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June 15, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1729-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Delivered Electronically

RE: Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2021, Proposed Rule 85 Fed. Reg. 22065 (April 21, 2020)

Dear Administrator Verma:

The New Jersey Hospital Association appreciates the opportunity to offer comments concerning the IRF PPS Proposed Rule for federal fiscal year 2021 on behalf of all the inpatient rehabilitation hospitals and units in the State of New Jersey; they are all members of NJHA.

New Jersey's rehabilitation hospitals have been an instrumental part of our state's response to the COVID-19 public health emergency. They have mobilized and transformed their physician, nursing and rehabilitation therapy teams and facilities to create COVID units, particularly during the height of New Jersey's experience with the spread of the virus. The clinical outcomes have been nothing short of miraculous for many patients who have walked out of our rehabilitation hospitals on their own steam after weeks of being on a ventilator and participating in an individually-tailored, interdisciplinary rehabilitation plan of care under the direction of a rehabilitation physician

Through the performance of our rehabilitation hospitals and long-term care hospitals, we have seen what is needed in terms of capability, clinical competence, personnel, equipment, and emergency response preparedness for post-acute care settings of all types to be more successful. There were some marked differences in patient treatment, outcomes, and safety in IRFs and LTCHs compared to other sites of care, and these are tied directly to those characteristics that distinguish IRFs and LTCHs from other settings. One of the most important characteristics that sets IRFs apart from other PAC settings is that physicians direct and provide the care furnished to the patients in IRFs, and the rehabilitation physician plays an essential role in determining the prognosis, diagnosis, and treatment of IRF patients.

NJHA offers the following specific comments on the rule proposal.

Proposal to Allow Non-Physician Providers to Perform Certain IRF Coverage Requirements
NJHA does not support CMS' proposal to allow NPPs to perform certain coverage requirements that currently must be furnished by the rehabilitation physician. As stated earlier, the marked difference in patient treatment, outcomes and safety in IRFs compared to other sites of care are

tied directly to certain characteristics - such as physician-directed care - that distinguish IRFs from other settings. The public health emergency further highlighted such differences; the long-term recovery needs of COVID-19 survivors render this policy particularly ill-timed and risky. The multi-faceted, vital role of the rehabilitation physician simply cannot be filled by NPPs due to the specialized training and education that rehabilitation physicians receive in order to handle the distinctive needs of highly complex medical rehabilitation patients.

Rather than finalize a proposal that creates substantial risk to patient care, quality and outcomes, NJHA encourages CMS to work with IRFs to find more significant ways to alleviate existing administrative burdens.

Proposed Removal of the Post-Admission Physician Evaluation
In the FY 2021 proposed rule, CMS proposes to make permanent the removal of the Post-Admission Physician Evaluation (PAPE) documentation requirement from the IRF coverage requirements. CMS temporarily relaxed this requirement in response to the COVID-19 public health emergency and said the agency would use the waiver to gauge the impact of permanent removal of the policy. Based on our members' positive experience with this temporary waiver, NJHA supports the proposal to permanently remove the PAPE from coverage requirements.

Other Proposed Revisions to the IRF Coverage Requirements
In this year's proposed rule, CMS says it is reviewing sub-regulatory guidance as part of its efforts to address provider administrative burden, and seeks to identify "any longstanding policies, instructions or guidance" that CMS believes "would be appropriate to codify through notice and comment rulemaking." Specifically, CMS proposes certain regulatory amendments related to the pre-admission screening (PAS) and the definition of a "week." NJHA requests CMS not codify the elements of the PAS included in the Medicare Benefit Policy Manual, or at minimum, not finalize elements that are duplicative with other portions of the patient medical record. NJHA also recommends CMS modify the timing requirement to complete admission from 48 hours to 2 calendar days. Lastly, NJHA supports CMS' proposal to clarify the definition of a "week."

Proposed CMG Weights and the Effects of COVID-19
NJHA encourages CMS to be proactive and to engage with industry stakeholders to analyze and properly account for the effects of COVID-19 on future adjustments to CMG weights. We anticipate that cost and claims data may have serious aberrations due to the public health emergency, and these should not negatively affect IRF PPS reimbursement. In addition, NJHA believes that amending the 60 percent rule to include cardiac and pulmonary cases that might be

COVID-19 related is appropriate. Further, CMG definitions should properly account for cognitive functional status, and CMS should begin researching appropriate cognitive functional measures.

Proposed Implementation of New Labor Market Area Delineations

NJHA strongly urges CMS to reverse or otherwise delay the adoption of the Office of Management and Budget core-based statistical area (CBSA) delineations (OMB Bulletin No. 18-04) to calculate area wage indexes for IRFs, SNFs, acute care hospitals, and other facilities. In the preamble to the proposed rule, CMS acknowledges that IRF's currently located in CBSA 35614 (New York-Jersey City-White Plains, NY-NJ) that would be located in new CBSA 35154 (New Brunswick-Lakewood, NJ) under the proposed changes to the CBSA-based labor market area delineations would experience a nearly 17 percent decrease in the wage index as a result of the proposed change. Even with the proposed transition policy that includes a five percent cap on reductions for FY 2021, the reduction in payments to New Jersey IRFs would be significant – and the cuts beginning in FY 2022 would be disastrous. New Jersey remains at the epicenter of the COVID-19 outbreak in the United States, and health facilities throughout the state have endured unprecedented financial hardship as a result of the pandemic. Moreover, CMS acknowledges that making such impactful changes in between decennial censuses is unusual. Now is not the time to break with tradition that calls for adopting major revisions to CBSAs following the release of labor market data from the decennial censuses. Doing so would unduly harm NJ IRFs and other health facilities. NJHA respectively yet strongly requests that CMS reverse or delay these changes until data from the decennial census can be factored into the delineations.

Proposed Payment Adjustments

Keeping wage adjustments aligned between sites of care is important because it keeps providers on a level-playing field for recruiting and retaining valuable staff. Therefore, NJHA supports using the concurrent year IPPS wage index. Despite the use of the concurrent year's IPPS wage index, CMS proposes to maintain the policy it enacted last year, which provides an upward adjustment for low-wage index IPPS hospitals. However, CMS has not applied this same adjustment to IRFs. This adjustment puts IRFs in certain markets at a considerable disadvantage when compared to their acute-care hospital neighbors that will receive a higher wage-index factor than the IRF. For certain markets, this essentially unwinds the parity created by CMS when it began using the current year IPPS wage index for IRFs in FY 2020. This discrepancy is particularly distressing this year due to CMS' proposed changes to the Core-Based Statistical Areas (CBSAs), via an updated bulletin from the White House Office of Management and Budget (OMB). For some IRFs, the combination of these two changes means not only will a hospital be re-designated to a low-wage area and receive a reduction in their wage-index, but the acute-care hospitals in their community will receive a higher wage-index figure than the IRF due to the IPPS wage-index policy. This potential disruption for low-wage hospitals is not accounted for in CMS' proposal to utilize these new OMB delineations. CMS should properly examine the potential effects of the combination of these two policies, and address any potential deleterious effects on access to care.

NJHA appreciates CMS' attempt to lessen disruption by implementing a five percent cap on any wage index reductions for FY 2021. However, this one-year transition only delays difficulties the

re-designated IRFs will have in recruiting and retaining personnel, which is particularly problematic as the entire IRF industry prepares to play a critical role in the long-term rehabilitation of COVID-19 survivors. The only way to ensure a fair payment system that reflects the regional variation of wages is to implement the same wage adjustments for all facilities in the same area. NJHA questions the rationale of paying two hospitals in the same neighborhood a different wage-adjustment.

Likewise, CMS should incorporate outlier payment reconciliation methods used for acute-care hospitals to improve outlier payment projections. Facility-specific payment adjustments, including the teaching facility payment adjustment, need updating.

Proposed Method for Applying the Reduction to the FY 2021 IRF Increase Factor
CMS proposed a detailed methodology for how it will apply a 2 percent reduction to the applicable market basket increase factor for IRFs that fail to meet the Quality Reporting Requirements (QRP). NJHA believes CMS should provide flexibility in its application of the IRF QRP payment penalty. Specifically, we ask CMS to allow providers an opportunity to correct any errors of data submission when a good-faith effort has taken place prior to the application of the noncompliance penalty, reserving the harsher penalties for flagrant offenders.

In all, NJHA shares CMS' goal of reducing administrative burdens, and looks forward to further discussion of ways to reduce provider burdens in meaningful ways. NJHA welcomes continued opportunities to collaborate with the Department of Health and Human Services and CMS in further refining and improving the IRF PPS. If you have any questions about NJHA's recommendations please contact Theresa Edelstein, Senior Vice President at tedelstein@njha.com.

Sincerely,

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