May 31, 2022 ***e-comment submitted electronically***

Administrator Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Attention: CMS 1767-P
7500 Security Boulevard
Baltimore, MD, 21244-1850

RE: Inpatient Rehabilitation Facility (IRF) Prospective Payment System for Federal Fiscal Year 2023 and Updates to the IRF Quality Reporting Program (CMS-1767-P)

Dear Administrator Brooks-LaSure:

The Tennessee Hospital Association (THA), on behalf of its over 140 healthcare facility members, specifically our members representing 36 hospitals that provide acute rehabilitation therapy services, appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule on the FY 2023 Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS), CMS-1767-P.

THA would like to express our appreciation again to HHS and CMS for providing necessary waivers that allow our members to appropriately respond and for the agencies' ongoing efforts to reduce regulatory burdens on health care providers during the pandemic. THA also appreciates the relatively brief proposed rule and CMS' continued efforts to make minor changes.

Payment Update

CMS proposes to increase the IRF standard rate for FY 2023 by 2.0 percent from $17,240 to $17,698, which amounts to an overall increase of an estimated $6,640,000 for Tennessee IRFs. However, given other payment adjustments which will be addressed in more detail through our comments, overall payments are only expected to increase in the aggregate by $3,187,000, about 1.5 percent over last year. With the continuation of the public health emergency (PHE), increased costs due to shifts in labor markets, disruptions to the vital supply chains, and with inflation, by some accounts, up as high as seven percent, operating costs for our facilities have drastically increased. THA believes the proposed payment increases, while appreciated, have not appropriately taken the cost factors into account. **THA urges CMS to consider additional funding opportunities and increases to the market basket to match the experienced costs of IRFs more closely.**

Area Wage Index Adjustments

THA is grateful that CMS is continuing the area wage index (AWI) policy changes that were implemented in the FY 2020 inpatient prospective payment system (IPPS) final rule which is

addressing the disparity in payments between rural and urban acute care hospitals and urge CMS to finalize the policy for FY 2023. **We echo our previous comments and request CMS implement similar policies for IRFs as the facilities compete in the same labor market as IPPS hospitals.** Providing acute care hospitals in low-wage index areas a temporary increase in their reimbursement exacerbates an already scare labor market issue. The pandemic has also broadened labor pools, with providers having to compete regionally and nationally. The difference between acute care facilities' and IRF wages is nonexistent.

We appreciate that CMS is only increasing the FY 2023 labor-related share from 72.9 percent to 73.2 percent. CMS should consider excluding the labor portion of capital costs for FY 2023 and going forward. Although there is not a material increase in the wage percentage, each increase to the labor-related share percentage penalizes any facility that has a wage index less than 1.0, which is all of Tennessee. There is growing disparity between high-wage and low-wage states that harms providers. Limiting the increase in the labor-related share helps mitigate that growing disparity.

We appreciate the establishment of a permanent five percent cap on decreases in the wage index, and CMS considering parts of the formula they can adjust. However, it does not correct the ongoing problem of the wide range in wage index amounts and the ever-widening gap which is occurring each year. A floor must be established in a non-revenue neutral manner with an annual cap placed on those CBSAs with high wage indices. The five percent cap does not benefit any Tennessee IRF and prior wage indexes have rarely fluctuated as much in our state. Tennessee providers would be paying for other providers' impacts, again, through a budget neutral adjustment that does not provide a greater benefit. **If CMS finalizes this policy, the agency should consider applying the cap in a non-budget neutral manner.**

Outlier Increase

CMS is proposing to increase the outlier threshold from $9,491 to $13,038, a 37.4 percent increase, in order to have 3.0 percent of the cases meet outlier criteria. This significant increase is estimated to result in a 0.8 percent point decrease in outlier payments and a dollar impact of a $70 million decrease in reimbursements. This data was in the middle of the COVID pandemic and will not be reflective of the patient spend in FY 2023. The increase in stop loss should be limited to no more than the 3.1 percent market basket update. Due to the COVID impact, relying on 2021 claims data may not be appropriate and could significantly lower the number of cases meeting the outlier threshold below the three percent estimate of aggregate payments. **Given these abnormal impacts, the outlier policy should be evaluated based on FY 2019 data. Additionally, any outlier change should be limited to no more than plus or minus the market basket in any given year**.

IRF Teaching Policy

THA and our members are supportive of the updated current policy affecting displaced medical residents along with the required documentation that needs to be included in the letter.

IRF Transfer Policy

THA and our members strongly oppose the proposed addition of discharges to home health into the IRF Transfer Payment Policy. The OIG conducted an audit of calendar year 2017 and 2018 Medicare claims data which was prior to the pandemic and the significant restructuring that has been required by each IRF. The data utilized is too old and out of touch with current operations especially considering the difficulty in discharging patients to other post-acute care settings. Until the pandemic is over, new data is available, and the prior authorization issues that IRF are experiencing are fixed, this transfer policy proposal should not be considered. The nearly a half billion dollar estimated cut each year in reimbursement will cause many IRFs to go out of business. Access to post-acute care services needs to be studied and solutions implemented to improve the continuing dilemma of how to discharge patients to the most appropriate care setting in a timely manner.

Health Equity

There is a large focus on health equity and disparities that THA is very supportive of across the board, from Medicare to Medicaid to our own communities. Our members understand the role healthcare providers play in collecting, analyzing, and using data to strive for better health outcomes. Following comments from Tennessee IRFs, we are largely supportive of a general framework that could be used across CMS quality programs. Standardization will be critical to analyze all of the data being collected. Any measure developed should be able to differentiate the wide range of patient functional levels, particularly in the post-acute care settings, and also allow clinicians the ability to distinguish functional dependency.

As the focus on health equity is sweeping, we also encourage the agency to consider what data they already have before adding additional reporting requirements on providers.

Conclusion

THA and our IRF members appreciate CMS's consideration of these comments and welcome continued opportunities to work with the agency in improving the IRF PPS. Thank you for the opportunity to share our thoughts and concerns. If you or your staff wish to discuss this letter, please contact me at anewell@tha.com.

Sincerely,

Amanda Newell
VP of Financial Policy