Federation of American Hospitals®

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Seema Verma, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW.
Washington, D.C. 20201

RE: CMS-1671-P, Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2018; Proposed Rule

Dear Ms. Verma:

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching, short-stay, rehabilitation, and long-term care hospitals in urban and rural America, and provide a wide range of acute, post-acute and ambulatory services. The FAH appreciates the opportunity to comment to the Centers for Medicare & Medicaid Services ("CMS") about the referenced Notice of Proposed Rulemaking on ***Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2018; Proposed Rule***.

I. Proposed Updates to the Inpatient Rehabilitation Facility Payment Rates, Area Wage Index, Facility-level Adjustments, and High-Cost Outliers

1. IRF Payment Update and Productivity Adjustment

While we concur with this mandated statutory update for FY 2018, we remain concerned with the future application of the productivity adjustment that will be included in FY 2019 rule updates and beyond. We understand that CMS is bound by statute to reduce the market basket update by a productivity adjustment in the Affordable Care Act ("ACA"). However, it is

unlikely that productivity improvements will be generated by the rehabilitation hospital industry at a pace matching the productivity of the economy at large on an ongoing, consistent basis as currently contemplated by the ACA.

2. Area Wage Index

The FAH requests changes to IRF wage index policy that recognize the realities of and promotes a modern, competitive labor marketplace. This is particularly important in light of the accelerating movement towards alternative payment models that remove the barriers separating payment systems based on site of care. Along these lines, CMS should make the IRF wage index concurrent with other post-acute care settings as well as acute care hospitals.

3. Facility-Level Adjustments.

Regarding the continued freeze of the facility-level adjustment factors, we strongly recommend that the CMS monitor these factors annually and adjust them if a material change is noted. CMS should provide as part of any IRF PPS rulemaking a detailed analyses of the Agency's review justifying either a continued freeze or an update to the adjustment factors. Finally, we ask that CMS adjust all three factors at a minimum once every three years in order to maintain payment accuracy. This will help ensure a dynamic and accurate IRF payment system that recognizes and responds to changes in the cost of care, and promotes the delivery of efficient and effective IRF services.

4. High-Cost Outliers

Regarding high-cost outliers, the Proposed Rule would increase the high-cost outlier threshold from $7,984 in FY 2017 to $8,656 in FY 2018. In six of the last seven years, the current CMS methodology has resulted in substantially less than the full 3% of outlier payments paid to providers. Further, our analyses over multiple year periods have indicated that there can be material changes in the determination of the IRF outlier threshold amount between a proposed and final rule. We recommend that a forecast error be factored into the subsequent year IRF-PPS payments or CMS amend the methodology used to develop the outlier threshold amount to ensure that the full 3% of outlier payments are paid out to IRFs. In addition, we ask that CMS update the final rule outlier threshold amount using the latest available data to ensure that the entire 3 percent outlier pool will be paid to IRF providers.

According to analysis of IRF rate setting files by our IRF membership, approximately 89% of all high-cost outlier payments are going to only 50% of inpatient rehabilitation hospitals and hospital-based units. The analysis of the most recent outlier data from the FY 2018 rate-setting file shows 113 IRFs received outlier payments at a level that was in excess of 10% of their total Medicare payment revenue (the range was between 13.5% and 51% of overall Medicare payments to these providers). This cohort of IRFs (the 90%-100% decile of outlier recipients) received the most outlier payments of any cohort ($93M), and these payments represented 37% of total outlier payments paid to all IRFs. Yet, contrary to what would be expected, this cohort's average CMI (1.24) was lower than the bottom 20 percent of IRFs receiving outlier payments.

The disconnect between acuity and outlier payments that this data reflects suggests CMS consider imposing a cap on outlier payments a hospital could receive. Any potential savings generated by such a cap should be restored to the base payment.

II. Proposals to Eliminate 25 Percent Penalty for Late IRF-PAIs and to Remove the Current Swallowing Item from the IRF-PAI

CMS is proposing to eliminate the 25 percent payment penalty that applies to claims for which an IRF-PAI has been submitted after the requisite deadline. We support this proposal as described. CMS is also proposing to remove from the IRF-PAI the current swallowing assessment item. We support both of these proposals as outlined in the Proposed Rule.

III. Proposed Refinements to the Presumptive Compliance Methodology ICD–10–CM Diagnosis Codes

1. The IRF 60 Percent Rule Should Be Eliminated

a. <u>The Rule is not Patient-Centered</u>

CMS should rescind the 60 Percent Rule because it is an outdated policy that is out of step with the Administration's vision of patient-centered care. If an orthopedic surgeon, oncologist, pulmonologist, rheumatologist, cardiologist, thoracic surgeon, organ transplant surgeon, or other medical practitioner or specialist has concluded her/his treatment of a patient in an acute care hospital and determined that the patient requires an IRF level of care and services, the patient should not be prevented from receiving that level of care by the restrictive effects of the 60 Percent Rule.

Decisions pertaining to where patients receive post-acute care should be made based on patients' rehabilitative, medical, and nursing needs and their physicians' judgment as to where those needs are optimally met. The 60 Percent Rule – and particularly the Rule's "presumptive methodology," which is the predominate mechanism through which the vast majority of IRFs achieve 60 Percent Rule compliance – is a reflection of "codes [that] represent the types of medical conditions that we believe clearly, and without further evidence, can be found to indicate that the criteria for the medical conditions that may be counted toward the 60 percent rule compliance calculation have been met…" FY 2014 IRF PPS Final Rule, 78 Fed. Reg. at 47883. (Emphasis added). In many instances, the 60 Percent Rule's restrictive effects are more heavily tilted toward the subjective "belie[fs]" undergirding the Rule and less tilted toward significant numbers of Medicare beneficiaries whose medical conditions and diagnoses do not satisfy the Rule and, consequently, may be unable to access IRF services.

The rationale that the 60 Percent Rule compensates for its restrictive effects by permitting an IRF to treat up to 40% of its patients whose conditions do not satisfy the Rule does not help the cancer patients or the cardiac patients who need IRF services but whose local IRF is in an untenable position of potentially not satisfying the Rule by admitting non-compliant patients. In these situations, the rule would not appear to be truly patient-centered. The essence of "patient-

centered" healthcare is not about numbers. It involves a physician making a healthcare decision in the best interests of his or her patient following close consultation with the patient and family. That decision is intended to ensure that the patient's needs are optimally met through the utilization of healthcare resources that are cost-effective, efficient, and will produce a quality outcome for the patient. If a physician or IRF clinician errs in referring or admitting a patient to an IRF, that error should be reconciled through the coverage and medical review processes regardless of the patient's medical diagnosis.

b. New Healthcare Delivery Paradigms Are Subsuming The 60 Percent Rule's Function

The Rule's overarching function is to act as a consistent limitation on the utilization of IRF services, and that is precisely the function being subsumed by the dynamics of a broad range of alternative payment models ("APMs") and quality improvement policies implemented by CMS over the past six years. The dynamics arising from these models and programs are literally creating new paradigms within the healthcare marketplace with implications for all healthcare providers, including IRFs.

When the IRF PPS was originally implemented approximately 15 years ago, there were few if any APMs such as accountable care organizations ("ACOs"), bundled payment initiatives, and various acute care hospital quality improvement and patient outcome initiatives, programs or measures such as Medicare Spending Per Beneficiary ("MSPB"). Medicare Advantage ("MA") enrolled fewer than 6 million enrollees, compared to today's approximately 19 million. Post-acute utilization firms which analyze expenditure trends associated with post-acute care utilization, were also not providing their services to hundreds of acute care hospitals and various health plans.

Individual physicians were also not facing the Medicare Access and CHIP Reauthorization Act's ("MACRA's") challenge of encouraging them to align with at-risk APMs and be more thoughtful about their healthcare utilization decisions, including for post-acute care. Indeed on June 20, 2017, when CMS issued its Proposed Rule for MACRA's FY 2018 Updates to the Quality Payment Program, it stated that "a clinician who is shown to have lower performance on the MSPB measure could focus on the efficient use of post-acute care and be able to see that improvement reflected in the cost improvement score in future years." This review could highlight opportunities for better stewardship of healthcare costs such as better recognition of unnecessary costs related to common ordering practices."

The cumulative effect of these new programs and directions is an intense focus on post-acute care utilization and arguably on IRFs in particular. Hospitals and other healthcare providers who refer their patients for post-acute care services are more accountable for their referral decisions, both for the outcomes of the care and services provided to their patients and for expenditures arising from that care. Now, many more hospitals, ACOs, and other "bundle-holders" are paying greater attention to the expenditures associated with their patients' post-acute care utilization, as well as to the quality outcomes of those patients.

These dynamics and effects have substantially eliminated the need for a policy like the 60 Percent Rule. If hospitals and physicians are held accountable for expenditures associated with their patients' post-acute care utilization and their outcomes, the restrictive effects of the 60 Percent Rule are unnecessary. We believe general acute care hospitals, physicians, and other "bundle-holders" should have broad flexibility to discharge their patients to whichever levels of post-acute care they deem appropriate. And those decisions should be influenced by the dynamics of the programs governing their decision-making – not by whether their patients' diagnoses do or do not satisfy the 60 Percent Rule.

In today's dynamic healthcare environment, the incentives for appropriate post-acute utilization act as a natural, self-regulating check on excessive utilization and expose the 60 Percent Rule as a regulatory anachronism that is no longer needed. **For the reasons discussed above, we respectfully urge CMS to rescind the 60 Percent Rule in its entirety**.

2. *Alternative: Expand the 60 Percent Rule's Compliant Conditions*

The restrictive effects of the 60 Percent Rule are caused by the limited number of patients that can satisfy the Rule, a symptom of the Rule not keeping pace with medical advances. There have been no major medical categories added to the Rule for more than 30 years – when the Rule was implemented in its current form, in 2004, the modifications to the list of medical categories comprising it were aimed at narrowing the types of arthritis and orthopedic cases that can satisfy it.

However, medical rehabilitation has achieved numerous advancements over the past 30 years, and these advancements have enabled IRFs to care for broader patient populations beyond those comprising the 60 Percent Rule, albeit, on a limited basis due to the Rule's restrictive effects. Several patient populations are especially ripe for inclusion in the 60 Percent Rule, including cardiac, cancer, pulmonary, and transplant cases. **We recommend that the Rule's list of conditions be expanded to include these medical categories**.

Also, to the extent CMS chooses to maintain the 60 Percent Rule, we reiterate our strong agreement with the suggestion of the American Medical Rehabilitation Provider's Association ("AMRPA's") that CMS should establish a Technical Expert Panel ("TEP") to create a forum for more regular dialogue between CMS and the IRF stakeholder community about the 60 Percent Rule and potential refinements.

3. *Proposed Code and IGC Modifications For Presumptive Testing*

   a. Traumatic Brain Injury ("TBI") Under IGC 2.21 and IGC 2.22; Hip Fracture IGCs 8.11 and 8.12; and Major Multiple Trauma ("MMT") Codes

CMS proposes to remove the TBI and hip fracture impairment group categories ("IGCs") noted above that are currently listed as exclusions on the IGC list in order to permit these IGCs to count toward the 60 Percent Rule's presumptive compliance methodology; CMS also proposes to include certain MMT codes in the presumptive compliance methodology. We appreciate CMS's recognition that these IGCs and certain MMT codes were inadvertently excluded from

the presumptive methodology as part of the transition to ICD-10, and we support these proposals to restore these IGCs and certain codes to the presumptive compliance code list.

b. Other Specified Myopathies (NEC), G72.89

CMS proposes to remove ICD-10-CM code G72.89 from the list of codes that count toward a facility's compliance percentage under the presumptive compliance method. G72.89 is used to code specified myopathies not elsewhere classified. Some common examples of such myopathies are disuse myopathy, chronic heart failure myopathy, myopathy associated with cardiac disease, COPD myopathy, and uremic myopathy. However, CMS believes that "some IRFs are using this code more broadly, including to represent patients with generalized weakness who do not meet the requirements in the 60 percent rule" and concludes that the removing the code from the presumptive compliance list altogether is the right solution.

CMS' belief that some IRFs are using G72.89 to represent patients who do not meet the presumptive compliance requirements of the 60 Percent Rule should not deprive IRFs that are using this code appropriately to code medical conditions that meet the presumptive compliance requirements. By removing G72.89 and its pairing with certain IGCs (principally 3.8) from the presumptive compliance code list altogether, IRFs will likely become reluctant to admit patients suffering from these myopathies, causing such patients to be denied the treatment they need and have historically had access to.

Accordingly, G72.89 should be retained on the presumptive compliance code list because it is the appropriate code for a variety of specified myopathies which, as neuromuscular disorders, fall into one of the CMS 13 conditions that satisfy the 60 Percent Rule. CMS' concerns can be adequately addressed by providing greater clarity regarding the use of the code.

4. *Effective Date of Proposed Code and IGC/Code Removals Should Be Delayed; Restored Codes And IGC/Code Pairings Due To Effects of ICD-10 Transition Should Be Effective Immediately*

a. Timing of Proposed Removal of Codes and IGC/Code Pairings

Since changes to the 60 Percent Rule can have large impacts on different IRFs depending on their individual patient mix, **the implementation of any proposed removal of codes and IGC/code pairings from the 60 Percent Rule's presumptive testing methodology should be delayed by at least one year in order to afford all IRFs undergoing presumptive testing to be reviewed based upon a compliance period that is comprised of at least 12 months of data reflecting the effects of any modifications to the codes and IGC/code pairings that may be implemented in the Final Rule**. CMS has previously delayed the effective date of these types of proposed changes to the 60 Percent Rule's presumptive testing methodology, and we respectfully urge that it do so here.

Moreover, any such removals that may be implemented by the Final Rule should be scheduled to apply to an IRF at the *beginning* of its compliance review period. CMS should not be permitted go back into earlier portions of an IRF's currently effective compliance review period and declare that codes and IGC/code pairings it utilized multiple numbers of months ago when the code or IGC/code pairing were presumptively compliant based on CMS's most recent rulemakings and policies, are no longer presumptively compliant effective October 1, 2017. All codes and IGC/code pairings currently proposed for removal have been previously utilized as valid presumptive codes and IGC/code pairings, and IRFs that have utilized them must be afforded a full compliance review period, i.e., at least 12 months, to make necessary adjustments to their patient admission, documentation, or coding practices in response to the effects of such removals should they be implemented in the pending Final Rule. **Therefore, we recommend that the effective date of any removals of codes or IGC/code pairings from the presumptive compliance code lists be applied to cost reporting periods beginning on or after October 1, 2018**.

b. *Timing of Restored Codes And IGC/Code Pairings Due To Effects of ICD-10 Transition Should Be Effective Immediately*

While code removals should be given sufficient lead time, we believe that for ICD-10-CM codes proposed to be restored to the list Presumptive Compliance (ICD-10-CM) or removed as an excluded etiologic diagnosis on the list "Impairment Group Codes That Meet Presumptive Compliance Criteria (ICD-10-CM) due to the effects of transitioning to ICD-10, **these proposed changes should be made effective retroactively for compliance review periods beginning on or after October 1, 2015**. Alternatively, these codes should be made effective for discharges on or after October 1, 2017, as proposed. We emphasize, however, that it is only these codes and IGC/code pairings that should become effective retroactively to October 2015 or alternatively, effective October 1, 2017.

5. *Proposed Subregulatory Process for Updated to 60 Percent Rule Presumptive Methodology List*

We are concerned about the proposal to use an informal subregulatory process for making "non-substantive" changes to the 60 Percent Rule presumptive methodology list. Without an adequate definition or descriptive meaning of the word "substantive," there is little objective indication as to which changes would be "substantive" and which ones would be "non-substantive." We believe that *any* change or modification to the presumptive testing methodology that would make the 60 Percent Rule more restrictive, regardless of how seemingly inconsequential the change may seem, should be viewed as "substantive" and thus should not be implemented outside of formal notice and comment procedures. Conversely, any change or modification to the presumptive testing methodology that would make the rule less restrictive stemming from the effects of the change, should be immediately implemented in the interest of ensuring that patients' access to IRF services is not being compromised due to a technical coding issue that could be corrected. **However, in the absence of more clarity and details pertaining to how this sub-regulatory process would work, including the meaning of "substantive" changes and the relationship of that meaning to the presumptive testing methodology, we recommend that process not be adopted as part of the Final Rule**.

Alternatively, if CMS finalizes this proposed sub-regulatory process, we respectfully request that it specifically clarify the meaning of "substantive" and that term's application to the 60 Percent Rule's presumptive testing methodology.

6. Transparency and Consistency in Presumptive Compliance Information

Recurring modifications to the list of codes and IGC/code pairings comprising the 60 Percent Rule's presumptive testing process makes it all the more important for IRFs to have access to presumptive testing data in order to achieve greater compliance and testing predictability. IRFs should be given access to relevant data used to determine testing results to permit them to compare their internal testing methodologies and compliance tracking tools to those used by Medicare contractors. This should include allowing IRFs to access patient-level detail and summary reports prepared by contractors. Such access would allow IRFs to match presumptive percentages issued by contractors to internally-generated percentages, thereby creating greater compliance precision, more compliance predictability, and reduced risk of non-compliance. **We respectfully request that CMS clarify its policy manuals and other regulatory or policy sources that rehabilitation hospitals/units are to be furnished with access to all pertinent data used by Medicare contractors when generating a presumptive compliance percentage as part of the 60 Percent Rule compliance testing process.**

IV. Proposed Revisions and Updates to the IRF Quality Reporting Program (QRP)

1. Measure Testing/Implementation and Data Completeness

The FAH has a history of supporting public reporting in payment programs, and recommending that the information reported to the public be accurate and comparable across providers. In addition, the FAH believes that the measures used in any of the quality reporting or pay-for-performance programs should provide value in the data generated in proportion to the intensity of the data-collection effort. Our experience is that this has not always been the case. Across all programs, too many measures have been introduced prematurely leading to significant implementation issues. The cost of fixing these issues is substantial and falls on the IRFs/facilities, contractors, and CMS. These costs could and should be avoided so that time and resources could more appropriately be devoted to patient care and quality improvement rather than fixing technical issues.

The FAH offers two recommendations to address these implementation issues: testing IRF measures before deploying them in quality programs; and boosting data quality and timeliness. First, the National Quality Forum (NQF) and its public-private partnership, the Measure Applications Partnership (MAP), which provides input into the quality and performance metrics used in the programs for acute and post-acute providers, are integral to meeting the goals of the CMS pay-for-value programs. The role of the NQF in this process is now well established and accepted and has assisted with providing greater transparency in measure selection for the wide variety of federal payment programs. The FAH appreciates that CMS recognizes the work of the NQF and the MAP in the discussion of the measures put forth for the IRF QRP. However,

the FAH strongly encourages CMS to not finalize measures for the IRF quality reporting until the measures are fully specified and tested in the IRF environment.

Second, an efficiently functioning infrastructure to support federal quality data collection and reporting is essential to producing valid data to inform payment adjustments. The FAH strongly encourages CMS to ensure there are sufficient resources available for appropriate oversight and testing of all data collection and reporting systems to ensure full functionality of the CMS and Centers for Disease Control and Prevention (CDC) data system and warehouses. The IRF hospitals represented by the FAH regularly experience system failures or inadequate access to measure data at both CMS and CDC, adding considerable and avoidable costs, in resources and time, to both HHS and the reporting IRFs, and eroding trust and confidence. The payment and quality programs are ineffective if the data being used to inform consumers and calculate payment are inaccurate or incomplete.

Further, for the federal quality payment programs to work well, providers need quick and complete access to their own data as well as patient data post-discharge in order to use it for quality improvement. Providing acute and post-acute hospitals with timely and complete patient level data is essential. In a refined post-acute quality payment structure, efforts should be focused on measures that truly make a difference in patient health and are predictors of the value of care delivered. Providers must be able calculate their own measure performance, which currently is not possible with many of the claims-based outcomes measures.

2. Accounting for Social Risk Factors in the IRF QRP

The FAH has long believed that appropriately accounting for social risk factors, such as sociodemographic status adjustment, is essential for accurately assessing health care provider performance for public reporting and accountability programs, particularly with respect to outcome measurement. All beneficiaries, including those with social risk factors, should receive the best possible care. At the same time, where social risk factors affect patient outcomes in ways that are beyond the control of healthcare providers, providers should not be penalized for nor discouraged from treating these patients. The metrics used for holding post-acute providers accountable need to properly balance these goals.

As noted in the December 2016 report of the HHS Assistant Secretary for Planning and Evaluation (ASPE), patients with social risk factors have worse outcomes and providers who treat them have poorer performance and greater financial penalties in the pay-for-performance programs. In considering various strategies for addressing this issue, the ASPE considered the need for measure developers to develop measures or statistical approaches that are suitable for reporting performance for beneficiaries with social risk factors; the need to study the relationship between social risk factors and health status to determine whether improved medical risk adjustment is part of the solution for recognizing differences in these patient populations; and the potential for targeted assistance to providers that disproportionately serve beneficiaries with social risk factors. The FAH agrees with these strategies.

In the proposed rule, CMS seeks comments pertaining to accounting for social risk factors for the IRF QRP programs. The FAH has long believed that appropriately accounting for social risk factors, such as sociodemographic status adjustment, is essential for accurately

assessing health care provider performance for public reporting and accountability programs, particularly with respect to outcome measurement. The FAH is pleased to offer some guiding principles for implementing social risk factor adjustments.

In the IRF proposed rule, CMS discusses stratification as a possible means of adjusting for disparities among different populations. First, while stratification may be a reasonable first step for addressing social risk factors, stratification should be viewed as a stop-gap tool, not a permanent solution. The FAH strongly encourages CMS to continue exploring more robust risk adjustment factors including community factors such as access to transportation, food, pharmacies, and other community and home services. Second, any adjustment for social risk factors must be accompanied by a process in which providers receive confidential reports showing their results. Third, public reporting of social risk factor-adjusted information on any CMS *Compare* website must be useful to patients, families, and providers.

3. Proposed Collection of Standardized Patient Assessment Data Under the IRF QRP

The CMS requests the collection of standardized assessment data across the four post-acute care settings to support efforts to drive improvement and better align healthcare quality across all settings. Beginning in FY 2020, IRFs will begin reporting SPAD for five patient assessment categories: 1) functional status; 2) cognitive function; 3) special services, treatments and interventions; 4) medical conditions and co-morbidities; and 5) impairments, and other categories as necessary. The data will be collected through the IRF PAI.

CMS proposes that each hospital note if it received information on patients upon admission and also note if the IRFs sent the SPAD items to the next provider upon discharge. The FAH members are concerned about the administrative burden associated with changes to the SPAD and the lack of comparability of the data across the PAC settings. The FAH believes that CMS significantly understates the provider burden and the cost to implement these changes and recommends that CMS continue to find mechanisms to streamline the collection of SPAD and work to ensure comparability across post-acute settings.

The FAH is concerned CMS continues to focus on whether the information was received on admission or transmitted on discharge instead of focusing on the use of the information in patient care. The evaluation of this type of information transmission and use is more appropriate for assessment by accreditation surveying agencies and not the quality reporting programs.

Finally, the FAH strongly recommends that CMS develop a robust and fully transparent methodology for proposed changes and updating of the SPAD. CMS proposes that non-substantive changes to the SPAD would not require formal notice-and-comment procedures, but rather changes would be made via subregulatory processes such as program guidance and contractor outreach. The FAH members have significant experience with contractor outreach, and the experience is variable at best. The FAH strongly encourages CMS to develop a consistent public methodology for making changes and to widely publicize the changes.

4. Quality Measures Currently Adopted for the IRF QRP

In the fall of 2018, CMS proposed to publicly report four previously finalized measures: 1) facility-wide Inpatient Hospital-onset Methicillin-Resistant Staphylococcus Aureus (MRSA) Bacteremia Outcome measure (NQF #1716); 2) Facility-wide Inpatient Hospitals-onset Clostridium Difficil Infection (CDI) Outcome Measure (NQF #1717); 3) Influenza Vaccination Coverage among healthcare Personnel (NQF #0431); and 4) Percent of Residents or Patients Who were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay) (NQF #0680). The FAH is concerned that the IRF performance on these measures is sufficiently strong that patients and their families will not be able to differentiate between high and low quality providers.

The measures are not appropriately targeted to assess the quality of care provided by IRFs. For example, the percent of patients that have facility-acquired MRSA or CDI are so small that even having one or two patients contract the infection would make an IRF appear to provide lower quality care compared to another IRF. In addition, the percent of patients with MRSA or CDI being reported is so low that it is difficult to differentiate providers. The FAH recommends removing from the IRF QRP the measure that compares the number of patients assessed and that have a plan of care. The results on this measure should be close to 100 percent at all hospitals, as such, it does not help differentiate high and low performing providers.

Moving forward, the FAH recommends that CMS refocus quality measurement in the IRF program on measures that truly differentiate one facility from another and highlight the goals and objects of the care provided in an IFR setting. Such measures might include falls with injury, so long as the measure is risk adjusted for the patient population being assessed. Because infection rates are very low in IRFs, the FAH strongly recommends that CMS only include one infection measure and include more on appropriately risk-adjusted IRF outcome measures. Currently, the IRF community incurs significant expenses collecting, reporting and analyzing infection data for conditions rarely found in these facilities. Those resources would be better allocated to measures assessing the care that is provided in an IRF.

5. Proposal to Replace Current Pressure Ulcer Quality Measure, Percent of Residents or Patients With Pressure Ulcers that Are New or Worsened (Short Stay) (NQF# 0678), With a Modified Pressure Ulcer Measure, Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury

The CMS proposes to remove the current pressure ulcer measure: (Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (short Stay)(NQF #0678) from the IRP QRP measure set and to replace it with a modified version of that measure, Chambers in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury beginning with the FY 2020 IRF QRP. . However, the newly proposed measure is not NQF endorsed, and the CMS reasoning for making the change is unclear. The information provided indicates significant variation between the two measures, and it is unclear what causes this wide variation. Such variation could be caused by coding variations. Since the current measure was included in the IRF QRP, clinicians have had to respond to multiple changes. These frequent changes in definitions and verbiage likely contribute to reduced reliability and validity of the measure. Until the proposed new measure is

tested and all research supporting the changes proposed in the measure made public, the FAH does not support the inclusion of the measure "Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury."

6. Proposed Removal of the All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge From IRFs from the IRF QRP

CMS proposes to remove the All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge From IRFs From the IRF QRP based on comments received that this measure is duplicative and possibly conflicting with the Potential Preventable 30-day Post-Discharge Readmission measure also finalized for reporting. The FAH is supportive of the removal of the All-Cause readmission measure.

V. RFI Responses on CMS Flexibilities and Efficiencies

We commend CMS for asking the IRF sector to take part in the broad dialogue about improvements that can be made to America's health delivery system, especially those aimed at reducing unnecessary burden for clinicians, providers, and most importantly, patients and their families. In the FAH's comment letter on the FY 2018 IPPS Proposed Rule, we detailed a number of needed changes that would assist providers in improving the quality of care we provide to our patients. These included improvements to items such as the regulatory structure, a rethinking of the framework for delivery system reform efforts, and attention to quality measurement programs would greatly enhance hospitals' ability to fulfill their mission of patient-centered care. This conversation is particularly critical in an age when the Agency is attempting to balance quality of care initiatives with the goal of fostering patient-centered practices and cost-efficient payment incentives.

1. Refine BPCI and other Alternative Payment Models ("APMs") to Allow Post-Acute Providers to Carry More Risk (With Commensurate Regulatory Waivers)

A key policy objective of APMs such as the Bundled Payment for Care Improvement Initiative ("BPCI") should be to encourage high quality patient outcomes through incentivizing more collaborative and coordinated decision-making around the efficient utilization of care and services, including PAC services. While hospitals and physicians can play important roles in making more patient-centric and efficient discharge decisions regarding their patients' PAC needs through improved discharge planning processes and better care transitions, optimal efficiencies for PAC utilization are achieved by the healthcare providers who are most familiar with and are actually providing the services through which those efficiencies are sought, i.e., PAC providers themselves. In addition to ensuring the voluntary nature of all models, FAH believes CMS should test an APM for IRFs that would not be derived from the IRF PPS, but instead would be developed around assuming the risk of caring for particular types of patients over a defined period of time and with sufficient regulatory relief. Allowing PAC hospitals to test the concept of receiving alternative reimbursement amounts or rates, along with commensurate regulatory waivers from traditional site-specific regulations, for providing care over a longer episode is an important step in CMS's ongoing efforts toward payment and care delivery modernization and reform and patient-centered care.

Achieving greater levels of PAC efficiency requires greater levels of relief from the restrictive effects of site-specific rules, regulations, and policies that effectively impede PAC providers from utilizing care plans, protocols, and patient care pathways designed to achieve high quality patient outcomes and more efficient utilization of healthcare resources and services. Some of these site-specific regulations and policies effectively preclude PAC providers, such as IRFs and long-term care hospitals ("LTCHs"), from treating whole classes of patient populations by virtue of patients' medical conditions or diagnoses.

Many of these regulations, such as the IRF 60% Rule and so-called "3-Hour Rule" and the home health "Homebound Rule," were developed more than a quarter-century ago for patient care and reimbursement models that did not account for the dynamics of 30-, 60- or 90-day episode frameworks that define today's alternative payment model landscape. Indeed, the restrictive effects of these and other site-specific PAC rules, regulations, and policies create a certain tension between APMs' patient care and payment policy objectives and PAC providers' clinical and operational capabilities to fully achieve those objectives. Indeed as we urge elsewhere in this comment letter, the effects of ACOs, bundled payment programs, MSPB, hospital readmissions, and Medicare Advantage on healthcare delivery and utilization of PAC services have created new paradigms, and these paradigms have obviated the need for the continued application of the IRF 60 Percent Rule.

2. *Clarify IRF Therapy Requirements*

a. <u>The IRF 3-Hour Rule</u>

Under 42 C.F.R. §412.622(a)(3)(ii), in order for an IRF claim to be deemed covered under Medicare, an IRF must demonstrate the following requirements for each patient, in addition to other coverage and admission criteria:

> Generally requires and can reasonably be expected to actively participate in, and benefit from, an intensive rehabilitation therapy program. Under current industry standards, this intensive rehabilitation therapy program generally consists of at least 3 hours of therapy (physical therapy, occupational therapy, speech language pathology, or posthetics/orthotics therapy) per day at least 5 days per week. In certain well-documented cases, this intensive rehabilitation therapy program might instead consist of at least 15 hours of intensive rehabilitation therapy within a 7 consecutive day period, beginning with the date of admission to the IRF. Benefit from this intensive rehabilitation therapy program is demonstrated by measurable improvement that will be of practical value to the patient in improving the patient's functional capacity or adaptation to impairments. The required therapy treatments must begin within 36 hours from midnight of the day of the admission to the IRF.

A central concern that therapists and other medical rehabilitation providers and caregivers have with the 3-Hour Rule – a non-patient-centered policy that is nonetheless central to patient care in an IRF – is that their judgment and expertise in developing the therapy and rehabilitation components of individualized patient care plans is oftentimes essentially made subservient to…the mechanics of a clock. The 3-Hour Rule places considerable weight on the

element of therapy and rehabilitation *time* for purposes of determining whether an individual patient needs IRF services. However, our concerns about the 3-Hour Rule are not limited to its impact on clinical judgment and patient-care. Our hospitals' therapy leaders spend considerable time each day scheduling for the 3-Hour Rule, then monitoring and documenting the compliance throughout the day, then auditing the total provision of therapy. Individual therapists must also do the same prior to and throughout each day.

While there can be exceptions to the 3-Hour Rule, these must be meticulously documented in a patient's chart and medical records, but oftentimes medical reviewers and other auditors review these exceptions, determine them as insufficient, and deny the claim based upon the patient's failure to have satisfied the Rule. Yet, the intensity of therapy or rehabilitation received by an IRF patient cannot be accurately measured by time or duration alone. While it is clear that intensive therapy would be almost impossible to deliver in five minutes, it is not at all clear that two hours of therapy, for example, could not constitute intensive therapy for many patients, given their medical complexity and rehabilitative care needs.

Therapy and rehabilitation time is one factor among several in measuring its intensity, but to view it as the only factor, or even the most important factor, ignores other critically important aspects and domains of the therapy and rehabilitation process that help provide an overall picture of its intensity, including (among others) therapy content; the skills of the therapist(s) involved; the level of patients' engagement; and patients' therapy outcomes. In sum, the 3-Hour Rule requirement is a cookie-cutter approach to patient care, and with its requirement that all patients receive the same thing, i.e., at least 3 hours of therapy and rehabilitation daily, it is not a patient-centered policy. The intensive therapy requirement should be aligned with IRF patient's unique medical and therapy needs and rehabilitation physicians' and therapists' clinical judgment.

3. Clarify The "Preponderance" Requirement For One-on-One Therapy

Through statements in rulemaking preambles appearing in the *Federal Register,* and in sub-regulatory pronouncements, CMS has stated that the "preponderance" of therapy provided to IRF patients should be delivered in a "one-on-one" mode, i.e., one therapist for one patient. Webster's Ninth New Collegiate Dictionary defines "preponderance" as "1: a superiority in weight, power, importance, or strength. 2 a: a superiority or excess in number or quantity b: MAJORITY". Under CMS's IRF therapy data collection initiative, 4 types of therapy are recognized:

1) individual therapy, i.e., one-on-one, where one therapist or one supervised therapist assistant provides treats one patient;

2) concurrent therapy, where one therapist or one supervised therapist assistant treats two patients who are performing different therapy activities;

3) group therapy, where one therapist or one supervised therapist treats 2 to 6 patients who are performing the same or similar therapy activities; and,

4) Co-Treatment therapy, where more than one therapist or supervised therapy assistant from different therapy disciplines treats one patient simultaneously.

There is inconsistency among CMS contractors and their interpretations of the term "preponderance" of therapy. IRFs that provide in excess of 50 percent of "one-on-one" therapy to their patients nonetheless experience claim denials under the theory that the "preponderance" of therapy received by the patient was not one-on-one therapy. The scrutiny on therapy mode has turned patient-specific therapy planning ("what is best for this patient?") into rote time counting – e.g., "how many more minutes of individualized therapy must this patient receive?," and "how many more minutes of concurrent or group therapy can this patient receive?" – that does not account for the individual progress or therapy needs of particular patients. Additionally, some CMS contractors do not recognize the clinical and therapeutic distinctions between "concurrent" and "group" therapies, interpret them as the same therapy mode, and use that interpretation as a basis for denying the claim.

Proposal: Clarify that the provision of concurrent and group therapy is permissible and shall not serve as a basis for denying an IRF claim so long as the amount of "one-on-one" therapy provided to the patient comprises at least 51 percent of the total amount of therapy provided. This clarification would formalize CMS's "preponderance" standard while ensuring that concurrent and group therapies remain available as therapeutic options to meet patients' needs as determined by their medical and therapy caregivers.

Proposal: Clarify that concurrent and group therapy and rehabilitation are distinct modes of therapy delivery and preclude contractors from treating them as the same type of therapy.

4. Reduce Quality Reporting Program ("QRP") Burdens, Improve Quality of Care and Patient Outcomes

"How can a healthcare provider optimize its quality improvement without understanding what happens to its patients weeks or even months after they received care or services from that provider?" This question is particularly important now in light of the growing use of claims-based measures in the Quality Reporting Program ("QRP") for Inpatient Rehabilitation Facilities ("IRFs") and other post-acute providers. The new "IRF Compare" website explicitly states that the quality measure information it contains "[e]ncourages inpatient rehabilitation facilities to improve the quality of care they provide to patients." However, under CMS' most recent policy regarding quality measure feedback data, IRF providers will only be furnished with annual aggregate feedback data for the claims-based measures in the IRF QRP – not patient-level data.

Another way to help IRFs in their quality improvement efforts is to remove the burden of reporting on measures that focus on infections with notably low incidence rates in the IRF setting. MRSA and CDI are two infections that have low incidence rates in IRFs, yet IRFs are required to report in-depth data on each. The time and resources necessary to successfully submit these data (which often indicates that no such infections were present) do not justify the relative infrequency with which these infections occur. Removing them from the IRF QRP would enable IRFs to spend more time on more significant measures. Furthermore, the system

used to report these infection measures, the National Healthcare Safety Network ("NHSN") is antiquated and cumbersome, and requires significant time to navigate. In addition to reconsidering the applicability of MRSA and CDI measures in IRFs, CMS should also review the NHSN and potential improvements that can be made to its functionality.

Proposal: Provide IRFs With Patient-level Quality Feedback Data on All Quality Measures

CMS should provide PAC providers with patient-level feedback data for their claims-based measures, including for readmissions. The lack of patient-level data for claims-based measures and the relative infrequency of claims-based measure reports hampers IRFs' ability to fully optimize the range of potential modifications to their patient care practices and procedures, thus diminishing their prospects at improving their quality of care – which is the purpose of the IRF QRP.

Proposal: Remove Low-Incidence Infection Measures MRSA and CDI from QRP

IRFs are currently required to report on quality measures for MRSA and CDI. When MRSA and CDI were proposed for inclusion in the IRF QRP in FY 2015, CMS cited two small-scale studies (comprised of 534 patients) that only addressed "community-onset" infections as justification for these measures. Our internal HealthSouth analysis, which was more comprehensive in scope than either of the studies cited by CMS when the proposal was finalized, showed that the incidence rates for MRSA and CDI in the studies were significantly overstated (9.2% for MRSA and 16.4% for CDI). Our data, comprised of over 200,000 Medicare and Medicare Advantage patients treated in 2009 and 2013, showed incidence rate of all infections (community- and hospital-acquired) was less than 2% for both MRSA and CDI. We also felt this data may be overestimated, since the present-on-admission field on the IRF-PAI was not a mandatory field and the infections that would have been considered to be present on admission under the IRF-PAI manual are more restrictive than the NHSN present-on-admission definitions.

Figure 1 below shows the hospital-acquired infection estimates from the FY 2015 Proposed Rule, our comment letter regarding 2009 and 2013 rates, and HealthSouth's MRSA, CDI, and CAUTI incidence reported in 2015 and 2016. MRSA and CAUTI affected less than 0.1% of all discharged patients and CDI affect less than 0.5% of discharged patients – an extremely low affected rate when considering the cost to providers of reporting these infections as well as the lost clinical time experienced by patients.

Figure 1[1]

	CMS data	2009	2013	2015	2016
MRSA	9.2%	.44%	0.3%	.03%	.02%
CDI	16.4%	.89%	.62%	.47%	.49%

[1] In analyzing MRSA and CDI billing codes in our IRFs, we examined the MRSA and CDI rates associated with approximately 90,000 HealthSouth IRF Medicare and Medicare Advantage patients treated during 2009, and 110,000 HealthSouth IRF Medicare and Medicare Advantage patients treated during 2013. Data for 2015 was based on data reported into the NHSN, over 140,000 discharges in 2015 and over 160,000 discharges in 2016.

CAUTI				.09%	.11%

Figure 2 below cites the time and financial cost to providers estimated by CMS in the FYs 2012 (CAUTI) and 2015 IRF PPS rules (MRSA/CAUTI). Almost $2.3 million a year is spent across the IRF sector for infections that affect less than 0.5% of IRF discharges. Over 55,000 hours of clinical time is spent reporting the required monthly denominators and meeting other monthly requirements of the NHSN (i.e., monthly reporting plans, annual surveys, etc.) rather than patient care. **Given the extremely low incidence of these infections and the unnecessary burden (estimated by CMS at $2.3 million and over 55,000 hours of time per year), we respectfully urge CMS to remove these measures from the IRF QRP. The 55,000 hours of clinical time is particularly concerning because that time being redirected from patient care and to reporting processes with little to no patient benefit**.

Figure 2

	Annual Time per IRF	Annual Time for All IRFs	Annual Cost per IRF	Annual Cost for all IRFs
CAUTI*	30 hours	34,480 hours	$1,247.70	$1,429, 864
MRSA/CDI	18 hours**	20,688 hours	$747.57	$853, 238
IRF PAI Total	**48 hours**	**55,168 hours**	**$1995.27**	**$2,283,102**

*This excludes the cost of reporting infections (the numerator), estimated to be $186.14 and 405 minutes per IRF per year and $213,322 and 7,735.5 hours for all IRFs per year since the incidence of CAUTIs is so low.
**The FY2015 IRF PPS Rule did not estimate time for MRSA and CDI, only cost. We extrapolated the time per IRF based on the cost in the FY2015 IRF PPS Rule and the cost and time estimates for CAUTI in the FY2012 IRF PPS Rule.

Proposal: Reduce Unnecessary Burdens of Quality Reporting via the CDC's National Healthcare Safety Network ("NHSN")

To further the reporting burden of low-incidence infection measures, providers are unable to electronically report monthly NHSN data whenever there are "no events" to report, which given the very low incidence rate of these infections is almost all of the time. Rather than sending NHSN electronic data that already exists in the medical record, clinicians must re-enter the information manually in the NHSN site – just to report that there are no infections to report. NHSN has stated they plan to allow providers to electronically report "no events" (recognizing the additional burden this causes on providers with a low incidence of infections), but the earliest that capability will be available to providers is 2020. Considering the annual burden, this is an additional expenditure of almost $7 million dollars and 165,000 clinical hours incurred by IRFs for reporting instead of meaningful infection control work. **The CDC could waive the requirement of providers to report the "no event" box, but has stated they have no intention to do so, suggesting that only CMS could provide a waiver to this requirement for QRP purposes. We respectfully request CMS to waive this requirement**.

Furthermore, NHSN was originally designed as a voluntary and confidential system for hospitals to report quality data, but is now used to report mandatory quality reporting program data to CMS. Certain features of the NHSN that make sense for a voluntary reporting program create additional burdens for reporting mandatory QRP data, not just for IRFs but for all many other healthcare provider types that use NHSN to meet regulatory requirements. These burdens

can be tremendous. A case study presented at the Association for Professionals in Infection Control and Epidemiology ("APIC") suggested infection preventionists in acute care hospitals spend around 5 hours a day to review and complete reports for infections in the NHSN. CMS estimates that IRFs spend 7.53 hours per month reporting to the NHSN, with an additional 10 minutes a year to submit Healthcare Worker Vaccination measure, which equates to 100 hours per year. This means that infection preventionists are spending hundreds of thousands of hours reporting into the NHSN.

Some additional technical changes to the NHSN could significantly relieve part of the reporting requirement burdens for all providers that use the system:

- The NHSN is governed by the Centers for Disease Control and Response ("CDC"), which is separate and distinct from the primary regulatory agency with jurisdiction over the IRF QRP, CMS. At times, the objectives of the CDC in managing the NHSN go beyond the scope of CMS regulatory requirements for quality reporting programs, including the IRF QRP. As such, the NHSN has essentially become the "gatekeeper" for infection data and can unilaterally create additional reporting requirements beyond CMS' standard rulemaking processes. **Since IRFs are financially penalized for incorrect or incomplete IRF QRP data, any elements outside of CMS regulatory requirements should not serve as a basis for financially penalizing IRFs**.

- Every month, providers must declare what they are planning to report to NHSN before they actually report it via submission of a "monthly reporting plan." Providers are required to submit multiple monthly reporting plans, since different requirements fall into different NHSN modules, and each NHSN module requires a separate monthly reporting plan. When the NHSN was a voluntary system, these monthly reporting plans permitted providers to indicate they were submitting complete and accurate data for a specific time period. Now that data reporting is predominantly mandatory, this additional step takes significant time to complete and creates an additional and arbitrary way for providers to fall out of compliance with regulatory requirements. For example, if a hospital does not complete an initial monthly reporting plan for a particular month, their data for that month – even if they are all entered into NHSN as required by the CMS measure – will not be transmitted to CMS, resulting in technical non-compliance. The most frequent error that requires correction for our IRFs is a failure to set up a monthly reporting plan, regardless of whether they have entered the actual quality data required. **Since providers must indicate what facility type (i.e., short acute care hospital, pediatric, rehabilitation hospital, etc.) during NHSN registration, the system should be altered to remove these extraneous monthly reporting plans and simply focus on whether the numerator and denominator data were submitted appropriately for each facility type**.

5. Address Root Cause of ALJ Backlog: Aggressive Auditing

The Office of Medicare Hearings and Appeals ("OMHA") is overwhelmed with an appeals backlog of Medicare claims denials from a vast host of auditors and contractors. Appellant providers must wait multiple years to have their appeals heard before an Administrative Law Judge ("ALJ"), far longer than any reasonable adjudication timeline. There are currently hundreds of thousands of appeals cases waiting for ALJ hearings, and the number is increasing despite OMHA's recent regulatory and operational attempts to stem the tide. The overwhelming number of appeals is largely due to the number of contract auditors; their overly aggressive approaches in reviewing claims for services; and their overlap with one another.

Technical denials – denials which focus on minor documentation or administrative issues – make up a large part of the backlog, clogging up the ALJ pipeline for more substantive cases. This problem is only exacerbated by the number and overlap between auditors. Multiple auditors are often auditing the same issues within a provider setting. Not only does this create confusion in terms of which auditor is requesting what, but it takes significant time to correctly process all auditor requests, even if another auditor has already requested the same material. A thorough review of the number and scope of CMS auditors should result in a reduction in the number of audits on Medicare providers, and in turn help materially reduce the backlog of claims denial appeals awaiting adjudication at OMHA.

> **Proposal**: Reduce, 1) the number of audits; and, 2) auditors reviewing the same issues.
>
> **Proposal**: **Reform the RAC Program –** Recovery Audit Contractors ("RACs") should be held accountable for their performance. CMS should reform the RAC program by: recouping payments from providers only after a final Administrative Law Judge ("ALJ") decision upholding the denial is issued; require RAC physicians to review and approve denials before issuing them to a provider; automatically overturn RAC denials determined inappropriate by RAC validation contractors ("RVCs") and informing providers of RVC determinations; and applying a financial penalty to RACs for poor performance, as measured by appeal overturn rate at the ALJ level.

6. Making IRF Care More Accessible for Medicare Advantage ("MA") Beneficiaries

MA plans are required to submit provider lists to CMS in order to demonstrate adequate access to various types of care, including specialty care. CMS maintains standards and metrics on access that MA plans must meet. However, IRFs are not a provider type that is required to be included on a plan's provider list. This causes gaps in access to rehabilitative care for MA beneficiaries enrolled in plans that do not include IRFs in their provider lists. We are aware of several geographic areas where we know an MA plan does not have a contracted in-network IRF within a reasonable time/distance. These plans often claim that "essential rehabilitation" is sufficiently provided by SNFs and rely exclusively on SNFs to provide such care.

Additionally, MA plans are inconsistent in the time it takes to approve or deny a request of coverage of IRF services. Many MA plans take too long to approve or deny a request for IRF coverage, and when a decision is made the patient has already been moved to another care setting, typically to a SNF, which may not be the appropriate care setting for the beneficiary. CMS should require MA plans to issue a precertification decision (approved or denied) within 24 hours of receipt of all necessary documentation.

> **Proposal**: Require Medicare Advantage ("MA") plans to include IRFs in their provider lists as part of a plan's access-to-care criteria.
>
> **Proposal**: Require MA Plans coverage decisions for IRF services within 24 hours.

7. Other IRF Proposals for Flexibility and Efficiency

a. CMS Should Withdraw or Simplify the "Program Integrity Enhancements to Provider Enrollment Process" Proposed Rule That Was Released in 2016 **–** The Proposed Rule, if implemented, would be overly burdensome and would require the implementation of changes that would be almost impossible to track and report. Under the proposal, providers and suppliers would need to identify all current and prior affiliation relationships held by the applicant's indirect owners, and then determine whether any of these "affiliations" are with a provider or supplier that has had a disclosable event.

b. Rationalize Public Company Reporting Requirements for Medicare Enrollment Publicly-traded companies should not be required to report any direct or indirect ownership interests held by mutual funds or other large investment or stock-holding vehicles on CMS Form 855. Since the ownership percentage of mutual funds or other large investment vehicles in publicly-traded companies may fluctuate daily, it is unreasonable and unnecessarily burdensome for publicly-traded providers or suppliers to track and report such changes. In addition, the ability of publicly-traded providers or suppliers to gather necessary information to report these mutual fund or other large investment vehicles is oftentimes unreasonably difficult, if not impossible.

c. CMS should consider postponing the implementation of the IMPACT ACT PAC Quality Measures – The PAC sector needs more time to test and implement the numerous changes that CMS has made to the IRF-PAI. IRFs need to test these changes to ensure proper coding of the new assessment items and ensure that these new quality measures and assessment items truly represent the various complexities of the patients.

d. Allow IRF Appeal Rights for Low Income Patient (LIP) to the PRRB **–** HHS should allow IRFs the same rights to appeal low-income patient ("LIP") determinations to the Provider Reimbursement Review Board ("PRRB") as acute care hospitals are granted in appealing Disproportionate Share Hospital ("DSH") determinations.

e. Create Guidance and Refinements to 60-Day Overpayment Rule – CMS should work with providers to refine and provide further guidance on various aspects of the final rule as needed.

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The FAH appreciates your consideration of our comments and recommendations on these important issues. If you have any questions, please do not hesitate to contact me or Steve Speil, Executive Vice President, of my staff at (202) 624-1500.

Sincerely,