MHA Michigan Health & Hospital Association | Leading Healthcare

June 1, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: CMS-1781-P, Medicare Proposed Rule to Update the Inpatient Rehabilitation Facility Prospective Payment System for Fiscal Year (FY) 2024

Dear Administrator Brooks-LaSure:

On behalf of its member hospitals, the Michigan Health & Hospital Association (MHA) appreciates this opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) regarding the proposed rule to update the Medicare fee-for-service (FFS) prospective payment system (PPS) for Inpatient Rehabilitation Facilities (IRFs) for fiscal year (FY) 2024. When all proposed changes are considered, the rule is estimated to increase FFS payments to Michigan IRFs by $5.8 million, or 3.1%, which fails to account for shortcomings in past market basket updates and the unprecedented financial strain hospitals in Michigan and across the United States (U.S.) continue to face. This also excludes the estimated impact of the 2% sequestration, estimated at $460,500 annually through FY 2032. Our specific comments are below.

Annual Payment Update

The MHA is disappointed with the CMS' proposed 3.3% annual market basket update given the surging inflation that hospitals continue to experience. As indicated above, when all proposed changes are considered, the rule is expected to increase IRF payments by only 3.1%, which is lower than the 4% increase in health care inflation for 2022 based on the U.S. Inflation Calculator. In addition, Medicare continues to pay less than the cost of providing care with the latest Medicare FFS margin data, indicating that, in total, Medicare payments cover only about 95% of the cost of care provided by hospitals. Absent substantial financial support in the final rule, IRFs will struggle to continue providing these vital services in their communities particularly as IRFs and other post-acute providers continue to face more intense labor shortages and challenges than inpatient hospitals in many cases. These staffing challenges impact the ability of inpatient hospitals to discharge patients in a timely manner, leading to increased expenses without commensurate revenue, higher length of stay and limited bed capacity in the hospital setting. The MHA has long advocated that the right care be provided at the right time in the most appropriate care setting. **We urge the CMS to modify the market basket update to provide an additional payment increase to help offset the unprecedented inflation currently faced by IRFs and other providers**.

We also remain concerned about the proposed application of the 0.2% productivity cut, which is estimated to reduce payments to Michigan IRFs by approximately $370,000 in FY 2024. Consistent with inpatient hospital patients, IRF patients are provided specialized, time-intensive, hands-on therapy services and care to help restore functionality. These types of services do not lend themselves to the proxy used by the CMS which is intended to capture new technologies, economies of scale, business acumen, managerial efficiencies and other changes in production**. The MHA urges the CMS to closely**

monitor the impact of such productivity adjustments and explore ways to use the agency's authority to offset or waive these adjustments.

Wage Index Policies

We continue to support the policy adopted for FY 2023 that implements a permanent 5% cap on any decrease to a provider's wage index, relative to the prior year. **However, the MHA urges the CMS to implement this policy in a non-budget-neutral manner which would both stabilize provider reimbursement and avoid further unexpected reductions for other providers.**

Proposed Modification to the Excluded Unit Regulation

Currently, to be paid under the IRF PPS, and excluded from the hospital inpatient PPS, an IRF unit of a hospital must be paid under the IRF PPS effective at the beginning of a cost reporting period and may not attain this payment status in the middle of a cost report period. This requirement is burdensome for hospitals as it is often difficult to predict the timing for completion of a construction project for a new IRF. This results in the hospital being unable to guarantee the completion at the beginning of a cost reporting period and can lead to significant revenue loss if the hospital must wait until the start of the next cost reporting period to be paid under the IRF PPS.

The CMS proposes to allow greater flexibility for hospitals to open an IRF excluded unit. Specifically, the CMS proposes to allow a hospital to open a new IRF unit anytime during the cost reporting year, if certain requirements are met. **The MHA believes this is a positive change that will increase access to IRF services and urges the CMS to finalize this proposal.**

Proposed Updates to the IRF Quality Reporting Program

As mandated by the Affordable Care Act, IRFs that receive Medicare payments have been required to participate in the IRF qualify reporting program (QRP) since 2014.The Improving Medicare Post-Acute Care Transformation (IMPACT) Act required, that starting FY 2019, providers must report standardized patient assessment data elements (SPADES) as part of the IRF QRP. Failure to comply with these requirements results in a 2-percentage point reduction in the annual market basket update. In the FY 2024 proposed rule, the CMS proposes to adopt two measures, modify an existing measure, and remove three measures. The CMS also proposes to begin public reporting of four measures.

Adoption of the Discharge Function Score Measure
The CMS proposes to adopt this assessment-based outcome measure that estimates the percentage of IRF patient who meet or exceed an expected discharge function score during the reporting period. The observed discharge function score is calculated by summing individual function item values from 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—in other words, based on the patient's characteristics and where they started in terms of function, how much 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". In the event that an IRF-PAI item is coded as "not attempted", the imputation approach inserts variables based on the value of other, non-missing items that are similar to the missing item resulting in the calculation making assumptions about what the patient would have scored on that item if it had been attempted based on their performance on other similar activities that were attempted.

The CMS proposes to begin publicly displaying data for this measure beginning with the September 2024 refresh of Care Compare, or as soon as technically feasible, using data collected from calendar year 2023. Displayed performance would be based on four quarters of data, updated quarterly**. The MHA**

opposes public reporting for this measure as it may inappropriately skew the decision-making process when patients and facilities are reviewing IRF performance prior to admission to an IRF. The MHA opposes adoption of this measure which is not currently endorsed by a consensus-based entity. The CMS states that it intends to submit the measure for endorsement as soon as feasible and is also proposing this measure for the Skilled Nursing Facility and Long-term Care Hospital QRPs. The methodology as proposed is extremely complex, which will increase cost and administrative burden on IRFs as they seek to comply with the new requirements. **The MHA urges the CMS to wait until this measure has undergone endorsement review by a census-based entity and demonstrates that it gleans useful information for patients and providers before adopting it for use in the IRF QRP.**

Adoption of Percent of Patients/Residents Who Are Up to Date with COVID-19 Vaccination Measure

The CMS proposes to adopt this assessment-based process measure beginning with the FY 2026 IRF QRP. This measure would report the percent of stays in which IRF patients are up to date on their COVID-19 vaccinations per the Centers for Disease Control and Prevention's (CDC's) latest guidance.

The CDC maintains different definitions of "up to date" and "fully vaccinated." The public and hospital and post-acute care patients likely have a limited appreciation for the differences in these definitions and could easily misreport their vaccination status to facility staff when asked, giving the public a misleading picture of the vaccination levels of a facility's patient population.

As shown in Michigan's booster vaccine data dashboard, vaccination administration rates can ebb and flow significantly based on factors outside the control of hospitals and other providers, including holidays, weather, vaccine/pharmaceutical supply chain management, staff availability and more. The frequency and speed with which these rates change will not accurately depict the vaccination rate of a facility's patients *or* staff.

Only 7.9% of individuals in the U.S. experience an overnight hospital stay annually. While hospitals support doing education of vaccinations during patient encounters, hospitals' ability to interact with and influence a statistically significant number of patients who are not up to date on their COVID-19 vaccinations is very limited. Moreover, with extreme staffing shortages plaguing our emergency departments, the resources to spend additional time gathering COVID-19 vaccine data, administering the vaccine, or doing extensive education on vaccination are limited.

The CDC confirms the following: "Adolescents and adults in rural areas had a much lower primary series completion rate and up-to-date vaccination coverage. Bivalent booster coverage was lower among non-Hispanic Black or African American (Black) and Hispanic or Latino (Hispanic) adolescents and adults compared with non-Hispanic White (White) adolescents and adults. Among adults who were open to receiving booster vaccination, 58.9% reported not having received a provider recommendation for booster vaccination, 16.9% had safety concerns, and 4.4% reported difficulty getting a booster vaccine." Hospitals fully support promoting vaccines among all populations, including at community-centered locations and through trusted community partners, in addition to hospital-operated facilities. However, these continuing disparities in vaccine uptake reflect not on the local hospital's efforts to vaccine their patients, but often in differences deeply rooted in culture, religion, ethnicity, socioeconomic status and more. These disparities should not be a measure associated with a hospital or an indicator to a potential patient of the safety of that hospital's environment; rather, they should be used to guide all vaccine advocates' efforts to increase vaccination rates in their communities.

The MHA respectfully requests the CMS to withdraw this proposal.

Modification of the COVID-19 Vaccination Coverage among Healthcare Personnel (HCP COVID-19 Vaccine) Measure

Beginning with the FY 2025 IRF QRP, the CMS proposes to modify the existing Healthcare Personnel (HCP) COVID-19 Vaccination measure used in the IRF QRP. The current measure assesses the number of HCP who have received a complete vaccination course against COVID-19. In this rule, the CMS proposes to replace the definition of "complete vaccination course" with a definition of "up to date" with the CDC recommended COVID-19 vaccines. The CMS proposes this modification to incorporate new CDC guidance related to booster doses and their associated timeframes.

The MHA supports vaccination as a means of keeping both staff and patients safe but we have concerns regarding this measure. The CDC maintains guidance that receiving a dose of COVID-19 vaccine may or should be delayed if a person has or has recently had COVID-19 infection. This could impact the timing of an employee's vaccine dosage, resulting in an inaccurate reporting of employees "up to date" on vaccination.

As mentioned above, disparities remain in different geographic areas, among races and more. These same disparities tend to exist within the healthcare workforce. Therefore, while hospitals and post-acute care facilities will continue to educate and encourage all employees to be vaccinated against COVID-19 to protect themselves and patients, challenges remain to overcome historical challenges and should not be measured against a hospital's ability to provide a safe environment.
The MHA opposes the proposed modification to the HCP measure and urges the CMS to not finalize the modified measure.

Removal of three measures from the IRF QRP

The CMS proposes to remove three measures from the IRF QRP beginning with the FY 2025 IRF QRP including the:

- Application of Functional Assessment/Care Plan measure;
- IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (Change in Self-Care Score) measure; and
- IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (Change in Mobility Score) measure.

The MHA supports the removal of these three measures and encourage the CMS to finalize the proposal to remove these measures. Specifically, the Application of Functional Assessment/Care Plan measure is topped out and no longer results in the intended effect.

<u>IRF-Patient Assessment Instrument Data Reporting Discrepancy</u>

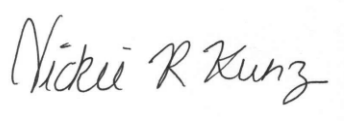
The MHA would like to highlight an issue identified by a member health system who noted that the new race and ethnicity tables adopted by the CMS on Oct. 1, 2022, do not align with the tables released by the Office of Management and Budget (OMB), as suggested by the Institute of Diversity and Health Equity. The health system's electronic medical record (EMR) vendor, EPIC, built its race and ethnicity tables based on the OMB tables. As such, the organization's race and ethnicity reporting does not align with the new CMS tables which results in duplicate work and repetitive questions to patients. This problem will impact any IRF that uses EPIC. **The MHA requests the CMS update its race and ethnicity tables to be consistent with the tables released by the OMB.**

<u>Summary</u>

The MHA appreciates this opportunity to provide comments to the CMS on the FY 2024 IRF proposed rule and believe that our proposed changes will have a positive impact on IRFs and all patients they

serve. If you have questions regarding this comment letter, please contact me at (517) 703-8608 or via email at vkunz@mha.org.

Sincerely,



Vickie R. Kunz
Senior Director, Health Finance