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President and CEO

June 2, 2023

The Honorable Chiquita Brooks-LaSure
Administrator Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2024 and Updates to the IRF Quality Reporting Program (CMS-1781-P)

Dear Administrator Brooks-LaSure:

The Federation of American Hospitals (“FAH”) is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children’s, and cancer services.

The FAH appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (“CMS”) regarding its Proposed Rule, Inpatient Rehabilitation Facility (“IRF”) Prospective Payment System for Federal Fiscal Year 2024 and Updates to the IRF Quality Reporting Program (“Proposed Rule”) published in the Federal Register on April 7, 2023.

MARKET BASKET UPDATE

For FY 2024, CMS proposes to update the 2021-based IRF market basket to reflect projected price increases according to the IHS Global Inc.’s (“IGI”) 4th quarter 2022 forecast with historical data through the 3rd quarter of 2022. Using that forecast, the proposed IRF market basket for FY 2024 is 3.2 percent. Using data from the same period, CMS estimates an offset to the IRF market basket for total factor productivity (“TFP”) of 0.2 percentage points. Consequently, CMS proposes an IRF PPS update of 3.0 percent for FY 2024. For hospitals that

do not successfully submit quality data under the IRF QRP program, the update is reduced by 2.0 percentage points to 1.0 percent. For the Final Rule, CMS will use later data on the market basket and TFP.

The FAH has serious concerns that the proposed market basket forecast is neither accurately nor adequately capturing the unique factors influencing the hospital and health care market today in general, and the market in which IRFs compete specifically. The scope and scale of the COVID-19 pandemic is unprecedented in our times with the constant barrage of challenges and pressures that hospitals have and continue to face. Chronic, preexisting nurse and caregiver shortages have exploded during the pandemic fueled by increased demand and workforce burnout from, among other factors, quarantines, surges, and stress.

In our public comments on the proposed FY 2023 IRF update, we expressed concern that inflationary cost pressures hospitals have been experiencing are not being captured in the IRF market basket. These concerns have been borne out by recent data released by the CMS’ Office of the Actuary (“OACT”). The below table shows the market basket forecast used for the FY 2021 through FY 2023 IRF PPS update compared to the actual inflationary increase experienced by IRFs based on later data:

IRF Market Basket¹	FY 2021	FY 2022	FY 2023
Forecast Used in the Update	2.4	2.6	2.6
Actual Based on Later Utilization	2.7	5.3	4.6
Difference	-0.3	-2.7	-2.0

As this table reflects, market basket updates to IRFs for FY 2021 through FY 2023 are understating the IRF base rate by a total of 5 percentage points in these years. The FAH urges CMS to consider an adjustment for forecast error to ensure that the FY 2024 rate increase is applied to a base rate that more accurately incorporates actual inflation in FY 2022 just as CMS is doing in two other contexts: the proposed FY 2024 skilled nursing facility (“SNF”) PPS update and the proposed FY 2024 capital IPPS update.

For the FY 2024 SNF update, CMS is proposing to increase the market basket update of 2.7 percent by 3.6 percentage points for forecast error in application of the FY 2022 update.² For the FY 2024 capital IPPS update, CMS is proposing a forecast error adjustment of 0.9 percentage points for an underestimate of FY 2022 capital inflation.³ If CMS adopted the FAH’s recommendation, it would be proposing an IRF update of 3.2 percent plus 2.7 percentage points for FY 2022 forecast error less 0.2 percentage points for TFP. The total update before incorporating later data for the Final Rule would be 5.7 percent.

¹OACT, 4th quarter 2022 release of the market basket information with historical data through the 3rd quarter of 2022 ([Market Basket Data | CMS](#)) for the actual update based on later utilization.

² 88 Federal Register, 21321, April 10, 2023

³ 88 Federal Register 27229, May 1, 2023.

The FAH is further concerned that the IRF update for FY 2024 includes a reduction for non-farm TFP of 0.2 percent. The COVID-19 pandemic has had unimaginable impact on US productivity and most estimates of labor productivity highlight uncharacteristic reductions. Even before the pandemic, OACT indicated that hospital productivity will be less than general economy wide productivity that is being used as an offset to the hospital market baskets.

In a memorandum dated June 2, 2022, OACT stated: “over the period 1990-2019, the average growth rate of hospital TFP using the two methodologies ranges from 0.2 percent to 0.5 percent, compared to the average growth of private nonfarm business TFP of 0.8 percent.” The memorandum also indicates that an assumed future rate of hospital industry productivity growth of 0.4 percent per year remains reasonable compared to an assumed rate of productivity growth in the private nonfarm business sector of 1.0 percent.⁴ While the annual TFP offset is based on a provision of the Affordable Care Act of 2010 and required by law, the FAH urges CMS to consider the appropriateness of this reduction when deciding whether to incorporate a forecast error adjustment to the FY 2024 IRF PPS update based on the understatement of the FY 2022 IRF PPS market basket.

In the FY 2023 IRF PPS Final Rule, CMS declined to provide an adjustment for forecast error indicating that “due to the uncertainty regarding future price trends, forecast errors can be both positive and negative.” However, for both the proposed SNF PPS update and the capital IPPS update, CMS provides for a forecast error adjustment when the difference between the update for a year and the actual level of the market basket based on later data differs by more than a threshold amount (0.25 percentage points for the capital IPPS and 0.5 percentage points for the SNF PPS).

FAH is asking for a consistent policy between these payment systems. The forecast error adjustment requested to the FY 2023 IRF PPS update was relatively small—below the 0.5 percentage point threshold for a forecast error adjustment for the SNF PPS (although greater than the 0.25 percentage point threshold for the capital IPPS). However, forecast error for the FY 2022 IRF PPS update is 2.7 percentage points—well in excess of the threshold for an adjustment under either the SNF PPS or the capital IPPS.

For both the SNF PPS and the capital IPPS, CMS is making the forecast error adjustments based on a threshold level of difference between the update and the market basket that was adopted through rulemaking in prior years. CMS may argue that it is not permitted by rulemaking procedures under section 1871 of the Act to adopt a forecast error adjustment for the FY 2024 IRF PPS update because such a policy was not proposed. However, the IRF market basket update for FY 2024 has been made subject to public comment in the FY 2024 IRF PPS Proposed Rule. The FAH’s suggestion is a logical outgrowth of a policy adjustment that is subject to public comment consistent with section 1871(a)(4) of the Act.

If CMS were to reject any comment that makes a suggestion to revise a market basket policy that was not explicitly proposed, there would be no point in making a public comment as

⁴ Paul Spitalnic, Stephen Heffler, Bridget Dickensheets and Mollie Knight, “Hospital Multifactor Productivity: An Update Presentation of Two Methodologies Using Data through 2019.” [Hospital Multifactor Productivity: An Updated Presentation of Two Methodologies Using Data through 2019 \(cms.gov\)](https://www.cms.gov/medicare/medicare-claims-reform/irf-pps/irf-pps-market-basket/irf-pps-market-basket-update-presentation-of-two-methodologies-using-data-through-2019).

CMS could reject any suggestion as being out-of-scope of the Proposed Rule as CMS did not make any explicit proposals to change its methodology for determining the market basket. As the FAH's comment is a logical outgrowth of a policy subject to public comment, CMS may certainly adopt our suggestion consistent with the rulemaking procedures in section 1871 of the Act.

For these reasons, the FAH requests CMS adopt a forecast error adjustment to the FY 2024 IRF PPS update based on the 2.7 percentage point difference in the IRF PPS market basket in FY 2022. Adopting our suggestion would make the market basket equal to 3.2 percent plus 2.7 percentage points less 0.2 percentage points or 5.7 percent.

REBASING AND REVISING OF THE IRF PPS MARKET BASKET

Beginning with FY 2024, CMS is proposing to rebase and revise the 2016-based IRF market basket cost weights to a 2021 base year reflecting 2021 Medicare cost report data submitted by both freestanding IRFs and distinct part IRF units within hospitals. CMS believes that 2021 represents the most recent and complete set of Medicare cost report data available. The cost reports are for providers with cost reporting periods beginning on or after October 1, 2020 and before October 1, 2021.

The Proposed Rule details the methodology used to rebase the market basket, which is generally the same methodology CMS used in creating the current 2016-based IRF market basket. That involves using Medicare cost report data to calculate weights for seven cost categories: Wages and Salaries; Employee Benefits; Contract Labor; Pharmaceuticals; Professional Liability Insurance; Home Office Contract Labor; and Capital. A residual category captures all remaining costs.

As CMS does customarily when it rebases and revises the IRF market-basket, CMS also proposes to revise the labor-related share of the standard payment conversion factor for FY 2024. CMS proposes a total labor-related share of 74.1 percent for FY 2024 that is 1.2 percentage points higher than the FY 2023 labor share of 72.9 percent. The higher labor-related share is primarily due to the incorporation of the 2021 Medicare cost report data, which increased the compensation cost weight by approximately 0.8 percentage point compared to the 2016-based IRF market basket.

The large increase in the labor-related share is a result that the FAH expected given our concerns about labor costs increasing at a higher rate than other hospital costs during the pandemic. It follows that the labor-related share of total IRF costs would increase as a result of labor shortages that have increased employed hospital clinical staff wages as well as forcing hospitals to rely on higher cost contract clinical staff.

In general, the FAH is supportive of CMS' proposal to both rebase and revise the IRF PPS market basket and revise the labor-related share of the standardized payment conversion factor. However, CMS' proposal to rebase and revise the labor-related moves the base year for the IRF market basket to 2021 which may not fully incorporate the structural cost changes that IRFs have experienced since the pandemic. The FAH urges CMS to consider a

shorter period than 5 years for the next rebasing and revising of the IRF market basket and revision to the standard payment conversion factor labor share. **Our recommendation would be that CMS plan to rebase and revise the IRF market basket and labor-share in two years so that it is based on an FY 2023 year that more fully incorporates changed cost structures resulting from the pandemic as well as the dynamics of the evolving hospital workforce shortage.**

CMG RELATIVE WEIGHTS AND AVERAGE LENGTH OF STAY FOR FY 2023

CMS has proposed updates to Case-Mix Group (“CMG”) relative weights and average length of stay values using fiscal years (“FY”) 2022 IRF claims and 2021 IRF cost reporting data. **The FAH supports CMS’ update to the CMG relative weights and average length of stay values for FY 2024 and encourages CMS to use the latest available data to update these in the Final Rule.**

WAGE INDEX

For FY 2023 and future years, CMS finalized a permanent cap of 5 percent on reductions to the wage index for any reason. CMS believes providers generally experience fluctuations in the wage index annually of less than 5 percent. The FAH appreciates CMS’ recognition of how disruptive volatile drops in the area wage index can create significant challenges for IRFs and the FAH strongly supports a 5 percent stop-loss to minimize annual reductions in the area wage index value and to help mitigate wide annual swings that are beyond a hospital’s ability to control. **The FAH urges CMS to adopt the 5 percent stop-loss in a non-budget neutral manner.**

The wage index values of the existing hospitals subject to the cap will continue to differ significantly from the currently published tables. Existing providers must refer to the rate-setting file to verify their correct wage index values to ensure the MACs are updating the correct values in the system. **We encourage CMS to release wage index tables in the Final Rule that incorporate the cap on CBSA’s that meet the 5 percent decrease criteria, in order to avoid errors in the payment rates established by the Medicare Administrative Contractors (“MACs”).**

FACILITY-LEVEL ADJUSTMENT FACTORS

The FAH appreciates CMS’ thoughtful analysis and discussion on the facility-level adjustment factors (“FAFs”), including the adjustments for Low Income Patient (“LIP”), rural and teaching factors. IRFs need predictability and relative stability from year-to-year in these facility-level adjustments. The FAH recommends that CMS take steps to ensure that regardless of the underlying methodology, hospitals can be assured there will not be dramatic swings in the facility-adjustment factors (“FAFs”) from year-to-year.

Using the supplied data, as part of the FY 2023 rulemaking process, the consulting firm Dobson|DaVanzo conducted analyses on the methodology used to update these facility-level adjustment factors. The Dobson|DaVanzo report is included as an Appendix to this letter. We appreciate CMS’ cautious approach in analyzing and seeking comments on the three payment factors prior to implementing any proposed changes.

As noted in the report, although Dobson|DaVanzo could not duplicate RAND’s method using claims level detail, their analyses using IRF rate-setting file data (at the aggregate facility level) compared favorably to CMS’ data for the LIP and Rural coefficients. These coefficients remain relatively stable year-to-year in both analyses. The LIP factor has steadily trended upward since FY 2014, with the largest increase occurring in FY 2023. We think the Public Health Emergency is having an impact on LIP to some degree given the change in mix of patients that has occurred. This may level off and recede to some degree in coming years.

After initially trending downward, the Rural factor has remained relatively consistent at 0.100 from FY 2018 to FY 2023. While the underlying data appear to support a decrease in the Rural factor from .149 to .100, this would create a significant payment reduction for rural IRFs that may require consideration of a phase-in period. It is also important to note that the current methodology employed by CMS uses an averaging of the last three years in setting these factors. It will be imperative to continue using this averaging approach if CMS updates these factors. Based on these results, CMS could consider updating the LIP and Rural factors using the current CMS methodology with a phase-in period and averaging the factors using the latest 3 fiscal years’ results.

Like CMS’ results, the Dobson|DaVanzo report notes a wide instability in the Teaching adjustment, albeit at a much lower level, without any major contributing factors identifying why these swings occurred. Below is a chart comparing the Dobson|DaVanzo findings to CMS’ data.

DD (All IRFs)				CMS (All IRFs)			
Fiscal Year	log (dsh)	log (teaching)	rural	Fiscal Year	log (dsh)	log (teaching)	rural
FY 2014	0.3890	1.2224	0.1092	FY 2014	0.3177	1.0163	0.149
FY 2015	0.3490	1.3596	0.1244	FY 2015	0.3809	1.9791	0.141
FY 2016	0.3449	1.4558	0.1202	FY 2016	0.4363	3.1820	0.130
FY 2017	0.3347	1.4483	0.1177	FY 2017	0.3880	3.0946	0.124
FY 2018	0.3736	1.2308	0.1005	FY 2018	0.4377	2.2472	0.107
FY 2019	0.3885	1.2028	0.0938	FY 2019	0.4572	2.1450	0.099
FY 2020	0.3960	1.2928	0.0860	FY 2020	0.4367	2.4413	0.090
FY 2021	0.4025	1.4518	0.0941	FY 2021	0.4382	3.0467	0.096
FY 2022	0.3934	1.5147	0.1065	FY 2022	0.4165	3.3506	0.107
FY 2023	0.4386	1.6036	0.0999	FY 2023	0.5092	3.7910	0.100

The Teaching coefficient lacks the same stability and operating environment logic that was present in the LIP and Rural analyses. While the Dobson|DaVanzo work considered multiple approaches to solving the instability found in the development of the Teaching factor, no simple solution was evident. In the end, the Dobson|DaVanzo report found that the use of the current IPPS teaching payment formula may be one viable option for CMS to consider.

The use of the IPPS teaching payment formula has some merit. IRF units comprise 74% of teaching IRFs (72 of 101). Creating payment parity between the IRF and IPPS teaching payment amounts would result in consistent payment policy, since the cost structure would be the same in these IRFs as that of the acute care hospitals in which they operate. The current IRF Teaching payment factor results in Teaching payments in excess of the IPPS payment amounts that do not appear justified based on studies conducted on medical education cost versus

payment. Based on this work and analyses, we do not support an increase in the IRF Teaching factor beyond the FY 2014 level.

Based on the Dobson|DaVanzo report, we recommend that CMS consider updating the LIP and Rural coefficients using the average of the most recent three years while continuing to study factors leading to teaching program costs and consider the use of the IPPS teaching adjustments for IRFs. If CMS decides to update any of the three payment adjustments in FY 2025, we recommend phasing in these payment adjustments over a three-year period.

HIGH-COST OUTLIERS

The outlier policy is an important component of the IRF PPS that helps ensure that payments for high cost patients more accurately reflect the more intensive level of services they receive, thereby supporting access to care. However, we have concerns that outlier payments under the IRF PPS are not always targeted to patients who require more intensive services with related higher costs.

CMS estimates that IRF outlier payments, as a percentage of total estimated payments, would be approximately 2.3 percent in FY 2023. The Proposed Rule would correct this underpayment to IRFs in FY 2024 by decreasing the High-Cost Outlier (“HCO”) threshold from \$12,526 in FY 2023 to \$9,690 in FY 2024. The table below shows the outlier threshold trending from FY 2015 through the proposed FY 2024.

The FAH supports lowering the fixed outlier threshold amount to maintain the current 3% outlier pool. In addition, CMS should include historical outlier reconciliation dollars in the outlier projections to ensure more accurate calibration of the outlier payment amounts.

The FAH also has concerns that outlier payments to providers have continued to be concentrated among an increasingly small number of providers. Analysis of the 25 IRFs receiving the highest outlier payment amounts reveals that outlier payments will represent anywhere from 12.15% up to 77.56% of their total IRF PPS payments in FY 2024. Based on the CMS data, many of these IRFs would see significant increases in their outlier payment amounts and the percentage of outlier payments to total IRF PPS payments. While outlier payments are important to help facilities with extremely costly cases, we are concerned that factors other than patient complexity and case mix may be driving these extra payments. To address this over reliance on outlier payments by some facilities, CMS may want to consider additional future policies such as a reconciliation process or possibly a cap on outlier payments, which is applied under the home health payment system.

ALLOWING DISTINCT PART UNITS MID-COST REPORTING PERIOD

The FAH strongly supports the proposed amendment to 42 CFR 412.25(c) and appreciates CMS’ recognition that the existing limitation on mid-cost reporting status changes from not excluded to excluded arose from particular administrative difficulties associated with cost-based reimbursement that are no longer material. In light of the adoption of a prospective payment system for IRFs and Inpatient Psychiatric Facilities (IPFs) and the costs associated with

the current rule, it is appropriate to provide hospitals with greater flexibility and amend section 412.25(c) to permit a hospital to open a new excluded unit or to change the status of a unit to excluded at any time within the cost reporting year with written advance notice to the MAC, as proposed.

Current regulations at 42 CFR 412.25(c) specify when the status of an excluded IRF or IPF unit may be changed from “not excluded from the IPPS” to “excluded from the IPPS” and be paid under the IRF or IPF PPS or vice versa. Currently the status of change from not excluded to excluded from the IPPS may only be done at the start of the cost reporting period. If a unit is added to a hospital after the start of a cost reporting period, it cannot be excluded from the IPPS before the start of a hospital's next cost reporting period. However, the status of change from excluded to not excluded from the IPPS may be done at any time during a cost reporting period, subject to certain conditions

CMS provides background for these policies, which were implemented before the establishment of the IRF PPS and the IPF PPS and were established to address the administrative complexity associated with cost-based reimbursement for excluded IRF and IPF units. Stakeholders have observed that only permitting status changes from not excluded to excluded to be made before the start of a cost reporting period is no longer necessary, creates an unnecessary burden, and does not take into account challenges hospitals face completing construction projects to expand capacity before the start of a cost reporting period.

Noting that cost allocation is no longer used for payment purposes because IRF and IPF units are paid under the IRF PPS and IPF PPS respectively, CMS appropriately concludes that the restriction that limits an IPF or IRF unit to being excluded from the IPPS only at the start of a cost reporting period is no longer necessary. Moreover, the existing rule imposes unnecessary costs on providers, particularly with respect to new construction that cannot be effectively and efficiently timed based on the cost reporting period. Thus, it proposes to revise its regulations at §412.25(c)(1) to establish a uniform rule for status changes for IRF and IPF units that would permit the unit’s status to be changed from not excluded to excluded (or excluded to not excluded) at any time during a cost reporting period.

The hospital would be required to notify the MAC and the CMS Regional Office in writing of the change at least 30 days before the date of the change, and it would have to maintain the information needed to accurately determine costs that are or are not attributable to the IRF or IPF unit. Additionally, any change in the status of an IRF or IPF unit (i.e., from not excluded to excluded or vice versa) that is made during a cost reporting period must remain in effect for the rest of that cost reporting period.

The FAH strongly supports this proposal allowing units to open, operate, and be paid under the applicable PPS mid-cost reporting period. The current policy is no longer necessary since IRFs and IPFs have their own prospective payment systems and the current approach creates unnecessary burden, and does not take into account the vast challenges hospitals face completing construction projects to expand capacity before the start of a cost reporting period.

IRF QUALITY REPORTING PROGRAM (“QRP”)

- **Proposed Modification to COVID-19 Vaccination Coverage Among Healthcare Personnel (“HCP”) Measure**

CMS proposes to modify the COVID-19 Vaccination Coverage among HCP measure to replace the term “complete vaccination course” with the term “up to date” in the vaccination definition. CMS also proposes to update the numerator to specify the time frames within which an HCP is considered up to date with recommended COVID-19 vaccines, including booster doses, beginning with the FY 2025 IRF QRP.

The FAH remains concerned that the current specifications are flawed given the lack of a stable definition of “up to date” and that the numerator, which refers the end user to a document with varying definitions of “up to date,” could negatively impact the reliability and validity of the measure. A standardized way to collect this information must be made available. The FAH continues to believe that it is too soon to include a measure on COVID-19 vaccinations since the underlying evidence for this measure is still emerging and methods for addressing measure collection challenges related to anticipated “booster” shots will likely be required.

Should CMS choose to move forward with this measure, we recommend that it be aligned with the requirements of the Hospital Conditions of Participation (“COPs”) and allow not only medical contraindications but also capture when individuals decline vaccination. We also recommend CMS revise the measure specifications to require data to be submitted in monthly or quarterly periods instead of one week a month for each quarter, in line with other Quality Reporting Program (“QRP”) measures. The updated specifications and testing results must also be endorsed by the Consensus-Based Entity (“CBE”) prior to implementation in the IRF QRP.

- **Proposed Adoption of Discharge Function Score Measure**

CMS proposes to adopt the Discharge Function Score (“DC Function”) measure in the IRF QRP beginning with the FY 2025 IRF QRP. The FAH does not support the inclusion of this measure at this time, as we believe that additional testing and refinements are needed. Specifically, it is not clear how CMS plans to calculate an overall “expected” discharge for 10 separate functional items (e.g., eating, oral hygiene). We also have significant concerns in the current calculations of the “expected” discharge score for this measure. Given the complexity of these calculations and existing issues involving these expected discharge scores, it is premature to move to an expanded discharge function score.

The FAH is concerned that the statistical imputation model used in the measure will supersede the clinical judgement of providers assessing their patients, pursuant to CMS guidance. We also believe that it is also not clinically or statistically appropriate to assign or infer the score for one functional item from an unrelated item. For example, when a patient receives tube feedings or parenteral nutrition (the patient does not eat or drink by mouth and relies solely on nutrition and liquids through tube feedings or total parenteral nutrition [TPN] due to a new (recent onset) medical condition), item GG0130A, Eating, is to be coded as “88 Not attempted due to medical condition or safety concerns.” In the revised imputation method under

the proposed function measure, however, this patient’s functional status could be recoded at a higher level based on the most likely score of other, completely unrelated functional items. Activity not Attempted (“ANA”) codes are not missing data but rather are coded in accordance with CMS’ IRF-PAI guidance for patients not able to attempt a GG functional item.

We are also concerned that combining self-care and mobility into one measure may disadvantage certain patients, as some patients have an imbalance of impairment between upper mobility and lower mobility. Self-care and mobility items should be assessed and reported independently to provide the most accurate assessment of a patient’s abilities and disabilities.

Current mobility and self-care measures are not standard or interoperable across post-acute care facilities, as denominators differ in the measure calculations across providers. Until this is resolved, calculating a cross-setting function measure will not be meaningful in characterizing patients or comparing their outcomes across the different post-acute care settings.

The FAH believes that additional work must be completed prior to implementation in this program, including endorsement by the CBE, additional data and testing information including the demographics and function data of the patient population used for testing so that stakeholders can fully understand the scope of this measure, and how, if at all, these changes may impact certain patient groups.

- **Proposed Removal of the Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function**

CMS proposes to remove the Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (“Application of Functional Assessment/Care Plan”) measure from the IRF QRP beginning with the FY 2025 IRF QRP. The FAH supports removal of this measure from the IRF QRP given the lack of variation in performance scores.

- **Proposed Removal of the IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients and Removal of the IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients**

CMS proposes to remove the IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (“Change in Self-Care Score”) and the IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (“Change in Mobility Score”) measures from the IRF QRP beginning with the FY 2025 IRF QRP.

The FAH does not support retiring the Change in Self-Care and Change in Mobility measures. While these measures may be highly correlated with their respective Discharge Self-Care and Discharge Mobility scores, they are measures of patients who meet or exceed a specific risk-adjusted goal and representative of the goals of IRF care as a whole.

- **Principles for Selecting and Prioritizing IRF QRP Quality Measures and Concepts Under Consideration for Future Years – Request for Information (“RFI”)**

CMS seeks comments on its set of principles for selecting measures for the IRF QRP, identified measurement gaps, and measures that are currently available for use or may be adapted for the IRF QRP. Additionally, CMS points to its newly released “Universal Foundation” of quality measures as the approach it will take to focus provider attention and reduce provider burden, as well as identify disparities in care, prioritize development of interoperable, digital quality measures, allow for cross-comparisons across programs, and help identify measurement gaps. This approach, in theory, builds from CMS’ Meaningful Measures 2.0 framework and drives the development and updating of the National Quality Strategy.

The CMS Meaningful Measures 2.0 framework was designed to address measurement gaps, reduce burden, and increase efficiency by using only high-value quality measures, align measures across public and private programs and partners, prioritize outcome and patient-reported measures, transform measures to be fully digital and reflect social and economic determinants. The FAH offers the following general themes for consideration when implementing additional measures into the IRF QRP:

- Focus on health care priorities: The measures should focus on salient healthcare issues for this setting of care. These may relate to novel, urgent concerns or longstanding challenges for which there has not been much progress.
- Does not add unnecessary burden: Quality reporting is not “burden-free,” as data collection and surveillance is vital to care improvement; rather, quality measurement should not interfere with the provision of high-quality care by requiring unnecessary administrative busywork.
- Consists of complementary measures: The complete list of measures should be complementary and demonstrate the patient journey rather than providing a list of measures from which to pick and choose; together, the measures should provide a well-rounded assessment of performance across the organization and to the extent possible, improve patient outcomes.
- Fully tested for the IRF setting: CMS’ definition of “fully developed” includes empiric validity testing for the setting in which the measure will be used. Recently, we’ve seen CMS adopt more structural and process measures that haven’t been fully tested for the program or setting of care in which the measure is implemented.
- **Proposed COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date Measure**

CMS proposes to adopt the COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date (“Patient/Resident COVID-19 Vaccine”) measure for the IRF QRP beginning with the FY 2026.

The FAH supports the intent of this measure but has several concerns when applying this measure to IRFs. Specifically, IRFs, particularly freestanding hospitals, do not have immediate or ongoing access to COVID-19 vaccines and/or boosters and will have difficulty reporting and demonstrating improvement on this measure. Patients interested in receiving the COVID-19 vaccine or booster, have likely received the option in acute care before they arrived or will have access in the community after discharge.

We also believe that the current specifications are flawed given the lack of a well-defined definition of “up to date.” The current numerator specifications refers the end user to a [website](#) outlining when primary and booster doses are recommended and this lack of a well-defined set of specifications could negatively impact the reliability and validity of the measure. A standardized way to collect this information must be made available.

The FAH continues to believe that it is too soon to include a measure on COVID-19 vaccinations since the underlying evidence for this measure is still emerging and methods for addressing measure collection challenges related to anticipated “booster” shots will likely be required. This measure should also be tested based on the updated specifications and achieve endorsement by the CBE prior to its implementation in IRF QRP.

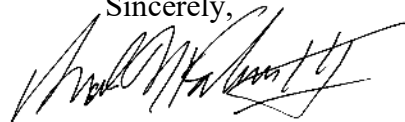
- **Form, Manner, and Timing of Data Submission under IRF QRP**
 - **Proposed reporting schedule for the data submission of the IRF-PAI assessment data for the COVID-19 Vaccine: Percent of Patients/Residents who are up to date measure beginning with FY 2026 IRF QRP**

CMS proposes that IRFs would be required to report the IRF-PAI assessment data related to the Patient/Resident COVID-19 Vaccine measure beginning with patients discharged on October 1, 2024, for purposes of the FY 2026 IRF QRP. Starting in CY 2025, IRFs would be required to submit data for the entire CY beginning with the FY 2027 IRF QRP. CMS also proposes to add a new item to the IRF-PAI in order for IRFs to report this measure. Specifically, a new item would be added to the IRF-PAI discharge assessment to collect information on whether a patient is up to date with their COVID-19 vaccine at the time of discharge from the IRF.

It is unclear how one quarter of data will be meaningful given the community vaccination rate varies over time and as definitions update. Due to the limited access to COVID-19 vaccines, IRF providers are not collecting or tracking this information and it would require additional data elements. While the assessment instrument used by IRFs, the IRF PAI recently doubled in length on October 1 from 15 to 30 pages, those additional assessments at admission and discharge are time consuming and reduce clinical time with the patient. Any new item to be added to data collection must have clinical value, which this measure does not. Compliance would be further complicated by IRF patients who are unwilling or unable to provide proof of their COVID-19 vaccination status. As a result, the FAH does not support inclusion of this measure and the associated data collection burden at this time.

* * *

The FAH appreciates the opportunity to offer comments on the FY 2023 IRF PPS Proposed Rule. If you have any questions or would like to discuss further, please do not hesitate to contact me or a member of my staff at (202) 624-1534.

Sincerely,




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Memorandum

Date: [Pick the date]

To: Justin Hunter and Robert Wisner
Encompass Health Corporation

From: [Type the sender name]

Subject: Estimation of Updated IRF PPS Facility-Level Adjusters and Simulation Summary

The Centers for Medicare and Medicaid Services (CMS) adjusts payments for Inpatient Rehabilitation Facilities (IRFs) based on patient and facility characteristics to account for variations in treatment costs. CMS uses three-year averages for three facility adjustments: 1) Low-Income Percentage (LIP), 2) Rural Status, and 3) Teaching Status. Since FY2014, each of these adjustments has been frozen at the FY2014 factor levels to maintain payment stability and reduce volatility that may have occurred had CMS updated the facility adjusters annually. In the FY2023 IRF PPS proposed rule, CMS presented results from its calculations of the three facility level adjustment factors by year from the current law (FY2014) factors through FY2023. In its commentary of the results, CMS indicated concern for the volatility and significant increases observed in the teaching adjustment factor, which rose from 1.0163 in FY2014 to 3.7910 in FY2023 and solicited input regarding the observed changes and possible methodology refinements. Dobson DaVanzo replicated CMS' facility adjustments based on publicly available information and found similar directionality as reported by CMS, but differences in magnitude, particularly for the teaching adjustment. We explored several alternative simulations to understand any redistributive impacts of possible refinements to the facility adjustment calculation.

dobson DaVanzo replication of CMS IRF PPS Facility Adjustment Coefficients

Data and Methods

We used data from IRF rate setting files for FY2012-2023 to model facility-level adjustment factors under the IRF PPS. Rate setting files include estimates of average cost per case, payment per case (with and without outliers), facility case-mix index, rural status, low-income portion, and teaching portion.

Our approach is an approximation of CMS' methodology and our variable creation is restricted relative to the actual CMS approach. For instance, CMS uses MAC-determined low-income portions and teaching status for payment purposes (not the Provider Specific File data). However, the rate setting file contains only the publicly available form of this information. Similarly, the method for calculating IRF cost per case in the rate setting file differs from the method used by RAND⁵ to determine the facility-level adjustment factors. The rate setting file applies a facility-wide ratio of costs-to-charges (RCC) to claim charges whereas RAND uses department-level RCCs applied to revenue center charges on the claim; the facility-level RCC is applicable as a proxy for facility-level regressions, but results may differ subtly in case-level modeling. Finally, the RAND model uses number of 'equivalent' Medicare discharges that account for short-stay outlier cases, whereas the number of discharges in the rate setting file does not account for short-stay outliers. However, the rate setting file adjusts the IRF case mix index to account for short-stay outliers.

We followed CMS rulemaking and technical reporting documents⁶ to specify our regression approach for deriving updated payment factors for rural, LIP and teaching adjusters, as well as the approach to constructing budget neutrality factors. This involved constructing a case-weighted logarithmic regression model to predict average facility cost per case (standardized for case mix and wage index) based on facility-level factors (i.e., rural, LIP, teaching, and freestanding/unit status). This analysis was performed for each rate setting file year from 2012 to 2023. To replicate the CMS methodology, we computed a three-year moving average of the regression results. For example, for FY2014 we used results from the FY2012-2014 files and for FY2023 we used the results from FY2021-2023 files. Note that the data in the Rate Setting files typically lag the rate setting period by 2 years, so this three-year moving average would be consistent with the CMS approach.

Findings

In Dobson DaVanzo's modeling results (shown below in Exhibit 1), we note directional consistency with CMS' results for all three coefficients over time. Dobson DaVanzo's results for DSH (LIP) and rural coefficients are generally similar in magnitude to CMS' results; however, Dobson DaVanzo's teaching coefficients, while directionally consistent with CMS, are of a much smaller magnitude.

⁵ RAND is the CMS contractor for IRF PPS analytic support.

⁶ IRF Rules and Related Files: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRF-Rules-and-Related-Files>; IRF PPS Facility-Level Payment Adjustments Methodology (PDF): <https://www.cms.gov/files/document/irf-pps-facility-level-payment-adjustments-methodology.pdf>

Exhibit 1: Dobson DaVanzo (DD) Estimated IRF PPS Facility Coefficients as Compared to CMS-Reported Estimates

DD (All IRFs)

Fiscal Year	log (dsh)	log (teaching)	rural
FY 2014	0.3890	1.2224	0.1092
FY 2015	0.3490	1.3596	0.1244
FY 2016	0.3449	1.4558	0.1202
FY 2017	0.3347	1.4483	0.1177
FY 2018	0.3736	1.2308	0.1005
FY 2019	0.3885	1.2028	0.0938
FY 2020	0.3960	1.2928	0.0860
FY 2021	0.4025	1.4518	0.0941
FY 2022	0.3934	1.5147	0.1065
FY 2023	0.4386	1.6036	0.0999

CMS (All IRFs)

Fiscal Year	log (dsh)	log (teaching)	rural
FY 2014	0.3177	1.0163	0.149
FY 2015	0.3809	1.9791	0.141
FY 2016	0.4363	3.1820	0.130
FY 2017	0.3880	3.0946	0.124
FY 2018	0.4377	2.2472	0.107
FY 2019	0.4572	2.1450	0.099
FY 2020	0.4367	2.4413	0.090
FY 2021	0.4382	3.0467	0.096
FY 2022	0.4165	3.3506	0.107
FY 2023	0.5092	3.7910	0.100

Discussion of FY2014 – FY2023 Results

The Rural Coefficient Decreased

Like CMS’ analysis, the Dobson DaVanzo analysis shows a decreasing rural coefficient from FY2014 to FY2023. The Dobson DaVanzo and CMS analyses show remarkable consistency in the FY2022 and FY2023 rural coefficients, where after rounding the Dobson DaVanzo values to the same number of decimal points as reported by CMS, the values exactly match. We note stability in the rural coefficient in both the CMS and Dobson DaVanzo models; since FY2018, the coefficient has been in the 0.09 to 0.10 range.

The LIP Coefficient Increased

CMS and Dobson DaVanzo analyses indicate a rising LIP coefficient from FY2014 to FY2023. The magnitude of the coefficients across the two analyses is generally similar and shows analogous trends. For instance, both analyses show a slight decrease in the LIP coefficient from FY2016 to FY2017, a general rising trend from FY2017 through FY2021, a slight decrease from FY2021 to FY2022, followed by a rise from FY2022 to FY2023. As with the rural coefficient, we see much more stability in the LIP coefficient over time relative to the teaching coefficient.

The Teaching Coefficient Increased and Showed Volatility

Similar to CMS' findings, we see variability and increases in the teaching coefficient from FY2014. Initial hypotheses of the observed volatility in the teaching coefficient are below:

- CMS' transition to the use of section GG functional status data in place of the former FIM® Instrument and related updates to the CMG groups and values in FY2020 may have influenced case-mix index values which are used to standardize the regression models.
- Covid-19 PHE waivers may have fundamentally changed patient mix (dropping volume, different case mix, changing costs per case).
- Volatility observed (such as the decrease in the teaching coefficient between FY2017 and FY2018) may be attributed to changes in the case-mix adjustment effect. For instance, if case mix for teaching facilities rises faster than for other non-teaching facilities, then because the dependent variable is standardized by case mix, the teaching coefficient would fall.
- We examined the annual change in 3-year moving average of case-mix and wage-index standardized costs per case and see that the costs for teaching IRFs rose at a faster rate as compared to non-teaching IRFs beginning in FY2017, as shown below in Exhibit 2. Given the small overall number of teaching IRFs, any change in case volume among the pool of teaching IRFs would likely impact the magnitude of the teaching coefficient.

Exhibit 2: Annual Growth Rate of 3-year Moving Average in Adjusted Cost per Case⁷

Fiscal Year	Non-Teaching IRFs	Teaching IRFs
FY14 ---> FY15	1.0%	-0.6%
FY15 ---> FY16	0.3%	0.5%
FY16 ---> FY17	0.5%	-0.4%
FY17 ---> FY18	0.5%	1.6%
FY18 ---> FY19	1.0%	2.1%
FY19 ---> FY20	1.5%	1.9%
FY20 ---> FY21	0.3%	0.9%
FY21 ---> FY22	0.8%	1.4%
FY22 ---> FY23	2.2%	7.4%

- Correlation between the 3 independent variables (teaching, LIP and Rural factors) may also play a role – significant changes observed in one may impact another.

⁷ Adjusted cost per case is defined as: cost per case/ (case mix index*(wage index*labor share + non-labor share)).

- A few extreme outliers may be impacting the findings. (Even after taking the log of the outcome variable, a few extreme outliers may distort the magnitude of the effect size.)
- Dobson DaVanzo's analytic approach approximates CMS' methodology and is restricted to publicly available data. As such, methodological and data source differences may be influencing the teaching results.

Summary of FY2014-2023 Findings

Ultimately, we notice similar issues and volatility in both the Dobson DaVanzo and CMS' analysis of the facility adjustment coefficients over time. The teaching adjustment results appear to be problematic in their instability and in the magnitude of increase over time, particularly in CMS' analysis. Given this, and as indicated in the proposed rule, using the FY2023 updated factors does not appear to be a reasonable option.

Dobson DaVanzo Simulations of CMS IRF PPS Facility Adjustment Coefficients

We explored alternative scenarios CMS may wish to consider to reduce the volatility seen in both CMS and Dobson DaVanzo's analyses of the teaching adjustment coefficients over time. We simulated facility level payment impacts for each of these scenarios:

1. Cap teaching adjustment at the current IPPS teaching formula; use CMS' FY2014 LIP and Rural coefficients
 - 1a. Cap teaching adjustment at the current IPPS teaching formula; use CMS' FY2023 LIP and Rural coefficients
2. Update the LIP and Rural coefficients to CMS FY2023 values, but continue to freeze teaching at CMS FY2014 coefficient
3. Include only freestanding IRFs in the calculation of FY2014 teaching facility coefficients
4. Use CMS' FY2023 facility adjustment coefficients
5. Use DD-calculated FY2023 facility adjustment coefficients

Detailed Discussion of Dobson DaVanzo Simulation 1a (Cap teaching adjustment at the current IPPS teaching formula; use CMS' FY2023 LIP and Rural coefficients)

Given the regulatory stability of the Inpatient Prospective Payment System's teaching adjustment formula, the questionable findings we and CMS observed in the recent IRF PPS teaching coefficient results, we explored scenario 1a.

In this simulation, we used the current IPPS IME operating adjustment formula^{8,9} to calculate the IRF teaching adjustment coefficient, and the CMS FY2023 LIP and Rural coefficients (0.5092 and

⁸ $1.35 \times [(1 + \text{resident to bed ratio})^{.405} - 1]$. IRF resident to bed ratio was derived from 2019 and 2020 cost report data (Worksheet E-3 Part II)

⁹ The IPPS Teaching (IME operating adjustment) formula ($1.35 \times [(1 + \text{resident to bed ratio})^{.405} - 1]$) has been static since FY2003. In the IPPS FY2023 IPPS NPRM, CMS is proposing to modify the methodology for calculating direct GME payments to teaching hospitals. Specifically, the

0.100, respectively). We then compared estimated total FY2023 payments from this simulation to the CMS reported FY2023 numbers to estimate the payment impacts (as shown in Exhibit 3).

Rural IRFs are significantly impacted by this approach, largely driven by the use of the FY23 rural coefficient. As mentioned above, the decrease observed in the rural coefficient over time in both the CMS and Dobson DaVanzo models suggests that a decrease in the rural adjustment may be justified given the stable and decreased rural coefficient seen in analyses of recent fiscal years. Additionally, a large decrease in payments is observed for IRFs with a Resident to ADC ratio above 19 percent. Given these redistributive effects compared to current law, if CMS chooses to modify or update the facility coefficients, a transition (phase-in or stop-loss) policy would help to ease providers into the changes.¹⁰

Exhibit 3: Estimated Impacts of Simulation 1a

Facility Classification	Number of IRFs	FY 23 Estimated PPS Payment	Simulated PPS	Difference	% Change
Urban unit	653	\$3,568,228,964	\$3,578,281,587	\$10,052,623	0.3%
Rural unit	133	\$404,498,710	\$389,882,137	-\$14,616,573	-3.6%
Urban hospital	317	\$5,144,036,291	\$5,153,838,071	\$9,801,780	0.2%
Rural hospital	12	\$123,664,549	\$118,426,720	-\$5,237,829	-4.2%
Urban For-profit	396	\$4,903,049,111	\$4,917,139,373	\$14,090,262	0.3%
Rural For-profit	35	\$189,140,902	\$181,667,056	-\$7,473,846	-4.0%
Urban Non-Profit	489	\$3,318,397,242	\$3,324,831,008	\$6,433,766	0.2%
Rural Non-Profit	88	\$281,080,501	\$270,657,434	-\$10,423,067	-3.7%
Urban Government	85	\$490,818,902	\$490,149,276	-\$669,626	-0.1%
Rural Government	22	\$57,941,856	\$55,984,367	-\$1,957,489	-3.4%
Urban	970	\$8,712,265,255	\$8,732,119,658	\$19,854,403	0.2%
Rural	145	\$528,163,259	\$508,308,856	-\$19,854,403	-3.8%

Urban by region	Number of IRFs	FY 23 Estimated PPS Payment	Simulated PPS	Difference	% Change
Urban New England	29	\$351,703,709	\$352,146,192	\$442,483	0.1%
Urban Middle Atlantic	121	\$1,105,304,474	\$1,096,789,588	-\$8,514,886	-0.8%
Urban South Atlantic	158	\$1,754,034,378	\$1,757,609,007	\$3,574,629	0.2%
Urban East North Central	158	\$1,076,081,314	\$1,077,062,467	\$981,153	0.1%

proposed change would impact how the GME FTE cap is applied when the hospital's weighted FTE count is greater than its FTE cap. This would not impact our analysis, where we are using the IME operating adjustment formula, for which there have been no proposed changes.

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Indirect-Medical-Education-IME>

<https://www.cms.gov/newsroom/fact-sheets/fy-2023-hospital-inpatient-prospective-payment-system-ipps-and-long-term-care-hospitals-ltch-pps>

¹⁰ Permutations of this simulation could also be options for CMS to consider:

- Use the IPPS teaching formula for the IRF teaching coefficient; continue to freeze the rural and LIP coefficients until the teaching coefficient is stabilized, or
- Use the IPPS teaching formula for the IRF teaching coefficient; update the rural coefficient based on the latest data but continue to freeze the LIP coefficient until the teaching coefficient is stabilized.

Urban East South Central	55	\$541,370,971	\$542,170,782	\$799,811	0.1%
Urban West North Central	76	\$486,832,796	\$487,880,381	\$1,047,585	0.2%
Urban West South Central	197	\$1,916,199,259	\$1,914,875,257	-\$1,324,002	-0.1%
Urban Mountain	79	\$689,633,059	\$695,611,983	\$5,978,924	0.9%
Urban Pacific	97	\$791,105,295	\$807,974,000	\$16,868,705	2.1%

Rural by region	Number of IRFs	FY 23 Estimated PPS Payment	Simulated PPS	Difference	% Change
Rural New England	5	\$31,597,054	\$30,388,623	-\$1,208,431	-3.8%
Rural Middle Atlantic	10	\$20,450,608	\$19,580,712	-\$869,896	-4.3%
Rural South Atlantic	16	\$94,124,004	\$90,102,852	-\$4,021,152	-4.3%
Rural East North Central	23	\$83,014,794	\$79,866,105	-\$3,148,689	-3.8%
Rural East South Central	20	\$78,369,180	\$76,036,657	-\$2,332,523	-3.0%
Rural West North Central	20	\$56,249,053	\$53,954,998	-\$2,294,055	-4.1%
Rural West South Central	42	\$144,923,352	\$139,494,598	-\$5,428,754	-3.7%
Rural Mountain	6	\$9,019,488	\$8,664,521	-\$354,967	-3.9%
Rural Pacific	3	\$10,415,726	\$10,219,791	-\$195,935	-1.9%

Teaching Status	Number of IRFs	FY 23 Estimated PPS Payment	Simulated PPS	Difference	% Change
Non-teaching	1012	\$7,969,532,093	\$7,997,118,319	\$27,586,226	0.3%
Resident to ADC less than 10%	59	\$889,697,087	\$881,968,725	-\$7,728,362	-0.9%
Resident to ADC 10%-19%	34	\$339,056,464	\$324,837,311	-\$14,219,153	-4.2%
Resident to ADC greater than 19%	10	\$42,142,870	\$36,504,160	-\$5,638,710	-13.4%

DSH Patient Percentage	Number of IRFs	FY 23 Estimated PPS Payment	Simulated PPS	Difference	% Change
DSH PP = 0%	64	\$252,364,430	\$248,092,692	-\$4,271,738	-1.7%
DSH PP < 5%	127	\$1,093,064,193	\$1,077,291,994	-\$15,772,199	-1.4%
DSH PP 5%-10%	260	\$2,481,178,193	\$2,467,472,834	-\$13,705,359	-0.6%
DSH PP 10%-20%	388	\$3,427,638,684	\$3,428,529,135	\$890,451	0.0%
DSH PP > 20%	276	\$1,986,183,014	\$2,019,041,859	\$32,858,845	1.7%

Conclusion

In summary, we see similar variability as found by CMS in the teaching coefficient over time, albeit at a lesser magnitude. Given this, Dobson DaVanzo explored several alternatives and found that the use of the current IPPS teaching payment formula (which would lend stability to the IRF teaching adjustment over time) may be one viable option for CMS to consider. While we note that IRF teaching costs appear to be increasing relative to non-teaching IRF costs, until we understand why that is the case, it would seem premature to allow the teaching coefficient to increase to the FY2023 level. Given the general stability of the rural and LIP coefficients, CMS could consider moving forward with an update to these two factors. If CMS decides to do this, it could consider phasing in these factor changes over a 2 or 3-year period to provide for a smoother transition.