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June 7, 2021

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1748-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted via regulations.gov

Re: 42 CFR Part 412 (CMS-1748-P) Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2022 and Updates to the IRF Quality Reporting Program

On behalf of Uniform Data System for Medical Rehabilitation (UDSMR) and the nearly nine hundred inpatient rehabilitation facilities we provide services to, we are pleased to present our comments on 42 CFR Part 412 (CMS-1748-P) Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2022 and Updates to the IRF Quality Reporting Program, published on April 12, 2021, in the *Federal Register*. With over thirty years of experience, UDSMR provides coding, clinical, quality improvement, and technical support services to IRFs and other postacute care (PAC) providers. UDSMR appreciates the opportunity to provide ongoing feedback to CMS and hopes to work with CMS toward solutions that meet the needs of IRF providers and patients.

Before proceeding with our comments, we present the following executive summary, which highlights our concerns and recommendations.

Executive Summary:

UDSMR appreciates CMS's annual updates to the IRF payment system, but the increase in the SPCF continues to hide underlying issues with the construction of the CMGs and masks negative changes to the CMG relative weights and LOS values that are inconsistent with current clinical needs. IRFs have continued to provide a high level of care during the COVID-19 Public Health Emergency (PHE), and decreases to the CMG relative weights and LOS values do not address the increasing patient severity and the medically complex situations IRFs continue to address on a daily basis. These proposed adjustments neither account for newer coding practices nor provide adequate coverage and payment for severe patients who benefit from IRF services. IRFs and patients who benefit from an IRF level of care should not be penalized for the construction and maintenance of a payment system that was based on analysis of data that was not proven to be reliable and valid and that continues to update its assessment guidance.

We also support concerns from our subscribers about ongoing updates to the Quality Reporting Program and the implementation and consideration of unproven quality measures that add administrative burden without evidence of reliability, validity, or the

ability to differentiate performance among providers. Although IRFs recognize the relative importance of certain measure domains and concepts, CMS should not implement those domains and concepts until (1) the measures meet the criteria to be formally endorsed by the National Quality Forum (NQF) or (2) substantial testing and evidence can be provided to suggest that public reporting of any information will benefit patients and providers.

Concerns:

1. Regarding the proposed refinements to the FY 2022 IRF PPS CMG relative weights and length of stay:
    a. The majority of the CMG relative weight changes are negative, suggesting that patient severity or the cost of care has decreased during the COVID-19 PHE.
    b. Decreased LOS values will affect over 20% of cases even though LOS has increased during the COVID-19 PHE.
    c. These changes will negatively affect patients' access to resources and an IRF level of care.
2. UDSMR supports IRFs who are concerned that continued implementation of unproven quality measures would add administrative burden without any evidence that these measures are reliable, are valid, or differentiate between providers.

Recommendations:

1. UDSMR recommends the following with respect to the proposed IRF PPS payment updates:
    a. CMS should not reduce any of the CMG relative weights and LOS values until the COVID-19 PHE is ended.
    b. CMS also should look to revise the CMGs and underlying data collection to account for new populations of cases, such as patients receiving services following COVID-19.
2. UDSMR suggests that CMS delay implementation of future quality measures until:
    a. Measures receive NQF endorsement.
    b. Measures adequately differentiate performance among providers.
    c. All efforts to minimize administrative burden are considered.

The remainder of this letter addresses our concerns and recommendations in detail.

1. **Regarding the proposed refinements to the FY 2022 IRF PPS CMG relative weights and length of stay:**
   a. **The majority of the CMG relative weight changes are negative, suggesting that patient severity or the cost of care has decreased during the COVID-19 PHE.**
   b. **Decreased LOS values will affect over 20% of cases even though LOS has increased during the COVID-19 PHE.**
   c. **These changes will negatively affect patients' access to resources and an IRF level of care.**

   As stated in section IV of CMS-17489-P.

1a. The majority of the CMG relative weight changes are negative, suggesting that patient severity or the cost of care has decreased during the COVID-19 PHE.

Table 3 of the proposed rule shows that the CMG relative weight changed by less than 5% for 97.3% of all cases but does not specify the percentage of cases whose relative weights will be reduced by up to 5%. UDSMR's analysis of current FY 2021 Medicare IRF-PAI data indicates that although the relative weights will change by less 5% for 97% of cases, these values will decrease by up to 5% for over 55% of all cases and by 5% to 15% for nearly 2% of cases. Thus, the relative weight values will decrease for a majority of IRF cases.

Of particular concern is that CMS is proposing to reduce the relative weight values for patients with a stroke, traumatic brain injury, or traumatic spinal cord injury. CMS has proposed reducing the relative weight for eighteen of the twenty-four stroke CMGs, nineteen of the twenty traumatic brain injury CMGs, and sixteen of the twenty-eight traumatic spinal cord injury CMGs.

UDSMR's analysis indicates that the average motor score has decreased during the COVID-19 PHE for each of these CMGs, suggesting that these patients are being admitted at lower functional levels than they have historically. This suggests that (1) the underlying payment model and CMGs are flawed or (2) the data being used for these proposed changes is not representative of the current population of IRF cases.

We strongly urge CMS to reconsider these proposed reductions, which could negatively affect IRFs' ability to provide intensive rehabilitation services to patients.

1b. Decreased LOS values will affect over 20% of cases even though LOS has increased during the COVID-19 PHE.

Using current FY 2021 Medicare Fee-for-Service IRF-PAI data to date, UDSMR's analysis shows the following changes to the CMG LOS values:

CMS Average LOS Category	Percentage
Increased by 5 days or more	0.0%
Increased by 2–4 days	0.3%
Increased by 1 day	7.7%
No change	71.2%

CMS Average LOS Category	Percentage
Decreased by 1 day	20.4%
Decreased by 2–4 days	0.4%
Decreased by 5 days or more	0.0%

We are increasingly concerned about the reductions in the CMG LOS for over 20% of cases, as noted above.

During the COVID-19 PHE, the overall IRF Medicare Fee-for-Service LOS has increased slightly for cases that are not short stays, early transfers, or expired cases. The average LOS for these cases was 13 days in the fourth quarter of 2019 but rose to 13.6 days in the first quarter of 2021. Based on this information, the CMG LOS values should be increased rather than reduced.

Additionally, on January 1, 2021, CMS provided additional ICD-10 codes to identify patients with conditions related to COVID-19 and patients with a history of COVID-19. Our analysis of these cases suggests that these patients have longer stays, yet these codes have not been added as tiered comorbidities, which would potentially provide additional LOS and payment.

We highly recommend that CMS not reduce LOS values and that it instead use more recent data, which suggests that LOS has increased. We also recommend that CMS evaluate the inclusion of the COVID-19-related ICD-10 codes as tiered comorbidities in order to provide the additional LOS that these patients may require.

1c. These changes will negatively affect patients' access to resources and an IRF level of care.

Accounting for the relative weight and LOS changes noted previously, UDSMR's analysis of Medicare Fee-for-Service data to date suggests the following impact on payment weights:

RIC	FY 2021 Average Payment Weight	FY 2022 Average Payment Weight	Difference	% Difference
01 Stroke	1.5385	1.5279	−0.0106	−0.7%
02 Traumatic brain injury	1.3343	1.3102	−0.0241	−1.8%
03 Nontraumatic brain injury	1.2972	1.2988	0.0016	0.1%
04 Traumatic spinal cord injury	1.8716	1.8796	0.0079	0.4%
05 Nontraumatic spinal cord injury	1.4693	1.4575	−0.0117	−0.8%
06 Neurological	1.3309	1.3392	0.0083	0.6%
07 Fracture of lower extremity	1.3526	1.3467	−0.0060	−0.4%
08 Replacement of lower extremity	1.0735	1.0839	0.0104	1.0%
09 Other orthopaedic	1.2071	1.2167	0.0096	0.8%
10 Amputation of lower extremity	1.4444	1.4468	0.0024	0.2%
11 Amputation of non-lower extremity	1.2948	1.2580	−0.0368	−2.8%
12 Osteoarthritis	1.1795	1.1814	0.0019	0.2%
13 Rheumatoid/other arthritis	1.2349	1.2278	−0.0071	−0.6%
14 Cardiac	1.1573	1.1695	0.0123	1.1%

RIC		FY 2021 Average Payment Weight	FY 2022 Average Payment Weight	Difference	% Difference
15	Pulmonary	1.2329	1.2366	0.0037	0.3%
16	Pain syndromes	1.0796	1.0857	0.0060	0.6%
17	Major multiple trauma w/o BI or SCI	1.3525	1.3666	0.0141	1.0%
18	Major multiple trauma with BI or SCI	1.5294	1.5305	0.0010	0.1%
19	Guillain-Barré syndrome	1.9313	1.8726	−0.0587	−3.0%
20	Miscellaneous	1.2194	1.2304	0.0110	0.9%
21	Burns	1.3704	1.4353	0.0649	4.7%
Total		**1.3369**	**1.3383**	**0.0014**	**0.1%**

If the SPCF had not been increased, we would have seen decreases in payment to a number of patients based on CMS's proposed changes.

Although IRFs are fortunate that the SPCF has been increased, the populations whose payment weight will decrease will not receive the full benefit of this increase. Instead, we project the following changes to the average unadjusted payment:

RIC		FY 2021 Average Unadjusted FPP	FY 2022 Unadjusted Average FPP	Difference	% Difference
01	Stroke	$25,932.85	$26,392.16	$459.30	1.8%
02	Traumatic brain injury	$22,491.31	$22,630.94	$139.63	0.6%
03	Nontraumatic brain injury	$21,865.94	$22,434.04	$568.10	2.6%
04	Traumatic spinal cord injury	$31,548.32	$32,466.04	$917.71	2.9%
05	Nontraumatic spinal cord injury	$24,765.87	$25,175.92	$410.05	1.7%
06	Neurological	$22,433.03	$23,131.82	$698.79	3.1%
07	Fracture of lower extremity	$22,799.67	$23,260.94	$461.26	2.0%
08	Replacement of lower extremity	$18,094.46	$18,722.06	$627.60	3.5%
09	Other orthopaedic	$20,346.52	$21,015.36	$668.85	3.3%
10	Amputation of lower extremity	$24,347.28	$24,991.31	$644.03	2.6%
11	Amputation of non-lower extremity	$21,824.76	$21,729.03	−$95.72	−0.4%
12	Osteoarthritis	$19,881.45	$20,406.74	$525.29	2.6%
13	Rheumatoid/other arthritis	$20,815.84	$21,207.63	$391.79	1.9%
14	Cardiac	$19,506.74	$20,201.37	$694.63	3.6%
15	Pulmonary	$20,782.09	$21,360.55	$578.46	2.8%
16	Pain syndromes	$18,198.41	$18,752.66	$554.25	3.0%
17	Major multiple trauma w/o BI or SCI	$22,797.49	$23,604.59	$807.10	3.5%
18	Major multiple trauma with BI or SCI	$25,779.91	$26,435.53	$655.63	2.5%
19	Guillain-Barré syndrome	$32,554.04	$32,345.15	−$208.89	−0.6%
20	Miscellaneous	$20,553.78	$21,252.17	$698.39	3.4%
21	Burns	$23,098.99	$24,791.34	$1,692.35	7.3%
Total		**$22,534.46**	**$23,116.74**	**$582.28**	**2.6%**

Even though the overall population can expect a 2.6% increase in payment, stroke and traumatic brain injury cases will not receive a similar increase. Additionally, the increases for these cases may not cover the added expenses incurred during the COVID-19 pandemic. This, in turn, may cause an undue financial burden on IRFs and potential affect their ability to care for these patients.

We urge CMS to use more recent data in order to ensure adequate payment for all cases and to address the trend in increased LOS and severity.

2. UDSMR supports IRFs who are concerned that continued implementation of unproven quality measures would add administrative burden without any evidence that these measures are reliable, are valid, or differentiate between providers.

Our subscribers have expressed to us their concerns about the COVID-19 vaccination measure and the potential issues this measure may cause from both a reporting and an operational standpoint. Three concerns have topped their list.

First, it has been suggested that this measure has the potential to jeopardize already critical workforce issues if facilities attempt to produce a positive performance by either not hiring or letting go of staff who choose not to be vaccinated. Every IRF considers the information that is being publicly reported to be important, but quality measures should not negatively affect the provider workforce and the ability to provide care to patients.

Second, the reporting requirements for this measure seem overly burdensome, especially when combined with the reporting requirements for the influenza vaccination. Because the CDC is already collecting information on COVID-19 vaccinations, requiring IRFs to collect and report the same information is duplicative. Additionally, CMS's specifications do not account for whether a booster will be required in the future or how they will consider vaccinations that may have occurred six to twelve months prior to the reporting period.

Finally, this measure has not received NQF endorsement, and it has not been tested among providers to determine whether the information will be reliable and valid and whether it will differentiate performance among providers.

Despite not having this measure in place, IRFs have provided safe and effective care to patients throughout the COVID-19 PHE. Vaccination is a key to reducing both the prevalence of COVID-19 and the risk of infection among patients, but this measure does not have enough evidence to justify the additional burden it places on providers.

CMS should consider implementing this quality only if it is endorsed by the NQF, it demonstrates that it can differentiate performance among providers, and it can be shown to increase the safety of staff members and patients alike.

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In closing, UDSMR appreciates both the opportunity to comment on this proposed rule and CMS's careful consideration of the concerns and issues raised in this letter. With over thirty years of experience providing coding, clinical, and quality improvement services to IRFs and other PAC providers, UDSMR welcomes the opportunity to work with CMS to provide ongoing feedback regarding refinements to the IRF PPS and the IRF QRP. If you have any questions about these comments or require additional information, please contact us at 716-817-7800.

Sincerely,

Pawel Wieczorek
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