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June 2, 2023

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Submitted via regulations.gov

RE: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2024 and Updates to the IRF Quality Reporting Program

Dear Administrator Brooks-LaSure:

On behalf of our more than 200 member hospitals and health systems, including 39 facilities reimbursed under the inpatient rehabilitation facility ("IRF") prospective payment system, the Florida Hospital Association ("FHA") appreciates the opportunity to express our support and concerns related to the proposed changes to the IRF prospective payment system ("IRF PPS") for fiscal year ("FY") 2024.

Proposed Market Basket Increase and Productivity Update

CMS proposes a FY 2024 payment update of 3.0% for the IRF PPS. This proposed payment update was based on a 3.2% market basket update, less a 0.2% productivity adjustment. Florida's Inpatient Rehabilitation Facilities will receive an update approximately consistent with the national average.

Hospitals, including IRFs, have been facing unprecedented inflation. The most recent analysis from Kaufman Hall in its *National Hospital Flash Report* indicates that from 2020 to present, overall expenses have risen by 18% for hospitals. This has been driven in large part by labor costs, including contract labor costs, which have risen 258% since 2019. These increases have been felt sharply by IRFs, which must not only meet hospital-level requirements, but also are mandated to have specialized personnel such as rehabilitation nurses and therapists. These requirements are why CMS estimates that labor-related costs account for nearly three quarters of IRFs expenses.

These national trends are consistent with the experience of Florida's IRF providers. One 12 hospital IRF system in Florida reports a 14% increase in costs associated with salaries, wages, employee benefits, and contract labor. Another similar sized system reports increases in salaries during the COVID-19 PHE of approximately 20% for registered nurses, 35% for nurse aides, and 20% for respiratory therapists. In total, that system experienced a 12.6% increase in salaries, wages and benefits.

Inflationary and labor shortage pressures on IRFs and other hospitals will continue, with the Department of Health and Human Services (HHS) finding that health care workforce shortages will persist well into the future. As these pressures continue to mount, IRFs will be increasingly challenged to provide the highly skilled personnel needed to care for their complex patient mix.

Labor is not the only expense experiencing large growth in recent years. Hospital supply costs per patient have risen 18.5% between 2019 and 2022. Drugs, and especially specialized drugs, make up a large portion of this increase, with an HHS study finding that many commonly used drugs have had their price increase by more than 30% in recent years. Again, these increases are felt acutely by IRFs, which are caring for patients with some of the most complex post-acute care needs. These financial pressures on IRFs also have upstream effects on their acute-care partners, as shown in a December 2022 American Hospital Association study that revealed a 14% increase since 2019 in the average length of stay of hospital patients awaiting discharge to an IRF. This is due to staffing shortages in IRFs as they navigate the aforementioned challenges.

While these pressures have continued to mount, CMS' annual market basket updates have been inadequate to meet these rising costs. For FY 2024, the agency proposes a market basket update of only 3.2%. In FY 2021, 2022 and 2023, it provided only 2.4%, 2.6% and 4.2% market basket increases, respectively.

CMS' updated figures have demonstrated the deficiency in these figures, with more recent estimates showing the market basket for these years to be 2.7%, 5.3%, and 4.6%, respectively. The missed projections are tantamount to permanent underpayments to IRFs, since future payment adjustments continue to be built off of these market basket updates. **We are deeply concerned about increased costs to hospitals that are not reflected in the recent market basket adjustments and ask CMS to discuss in the final rule how the agency will account for these increased costs.**

Rebasing of the IRF Market Basket

FHA supports and appreciates CMS' proposal to update the market basket using the most recently available data. Rebasing the market basket no less than every four years ensures that IRF payments are updated to accurately reflect the mix of goods and services provided by IRFs. However, FHA is concerned that, while the labor market and input costs are now very different than they were pre-pandemic, as discussed above, the proposed new market basket does not differ substantially from the current market basket. More specifically, the proposed FY 2021-based market basket produces almost identical updates as the current, FY 2016-based market basket.

FHA generally supports this update, although FY 2023 may be a better year for CMS to use for the rebasing, as inflationary pressures and cost increases seem to have moderated somewhat during

this year. **FHA requests that CMS consider updating the IRF PPS market basket using FY 2023 in a future rulemaking to better align permanent changes that have occurred in more recent years.**

Proposed Wage Index Policies

FHA is appreciative of recent changes to wage index policies that have helped provide stability to IRF payments, including the application of a 5% cap on any reduction in an IRF's wage index from one year to the next. As discussed last year, we also encourage CMS to implement these caps in a non-budget neutral manner. FHA believes this is the only way to mitigate volatility caused by wage index shifts. **Therefore, we respectfully encourage the agency to modify its methodology to ensure these adjustments are made in a non-budget-neutral manner.**

CMS Special Exceptions and Adjustment Authority

Bipartisan coalitions in both the Senate and House of Representatives recently called on CMS to use its broad authority to reevaluate the hospital market basket update and implement a retrospective payment adjustment to account for the difference between the projected market basket update for FY 2022 and the actual market basket in FY 2022. These coalitions are being led by Sens. Bob Menendez and Kevin Kramer and Reps. Carol Miller and Brad Schneider. The coalition letters to Administrator Brooks LaSure regarding their concerns about the FY 2024 payment update CMS announced in the FY 2024 IPPS/LTCH PPS proposed rule state that CMS's use of historical data does not account for the higher costs of providing care, including the increases in labor and supply costs. Moreover, the letters express concern about the productivity adjustment that CMS applies to reduce the market basket update, because it is more likely that hospitals now are experiencing productivity declines instead of gains.

The letters therefore urge CMS to adopt a retrospective payment adjustment in the final rule to account for the differences between the FY 2022 market basket update and the actual market basket. Although these letters specify the IPPS, CMS should make the same types of changes to the IRF PPS.

IRF Quality Reporting Program (IRF QRP)

The Affordable Care Act mandated that reporting of quality measures for IRFs begin no later than FY 2014. The Improving Medicare Post-Acute Care Transformation (IMPACT) Act requires that, starting FY 2019, providers must report standardized patient assessment data elements and quality measures as part of the QRP. Failure to comply with IRF QRP requirements will result in a 2.0 percentage-point reduction to the IRF's annual market-basket update. For FY 2024, CMS requires the reporting of 18 quality measures by IRFs.

CMS proposes to adopt two new measures as well as a modified version of an existing measure while removing three measures. CMS also proposes to begin public reporting for four measures.

Modified COVID-19 Vaccination Coverage among Health Care Personnel (HCP) Measure

Beginning with the FY 2025 IRF QRP, CMS would adopt a modified version of the COVID-19 Vaccination Coverage among health care personnel ("HCP") currently used in the IRF QRP. While the current measure assesses the number of HCP "who have received a complete vaccination course against COVID-19," CMS would replace this term with "who are up to date" with their vaccination as recommended by the Centers for Disease Control and Prevention at the time of the reporting period.

The FHA supports appropriate vaccination of HCP to guard against transmission of and exposure to infection diseases within the hospitals, and to protect patients and staff. However, the evidence around the optimal cadence for booster doses of COVID-19 vaccines, as well as the seasonality of the virus itself, is evolving rapidly. Even federal guidance on vaccine utilization is frequently in flux; for example, as CMS notes in the Proposed Rule, the monovalent booster recommended by the CDC is no longer authorized for individuals 12 years or older.

Over the past several months, CDC and FDA have indicated they are seriously considering adoption of a once-yearly regimen for COVID-19 vaccinations, comparable to the well-established approach used for influenza vaccination.

We recommend CMS withdraw the proposed mandatory reporting requirement and continue to collect up-to-date vaccination status on a voluntary basis. Once FDA and CDC have completed their recommendations on an updated vaccination schedule, CMS considers ways to minimize the burden of data collection and reporting by working with provider stakeholder, and can offer a single annual reporting period, then a new proposed rule should be offered.

FHA is concerned that CMS is overlooking the administrative burden associated with collecting and reporting COVID-19 vaccination statute. We encourage CMS to learn from the experience of implementing the previous version of this measure and anticipate logistical challenges of data collection and reporting when considering this new version for inclusion in its various quality reporting programs.

Health care facilities are collecting and reporting data on up to date COVID-19 vaccination status on a voluntary basis. However, facilities have reported that this collection process is quite administratively burdensome under CDC's current up to date definition. This is because the collection protocol uses a reference time-period for determining up to date status that changes every quarter. Practically speaking, this means that HCP who counted as up to date in a given quarter may no longer be up-to-date in the next quarter.

Furthermore, CDC's vaccination guidance suggests that some individuals with certain risk factors should consider receiving an additional booster dose within four months of receiving their first bivalent dose. Yet, hospitals usually do not have routine access to data to know which of their HCP may need an additional booster. In fact, collecting accurate data on HCPs underlying risk factors likely would require hospitals to both obtain permission to have such data, and a mechanism to keep the data fully secure. This would be a resource intensive process, that would make reporting incredibly difficult.

Insofar as CMS moves forward with this measure, the adoption of a once-yearly vaccination regime would alleviate some of the administrative complexity of collecting up to date vaccination status. While we do not yet know the precise timing, recent discussions from the FDA and CDC's vaccination advisory committees, as well as public statements from the agencies and White House, suggests that such a schedule could be adopted as soon as Fall 2023. By delaying the required reporting of "up to date" vaccination status, CMS could align its reporting requirements around this more efficient approach.

As CMS continues to implement the HCP COVID-19 vaccination measure across its programs, we also urge it to consider other important implementation issues. For example, we that CMS get the measure endorsed by a consensus-based entity (CBE). A CBE endorsement process will enable a full evaluation of a range of issues affecting measure reliability, accuracy and feasibility. Given the urgency of addressing the COVID-19 pandemic, the current version of the measure never went through a CBE endorsement process and is relatively new to the CMS quality reporting programs. As a result, we have not yet had a holistic evaluation regarding whether the measure is working as intended (e.g., reflecting vaccination rates accurately, achieving CMS's stated goals of encouraging vaccination).

CMS also should consider what may not be reflected in the data and how incomplete data could impact information provided to patients. Many HCPs are not vaccinated because of religious or medical reasons. Understanding whether an HCP is not up to date because of religious or medical reasons will become even more difficult to ascertain as the CMS withdraws the condition of participation that requires health care facility staff to be vaccinated. Similar to the burden associated with hospitals tracking HCP risk factors (described above), hospitals will not have access to HCP reasons for not receiving the COVID-19 vaccine. As patients consider a facility's up to date vaccination rates the numbers should not be skewed by HCP who are not up to date because of religious or medical reasons.

Finally, CMS needs to consider how to implement this measure in a way that is consistent and logical with other sources of information regarding vaccination among health care personnel. The time lag between data collection and the publicly reported rate will result in a mismatch between the true rate of health care personnel who are up-to-date with their vaccinations and the rate that is

displayed on Care Compare; CMS needs to clearly communicate what publicly reported data reflects.

Discharge Function Score Measure

CMS proposes to adopt a Discharge Function Score measure beginning with the FY 2025 QRP (New measure for patients discharged on or after October 1, 2023). This measure would report the percentage of IRF patients who meet or exceed an expected discharge function score, which combines mobility and selfcare items that are collected on the mandatory inpatient rehabilitation facility-patient assessment instrument (IRF-PAI). CMS proposes to use a statistical imputation methodology to recode any instances where "activity not attempted", skipped or dashed data elements in Section GG of the IRF-PAI are documented. The agency issued the same proposals for the Skilled Nursing Facility (SNF) and Long-term Care Hospital (LTCH) QRPs as well in their respective rules, terming the measure a "cross-setting" measure. **FHA has several concerns with the adoption of this measure in its current form**.

While this cross-setting discharge function score measure appears to fulfill requirements of the IMPACT Act better than the current, setting-specific self-care and mobility discharge score measures used in the SNF, LTCH and IRF quality reporting programs (which CMS proposes to remove in this same rule), we continue to doubt the cross-setting applicability of this measure considering the different patient populations served by the various post-acute care settings. **The Proposed Rule even notes that the measure has not yet been reviewed by a consensus-based entity, meaning that it is not clear that the information produced by the measure will be valuable.**

The measure uses information from Section GG items that appear on all four of the patient assessment instruments across the various post-acute care settings. While patients are assessed using the same or similar items, the capabilities and goals of patients differ widely by setting. The measure developer notes that the measure is risk adjusted and calculated individually by setting; then, the calculation for measure performance "rolls up" information from several items to calculate an overarching score. Risk adjustment takes many variables into account, and denominators vary by setting (for example, the denominator for the measure when calculated in the IRF and LTCH QRPs includes all eligible stays, regardless of payer, while for the SNF QRP the denominator consists of patients/residents under Medicare fee-for-service only).

While we appreciate the work the developer has done to attempt to account for the myriad of differences in patient populations across the various settings – including demographics, case mix, severity of illness, length of stay and comorbidities – at some point these variables alter the underlying calculation of the cross-setting measure and result in four different measures. In other words, discharge function is calculated in a way that is not truly standardized, as the IMPACT Act intended.

It is at this point we ask whether it is necessary to force a measure that is "cross-setting" in name only into CMS quality programs; perhaps if testing of the measure demonstrates that this measure produces statistically meaningful information that can be used to inform improvements in care processes, it is. But until we have that information from the endorsement review process by a CBE, the FHA has doubts about this measure's utility.

In addition, the measure uses a statistical imputation approach to account for "missing" assessment elements when codes on the assessments note that the "activity was not attempted" (ANA). In the event of an assessor coding an item as "not attempted," the imputation approach inserts variables based on the values of other activities that were completed; in other words, the calculation makes 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 scored. CMS argues that this approach "increases precision and accuracy and reduces the bias in estimates of missing item values."

While we understand that scores would be influenced more heavily by individual assessment items if there are fewer included in the calculation, CMS errs in labeling items coded ANA as "missing." **When an activity is not attempted, it is likely because it would be clinical inappropriate or dangerous for a patient to attempt it; for example, it would be ill-advised (and painful) for a patient with a healing wound on one side to roll left to right. In such a case, making assumptions about the patient's function based on other activities would, in fact, not improve the precision of the score.**

We also question whether it is precise and accurate to generically apply an "expected" discharge score based on statistical regressions to unique patient populations, and whether the comparison of observed to "expected" function could wholly be attributed to the facility's quality of care. The calculation approach for the "expected" discharge score is opaque, which makes it difficult for providers to know what they're working towards. In reality, providers strive to help each individual achieve their own specific goals related to function, independence and overall health. These goals are not based on statistical regressions. **Without further testing and review of the proposed Discharge Score measure by a CBE, we are not certain that this measure brings value to the QRP and thus cannot support it for adoption.**

Patients/Residents who are Up to Date with COVID-19 Vaccination Measure.

Beginning with the FY 2026 IRF QRP, CMS proposes to adopt this assessment-based process measure that reports the percentage of stays in which patients in an IRF are up to date with their COVID-19 vaccinations per the CDC's latest guidance. The agency reasons that the measure would, when publicly reported, provide useful information for patients and their caregivers when choosing a facility, and "would be an indirect measure of IRF action" since the IRF would, according to CMS, have the opportunity to administer the vaccine to patients during their stay, coordinate a follow-up

visit for the patient to obtain the vaccine at their physician's office or local pharmacy, or educate the patient about the importance of staying up to date with vaccinations. CMS also proposes to adopt this measure for the SNF and LTCH QRPs in their respective rules.

As noted above, FHA supports the vaccination of health care providers and communities for COVID-19 and acknowledges the importance of up to date vaccinations. However, this measure has not been tested for validity and reliability and thus we cannot support it without knowing that it is, at minimum, feasible to report and likely to produce statistically meaningful information.

Furthermore, we are not clear that the conceptual construction of the measure is the best way to encourage vaccination, especially in post-acute settings where care is delivered in episodic rather than longitudinal fashion. When reviewed by the National Quality Forum (NQF)'s Measure Applications Partnership (MAP) during the 2022-2023 review cycle, the Post-acute/Long-term Care Workgroup voted "Do Not Support" for this measure, meaning that a multi-stakeholder panel of experts representing providers, patients and payers do not support this measure for inclusion in the IRF QRP.

Vaccination status among patients/residents is subject to many patient-level factors outside of the control of providers. For post-acute facilities and providers, it may be infeasible or inappropriate to offer vaccination for patients due to length of stay, ability to manage side effects and medical contraindications, or other logistical challenges to gathering information from a patient who may have received care from multiple proximal providers. Even without these challenges, however, patients/residents may choose to forgo vaccination despite a provider's best efforts.

It is possible that post-acute care facilities could have a robust effort to encourage vaccination among their patients/residents, but still have relatively low rates of vaccination. As the Health Equity subcommittee of the NQF MAP noted in its review of this measure, cultural norms often play a large role in vaccine confidence. While post-acute providers will always seek to counsel vaccination in a culturally sensitive way, they also want to honor the choice of their patients once they have offered their clinical advice.

We reiterate that we understand the importance of vaccination in protecting patients from the most serious outcomes of COVID-19. However, it is unclear whether the use of this measure will produce those results or if it is feasible for post-acute care facilities to collect and report the information necessary. The measure consists of a single yes or no item on the IRF-PAI without any requirements for documentation or validation of vaccination status; while we acknowledge that additional documentation would be unduly burdensome for providers to collect, without it the measure is a mere checkmark in a box with no evidence that it leads to improved quality of care (since, as stated above, the measure has not been fully tested).

For these reasons, **we do not support the adoption of this measure in the IRF QRP.** CMS also may want to consider whether alternative measure constructions focused on the actions providers take in encouraging vaccination might be better suited to achieving the goal of higher vaccination rates.

We thank you for the opportunity to provide these comments. If you have any questions please do not hesitate to reach out to Michael Williams, FHA's Senior Vice President of Federal Affairs at michaelw@fha.org.

Sincerely,

Mary C. Mayhew
President and CEO
Florida Hospital Association