

June 7, 2021

Ms. Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, Maryland 21244-1850

**RE: CMS-1748-P, Medicare Program: Inpatient Rehabilitation Facility Prospective Payment System for Fiscal Year 2022 Rates; Proposed Rule**

Dear Ms. Brooks-LaSure:

The Michigan Health & Hospital Association (MHA) appreciates this opportunity to provide comments to the Centers for Medicare & Medicaid Services' (CMS) regarding the fiscal year (FY) 2022 proposed rule to update the **Medicare Inpatient Rehabilitation Facility (IRF)** prospective payment system (PPS). This rule is expected to increase Medicare fee-for-service (FFS) payments to Michigan IRFs by \$3.2 million, or 1.6%, in FY 2022.

**COST OUTLIER THRESHOLD**

The CMS has established a target of 3% of total IRF PPS payment to be set aside for high-cost outlier payments. To achieve this target for FY 2022, the CMS proposes a 16.3% increase to the \$7,906 current threshold increasing it to \$9,192. The CMS has used FY 2020 claims to establish the FY 2022 threshold. **We oppose the use of FY 2020 data for establishing the FY 2022 threshold given the significant impact of the COVID-19 pandemic and request that the CMS maintain the current threshold.**

**IRF QUALITY REPORTING PROGRAM**

**IRF ADOPTION OF COVID-19 VACCINATION AMONG HEALTHCARE PERSONNEL (HCP) MEASURE**

The MHA appreciates that this proposed measure represents an effort by the CMS to advance measurement to address the public health emergency and provide consumers with data to make an informed decision when choosing an IRF. **However, we believe that advancing this measure prior to full approval by the Food and Drug Administration (FDA) is premature. As such, we oppose the adoption of this measure at the present time for reasons highlighted below.**

*Vaccine hesitancy*

The COVID-19 vaccines are currently approved through an emergency use authorization and a significant number of Americans have chosen not to be vaccinated because of concerns regarding serious adverse events, the compressed timeline for development and approval, and general mistrust of the government and public health community. Vaccine hesitancy has created challenges among the general public and among HCP.

*Unintended consequences and legal risk*

If this measure were adopted and publicly reported, IRFs would be held accountable for HCP vaccinations. The MHA is concerned that some IRFs may choose to mandate that HCP receive the vaccine as a strategy to achieve high performance, creating ethical and legal issues. Mandating the vaccine may also result in HCP leaving their positions, putting an additional strain on an already

**Brian Peters**, Chief Executive Officer

challenged workforce with many vacant positions in not only IRFs but across all healthcare settings. MHA members have also expressed concern about the legal risk to their organization if HCP experience an adverse event related to the vaccine. We also believe publicly reporting HCP vaccination rates may inappropriately pit facilities against one another based on public opinion regarding the vaccine.

#### *Timeliness*

Given the time-sensitive nature of this measure, the CMS proposed to use a shortened reporting period (October-December 2021) for the FY 2023 program year, followed by quarterly reporting deadlines starting with the FY 2024 program. The MHA questions whether this information will be of value in 2023 and beyond for quality improvement or consumer-decision making given the time associated with data collection, submission, and validation.

We support and encourage that consumers have access to real-time meaningful data to help inform healthcare decision-making but believe that the use of a single, dated measure is not a true reflection of the safety or quality of care delivered at the SNF.

#### *Duplicative reporting is administratively burdensome*

The MHA recognizes that COVID-19 vaccination reporting is already required by the Michigan Department of Health and Human Services via the Michigan Care Improvement Registry (MCIR) system. We believe that requiring additional HCP vaccination data to be reported into the NHSN is redundant and burdensome particularly as SNFs struggle to meet current COVID-19 data reporting requirements at the state and national level.

**While the MHA opposes the adoption of the COVID-19 HCP vaccination measure in any of the quality reporting programs for FY 2022, we understand the intent of the measure and urge the CMS to consider the following:**

- **Delay the measure adoption until the vaccine has been given full approval by the FDA and the measure specifications are complete and have been endorsed by the NQF.**
- **Utilize HHS TeleTracking COVID-19 vaccination data to track vaccination rates at the facility level.**
- **Direct consumers to use the HHS TeleTracking site as the data is reflective of current HCP vaccination rates.**

#### **REQUEST FOR INFORMATION: CLOSING THE HEALTH EQUITY GAP**

Upon the 2017 launch of the “Patients over Paperwork” Initiative, the CMS’ goal was to reduce unnecessary regulatory burden and enable providers to concentrate on their primary mission of improving patient health outcomes which is supported by the MHA and other stakeholders.

The CMS outlines several areas within this RFI in which additional quality measures and standardized patient assessment data elements (SPADEs) may be implemented in the future. **The MHA has significant concern about adding additional SPADEs since this may ultimately increase burden and negatively impact patient experience.**

As CMS considers additional measurement to address health equity, **the MHA urges the CMS to honor its “Patients Over Paperwork” initiative and streamline, align, and focus on those measures that matter most for patient care and outcomes. We recommend leveraging existing solutions and datasets, while standardizing and streamlining data collection processes and ensuring consistency of definitions, categories and variables such as race and ethnicity across all federal programs to reduce administrative burden and enable clinicians to focus on patient care.** The MHA urges the CMS to develop support for providers for capturing, using, and exchanging information within and across service lines.

**The MHA urges the CMS to consider the following recommendations:**

- **Choose, adopt, and adequately incentivize the use of a single standard data set** that captures necessary and sufficient information on non-clinical patient characteristics. **This should be minimally burdensome to providers** and we recommend the adoption of standardized screening tools such as PRAPARE, AAFP’s EveryONE project, or the CMS ACH Health-Related Social Needs screening tool, or the use of z-codes.
- **Distribute resources into community safety net programs to properly address social needs identified in data collection.** We urge the CMS to continue expanding the portfolio of programs and resources to support data analyses and quality improvement activities to bridge hospital-level efforts with post-acute and community-based programs and models to close health equity gaps due to lack of resources and accessibility to help strengthen the standardized collection of social needs data.
- **Expand disparity methods to include stratified results beyond current dual eligibility stratification since stratifying by dual eligibility status alone is not sufficient.** This is an easily accessible proxy measure that in no way captures the breadth of social determinants. We urge the CMS to include race and ethnicity, language preference, veteran status, health literacy, sexual orientation, and disability status which will enable a more comprehensive assessment of health equity to further identify and develop actionable strategies to promote health equity.
- **Reconsider creation of a facility equity score:** Although this is modeled from the Health Equity Summary Score (HESS) developed for the Medicare Advantage plans, the development of this score was virtually conceptual and not currently being utilized. By combining multiple measures and risk factors using output from the CMS disparity methods there would be a resulting “composite like” score. **The MHA believes a vague “composite-like” measure is not actionable or useful and cannot be feasibly and accurately calculated.**
- Consider a potential future measure regarding **organizational commitment to health equity.** We believe that consideration should be given to an attestation-based structural measure of a disparities impact statement (DIS) or organizational pledge that outlines how infrastructure supports the delivery of care that is equitable for all patient populations.

We believe that our recommended changes would result in a positive outcome for IRF and the Medicare beneficiaries and all patients they serve. If you have any questions, please contact me at (517) 703-8608 or via email at [vkunz@mha.org](mailto:vkunz@mha.org).



Sincerely,  
Vickie R. Kunz  
Senior Director, Health Finance