June 22, 2018

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


Dear Ms. Verma:

On behalf of our 48 hospital-based and free-standing rehabilitation facility members, the Illinois Health and Hospital Association (IHA) is taking this opportunity to formally comment on the proposed rule establishing new policies and payment rates for hospital rehabilitation services for federal fiscal year (FFY) 2019. IHA has strong concerns with certain provisions and presents the following comments for your consideration:

**CHANGE IN THE CASE-MIX METHODOLOGY FOR FFY 2020:**

CMS has proposed significant changes to its Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI) beginning in FFY 2020. It believes that these changes, taken together, will reduce the administrative burden for inpatient rehabilitation facilities. The new methodology would be implemented in a budget-neutral manner.

There are several concerns with the proposal that IHA would like to raise:

- The Improving Post Acute Care Transformation (IMPACT) Act of 2014 includes specifications for both standardized patient assessment data and payment for inpatient rehabilitation facilities. **IHA requests that CMS provide more information showing how its proposed methodology conforms to the provisions of the IMPACT Act.**

- IRF clinicians have only begun reporting their patients’ functional status under the new assessment guidelines within the past year. Consequently, we are concerned that there has been insufficient guidance provided by CMS, up to this point, to ensure the accuracy of the data. **IHA requests that CMS provide more opportunities for education and outreach to IRF providers to ensure that the facilities are properly reporting their patients’ functional status**
(which will now be based on three components: Motor score, Memory score and Communication score), combined with age.

IHA requests that CMS also address the following questions in the final rule, as raised by our members:

- How will co-morbid conditions be reported and scored?
- How will cognitive abilities for stroke patients be reported?
- Will this change lessen the severity classification of the most serious cases?
- Will CMS share its data upon which it concludes that this change is budget neutral?
- Should a change as drastic as this require more study?
- Does this change conform to the provisions of the IMPACT Act?
- Does such a drastic change in the case-mix methodology require more study?

Before these changes are implemented, IHA recommends that the agency perform more analysis and more importantly, solicit additional feedback from IRF stakeholders before implementation. Implementation in FFY 2020 is too soon. Therefore, IHA opposes this change in case-mix methodology as proposed, and strongly recommends that CMS rescind its proposed changes to the case-mix methodology for FFY 2020 in the final rule, or at the very least, delay implementation until more assurance as to the accuracy of the data can be verified.

**INCREASE IN THE FIXED COST OUTLIER THRESHOLD:**

CMS proposes an increase to the fixed-loss, standard-rate outlier threshold from the FFY 2018 amount of $8,679 to $10,509, an increase of just over 21 percent. The rationale is that this amount is required to maintain Medicare outlier payments at 3 percent of total IRF payments. IHA is concerned that this increase will result in significant financial losses for hospitals that treat a comparatively high volume of outlier cases and recommends that CMS reduce this threshold amount when it publishes the final rule for FFY 2019.

**FACILITY WAGE INDEX: LOSS OF RURAL DESIGNATION AND RURAL ADD-ON ADJUSTMENT:**

The adoption of the revised Core-Based Statistical Area (CBSA) wage delineations in FFY 2016 resulted in certain inpatient rehabilitation facilities (IRFs) being reclassified from rural counties to urban counties. Consequently, those facilities began a three-year transition towards the elimination of their 14.9 percent rural add-on adjustment starting in FFY 2016. In FFY 2016, the rural add-on adjustment was 9.94 percent; in FFY 2017, the adjustment was reduced to 4.97 percent and the add-on will be completely eliminated beginning in FFY2018.

Although not specifically addressed by CMS in the FFY 2019 proposed rule, these significant payment reductions were (and are) difficult for smaller facilities to absorb over a three-year period. The loss of this add-on adjustment during the first transition period (which began in FFY 2016) caught these rehabilitation facilities completely off guard, with virtually no time to
petition for a temporary regulatory fix or to prepare internally for the negative impact, which for some of these facilities is devastating.

Because the current regulations governing geographic reclassifications provide no opportunity for post-acute providers to petition for an area reclassification, IHA recommends that CMS, at the very least, extend the transition period to at least five years, or allow the affected facilities to apply for a reclassification back to rural status for at least a five-year period, similar to the three-year reclassification option available to critical access hospitals whose classification status was changed in FFY2015.

Ms. Verma, thank you again for the opportunity to comment. If you or your staff has any questions on the comments, they should be addressed to Thomas Jendro, senior director of finance, at 630-276-5516 or tjendro@team-iha.org.

Sincerely,

A.J. Wilhelmi
President & CEO