June 10, 2025

The Honorable Mehmet Oz
Administrator, Centers for Medicare & Medicaid Services
Hubert H. Humphrey
Room 445-G
Washington, DC 20201

Re: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2025 and Updates to the IRF Quality Reporting Program; CMS-1829-P

Dear Administrator Oz:

On behalf of the Arizona Hospital and Healthcare Association and our more than 80 hospitals, healthcare and affiliated health system members, we are pleased to present CMS with the following comments on the Fiscal Year 2026 Inpatient Rehabilitation Facility ("IRF") Prospective Payment System ("PPS") Proposed Rule (90 Fed. Reg. 18534) (referred to herein as the "Proposed Rule"). Our comments have been divided into two sections: Payment Updates, IRF Quality Reporting Program,

Payment Updates

A. Proposed Update to the Case-Mix Group (CMG) Relative Weights and Average Length of Stay Values for FY 2023

We support CMS' update to the CMG relative weights and average length of stay values for FY 2026 and encourage CMS to use the latest available data to update these in the final rule.

B. Proposed Market Basket Increase Factor and Productivity Adjustment

While AzHHA supports the proposal to update the market basket using the latest available data, we remain concerned that the impacts of the inflationary economic environment, workforce challenges, and pending tariffs are not adequately factored into the payment rate update. We recommend that CMS review the input data for the annual market basket updates and determine how it can better reflect real-time economic and operational conditions.

We are particularly concerned about the continued application of the market basket "productivity adjustment," especially given the rise in hospital costs. Therefore, we recommend that CMS monitor the impact of productivity adjustments on rehabilitation hospitals and provide feedback to Congress as required under the ACA, as well as reducing the current productivity adjustment.

C. Proposed Wage Index Adjustments

Inpatient Prospective Payment System (IPPS) hospitals have policies in place which allow for wage index reclassification for acute care hospitals. These changes have resulted in many of the acute care hospitals across the country receiving wage index increases higher than would be assigned their Core Based Statistical Areas (CBSAs). Unfortunately, IRFs do not have similar policies allowing for wage index reclassification, resulting in disparities between the IPPS wage index and IRF wage index for hospitals within the same CBSA. Due to this disparity, AzHHA recommends CMS continue to refine wage index policies to create parity across all provider types in the same market areas.

D. Proposed Update for High-Cost Outliers

In prior letters, AzHHA has expressed concern that the high-cost outlier payments are not are not always targeted to patients who require more intensive services with related higher costs. While we support the reduction to the outlier amount for FY2026, we recommend CMS implement a new methodology to set the fixed loss outlier amount using a three-year weighted average approach in future rulemakings in order to reduce the volatility to the outlier amount and add more stability to the overall payment system while maintaining outlier payments at 3% of total IRF payments.

IRF Quality Reporting Program (QRP)

A. Proposed Removal of the COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) Measure and the COVID-19 Percent of Patients Up-to-Date Measure

AzHHA supports the removal of these measures because the COVID-19 public health emergency has concluded and the burden to report these measures outweighs the benefit of their continued collection by IRFs.

B. RFI on Future IRF QRP Measure Concepts: Interoperability, Well-Being, Nutrition & Delirium

As CMS begins to consider adding additional quality measures, AzHHA urges CMS to consider data that IRFs already collect to prioritize burden reduction.

- ***Interoperability****:* AzHHA conditionally supports the idea of an interoperability measure so long as it does not increase provider burden. CMS should focus on a simple measure that furthers the principles of the Meaningful Use measures: improving transparency in certified health IT; promoting standards-based data exchange; and supporting public health reporting and patient access.
- ***Well-being****:* Measuring quality-of-life reinforces the need for a more holistic approach to health and healthcare and incorporates a person's physical health, psychological state, level of independence, social determinants, relationships, and personal beliefs.

Having a better understanding of what motivates patients allows therapists to engage them in purposeful activities and help them meet their goals.

- ***Delirium****:* In terms of a measure concept for the IRF QRP, utilizing the existing delirium assessment, C1310. Signs and Symptoms of Delirium (from CAM©) should be prioritized because it is already collected for all patients at admission and discharge. Any future measure should take into consideration evaluating the presence and frequency of symptoms at discharge compared to the presence and frequency of symptoms at admission, with the intent to reduce presence and frequence of delirium since admission. However, CMS should consider whether a delirium measure is appropriate for the IRF setting at all. In contrast to other post-acute settings, delirium is not nearly as prevalent in IRFs where patients must tolerate intensive therapy.

C. RFI on future revisions under consideration for the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI)

CMS also sought feedback on several changes under consideration for the IRF-PAI, such as how to clarify the definition of unplanned discharges, if a pediatric IRF-PAI should be developed and additional ways the IRF-PAI could be revised to reduce burden and streamline data collection.

- ***Pediatric IRF-PAI***: Given the small population of pediatric patients, AzHHA does not support the creation of a separate IRF-PAI for pediatric patients. Instead, CMS should consider creating skip-logic for the IRF-PAI that is based on age appropriateness of the patient to allow for an individualized plan of care that reflects each patients' needs.
- ***Wheel/walk logic*****:** Currently, if a patient can walk 10 feet either at admission or discharge, even heavily assisted, then "walking" becomes the standard for outcome measurement. Many patients who can walk 10 feet heavily assisted will only mobilize outside the hospital in a wheelchair. Therefore, the licensed therapist in charge of a patient's care should be able to make the decision if a safe discharge should be walking or wheeling.

D. CMS Deregulation RFI

CMS included a separate RFI asking for where CMS could reduce burden or duplicative requirements across all CMS programs. Below are several suggestions.

- ***Discontinue the Inpatient Rehabilitation Facility Review Choice Demonstration (RCD)****:* The IRF RCD is a CMS demonstration program that requires 100% of all traditional Medicare claims for inpatient rehabilitation in select states to undergo review by a private contractor prior to processing. The process involves submission of full medical documentation and additional time by clinical staff, creating a significant burden. Misapplication of the IRF coverage standards under the RCD's premise of identifying fraud in the IRF PPS can prevent qualified patients from accessing medically necessary rehabilitation care. Without any indication of

fraud in the IRF payment system, the RCD program represents a poor use of time and resources for providers, patients, and the federal government.

- ***Discontinue IRF Respiratory Reporting***: During the COVID-19 pandemic, hospitals and other providers were required to report certain data related to the spread of the disease and ability of hospitals to care for patients such as bed availability, ICU capacity, and number of patients with confirmed COVID-19. IRFs along with Inpatient Psychiatric Hospitals (IPFs) were exempt from this reporting and reported data on an annual basis. When COIVD-19 public health emergency ended, these COVID reporting requirements for hospitals were made permanent as a Medicare Condition of Participation (CoP). CMS guidance requires IRFs to complete one week of reporting annually in January of each year to be compliant with this CoP. This data collection does not provide relevant information to understand the overall capacity of hospitals to care for patients with a respiratory illness nor does it provide enough information and likely represents duplicative reporting as 90 percent of IRF patients come from the acute care hospital.

Thank you for the opportunity to comment on this rulemaking. Please feel free to contact me with any questions.

Sincerely,

Director of Financial Policy and Reimbursement, AzHHA

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