



June 1, 2023

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

SUBMITTED ELECTRONICALLY VIA <http://www.regulations.gov>

Re: Medicare Program; 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 Association of Rehabilitation Nurses (ARN) – representing approximately 4,500 rehabilitation nurses and more than 14,000 Certified Registered Rehabilitation Nurses (CRRN) that work to enhance the quality of life for those affected by physical disability and/or chronic illness – appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services (CMS) Fiscal Year (FY) 2024 Inpatient Rehabilitation Facility Prospective Payment System Proposed Rule (CMS-1781-P).

Rehabilitation nursing is a philosophy of care, it is not limited to a work setting or a phase of treatment. We base our practice on rehabilitative and restorative principles by: (1) managing complex medical issues; (2) collaborating with other specialists; (3) providing ongoing patient/caregiver education; (4) setting goals for maximum independence; and (5) establishing plans of care to maintain optimal wellness. Rehabilitation nurses practice in all settings, including freestanding rehabilitation facilities, hospitals, long-term subacute care facilities/skilled nursing facilities (SNFs), long-term acute care facilities, comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHAs), and private practices.

Rehabilitation nurses take a holistic approach to meeting patients' nursing and medical, vocational, educational, environmental, social, spiritual, and safety needs. We lead and coordinate rehabilitation, restorative care, and community reintegration for populations across all age groups and ethnicities across the care continuum, from ambulatory care to hospice. Rehabilitation nurses begin to provide care to individuals, their families, and caregivers soon after the onset of a disabling injury or chronic illness and continue to provide specialty care, patient and family education, and care transition planning that empowers these individuals to return home, work, and/or school. Rehabilitation nurses, in collaboration with interdisciplinary teams, provide comprehensive, population-specific care management to access health care services, adaptive technology and equipment, and community resources.

ARN supports all efforts to ensure persons with disabilities and chronic illnesses have access to the appropriate level of rehabilitation services to maximize functional outcomes, independence, and quality of life. Specifically, as a part of its mission, ARN is committed to working with policymakers at the local, state, and federal levels to advance policies and programs that

promote maximum independence for all persons in need of rehabilitation. As such, we are pleased to offer the following comments on the proposed rule.

Proposed Update to the Case-Mix Group (CMG) Relative Weights and Average Length of Stay (ALOS) Values for FY 2024

Each year, CMS updates CMG relative weights and ALOS values. These values are used in the payment formula in the IRF payment system. Data used to update the CMG weights and ALOS values are obtained from IRF cost reports, which are produced by IRFs that tabulate data on the cost of care. In FY 2024, CMS notes that 99.4% of all cases are changed by less than 5% (increase or decrease), which will result in a decreased re-distributional effect of the payments to each IRF within the payment system. ARN would like to highlight that while 99.4% of cases have little change, 0.6% are seeing very significant changes. ARN is concerned that the decreases to the CMG relative weights and ALOS values don't reflect the medical complexity of the patients our members treat in IRFs. These cases reflect patients with serious conditions that will likely need another level of care following the IRF visit that is not their home. When the discharge occurs before the ALOS for the respective CMG, IRFs will receive a transfer payment penalty. Therefore, CMS should look to revise the CMG relative weights and ALOS values to ensure adequate coverage and reimbursement for the services required to treat patients in IRF settings.

Proposed FY 2024 IRF PPS Payment Update

CMS estimates that overall IRF payments for FY 2024 would increase by 3.7 percent (or \$335 million) compared to payments in FY 2023. ARN members appreciate a positive update in IRF payments for FY 2024; however, we believe this increase is insufficient to sustain IRF operations in light of the increasing costs for supplies, salaries, resources, and other essential expenses. Nursing salaries have increased over the last three years throughout the COVID-19 public health emergency to protect the nation's nursing workforce and everyday goods and services are getting more expensive.

It is important to note that acute care hospitals tend to have greater patient volume compared to IRFs; however, IRFs specialize in providing intensive rehabilitation services to patients who require a higher level of care than what can be provided in other settings, such as skilled nursing facilities or outpatient rehabilitation centers. IRFs focus on the rehabilitation and recovery of individuals with conditions such as stroke, spinal cord injury, traumatic brain injury, or major orthopedic surgeries. Our members who work in IRF settings help patients adjust to health patterns that are more restorative and rehabilitative; therefore, IRFs require more resources and are using consumables, such as those that are used to reestablish bladder control or GI function, at a rate different than acute care hospitals. Furthermore, the IRF's discharge to community rate is higher than other settings, meaning that a larger proportion of patients who receive care in an IRF setting are discharged back to their community rather than transferred to another type of care facility. This indicates a successful transition from the IRF to a more independent living arrangement where individuals may return to gainful employment and resume working and earn an income after a period of limitations due to disability and/or medical treatment.

Proposed Modification to the Regulation for Excluded Inpatient Rehabilitation Facility Units Paid Under the IRF PPS

To provide greater availability of inpatient rehabilitation beds, CMS is proposing changes to allow more flexibility for hospitals to open excluded units. ARN supports this proposal and applauds CMS for working to increase access to rehabilitative care while alleviating unnecessary administrative burden.

IRF Quality Reporting Program (QRP)

CMS is proposing to adopt new measures, remove three measures, and proposing a new public reporting policy. ARN believes it is important to periodically review and refine measures to ensure that they align with current practice and contribute to improved quality of care delivered by IRFs. ARN appreciates CMS for working to improve the IRF QRP and ensuring that IRFs are delivering high-quality care and achieving positive patient outcomes.

To start off, ARN is supportive of the removal of the Application of Functional Assessment/Care Plan measure. IRFs are already required to provide a plan of care outlining specific treatment and rehabilitation goals for patients receiving services in an IRF. Due to this requirement, it is unnecessary for IRFs to report on this measure. ARN believes that removing redundant measures from the IRF QRP reduces the administrative burden on IRFs and allows them more time to focus their attention on areas that improve quality and care.

Additionally, while we appreciate CMS' efforts to enhance the overall quality of care provided to IRF patients, ARN opposes the addition of the following new measures.

- CMS proposes to adopt the COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date (Patient/Resident COVID-19 Vaccine) measure beginning with the FY 2026 IRF QRP.
- CMS proposes to modify the COVID-19 Vaccination Coverage among Healthcare Personnel (HCP COVID-19 Vaccine) measure beginning with the FY 2025 IRF QRP.

ARN worries that reporting and tracking these measures will necessitate additional administrative burden for IRFs. These measures will pose unique challenges due to the varying comorbidities and preexisting conditions that individuals may have as these factors will impact the specific vaccine recommendations for different medical conditions. One of the challenges in the context of COVID-19 vaccination is the varying recommended number of boosters for different individuals – not everyone will have the same recommended number of boosters. Complying with CDC guidelines may be challenging, and this information may be hard to reflect in reporting. Moreover, it will be time consuming to collect this information, leading to increased administrative burden, especially if CDC revises its guidance.

In order for IRFs to comply with data collection, reporting and potential audits related to COVID-19 vaccine measures, increased time, personnel, and financial resources will be required. These resources would be better utilized for direct patient care, rehabilitation services, or other quality improvement initiatives that align more closely with the primary mission of IRFs. Therefore, ARN believes the costs associated with these measures far outweigh the benefits of its use in the IRF QRP.

Should CMS decide to implement these measures, ARN seeks clarification on the following questions:

- How will information about HCP vaccines percentage be aggregated? (# of HCP primary series vs # of HCP primary + 1-2 booster)
- Will this measure be reported and where will it be made available? Will hospitals with greater # of HCP with primary + 1-2 boosters get more stars? Will there be additional reimbursement for collecting this data? ARN worries about the potential for negative ramifications if this data is publicly reported. For example, a patient may steer away from a facility fearing greater COVID exposure risk.
- Will employees without booster(s) be mandated to get booster(s)? Will booster(s) be required annually/seasonally like the flu vaccine?

ARN also respectfully disagrees with the proposal to begin the public reporting of the Transfer of Health Information to the Provider—PAC Measure and the Transfer of Health Information to the Patient—PAC Measure. IRFs are already required to collect this information in IRF PAI; therefore, this reporting requirement is duplicative. ARN recommends that CMS avoid implementing redundant measures particularly when it may lead to duplicating data collection and reporting across different systems or platforms.

Finally, ARN seeks clarification about how CMS plans to use the data collected through the IRF QRP. As we have commented above, IRFs dedicate a lot of time and effort to comply with data collection and reporting requirements, which contributes to excessive administrative burden. We recognize that data collected through the IRF QRP can be extremely valuable and utilized for research and the development of evidence-based policies and practices; however, data collection and reporting takes time away from patient care and ultimately impacts workforce burden and burnout. Therefore, ARN encourages CMS to provide more details around the data collection and how the data will be used, and to consider the burden reporting on an already depleted workforce.

Health Equity Update

CMS continues to consider stakeholder comments on improving equity in health care. ARN appreciates CMS' considerations of our comments in last year's proposed rule, and we continue to look forward to working together to advance health equity.

ARN thanks CMS for the opportunity to provide these comments. If you have any questions, please contact ARN's Health Policy Associate, Jeremy Scott at jscott@dc-crd.com. We thank you for your consideration of our comments.

Sincerely,



President Maria Radwanski, MSN, RN, CRRN