May 31, 2022

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 2023 and Updates to the IRF Quality Reporting Program; CMS-1767-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 2023 Inpatient Rehabilitation Facility ("IRF") Prospective Payment System Proposed Rule (87 Fed. Reg. 20218) (April 6, 2022) (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") 2021 IRF claims and 2020 IRF cost reporting data. We support CMS' update to the CMG relative weights and average length of stay values for FY 2023 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

AzHHA supports the proposal to update the market basket using the latest available data, but 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. The SNF payment system had a 1.5 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 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. Solicitation of Comments on the IRF Transfer Policy:

CMS is requesting input on the potential addition of home health into the IRF Transfer Policy in future rulemaking, i.e., for patients discharged prior to their CMG's average length of stay ("ALOS") their case would see payment reduction, similar to early transfers to SNFs, acute hospitals, LTCHs, or other IRFs.

AzHHA does not support the addition of home health to the IRF Transfer Policy, and CMS should not propose it in the future. Patients' goals after an IRF stay are to discharge back to the community; IRFs should not be penalized for discharging patients who have attained a functional improvement level enabling them to return home to do so when they are ready. Many IRF patients qualify for home health upon discharge, and while not as intensive, home health helps maintain the functional and cognitive improvements developed while at the IRF.

While CMS has suggested early transfers to home health from IRFs possibly may be a "substitution of care," this is not supported in the data, which show vast majority of those patients discharged to home health before the ALOS receive equal or less physical therapy and nursing visits and minutes compared to patients discharged to home health on or after their CMG's ALOS.

## III. IRF Quality Reporting Program

AzHHA's IRF members are generally supportive of creating a cross-setting function measure for post-acute care (PAC) providers but we request further details on measure specifications. Prior to implementing such a measure, CMS should standardize mobility and self-care measure denominators across PAC settings. Any measure developed must be able to differentiate a wide range of patient functional levels across each PAC setting and preserve the ability to distinguish functional dependency. The measure should allow clinicians to use their professional judgement when determining whether a Walk or Wheelchair score is most appropriate, as was the case under the FIM assessment.

While we strongly support CMS' effort to ensure the safety of patients and healthcare providers from infection from COVID-19, too many unknowns remain about the course of the disease to

support development of a PAC patient COVID-19 vaccination coverage measure at this point. There are considerable differences in acceptance of COVID-19 vaccinations throughout the United States, making this measure less meaningful in distinguishing IRFs' performance. Too many unknowns also remain in order to develop a consistent definition of "fully vaccinated," such as if more than one booster of the vaccine will be necessary; the timing required for booster doses; patients' eligibility for COVID-19 boosters; and the trajectory of COVID-19 from the pandemic stage to an endemic or seasonal phase. Such unknowns could create confusion or the need to restructure the measure year-to-year, rendering its collection ineffective. **As such, we do not support development of a PAC patient COVID-19 vaccination coverage measure at this point.**

CMS should discontinue use of the *Clostridioides difficile* Infection (CDI) measure as it does not provide meaningful differences among hospitals. Barring its discontinuation, support moving to a digital Quality Measure (dQM) with a two-year transition period.

AzHHA supports the proposal to expand quality reporting measures to include all patients, regardless of payer status. CMS should reduce the 95 percent IRF-PAI completion threshold to align with other PAC providers standards and reduce provider burden given the increased length of the IRF-PAI.

## IV. Health Equity RFI

AzHHA commends CMS for their focus on health equity, but we ask the Agency to consider what data they already have (or will soon begin collecting) before requiring additional provider reported elements. CMS should reassess current and planned programs with a health equity lens, such as the IRF RCD and oversight of Medicare Advantage plans, to ensure they maintain access to care for beneficiaries.

CMS should also provide all PAC providers with patient-level feedback data for claims-based measures, so providers may improve and refine process for quality of care initiatives. We are hesitant to support any "check the box" type of structural measure for assessing hospital leadership involvement in healthcare equity, because this will not be a useful data point to differentiate hospitals on quality and equity. Finally, CMS should consider regulatory flexibilities that could help providers to effectively act on healthcare disparity gaps.

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

Sincerely,

Executive Vice President, AzHHA