



June 2, 2023

Chiquita Brooks-LaSure, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1781-P; Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2024 and Updates to the IRF Quality Reporting Program
Submitted electronically via <http://www.regulations.gov>

Dear Administrator Brooks-LaSure,

Trinity Health appreciates the opportunity to comment on policies set forth in CMS-1781-P. Our comments and recommendations reflect a strong interest in public policies that support better health, better care and lower costs to ensure affordable, high quality, and people-centered care for all.

Trinity Health is one of the largest not-for-profit, Catholic health care systems in the nation. It is a family of 123,000 colleagues and more than 26,000 physicians and clinicians caring for diverse communities across 26 states. Nationally recognized for care and experience, the Trinity Health system includes 88 hospitals, 135 continuing care locations, the second largest PACE program in the country, 136 urgent care locations and many other health and well-being services. Trinity Health has 15 medical groups with 1,324 primary care providers and 4,193 specialty care providers. Based in Livonia, Michigan, its annual operating revenue is \$21.5 billion with \$1.4 billion returned to its communities in the form of charity care and other community benefit programs.

Trinity Health has 17 Clinically Integrated Networks (CINs) that are accountable for approximately 2 million lives across the country through alternative payment models. Our health care system participates in 14 markets with Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs), which includes eleven markets partnering in one national MSSP Enhanced Track ACO, Trinity Health Integrated Care. All of these markets participated in the “enhanced track”, which qualifies as an advanced alternative payment model (AAPM). Two of the 14 markets also participate in CPC+. In addition, we have participated since 2014 in the Bundled Payments for Care Improvement Advanced (BPCIA) initiative and the Comprehensive Care for Joint Replacement (CJR) program across 37 hospitals. Our work—and experience in value-based contracting—also extends beyond Medicare as illustrated by our participation in 123 non-CMS APM contracts.

Proposed IRF Market Basket Update

CMS proposes to update IRF rates by a net of 3.0%, or \$335 million, in FY 2024.

Given the extraordinary inflationary environment and continued labor and supply cost pressures facing hospitals, Trinity Health is concerned the proposed update does not reflect the cost of delivering care nor does it account for

major shortcomings in past market basket updates. Hospitals are facing unprecedented financial strain. At Trinity Health, system-wide we are experiencing:

- 15% increase in labor costs.
- 17% increase in supply costs.
- 24% increase in drug costs.

In recent years, the data sources CMS used for developing annual payment updates have not accounted for the impact of inflation, nor have they captured the staggering increase in labor costs, including contract labor. Further, its March 2023 report to Congress, the Medicare Payment Advisory Commission (MedPAC) noted that in FY22, the forecast used to set payments was three percentage points lower than the cost increases hospitals actually experienced. This underpayment is one factor leading to significant financial challenges for Trinity Health and other health systems.

A net increase of 3.0% is woefully inadequate and will make CMS goals for IRFs—to improve outcomes and increase access to care—exceptionally more challenging. Trinity Health urges CMS to use its special exceptions and adjustment authority to make a one-time retrospective adjustment to the market basket of 10%-15% to account for what hospitals should have received in 2022 when accounting for inflation so this significant underpayment is not permanently baked into the market basket. We also ask that CMS consider another rebasing of the market basket next year when 2022 data is available to provide a more accurate update.

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

CMS adopted the COVID-19 Vaccination Coverage Among HCP measure as part of FY22 rulemaking. CMS proposes to modify the measure to align with CDC changes regarding whether an individual is considered “up-to-date” with COVID-19 vaccinations beginning in FY2025. Public reporting of the modified version of the measure would begin with the September 2024 Care Compare refresh or as soon as technically feasible.

Trinity Health assumes CMS is going to use publicly available data to drive facilities to improve, rather than a mandate, HCP vaccination. Should CMS retain this policy in the final rule, we would support adopting the CDC’s definition of “up-to-date” for consistency but urge CMS to make the measure an annual reporting requirement like the flu vaccine and not a quarterly requirement. However, as no decision has been made yet in terms of whether there will be an annual vaccine recommendation, this proposed policy may be premature.

In addition, we urge CMS to be very clear about any final reporting requirement as the current requirement can be problematic from a technical standpoint if a provider picked a week in a month that crossed between two months. In this instance, reporting is not received by the CMS system and providers appear as non-compliant. Lastly, we note this would increase reporting burden. We currently don’t have a requirement that colleagues report whether they have bivalent booster (and this would get more challenging as new bivalent formulas are released) and this will take significant amount of work to ask colleagues to submit documentation and pull into the NHSN.

Opening of New IRF Units

If finalized, the rule would eliminate the outdated requirement that IRF units only begin operating at the beginning of hospital cost-report periods and would permit the opening of a new IRF unit at any time during the cost report period, provided that the hospital notify its fiscal intermediary and the CMS Regional Office in writing of the change at least 30 days before the date of the change.

Trinity Health supports this change as it would increase access to care.

Adoption of Discharge Function Score Measure

Beginning with the FY 2025 IRF Quality Reporting Program, CMS would adopt this assessment-based outcome measure that estimates the percentage of IRF patients who meet or exceed an expected discharge score during the reporting period. CMS would also remove three overlapping measures in conjunction with this change.

Trinity Health does not support the proposed changes. The new assessment-based outcome measure is information that is already abstracted from the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI). The IRF-PAI has increased in length dramatically over the years and takes much longer to complete. The IRF-PAI requirements has increased the burden on IRFs already struggling with resources, including staffing challenges.

We don't support a policy of imputing for "missing" data, and we take issue with CMS labeling items coded as "activity not attempted" as "missing". In addition, If the goal is for the measure to be used in a cross-setting way, there are so many risk adjusters and differences in patient populations that CMS would likely end up with three different measures (one for IRF, one for SNF and one for LTCH) considering the differences in patient populations serves by various post-acute settings. Lastly, the measure itself is opaque in how it determines the "expected" score. We urge CMS not to finalize this proposal.

IRF Review Choice Demonstration

CMS announced the start of the IRF Review Choice Demonstration (RCD) in May. Under the RCD, IRFs in states in which it has rolled out will choose to have their claims reviewed under either a pre-claim review or a post-payment review process. After a six-month period, IRFs that demonstrate compliance with Medicare rules will be able to select one of three review processes for continued review.

While not rolling out nationwide, Trinity Health urges CMS to suspend the demonstration as it is overly burdensome and would require IRFs to divert critical resources to the process. In addition, there is the very real potential that the RCD would force restriction in access for Medicare beneficiaries since contractors have such a hard time properly evaluating IRF claims. Therefore, hospitals will risk getting zero payment for their Medicare patients. In addition, the process would:

- Perpetuate the long-standing issue of Medicare auditors lacking adequate knowledge of IRF-specific coverage and payment guidelines.
- Place an unwarranted burden on IRFs with no history of noncompliance.

Trinity Health continues to align with [comments](#) submitted by the AHA and we urge CMS to end the demonstration.

Conclusion

We appreciate CMS's ongoing efforts to improve policies across the delivery system. If you have any questions on our comments, please feel free to contact me at jennifer.nading@trinity-health.org or 202-909-0390.

Sincerely,

/s/

Jennifer Nading
Director, Medicare and Medicaid Policy and Regulatory Affairs
Trinity Health