June 24, 2019

The Honorable Seema Verma  
Administrator  
Centers for Medicare and Medicaid Services  
U.S. Department of Health and Human Services  
Attention: CMS-1710-P  
Hubert H. Humphrey Building  
200 Independence Avenue, Southwest  
Washington, D.C. 20201

Delivered Electronically


Dear Administrator Verma:

The American Medical Rehabilitation Providers Association (AMRPA) is pleased to submit these comments in response to the Inpatient Prospective Payment System (IPPS) Proposed Rule for Fiscal Year 2020, published in the Federal Register on May 3, 2019. AMRPA is the national trade association representing more than 650 freestanding inpatient rehabilitation hospitals and rehabilitation units of general hospitals (referred to by CMS as “IRFs” but referred to herein as “IRH/Us”), outpatient rehabilitation service providers, long-term care hospitals (LTCHs), and several skilled nursing facilities (SNFs). The vast majority of our members are Medicare participating providers.

In 2017, IRH/Us served 340,000 Medicare beneficiaries with over 380,000 IRH/U stays. On average, Medicare Part A payments represent approximately 60 percent of IRH/U revenues. IRH/Us provide hospital-level care, which is significantly different in intensity, capacity, and outcomes from care provided in non-hospital, post-acute care (PAC) settings. AMRPA members help their patients maximize their health, functional ability, independence, and participation in society so they are able to return to home, work, or an active retirement.

Our comments focus on the proposed changes to the IPPS wage index policies, specifically CMS’ proposal to address wage index disparities between high and low wage index hospitals. For the

---

2 Id.
reasons detailed below, AMRPA encourages CMS to take a comprehensive approach to wage index reforms and carry over any changes made to the acute-care hospital wage index to other hospitals settings, particularly the IRF prospective payment system (PPS).

I. CMS Should Apply Any Changes Made to the Acute-Care Hospital Wage Index to Other Hospitals Settings

CMS proposes to increase the wage index for hospitals with a wage index value below the 25th percentile, and decrease the wage index values for hospitals above the 75th percentile. CMS states it is doing this to disrupt what it terms as a “downward spiral.” According to CMS, this spiral exists because the wage index is based on a relative factor, which compares wage levels among hospitals. The low wage index hospitals file cost reports – the basis for wage index adjustments – that indicate lagging compensation relative to other hospitals (which results in a continually lowered wage index adjustment). CMS proposes to temporarily inflate low wage hospital indexes to break this cycle. However, CMS has informed us that it does not plan to carry over this wage adjustment policy to hospitals paid under other payment systems, including the IRF PPS.

AMRPA believes that failing to include other hospitals in this proposed wage adjustment is an oversight that will lead to unintended consequences in the labor market. Non-IPPS hospitals compete for much of the same types of staff as acute-care hospitals, such as nurses, therapists, physicians and administrators. This lack of parity between the two types of hospitals will create notable competitive advantages and disadvantages in certain geographic markets. In high wage areas, non-IPPS hospitals will have a distinct advantage, as they will not be subject to the proposed downward wage index adjustment. This will lead to acute-care hospitals being strained to compete for staff with the non-IPPS hospitals in their market.

Conversely, in low wage markets, non-IPPS hospitals will be put in an untenable position. As CMS already noted, hospitals in low wage areas are in a perpetual cycle of stagnant wage adjustments. Under this proposal, acute care hospitals will receive an artificial upward wage adjustment, while non-IPPS hospitals will not. These non-IPPS hospitals (that already suffer from the same “downward spiral” phenomenon CMS seeks to rectify) will be further strained to compete for staff with acute care hospitals that receive an upward wage index adjustment. While CMS may fix the wage index disparities for acute care hospitals, if it fails to carry over its policy, it will exacerbate the disparities for non-IPPS hospitals. In addition, many non-IPPS payments are actually to units of acute care hospitals, like a rehabilitation unit paid under the IRF PPS. In these instances, the staff in the unit are often employed by the acute care hospitals. Therefore, adjusting payments only under the IPPS would not account for all the wages paid for by that hospital.

AMRPA also notes that CMS does not plan to make this wage index adjustment permanent, but instead proposes to make it for a minimum of four years to allow low wage area acute care hospitals to break the downward cycle by increasing wages. However, the labor-market is dependent upon all providers in a given area, not just acute care hospitals. Therefore, if other hospitals do not receive

---

3 Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2020 Rates, 84. Fed. Reg. 19158, 19393 (May 3, 2019).
similar adjustments, CMS will not see a competitive labor market shift to the extent it otherwise would if all hospitals received these adjustments.

AMRPA further wishes to highlight an additional policy rationale for using the same wage index for all providers. In this year’s IRF PPS proposed rule, CMS proposes to update its wage index policies to move from using the prior year’s IPPS wage index, to the current year’s IPPS wage index. CMS states it is proposing this as part of its ongoing efforts to break down various outdated silos of care, which often create inefficiencies. AMRPA was encouraged by this proposal, and in fact had suggested it to CMS for several years. However, AMRPA is concerned that this IPPS proposal may essentially cancel out the benefits of the current year wage index proposal in the IRF PPS, as this proposal will create new, separate and artificial disadvantages between sites of care. For those reasons, AMRPA asks CMS to carry over all changes it makes to the IPPS wage index to all other sites of care that utilize the IPPS wage index for its payment system. This should include applying any changes it makes to the IPPS wage index to both freestanding rehabilitation hospitals and rehabilitation units of other hospitals in the IRF PPS.

AMRPA would like to be clear it offers no comment on the substance of the actual proposed IPPS wage index adjustment, including whether it is sound or equitable policy to redistribute wage index payments in the manner it proposes. Rather, AMRPA only urges CMS to ensure parity between sites of care by utilizing the same wage index across settings of care. This will ensure there are no unintended consequences to any specific types of providers due to CMS’ proposed changes, and will allow CMS to more effectively address the wage-related “spiral” through its updated policies.

***

AMRPA welcomes continued opportunities to collaborate with the U.S. Department of Health and Human Services (HHS) and CMS to create equitable and sustainable payment policies. If you have any questions about AMRPA’s recommendations, please contact us or Kate Beller, J.D., AMRPA Executive Vice President for Policy Development and Government Relations, (kbeller@amrpa.org / 202-207-1132).

Sincerely,

Richard Kathrins, Ph.D.
Chair, AMRPA Board of Directors
President and CEO Bacharach Institute for Rehabilitation

Mark J. Tarr
Chair, AMRPA Regulatory and Legislative Policy Committee
President and Chief Executive Officer, Encompass Health

---

4 Medicare Program: Inpatient Rehabilitation Facility (IRF) Prospective Payment System for Federal Fiscal Year 2020 and Updates to the IRF Quality Reporting Program, 84 Fed. Reg. 17244, 17276 (April 24, 2019).