GREATER NEW YORK HOSPITAL ASSOCIATION
555 WEST 57TH STREET, NEW YORK, NY 10019 • T (212) 246-7100 • F (212) 262-6350 • WWW.GNYHA.ORG • PRESIDENT, KENNETH E. RASKE

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Seema Verma
Administrator
The Centers for Medicare & Medicaid Services
US Department of Health and Human Services
Attention: CMS–1710–P, Mail Stop C4–26–05
7500 Security Boulevard, Baltimore, MD 21244–1850

Subject: [CMS–1710–P] Medicare Program; Inpatient Rehabilitation Facility (IRF) Prospective Payment System for Federal Fiscal Year 2020 and Updates to the IRF Quality Reporting Program; Federal Register/ Vol. 84, No. 79/ April 24, 2019/ Proposed Rules

Dear Ms. Verma:

On behalf of the 160 voluntary and public hospitals and health systems in New York, New Jersey, Connecticut, and Rhode Island that comprise the membership of Greater New York Hospital Association (GNYHA), I appreciate this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule for the fiscal year (FY) 2020 inpatient rehabilitation facility (IRF) prospective payment system (PPS) and related programs.

Our comment letter addresses the proposed removal of the list of compliant IRFs from the publicly available website where it is currently located; possible errors in the calculation of the IRF wage index; and proposed social determinants of health data collection.

Proposed Removal of the List of Compliant IRFs

GNYHA is concerned by CMS's proposal to no longer publish a list of compliant IRFs on the IRF Quality Reporting Program (QRP) website. Although individual providers would continue to have access to this information, we believe it should be publicly available to other stakeholders as is the case with quality reporting programs across other PPSs. GNYHA uses this publicly available information to calculate payment impacts to support our hospital and health system members. Furthermore, providing this type of information for all quality reporting programs in a single location would allow providers and other stakeholders to find it more easily. For example, the list of inpatient quality reporting (IQR) program compliant facilities is posted on Quality Net while the IRF QRP list is posted on the IRF QRP website.

GNYHA urges CMS to reconsider its proposal and continue to publicly post the list of IRFs that comply with the IRF QRP requirements. GNYHA also recommends that the lists of QRP-compliant facilities be posted in a standardized manner across the various PPS quality reporting programs to improve transparency.

Possible Issues with the IRF Wage Index Calculation

CMS proposed that the FY 2020 IRF wage index equal the FY 2020 pre-floor, pre-reclassified, unadjusted inpatient PPS (IPPS) wage index. **GNYHA supports this proposal because it would align the years of data used for the IRF wage index with those in the IPPS and outpatient PPS.**

However, GNYHA has been unable to match the published FY 2020 proposed IRF wage index values to the pre-floor, pre-reclassified wage index calculated in the FY 2020 IPPS proposed wage index public use file (PUF), which is based on the core-based statistical area (CBSA) in which the provider is geographically located and labeled the "CBSAGEO unadjusted wage index." The published IRF wage index values are consistently lower than the values published in the IPPS wage index PUF. If this discrepancy is due to an error in the IRF wage index calculation, IRFs would be underpaid for their services. If the discrepancy is instead due to the fact that the calculation is based on data that is not represented in the IPPS wage index PUF, CMS should make all applicable wage data public so that stakeholders can replicate the wage index calculations for all PPSs. **GNYHA requests that CMS investigate these discrepancies and make necessary modifications in the final rule so that IRFs are reimbursed accurately for their services.**

This wage index discrepancy also affects the FY 2020 inpatient psychiatric facility PPS, for which the published wage index values match the IRF wage index values, but not the values listed in the IPPS wage index PUF.

Proposed Social Determinants of Health Data Collection

GNYHA supports CMS's proposal to collect social determinants of health (SDOH) data within the standardized patient assessment data elements (SPADEs). The new SDOH requirement would gather data on race, ethnicity, preferred language, interpreter services, health literacy, transportation, and social isolation—factors that CMS writes "[have] been shown to impact care use, cost, and outcomes for Medicare beneficiaries."

However, CMS has proposed several new data collection requirements for IRFs in addition to those related to SDOH and is concerned that all of these new elements may be burdensome. **Therefore, GNYHA recommends that CMS require data collection on race, ethnicity, preferred language, and interpreter services, and make data collection on health literacy, transportation, and social isolation voluntary.** Many GNYHA members already collect information on race, ethnicity, preferred language, and interpreter services in order to provide culturally relevant services in a language that their patients understand. On the other hand, our members are just beginning to collect SDOH data, and even those with experience cite various workflow, privacy, and other challenges which GNYHA outlined in a response to a US Department of Health and Human Services Request for Information on Provider and Health Plan Approaches to Improve Care for Medicare Beneficiaries with Social Risk Factors.

Requiring a subset of the SDOH elements will give IRFs an opportunity to adjust to new data collection methods. Including health literacy, transportation, and social isolation as voluntary elements will indicate their relevance while potentially reducing the immediate data collection and reporting burden. These SDOH elements could potentially be added during future rulemaking. Along those lines, GNYHA recommends that CMS consider including the collection of housing status in the future. Research has indicated that individuals with unmet housing needs such as homelessness or substandard housing have higher health care costs and can be at risk for readmissions. Assessing patients for this need in IRF settings can help ensure that patients with housing-related needs are provided appropriate resources at the time of discharge. Screening questions already exist to assess for these particular needs, two of which are included in CMS's Accountable Health Communities screening tool.

GNYHA generally agrees that the addition of the SDOH SPADEs will facilitate communication between post-acute care settings and other health care providers. GNYHA also agrees that common standards and definitions are important for interoperability and communication across providers. As such, **GNYHA encourages CMS to ensure that the SDOH elements collected in IRF settings are aligned with future proposed SDOH data collection requirements in other settings.**

If you have questions or would like further information, please contact Rebecca Ryan (212-506-5514/rryan@gnyha.org).

Sincerely,

Elisabeth Wynn

Executive Vice President