3] CHA analysis of Medicare cost report data.
[4] 3.68% = (4.08% MBU - 0.4% ACA-mandated productivity factor)

increase necessary to maintain services more accurately than projections of cost inflation for FFY 2025 from the IGI data used in the proposed rule.

Further, CMS typically uses proxy data wherever possible to avoid circularity issues. However, this is not a reasonable argument against using cost report data. In many instances, the “proxy data” used to construct the MBU are based on the Bureau of Labor Statistics’ surveys of hospitals.[5] Therefore, using cost report data in this instance does not introduce any additional circularity to CMS’ calculation of the MBU than already exists.

If CMS fails to provide an adequate MBU, access to inpatient rehabilitation services for Medicare beneficiaries will be negatively impacted. The first order effect will harm beneficiary outcomes for those needing intensive rehabilitation. As a second order effect, the discharge delays that stem from patients who should be discharged to an IRF, but cannot be placed in a skilled-nursing facility due to patient needs, will exacerbate existing throughput issues and further reduce access to emergency department services and acute care beds.

Second, in prior comment letters,[6,7] hospitals have expressed concern that the MBU proposed (and subsequently finalized) in a given year was inadequate relative to input price inflation. Unfortunately, these concerns continue to be realized. Based on analysis of CMS files, since 2021, the MBU finalized by CMS using projected data has underpaid IRFs by 3.7% relative to what the actual market basket data determined hospitals should have been paid for services to Medicare beneficiaries per statute. The table below provides details.

**Medicare Underpayment of IRFs Due to Inadequate Market Basket Update (MBU)**
***Related to FFYs 2021 – 2023***

| FFY | Final Rule Projected MBU | MBU Based on Actual Data | IRF Under Reimbursement |
|---|---|---|---|
| 2021 | 2.4 | 2.8 | -0.4 |
| 2022 | 2.6 | 5.3 | -2.7 |
| 2023 | 4.2 | 4.8 | -0.6 |
| Total | N/A | N/A | -3.7 |

In both the skilled-nursing facility PPS and the capital input price index (CIPI) used to update capital IPPS payments, CMS makes “forecast error adjustments” when it underestimates the MBU. As an example, the table below illustrates the forecast error adjustments finalized in 2023 (2021 MBU) and 2024 (2022 MBU) and proposed for 2025 (2023 MBU).

[5] For example, the labor portion of the market basket update is based on the BLS’ hospital Employment Cost Index.
[6] https://calhospital.org/wp-content/uploads/2023/05/CHA-Combined-Comment-Letters-FFY2022-2023-IRF-PPS-Proposed-Rules.pdf
[7] https://calhospital.org/wp-content/uploads/2023/06/CHA-FFY-2024-IRF-PPS-Proposed-Rule-Comment-Letter-060223_Final.pdf

**Skilled-Nursing Facility Forecast Error Adjustments Finalized/Proposed**
***Related to FFYs 2021 – 2023***

| FFY | Final Rule Projected MBU | MBU Based on Actual Data | SNF Forecast Error Adjustment |
|---|---|---|---|
| 2021 | 2.2 | 3.7 | -1.5 |
| 2022 | 2.7 | 6.3 | -3.6 |
| 2023 | 3.9 | 5.6 | -1.7 |
| Total | N/A | N/A | -6.8 |

**Similar to the forecast error adjustments proposed in the FFY 2025 SNF and IPPS rule for the CIPI, CMS is asked to apply a one-time 3.7 percentage point "forecast error adjustment" to the proposed FFY 2025 IRF MBU of 4.08%[8] for a 7.78% update, prior to application of the 0.4% ACA productivity adjustment. This will account for the significant underpayment that occurred in FFYs 2021, 2022, and 2023, and help preserve access to intensive rehabilitation services for Medicare beneficiaries.**

While stakeholders asked CMS to provide a forecast error adjustment in response to the inadequate payment update in the FFY 2023 and 2024 IRF proposed rules, CMS declined to do so. The agency in 2023 responded (and referenced this response in the 2024 final rule) that:

> *Section 1886(j)(3) of the Act requires that the Secretary shall determine a prospective payment rate[9] 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,[10] 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.*

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[11] 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)[12]. The increase factor to be applied under this subparagraph for each of fiscal years 2008 and 2009 shall be 0 percent.[792]*

[8] Assumes CMS elects to use a data source for the market basket update that more appropriately reflects hospital cost growth.
[9] Emphasis added.
[10] Emphasis added.
[11] Emphasis added.
[12] (b)(3)(B)(ii)(VIII): Subsequent fiscal years is the market basket percentage increase.

The word “prospective” is not used in Section 1886(j)(3)(C)(i) to describe or modify the IRF “increase factor.” Further, it is noted that the section requires that the factor be based on an "appropriate percentage increase.”

The actual (appropriate) MBUs for 2021, 2022, and 2023 were cumulatively 3.7 percentage points higher than the final rule (projected) MBUs that CMS used to update IRF payment rates. This depressed MBU 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 for the fiscal years in question. Therefore, CMS should make a one-time adjustment to account for these significant underpayments.

California’s hospitals appreciate the opportunity to comment on the FFY 2025 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, federal policy, at mhoward@calhospital.org or (202) 488-3742.

Sincerely,

/s/
Chad Mulvany
Vice President, Federal Policy