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May 31, 2021

Chiquita Brooks-LaSure
Administrator Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1767-P

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:

Dear Administrator Brooks-LaSure:

The Florida Hospital Association (FHA), on behalf of its more than 200-member hospital and health systems appreciate the opportunity to provide comments to the Centers for Medicare and Medicaid Services' (CMS) inpatient rehabilitation facility (IRF) prospective payment system (PPS) proposed rule for fiscal year (CY) 2023.

- **The Proposed Rule seeks to update rehabilitation hospital payments by a 3.2% market basket ("MB") adjustment, reduced by a mandated productivity adjustment of 0.4%.**

For FY 2023, CMS is proposing a net increase in IRF PPS payments of 2.0% ($170 million), relative to FY 2022. This includes a 3.2% market-basket update offset by a statutorily-mandated cut of 0.4 percentage points for productivity, and a 0.8 percentage point cut related to high-cost outlier payments. FHA appreciates that CMS is using a methodology consistent to prior years however, **we are extremely concerned that this approach does not address the impact of the COVID-19 PHE**.

The PHE has required and continues to require IRFs to increase labor costs due to labor shortages that require increased compensation for full-time employees and increased use of more costly contract labor. These labor shortages are attributable to a number of factors, including quarantines, vaccine mandates, and apprehension and stress of healthcare staff resulting in their non-participation in the healthcare workforce (whether temporarily or permanently). Additionally, IRFs and other healthcare providers have incurred abnormally high costs associated with substantial additional paid time off for nurses and therapists suffering from COVID-19 or being quarantined due to potential exposure to this disease; increased operating costs related to purchases of additional PPE; increases in purchases of other supply costs; and increased costs of cleaning supplies, among other cost increases.

The health care sector is not unique in its experience with inflation; however, providers are unable to adjust their rates to account for rising costs. Research commissioned by the American Hospital Association (AHA), show an increase in hospital costs by more than 20% from 2019-2021. This includes a 36.9% increase in drug costs and a 19.1% increase in labor costs. These inflated cost drivers have remained stubbornly high throughout the PHE regardless of actual rates of hospitalization for COVID-19.

These inflationary pressures, coupled with the phasing out of the sequestration moratorium, will result in a net negative effect on hospital operating margins. **CMS should: a) identify alternative data sources to capture the true impact of the cost of the PHE and**

subsequent cost pressures on IRFs, or utilize a formula that better aligns the market basket with the cost to treat patients; and b) provide a one-time payment adjustment to supplement the cost of care.

- **CMS is proposing to apply a 5-percent cap on any decrease to a provider's wage index from its prior year wage index, regardless of the circumstances causing the decline.**

In order to increase the predictability of providers' payments under the IRF PPS and to smooth year-to-year fluctuations in providers' wage indexes, for FY 2023 and subsequent years, CMS is proposing a permanent 5.0% cap on any decrease to a provider's wage index relative to the prior year. FHA agrees that CMS should strive to reduce the uncertainty resulting from fluctuations in payment.

FHA supports this proposal, and further that it be implemented in non-budget neutral way.

- **CMS proposes to maintain the current IRF facility-level payment adjustments, which have been in effect since FY 2014.**

CMS is asking for feedback on its methodology used to calculate facility-level adjustment factors and suggestion on possible refinements in the future. IRF PPS facility adjustments have been frozen since 2014 to mitigate the prior year-to-year volatility that persisted even following attempts by the agency to stem this source of instability.

The adjustments provide an increase in per-case payments based on an IRF's rural status, percentage of low-income patients, and teaching status to account for differences in costs attributable to these characteristics. Prior annual updates were made in a budget-neutral manner, and any future changes would also likely be budget neutral.

While CMS is not proposing a change for FY 2023, the rule highlights what the annual facility adjustments would have been for FY 2015 through FY 2023, including substantial volatility. In other words, CMS's freeze of the facility adjustments has helped increase payment predictability and stability for the field, however, we would note that the teaching adjustment has been less stable than the rural or low-income adjustment. Moving forward, we support CMS's ongoing pursuit of a remedy to mitigate the volatility that persists. **However, given the concerns with uncertainty related to the teaching adjustment, CMS should consider alternatives, such as the formula included in the inpatient prospective payment system (IPPS)**.

- **CMS is seeking feedback from the field on whether to incorporate a "discharge to home health" element in the IRF transfer policy *in the future*.**

CMS is studying the effect of and is soliciting comments about including discharges to home health services received from a home health agency within 48 hours of referral or within 48 hours of the patient's return home. CMS estimates that implementing the policy would reduce expenditures by $993 million over a 2-year period.

When CMS implemented the IRF transfer policy over twenty years ago, the agency stated that they were analyzing claims data to determine the extent to which we could distinguish among

services that could be considered a substitution of care (general acute care, SNF, long term care) rather than an extension of the normal progression for inpatient rehabilitation care, and to determine the frequency and intensity of both **home health** and outpatient therapy services. Based on that metric the IRF PPS transfer policy is working effectively, especially when considering HHAs along the continuum of care as opposed to as a substitute.

CMS notes that the purpose of the existing transfer policy, and for the proposed change, is a desire to create a transfer program intended to disincentivize early discharges from IRFs. Per a study by the AHA, CMS does not appear to be using accurate data to understand how hospitals are utilizing HHAs. 2021 CMS data indicates that the agency overestimated the number of cases transferred from an IRF to home health by 14%. **CMS should evaluate the integrity of their data prior to implementing a new IRF transfer policy.**

In addition, an expansion of the transfer payment policy to include IRF discharges to home health care could make the current IRF PPS payment insufficient and unreliable. The IRF PPS reimburses providers for the average costs within a case-mix group (CMG) for the patient stay. An expansion of the transfer payment policy would disrupt the balance and design of the PPS and the new payment rate may be unable to properly compensate IRFs for their reasonable costs of care for patients with shorter stays. Patients should be transferred from an IRF when their care demands it, instead CMS has proposed the creation of a perverse incentive to keep a patient long enough to ensure adequate reimbursement.

Regarding access: policies that arbitrarily delay transfers to HHAs could alter IRF discharge processes, thereby delaying some IRF patients' access to timely home health care. A delayed discharge process could also limit another patient's access to IRF care, which could mean they spend additional time in an acute care hospital waiting for an available IRF bed; or alternatively even though he/she needs IRF care he/she nonetheless could be discharged from an acute hospital to another level of care that is not optimal for her/his rehabilitative and post-acute care needs.

FHA appreciates CMS's desire to increase savings or reduce costs. However, the proposed policy change could severely harm beneficiary access to IRF care and prevent patients from receiving timely access. **While there are benefits to home health rehabilitation, this is not a substitute for an IRF and should not be included in the transfer policy. FHA opposes any action to include home health discharges within the IRF PPS transfer policy**.

FHA appreciates your consideration of these comments. Please do not hesitate to contact me or Michael Williams at michaelw@fha.org if you have any questions.

Sincerely,

Mary C. Mayhew
President and CEO
Florida Hospital Association