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

Re: CMS-1694-P, 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 2019 Rates; Proposed Quality Reporting Requirements for Specific Providers; Proposed Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (Promoting Interoperability Programs) Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Medicare Cost Reporting Requirements; and Physician Certification and Recertification of Claims; Proposed Rule (Federal Register, Vol. 83, No. 88, May 7, 2018)

Dear Ms. Verma:

On behalf of our more than 200 member hospitals and nearly 50 health systems, 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 acute and long-term care acute hospital inpatient services for federal fiscal year (FFY) 2019. IHA commends the Centers for Medicare & Medicaid Services (CMS) for its thorough analysis to develop this rule. However, IHA has strong concerns with several provisions, and presents the following comments for your consideration:

PROPOSED CHANGES TO THE INPATIENT ACUTE HOSPITAL PPS (IPPS):

- Medicare Disproportionate Share Hospital (DSH) Program: The following comments pertain to individual components of the Medicare DSH methodology:
  - Medicare Cost Report Worksheet S-10: In the past, CMS had considered using Worksheet S-10 of the Medicare cost report as the source for charity care, bad debt and other data to measure uncompensated care. However, in the FFY 2017 final IPPS rule, CMS acknowledged that this worksheet is still comparatively new and has only been used for payment purposes in restricted ways, such as to provide a source of charity care charges in computing electronic health
record incentives. In addition, stakeholders have asserted that hospitals have not had enough time to learn how to present accurate and consistent data in this form, and that the definitions and instructions issued thus far by CMS are confusing and contradictory. Consequently, in the FFY 2017 final rule, the agency decided to defer the implementation of Worksheet S-10 until no later than FFY 2021 to allow sufficient time to address those concerns.

Despite suggesting that Worksheet S-10 would not be implemented until possibly FFY 2021, citing recent analyses, CMS implemented a three-year transition to the complete use of Worksheet S-10, starting in FFY 2018, essentially reducing the preparation period by three years. However, IHA continues to have concerns about the data which CMS uses to base its conclusions. **IHA restates our position that the S-10 uncompensated care data was not appropriate for use in FFY 2018, nor is it appropriate for use in FFY 2019. Consequently, IHA recommends that CMS suspend its usage of Worksheet S-10 until FFY 2021, as the agency had originally stated in its FFY 2017 IPPS final rule. An alternative recommendation from IHA is that CMS increase the transition period from the current three years (which, in FFY 2020, will be completely exhausted) to a minimum of five years.** IHA offers the following reasons for its recommendations:

- **Definition of Uncompensated Care:** A broad definition of uncompensated care costs will be important in accurately measuring a hospital’s unreimbursed costs, and it will ensure the most appropriate basis for distributing DSH payments based on uncompensated care payments in the future. Currently, Worksheet S-10 contains two major categories of cost. The first, summarized on line 19, is defined as the unreimbursed costs of Medicaid State Children’s Health Insurance Program and other state and local government indigent care programs. The second, summarized on line 30, is defined as the uncompensated care costs of charity care and bad debt, but does not include the unreimbursed costs of services to Medicaid patients.

CMS proposes that beginning in FFY 2018, uncompensated care costs would be defined to include line 30 of the Worksheet S-10. The agency reiterated that Medicaid shortfalls reported on line 19 of Worksheet S-10 (i.e. the unreimbursed costs of Medicaid State Children’s Health Insurance Program and other state and local government indigent care programs) would **not** be included in the definition of uncompensated care. That same approach is proposed for FFY 2019. **IHA continues to strongly recommend that the definition of uncompensated care include all unreimbursed and uncompensated care costs, including the unreimbursed costs of Medicaid**
State Children’s Health Insurance Program and other state and local government indigent care programs reported on line 19 of Worksheet S-10. This could be achieved by using Line 31 of the Worksheet.

Worksheet S-10 does not completely account for the costs incurred by hospitals in treating the uninsured. Hospitals may incur costs of treating uninsured patients that are not categorized as either charity care or non-Medicare bad debt and, consequently, are not appropriately reported on Worksheet S-10. For example, hospitals may provide discounts to uninsured individuals who are unable or unwilling to provide income information to the hospital. Consistent with IHA’s recommendation that CMS adopt a broad definition of uncompensated care costs, we also recommend that these “discounts” for uninsured individuals be included. These are clearly costs that hospitals incur in providing treatment to the uninsured. To not include them would inappropriately penalize these hospitals and would run contrary to the underlying intent of uncompensated care payments under the Affordable Care Act (ACA).

- **Inclusion of Direct Graduate Medical Education (GME) Costs in Cost-to-Charge Ratio:** Because the source of the cost-to-charge ratio (CCR) calculation on Worksheet S-10 is Worksheet C, those costs do not include the cost of direct GME. However, charges as reported in Column 8 include overhead charges that do account for direct GME. CMS does not propose to include GME costs in the cost-to-charge ratios in the rule. To correct this inconsistency, IHA recommends that the formula for calculating the CCR be modified to include direct GME costs.

Direct GME costs are allowable costs, but historically have been excluded on Worksheet C of the Medicare cost report because the Medicare program calculates a separate add-on payment for its share of those costs. However, those costs represent a significant portion of the overhead costs of teaching hospitals. Including direct GME costs on Worksheet S-10 would more accurately match charges with costs.

- **Audit of Worksheet S-10:** The FFY 2018 final IPPS and the proposed FFY 2019 IPPS rule both reference the use of the 2014 and 2015 cost report as the basis for the implementing Worksheet S-10 data. Due to the lack of consistent instructions and definitions on the preparation of that worksheet that were available to hospitals during that time, CMS allowed hospitals to submit revised 2014 worksheets no later than Sept. 30, 2016. An additional opportunity was provided by CMS to hospitals to submit corrected Worksheet S-10 data for both
2014 and 2015 no later than Jan. 2, 2018. CMS acknowledged that these revised worksheets would probably be more accurate because more clarity had been provided by the agency during the past two years, and hospitals became more comfortable with the reporting requirements. CMS also offered that audit instructions would be provided to Medicare Administrative Contractors (MACs) on the review of those worksheets. The post-audit revised S-10 schedules would ultimately be used in the calculation of the uncompensated care cost (UCC) component of the Medicare Disproportionate Share Hospital payment adjustment.

Currently, to our knowledge, no MAC audits of hospitals’ revised Worksheet S-10s have been performed. In fact, we are not aware if audit instructions from CMS have even been disseminated to the MAC. Therefore, it is presumptuous of CMS to propose to transition to the use of a cost report worksheet data which is unaudited. Hospitals are unable to project future Medicare DSH payments because it is unclear what information the MACs will request on audit and how that information would be incorporated into the payment calculation. It is also unclear as to what appeal rights hospitals would have if there is disagreement over the treatment of an item that is reported on the worksheet. The time required to resolve timely appeals also makes an immediate transition to the worksheet impractical.

To avoid the application of different audit processes by different contractors, IHA requests that CMS make public the auditing instructions for MACs relative to the amounts reported on Worksheet S-10 to ensure that these instructions are applied consistently among contractors across all regions. IHA strongly urges CMS to audit the S-10 data prior to proposing its use to verify that it is correct and complete. In addition, once CMS ensures the accuracy and consistency of the Worksheet S-10 data, a transition to its use, either through a phase-in approach and/or a stop-loss policy, is appropriate. We also believe that if a phase-in approach is used, a longer time period than the three-year proposed transition period (e.g., a five-year transition) may be warranted, such as the 10-year extended transition CMS implemented to phase-in the capital PPS several years ago. Implementation of these recommendations would help mitigate large payment fluctuations and promote stability in DSH payments to hospitals.

- **Charity Care for Insured Patients**: The instructions for completion of Worksheet S-10 limit the definition of charity care to deductible and/or coinsurance amounts only, disregarding the total charges for services. Consequently, for patients with high-deductible plans, the hospital could only include the amount
that the insurance plan has determined to be the patient’s responsibility, the “allowable amount,” as charity care. That amount is multiplied by the hospital’s specific cost-to-charge ratio (CCR) to determine the cost. This effectively understates the cost of the charity. For example, assume a $1,000 charge for patient services, a CCR of .25 and $400 as the patient’s responsibility. Per current S-10 instructions, the cost of care would equal $100 ($400 times .25) versus $250 ($1,000 times .25), which is the amount that conforms to industry standards and official financial statements.

- **Physician Attestation of Admission Certification Requirements:** As part of its larger efforts to reduce administrative burden, CMS proposes to remove from the Medicare Conditions of Participation (COP), the requirement that Part A physician certification statements detail where in the medical record that required information can be found. CMS also proposes to remove the requirement that a written inpatient admission order be present in the medical record as a specific condition of Medicare Part A payment.

**IHA supports CMS’ proposal to revise the hospital Conditions of Participation by removing the requirement that a written inpatient order be present in the medical record as a condition of Medicare Part A payment.** We believe this change will help CMS achieve its goals of: a) Reducing unnecessary administrative burden on providers, and b) Reducing denials of Part A payments for medically reasonable and necessary inpatient care due to “technical discrepancies,” such as a missing attending physician’s signature, which can occur in the course of daily hospital operations. IHA requests, however, that CMS provide additional clarity on the documentation medical reviewers will use to determine the physician’s intent to admit a beneficiary if a written inpatient admission order is not present in the medical record.

In the proposed rule, CMS acknowledges that hospitals are already required to substantiate medical necessity in the medical record by documenting relevant orders. CMS goes on to state that other available documentation (or the medical record as a whole) should support Medicare coverage criteria. The intent and recommendation of the ordering physician to admit the beneficiary as an inpatient should be clear in the medical record. Under current CMS policy, medical reviewers have the discretion to determine the intent to admit from the medical record in the rare instance a written order is not present. **If CMS finalizes this proposal, IHA asks that CMS specifically identify the “other” available documentation (e.g., progress notes), as well as any specific language that should be used in this documentation, to support the physician’s intent to admit the beneficiary as an inpatient.** This detail would help in educating physicians on the clinical indicators that CMS expects to be present in the medical record to support inpatient admissions.
• **Requirements for Hospitals To Make Public a List of their Standard Charges via the Internet:** IHA is pleased to respond to your request for comments on healthcare price transparency and to share progress made in Illinois. IHA supports price transparency that provides relevant and meaningful healthcare price information to patients making healthcare decisions and has developed price transparency principles which have been adopted by our members. These principles embrace the need for a collaborative approach between providers and public and private health plans to convey the value of care, as well as to ensure that patients understand the many factors that influence the final price of the care provided.

What we hear most often is that patients want to know their out-of-pocket financial obligations will be. Given that 93 percent of Illinoisans have health coverage and their health plan sets their cost-sharing financial obligations, we believe that information is best provided from their health plan. For those without healthcare coverage, healthcare providers should provide estimates of pricing, including available financial assistance, as well as assistance with additional information regarding public health coverage.

**Response to Updated Guideline to Post Charges on the Internet:** In the proposed rule, CMS expressed concern that challenges continue to exist for patients related to insufficient price transparency and states its concern that “chargemaster data are not helpful to patients for determining what they are likely to pay for a particular service or hospital stay.” It then goes on to update the guidelines to require the posting of charges on the internet in machine readable format by Jan. 1, 2019.

We agree that chargemaster data does not advance the goal of helping patients know their financial obligations for an episode of care. A catalogue of services representing a master charge list that has no bearing on the actual amount a patient or third-party payer will have to pay is not relevant information for the public. It is not particularly useful for commercially insured patients where the rates are contractually negotiated or government-covered patients where set rates are applied. As such, we do not believe posting the same information on the internet will be a helpful step.

The Healthcare Financial Management Association (HFMA) Price Transparency Task Force, comprised of providers, health plans, consumers and other stakeholders, developed helpful guidance and tools to advance price transparency, including definitions for charges, price and cost. We recommend these definitions be utilized in further price transparency discussions. Hospitals already have resources in place to provide patients with price estimates by either utilizing commercial software tools or their own price estimators. Illinois already has a law requiring the provision of an estimate for any procedure the patient is contemplating.
The rule lists the concern that challenges exist related to surprise out-of-network bills for physicians providing services at in-network hospitals and physician fees for emergency room services. As both these concerns are related to physician fees, posting hospital charges on the internet will do nothing to alleviate these problems. Illinois has passed legislation to hold patients harmless when out-of-network physicians provide services at in-network hospitals and requiring the physician and insurance plan to negotiate payment, thereby removing the challenge of surprise bills.

**Response to Price Transparency Questions:**

- **Standard Charges:** We believe the definition of standard charges should not mean the discounted rates across payers, as that is typically considered the allowed amount. It is also not useful to include each item on the chargemaster, but rather certain services or groups of services could be identified for which charges must be posted, similar to Illinois law. The main obstacle for making standard charges meaningful for patients is that the gross charge for services is not reflective of what the patient’s financial obligation will be. That obligation is directly related to what the patient’s health plan requirements are for their deductible, co-insurance or copay. That is why we believe the health plan is the best source for this information.

- **Information most beneficial:** The information most beneficial to patients is how much will their out-of-pocket obligation be and for commercial patients, that amount is determined by their health plan. Therefore, the health plan is the best source to provide that information. Most health plans in Illinois have developed cost estimator websites so their subscribers can obtain estimates of what their care would cost at specific providers and what their out-of-pocket obligation would be.

For those uninsured, hospitals should provide an estimated charge with information regarding its financial assistance policy and opportunities for health coverage. Illinois law already requires hospitals to furnish patients with charges estimates, upon request. Illinois law also requires hospitals to notify patients about financial assistance and provide free and discounted care depending on a patient’s income level. Additionally, payers and providers should provide corresponding quality information with pricing information to provide patients with a balanced presentation of the full value of the care they are seeking.

- **Provide Medicare payment comparison:** We do not believe that healthcare
providers should be required to provide patients with information on what Medicare pays for a particular service performed by a healthcare provider, as suggested in the proposed rule. Such a requirement would mean providers would need to process all patient claims additionally through a Medicare Pricer to determine payment, even when the patient is not covered by Medicare, thereby significantly increasing both administrative burden and cost. As Medicare coverage is mostly applicable to older adults, it would have limited relevance for certain women and children services. It would also create confusion to the patient as to why their charge and anticipated payment varied from the Medicare amounts, causing providers, health plans and Medicare to review and explain specific differences on millions of claims. In Illinois, Medicare payment only covers 90 percent of what it costs the hospital to provide care. Medicare payment is already woefully inadequate and typically commercial health plans are paying more to cover the losses incurred from Medicare and Medicaid plans. Giving Medicare payment information to patients would necessitate explanation of why it is not an appropriate comparison to their bill.

- **Enforcement:** The proposed rule invites comments pertaining to CMS enforcement of the price transparency requirements contained in section 2718(e) of the Public Health Service Act which requires hospitals to make public a list of standard charges, or in accordance with CMS guidelines, a policy for allowing the public to view those charges in response to an inquiry. In Illinois, most hospitals have elected to comply through a policy to view charges rather than post the chargesmaster as this provides opportunity for the important dialogue with the patient about finances. We suggest that an attestation added to the provider agreement seems reasonable and fines should not be assessed.

It’s important that providers and patients engage in dialogue about the price for their care. As referenced earlier, the HFMA Price Transparency Task Force developed helpful guidance and tools to advance price transparency as well as a companion report, *Understanding Healthcare Prices: A Consumer Guide*, which is used by many Illinois hospitals as they seek to assist their patients to better understand their financial obligations.

**Illinois Price Transparency:** As introduced above, Illinois has implemented a number of laws to address various pricing concerns: the need for price estimates, a website with hospital-specific charges by procedure, free care and discounts for the uninsured, communication of financial assistance availability and patient protections from “surprise” out-of-network bills. In addition, Illinois hospitals provide nearly $800 million annually in charity care measured at cost to assist patients in need.
Post charges and give estimates - The Illinois Health Finance Reform Act Sec. 4-4 (Reform Act) requires hospitals to publicly display charges for certain services, and upon request, provide prospective patients with information on the normal charge for any procedure or operation the patient may be considering.

Website with hospital-specific charges by procedure - The Reform Act Sec. 4.2 requires hospitals to submit inpatient and outpatient claims to the Illinois Department of Public Health (IDPH) then post average charges by hospital for over 50 most common services on the Hospital Report Card/Consumer Guide website, www.healthcarereportcard.Illinois.gov. The Illinois Hospital Report Card Act requires collection of certain hospital quality information that is also posted on the website.

Most health plans in Illinois have developed cost estimator websites so their subscribers can obtain estimates of what their care would cost at specific providers and what their out-of-pocket obligation would be.

Free care/discounts to uninsured – The Illinois Hospital Uninsured Patient Discount Act (HUPDA) requires uninsured residents below established income thresholds to be eligible for either 100 percent discount (free care) or discounts to 135 percent of the hospital’s cost. It also ties a maximum collectible amount to 25 percent of family income. The Illinois Fair Patient Billing Act (FPBA) requires a presumptive eligibility policy for financial assistance for certain categories of patients.

Billing information – FPBA requires specified information on hospital bills including availability of financial assistance, provide an itemized bill, upon request, and respond to billing inquiries within specified time frames.

Collection action - FPBA requires hospitals to give uninsured patients opportunities to apply for financial assistance, assess accuracy of their bill and avail themselves of a payment plan prior to any collection action. No legal action for non-payment is allowed against uninsured patients who have clearly demonstrated lack of income or assets to meet financial obligations. It also requires the offering of a payment plan to insured patients before collection action taken.

Out-of-network/Surprise bills – Public Act 96-1523 holds insured patients harmless for any increased out-of-pocket obligations from facility-based, out-of-network provider services at an in-network hospital. A facility-based physician or other provider is defined as one who provides radiology, anesthesiology,
pathology, neonatology or emergency department services in a participating hospital or ambulatory surgical treatment center.

FPBA requires notice to insured patients that healthcare professionals affiliated with the hospital may not be participating providers within the same insurance plans and networks as the hospital.

Healthcare is not like other industries where consumers are able to price shop for standardized commodities. Some outpatient procedures may lend themselves to greater standardization of service and price, but the underlying element that needs to be understood is that people are unique. Their care can vary because of their medical condition, length of time necessary to provide the care, necessary specific equipment, supplies and medication, complications requiring unanticipated procedures or other treatment ordered by the physician.

Illinois hospitals are eager to engage patients in financial conversations and assistance. We believe that the progress made in Illinois through laws and regulations has advanced price transparency by providing patients with information most helpful to them.

- **Documentation and Coding (D & C) Adjustment:** The final FFY 2017 IPPS rule included a provision that implemented one of the sections of the American Taxpayer Relief Act (ATRA) of 2014, which mandated a 0.8 percent reduction for each year during the four-year period from FFY 2014 through FFY 2017. In accordance with that law, CMS imposed the 0.8 percent reduction in FFY 2014, 2015 and 2016. However, instead of incorporating the last of the four 0.8 percent reductions in FFY 2017, CMS implemented a reduction amount to 1.5 percent, which is in non-compliance with the ATRA requirement. There was no provision in the FFY 2018 rule to restore this 0.7 percent excess reduction, nor is one included in the proposed FFY 2019 rule.

IHA submits this comment because we believe that CMS, by failing to restore the 0.7 percent adjustment, exceeded its statutory authority. Although the Medicare Access and CHIP Reauthorization Act (MACRA) revised the restoration process by replacing the single positive adjustment with a series of incremental positive adjustments between FY 2018-2023, CMS was never authorized to impose a permanent negative adjustment beyond FFY 2017. By retaining the 0.7 percent adjustment, CMS has effectively misapplied the adjustment amount directives issued by Congress. As a result of this misapplication, until CMS restores the 0.7 percent adjustment, our hospitals will experience a significant cut in their reimbursement for FFY 2019 (in addition to the reduction) already incurred for FFY 2018. **In conclusion, IHA believes that CMS does not have statutory authority to retain the 0.7 percent adjustment for either FFY 2019 or FFY 2018.** ATRA authorized CMS to make recoupment adjustments of $11 billion for
discharges occurring during FY 2014-2017, but such authority did not extend beyond this period. **In light of the clear Congressional intent supporting the restoration of the 0.7 percent adjustment, IHA strongly urges CMS to reverse its FFY 2018 position and restore the adjustment for both FFY 2018 and FFY 2019.**

- **Hospital Wage Index for Acute Care Hospitals:** For those hospitals that have been approved for reclassifications to other core-based statistical areas (CBSAs) in the past, and would experience negative financial impacts, CMS, consistent with its prior rulemaking, proposes that those hospitals must file a request to withdraw its reclassification status no later than 45 days after publication of the proposed rule. This policy has always been problematic because the Wage Index Public Use File used to develop the values published in the proposed rule is subject to correction if errors were made by the MAC when transmitting providers’ wage index and occupational mix data to CMS. Hospitals could withdraw their reclassification status based on information in the proposed rule, and with the publication of the final rule wage index values, discover that their original reclassified status was more desirable. This “Catch 22” situation continues in FFY 2018.

  Hospitals cannot make an informed decision concerning their reclassification status based on values in a proposed rule that are likely to change. **Therefore, IHA strongly recommends that in order to avoid these paradoxical situations in the future, CMS revise its current policy to permit hospitals to withdraw their reclassification status within 45 days of publication of the final rule.**

- **Additional Policies for Multi-Campus Hospitals:** CMS has proposed that a “main campus” hospital, having at least one remote location and operating under a common Medicare agreement, cannot obtain a rural reclassification or a “special” classification status of a Sole Community Hospital (SCH), Rural Referral Center (RRC) or Medicare Dependent Hospital (MDH) independent from its remote location. Combined data from both the main campus hospital and the remote location would be used to determine the provider’s eligibility for the classification. However, in the case of a Sole Community Hospital classification, the main campus hospital and the remote facility independently must meet the SCH classification criteria. In addition, the proposed rule is unclear as to an effective date; i.e., does this proposal affect new classification requests, thereby “grandfathering” in existing SCHs, RRCs and MDHs, or are those existing hospitals required to reapply according to the criteria presented in the proposed rule?

  IHA recommends the following two revisions/clarifications for inclusion in the final rule:
  
  - The impact of this proposal on the provision of healthcare services to the communities serviced by these types of hospitals at this time is unknown and the
proposed rule does not include an effective date. The rule also does not include any data as to how the distribution of these specially classified rural hospitals would be affected, and more importantly, how patients’ access to care would be affected. Therefore, CMS should rescind this proposal altogether until such time as research data is available to demonstrate this impact.

- At a minimum, in order to ensure that existing Sole Community Hospitals, comprised of a main campus and one or more remote campuses, can continue to provide services to their communities, CMS should exclude them from the evaluation of the qualifying criteria on a combined basis.

- **Reduction of Measures from the Inpatient Quality Reporting Program:** CMS is proposing to remove several measures currently required to be reported under the Inpatient Quality Reporting (IQR) and/or the Value-Based Purchasing (VBP) programs. These measures are either no longer relevant or are duplicated among programs. IHA supports this proposal.

**PROPOSED CHANGES TO THE LONG-TERM CARE HOSPITAL PPS (LTCH-PPS):**

- **Proposed Reduction in LTCH Site-Neutral Payment Rates:** CMS estimates that the overall impact of all proposed changes affecting Medicare payments to LTCHs in FFY 2019 for both standard and site-neutral cases, as compared to payments made in FFY 2018, is a reduction of 0.1 percent. We are very concerned about the decrease in payment for these services, as the provision of needed services to beneficiaries could be impacted. There are only seven IHA LTCH members; those that treat patients with significant and complex conditions are especially financially vulnerable. A reduction of services in any of these providers would severely hurt access for beneficiaries in their communities. While IHA recognizes that many of the policies for rate setting are set in statute, we strongly encourage CMS to review and apply the most current data when developing those rates; this may mitigate potentially devastating impacts on LTCH providers and consequently, to Medicare beneficiaries who need these services.

- **Proposed Elimination of the “25 Percent Rule”:** The 25 Percent Rule payment policy implements a reduction to the LTCH-PPS payment amount when the percentage of an LTCH’s Medicare patients from any one referring hospital exceeds 25 percent. Once that threshold is reached, payment for all subsequent Medicare discharges, within the reporting period from that one referring hospital, is the lower of the LTCH-PPS rate or the Acute IPPS rate. Various pieces of previous legislation delayed full implementation of that policy; however that delay sunsets for cost reporting periods beginning in 2017.
CMS is proposing to permanently withdraw the 25 Percent Rule because it believes that the LTCH site-neutral policy, implemented in 2017, renders it unnecessary. **IHA strongly supports this proposal.**

- **Fixed Cost Outlier Threshold:** CMS proposes an increase to the fixed-loss, standard-rate outlier threshold of approximately 11.9 percent, when compared to the threshold amount in FFY 2018. **IHA is concerned that this increase will result in significant financial losses for hospitals that treat a comparatively high volume of outlier cases; consequently, we recommend a reduced outlier amount to be included in the final rule.**

Ms. Verma, thank you again for the opportunity to comment. If you have any questions or comments regarding this letter, please contact Tom Jendro, senior director of finance, at 630-276-5516 or tjendro@team-iha.org.

Sincerely,

A.J. Wilhelmi
President & CEO
Illinois Health and Hospital Association