



June 2, 2023

The Honorable Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Blvd
Baltimore, MD 21244

Re: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2024 and Updates to the IRF Quality Reporting Program; CMS-1781-P

Dear Administrator Brooks-LaSure:

On behalf of the Arizona Hospital and Healthcare Association and our more than 80 hospital, healthcare and affiliated health system members, we are pleased to present CMS with the following comments on the Fiscal Year 2024 Inpatient Rehabilitation Facility ("IRF") Prospective Payment System ("PPS") Proposed Rule (88 Fed. Reg. 20950) (April 7, 2023) (referred to herein as the "Proposed Rule").

I. Payment Updates

A. Proposed Update to the Case-Mix Group (CMG) Relative Weights and Average Length of Stay Values for FY 2023

CMS has proposed updates to CMG relative weights and average length of stay values using fiscal years ("FY") 2022 IRF claims and 2021 IRF cost reporting data. We support CMS' update to the CMG relative weights and average length of stay values for FY 2024 and encourage CMS to use the latest available data to update these in the final rule.

B. Proposed Market Basket Increase Factor and Productivity Adjustment

While AzHHA supports the proposal to update the market basket using the latest available data, we remain concerned that the impacts of the Public Health Emergency ("PHE") are not adequately factored into the payment rate update. **The PHE, along with inflation, have significantly driven up operating costs for all Arizona hospitals, including IRFs. We believe the market basket increase is woefully inadequate.** The Skilled Nursing Facility ("SNF") payment system had a 3.6 percent "forecast error" adjustment in their proposed rule, indicative of the complexity in accurately accounting for the unprecedented challenges driving up costs. CMS should make an additional increase to the IRF PPS market basket factor to more closely match payment rates with the cost of IRF operations.

We are also concerned about the continued application of a market basket “productivity adjustment,” especially given how the PHE has disrupted normal hospital productivity efforts. **We request CMS to monitor the impact productivity adjustments have on rehabilitation hospitals and ask CMS to provide feedback to Congress (as these were statutorily required under the Affordable Care Act) and reduce the productivity adjustment.**

C. Proposed Revision and Rebasing of the IRF PPS Market Basket to a 2021 Base year

AzHHA generally supports the update, although FY 2023 would be a better year for CMS to use for rebasing, as inflationary pressures and cost increases seemed to have moderated somewhat in this year. We also respectfully urge CMS to emphasize the importance of full and accurate cost reporting.

D. Proposed Wage Index Adjustments

AzHHA members encourage CMS to release wage index tables in the Final Rule that incorporate the cap on Core Based Statistical Areas (“CBSAs”) that meet the five percent decrease criteria to avoid errors in payment rates by the Medicare Administrative Contractors (“MACs”). We further encourage CMS to implement similar policies contained in the Inpatient Prospective Payment System (“IPPS”) to address wage disparities between high and low wage index IPPS hospitals and IRFs.

E. Recommendations on the Low-income Patient, Teaching Status, and Rural Coefficients Facility-Specific Adjustment Factors

We recommend that CMS provide an update to the Rural adjustment and Low-Income Patient (“LIP”) adjustment factors using the current CMS methodology of utilizing the last three fiscal years of data. The Teaching adjustment does not have the same stability as the other two adjustment factors, and confounding factors may be impacting the calculations. Based on analyses from Dobson|DaVanzo, we recommend that CMS update LIP and Rural coefficients using the average of the most recent three years while “capping” the Teaching coefficient at the IPPS level. If CMS decides to update these three payment adjustments in the future, we recommend phasing in these payment adjustments over a two or three-year period.

F. Proposed Update for High-Cost Outliers

Due to the apparent mismatch of hospitals receiving high-cost outlier payments with data showing no increases in case-mix indices, CMS should consider: (1) capping the overall outlier payments an IRF can receive at ten percent of its total IRF PPS reimbursement (consistent with outlier payment methods in the Home Health PPS); or (2) reducing the overall three percent outlier pool.

II. IRF Quality Reporting Program

A. Proposed Modification to COVID-19 Vaccination Coverage Among Healthcare Personnel (“HCP”) Measure

While CMS has proposed a modification of the COVID-19 Vaccination Coverage among HCP, AzHHA recommends that CMS remove the measure to reflect the end of the PHE and recent announcements that CMS will soon be removing the COVID-19 vaccination mandate for healthcare workers. If, instead, CMS chooses to move forward on the measure, they should align it with the requirements of the Hospital Conditions of Participation (“COPs”) and allow not only medical exemptions but religious exemptions. We also recommend CMS revise the measure specifications to have data submitted in monthly or quarterly periods instead of one week a month for each quarter, in line with other Quality Reporting Program (“QRP”) measures.

B. Proposed Adoption of COVID-19 Vaccine: Percent of Patients/Residents Who are “Up to Date”

In addition to removing the QRP for HCP regarding COVID-19, we recommend CMS withdraw its proposed adoption of the COVID-19 vaccine for patients/residents who are “up to date” due to the end of the PHE. Patients interested in an updated vaccine will likely have had the option to receive one in the acute setting prior to their admission to the IRF. While we understand that vaccination is one of the best ways to prevent infection or severe illness, as we are no longer in the PHE it will likely be increasingly difficult for healthcare providers to gather patients’ vaccination status information and determine if it is accurate or not. IRFs, particularly freestanding rehabilitation hospitals, do not have immediate or ongoing access to COVID-19 vaccines and/or boosters, and will have difficulty affecting this measure. Moreover, the vaccine has known side-effects which are not conducive to participating in intensive rehabilitation therapy.

C. Proposed Adoption of Discharge Function Score Measure Beginning with the FY 2025 IRF QRP

AzHHA members do not support the adoption of the proposed Discharge Function Measure in its current form. We recommend that CMS either modify this measure or choose not to implement it.

We are concerned that the statistical imputation model used in the measure will supersede the clinical judgement of providers assessing their patients, pursuant to CMS guidance. It is not clinically or statistically appropriate to assign or infer the score for one functional item from an unrelated item. For example, when a patient receives tube feedings or parenteral nutrition (the patient does not eat or drink by mouth and relies solely on nutrition and liquids through tube feedings or total parenteral nutrition (“TPN”) due to a new (recent onset) medical condition), item GG0130A, Eating, is to be coded as “88 Not attempted due to medical condition or safety concerns.” In the revised imputation method under the proposed function measure, however,

this patient's functional status could be recorded at a higher level based on "the most likely score" of other, completely unrelated functional items.

Additionally, Activity not Attempted ("ANA") codes are not "missing data" as CMS indicates in the Proposed Rule, but rather are coded in accordance with CMS' IRF-PAI guidance for patients not able to attempt a GG functional item. We are concerned that the model was built utilizing data from a small subset of the IRF patient population (i.e. patients without any ANA or including skipped or dashed codes) which is not fully representative of the patients treated in IRFs.

We are also concerned that combining self-care and mobility into one measure may disadvantage certain patients, as some patients have an imbalance of impairment between upper mobility and lower mobility. Self-care and mobility items should be assessed and reported independently to provide the most accurate assessment of a patient's abilities and disabilities.

Furthermore, the proposed combined measure has not been tested for reliability, validity, or feasibility, nor has it gone through the National Quality Forum ("NQF") measure development process. CMS and its contractor, Acumen, should release more data for stakeholders to fully understand the scope of this measure and how if at all it may impact certain patient groups.

Finally, current mobility and self-care measures are not standard or interoperable between post-acute care ("PAC") providers, as denominators differ in the measure calculations across providers. Until this is resolved, calculating a cross-setting function measure will not be meaningful in characterizing patients or comparing their outcomes across the different PAC settings.

D. Removal of the Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and Care Plan

Overall, AzHHA members generally support the removal of this process measure but continue to believe providers should be setting and tracking individual patient functional goals for their plan of care.

E. Proposed Removal of the IRF Functional Outcome Measures: Change in Self-Care Score and Change in Mobility Score for Medical Rehabilitation Patients

AzHHA members suggest that CMS reconsider retiring the Change in Self-Care and Change in Mobility measures. While these measures may be highly correlated with their respective Discharge Self-Care and Discharge Mobility scores, they are measures of patients who meet or exceed a specific risk-adjusted goal and representative of the goals of IRF care as a whole.

F. Request for Information: Principles for Selecting and Prioritizing IRF QRP Measures and Concepts under Consideration for Future Years

In general, AzHHA members hope CMS will prioritize measures and concepts for the future that reduce burden for providers and that CMS consider removing measures that may not provide clinical value. Below are some more specific suggestions:

1. For Cognitive Function, CMS should be cautious in developing any quality measures based on change in cognitive function as it may have unintended consequences for patients' access to care.
2. While we appreciate CMS' work to address behavioral and mental health, a quality measure for these may not be as relevant for the inpatient rehabilitation setting. If CMS does pursue this, IRFs are already required to collect PHQ 2 to 9, and this could be utilized for any developed measure.
3. Patient Satisfaction and Experience measures have been considered previously; due to the associated cost and burden of data collection for small, hospital-based IRFs, we do not recommend CMS move forward with this.
4. For IRFs, measures on pain management may not be appropriate, as pain is an inherent part of intense rehabilitation therapy; a pain measure could be designed to assess whether staff were responsive to and helped manage patients' pain instead of reporting its existence.

G. Additional QRP Comments

We respectfully urge CMS to release additional patient-specific data and information for claims-based quality measures, at least quarterly. Additionally, as CMS considers the removal of several measures under this Proposed Rule, it should also consider removal of the Catheter Associated Urinary Tract Infection ("CAUTI") Outcome measure, as measure performance among IRFs is so high and unvarying it does not provide a meaningful distinction in quality among providers.

Thank you for the opportunity to comment on this rulemaking. Please feel free to contact me with any questions.

Sincerely,

A handwritten signature in cursive script, appearing to read "Amy Lystra".

Director of Financial Policy and Reimbursement, AzHHA