The Functional Assessment Specialists

Uniform Data System

for Medical Rehabilitation

Telephone
716.817.7800

Fax
716.568.0037

E-mail
info@udsmr.org

Web site
www.udsmr.org

Suite 300
270 Northpointe Parkway
Amherst, NY 14228

University at Buffalo
The State University of New York

June 10, 2020

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1729-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted via regulations.gov

Re: 42 CFR Part 412 (CMS-1729-P) Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2021

Dear Administrator Verma,

On behalf of Uniform Data System for Medical Rehabilitation (UDSMR) and the more than nine hundred inpatient rehabilitation facilities we provide services to, we are pleased to present our comments on 42 CFR Part 412 (CMS 1729-P) Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2021, published on April 21, 2020, in the *Federal Register*. With over thirty years of experience, UDSMR provides coding, clinical, quality improvement, and technical support services to IRFs and other post-acute care (PAC) providers. UDSMR appreciates the opportunity to provide ongoing feedback to CMS and hopes to work with CMS toward solutions that meet the needs of IRF providers and patients.

Before proceeding with our comments, we present the following executive summary, which highlights our concerns and recommendations.

Executive Summary:

UDSMR appreciates CMS's annual updates to the IRF payment system, but the increase in the SPCF is hiding underlying issues with the construction of the CMGs that utilize quality indicator data. CMS still has not provided evidence that the calculated motor score used for payment is reliable and valid, nor has it provided access to a combined data set in order to allow IRFs to analyze and recommend alternatives. IRFs now operate in a compromised position with respect to payment for cases discharged on or after October 1, 2019. CMS continues to reimburse IRFs through a poorly constructed payment model that lacks the evidence needed to instill confidence in the financial projections or to help IRFs make informed decisions or recommend alternatives. UDSMR continues to have concerns about the CMGs and the IRF Prospective Payment System (IRF PPS) and recommends that CMS make its process transparent and provide evidence of a reliable and valid model.

UDSMR also is concerned that the updates to the CMG relative weights and LOS values rely on data from a period during which the underlying data elements that produce the CMGs were not utilized for payment. Since the October 2019 implementation of the FY 2020 CMGs, UDSMR has observed changes to IRF measures of average patient severity that differ significantly from the projections provided in CMS's rate-setting file, which

utilizes FY 2019 data. Without consideration for these changes in patient severity, UDSMR is concerned that the proposed FY 2021 relative weights and LOS values may negatively influence the care provided to very severe IRF patients.

UDSMR supports regulatory relief efforts that would prevent Medicare contractors from inventing restrictive definitions or other criteria that go beyond Medicare law and regulations, ultimately denying access or payment to IRFs for patients who meet medical necessity standards and would benefit from the care provided by an IRF. Erroneous denials are harmful to patients and to the inpatient rehabilitation infrastructure. Patients and providers should have confidence that Medicare covers any care provided consistent with the criteria for medical necessity under Medicare without argument or delay. We believe that these determinations are currently suited more for IRFs than for Medicare contractors. In an effort to provide more clear and consistent expectations for IRFs, we support the proposal related to the codification of the specific preadmission screening requirements, with the removal of a few required elements. Although we agree that CMS should create consistent requirements between the Code of Federal Regulations (CFR) and the *Medicare Benefit Policy Manual* (*MBPM*), we are concerned that codification of preadmission screening requirements may increase the number of patients denied access to IRF care due to erroneous interpretations of these requirements by Medicare contractors.

UDSMR supports the proposal to remove the postadmission physician evaluation (PAPE). We agree that similar or duplicative information may exist as part of the preadmission screening documentation or in other physician documentation produced upon a patient's admission to an IRF.

UDSMR strongly supports the role of the rehabilitation physician role within the IRF and, more specifically, the need for the rehabilitation physician to lead and direct the care provided in the IRF. UDSMR does not support proposals that would potentially harm patients by reducing the quality of care provided by IRFs. Although we believe there are opportunities to reduce the administrative burden for rehabilitation physicians, we do not support proposals that would diminish the lead role of the rehabilitation physician in the IRF.

In summary, UDSMR urges CMS to provide basic evidence that the IRF payment system and underlying CMGs result from reliable and valid results and provide the appropriate amount of resources to care for the increasing severity of IRF patients. We also encourage CMS to provide a more transparent process that allows industry stakeholders to work with CMS toward solutions that meet the needs of IRF providers and patients.

Concerns:

1. Regarding the proposed refinements to the FY 2021 IRF PPS CMG relative weights and length of stay:
    a. They lack sufficient research, testing, and analysis.
        i. CMS has not provided IRFs with testing results suggesting that the motor score for CMGs is reliable and valid.
        ii. The continued use of the functional data collected alongside another similar but different set of functional data calls into question the integrity of the data used to make changes to the payment system.
    b. They will negatively affect patients' access to resources and an IRF level of care.
2. UDSMR supports the codification of certain preadmission screening requirements but is concerned about the following:
    a. The inclusion of preadmission screening elements that are not clearly defined or are not relevant to determining medical necessity prior to admission
    b. The expansion of denials of access to IRF care due to erroneous interpretations of these requirements by Medicare contractors
3. UDSMR supports removing the PAPE but is concerned about any historical or future denials of IRF claims based on the requirements in § 412.622(a)(4)(ii).
4. Any proposal that has the potential to diminish the role of a rehabilitation physician as the leader of IRF care would negatively affect the quality care and would unnecessarily put patients at risk.

Recommendations:

1. UDSMR recommends the following with respect to the proposed IRF PPS payment updates:
    a. CMS should not reduce the CMG relative weight and LOS values until it completes the following:
        i. Provide a limited data set that matches patient-level IRF-PAI assessment data to claims/cost data in order to allow stakeholders to analyze and potentially model alternative recommendations.
        ii. Conduct monthly or quarterly stakeholder or technical expert panel (TEP) payment model meetings for the purposes of providing additional transparency and discussing and reviewing payment model–related analyses and information.
        iii. Resolve the remaining issues related to the admission assessment guidelines by working with clinical industry experts to establish clear and concise examples and instructional materials that remove the need for "clinical judgement."
        iv. Collect two to three years of standardized patient assessment data elements following the period where provider confusion existed due to the collection of similar but slightly different items that measure the exact same construct.
    b. Provide evidence that any calculated value used for payment models can be proven to be reliable and valid. This should require that each of the following measures for reliability and validity is met:
        i. Test-retest reliability: This will address whether the calculated value (such as a motor score) is consistent across time. In order to assess this, CMS/RTI should examine the correlation between the motor score at two different points in time (perhaps admission and discharge) to determine whether the measure value is consistent over time.
        ii. Internal consistency: This will address whether there is reliable consistency between responses to the items that make up a measure, such as a motor score. UDSMR suggests using a split-half correlation or providing a Cronbach's alpha value.
        iii. Construct validity: This will address whether the measure (such as a motor score) is capable of measuring what it claims to measure. CMS should provide evidence that the resulting measure is highly correlated with an existing measure of its intended construct.
        iv. Predictive validity: This will address whether the measure (such as a motor score) is capable on its own of predicting outcomes or other values of importance—in this case, providing evidence that the measure can predict length of stay or cost or other outcomes.
2. UDSMR has the following recommendations with respect to the proposal to amend the preadmission screening requirements:
    a. Amend § 412.622(a)(4)(i)(B) to include detailed requirements for the preadmission screening documentation, with the exception of the following:
        i. The frequency and duration of treatment
        ii. Anticipated postdischarge services

   b. Amend § 412.622(a)(4)(i)(D) to include the need for a rehabilitation physician to review and concur with findings prior to the IRF admission.

   c. Amend chapter 1, section 110.1.1, of the *MBPM* to remove the following requirements for the preadmission screening:

      i. The frequency and duration of treatment

      ii. Anticipated postdischarge services

   d. CMS should resolve any instances where the incorrect interpretation of the existing CFR has resulted in a denial of an IRF claim.

   e. In order to avoid erroneous denials of access to IRF care, CMS should also convene meetings or technical expert panels (TEPs) with industry stakeholders to consider any further changes to requirements in the CFR or *MBPM* related to preadmission screening requirements.

3. UDSMR makes the following recommendations with respect to the proposal to remove the PAPE:

   a. Remove the postadmission physician evaluation documentation requirement described in § 412.622(a)(4)(ii).

   b. Remove or rescind chapter 1, section 110.1.2, of the *MBPM*.

   c. CMS should resolve any instances where denial of an IRF claim was based upon the documentation requirements outlined in § 412.622(a)(4)(ii).

4. UDSMR does not support any proposal that has the potential to diminish the role of the rehabilitation physician as the leader of IRF care.

The remainder of this letter addresses our concerns and recommendations in detail.

1. Regarding the proposed refinements to the FY 2021 IRF PPS CMG relative weights and length of stay:

a. They lack sufficient research, testing, and analysis.

i. CMS has not provided IRFs with testing results suggesting that the motor score for CMGs is reliable and valid.

ii. The continued use of the functional data collected alongside another similar but different set of functional data calls into question the integrity of the data used to make changes to the payment system.

b. They will negatively affect patients' access to resources and an IRF level of care.

As stated in section IV of CMS-1729-P.

Before addressing each of the concerns noted above, as previously stated in this comment letter, UDSMR strongly recommends the following with respect to the proposed IRF PPS payment updates:

1. CMS should not reduce the CMG relative weight and LOS values until it completes the following:
    a. Provide a limited data set that matches patient-level IRF-PAI assessment data to claims/cost data in order to allow stakeholders to analyze and potentially model alternative recommendations.
    b. Conduct monthly or quarterly stakeholder or technical expert panel (TEP) payment model meetings for the purposes of providing additional transparency and discussing and reviewing payment model–related analyses and information.
    c. Resolve the remaining issues related to the admission assessment guidelines by working with clinical industry experts to establish clear and concise examples and instructional materials that remove the need for "clinical judgement."
    d. Collect two to three years of standardized patient assessment data elements following the period where provider confusion existed due to the collection of similar but slightly different items that measure the exact same construct.
2. Provide evidence that any calculated value used for payment models can be proven to be reliable and valid. This should require that each of the following measures for reliability and validity is met:
    a. Test-retest reliability: This will address whether the calculated value (such as a motor score) is consistent across time. In order to assess this, CMS/RTI should examine the correlation between the motor score at two different points in time (perhaps admission and discharge) to determine whether the measure value is consistent over time.
    b. Internal consistency: This will address whether there is reliable consistency between responses to the items that make up a measure, such as a motor score. UDSMR suggests using a split-half correlation or providing a Cronbach's alpha value.
    c. Construct validity: This will address whether the measure (such as a motor score) is capable of measuring what it claims to measure. CMS should provide evidence that

the resulting measure is highly correlated with an existing measure of its intended construct.

d. Predictive validity: This will address whether the measure (such as a motor score) is capable on its own of predicting outcomes or other values of importance—in this case, providing evidence that the measure can predict length of stay or cost or other outcomes.

1a. The proposed refinements to the case-mix classification and FY 2021 IRF PPS payment system lack sufficient research, testing, and analysis.

The supporting research technical document from RTI related to the research, testing, and analysis of the FY 2020 IRF PPS payment model does not offer sufficient evidence that the selected items, the motor score, and the resulting model are suitable replacements for the previous payment system. Although CMS and RTI conducted some analyses to determine the overall financial impact, the document fails to indicate whether each item chosen for the motor score is needed or can predict costs on its own. Without transparency and additional information, providers do not have confidence that the IRF PPS payment model will provide the resources necessary to care for their patients.

i. CMS has not provided IRFs with testing results suggesting that the motor score for CMGs is reliable and valid.

Although the individual items chosen for motor score were previously tested in the PAC PRD for reliability and validity, the resulting motor score has not been tested for—and has not demonstrated—its reliability and validity. CMS and its contractor, RTI International, have failed to provide the necessary information indicating that the motor score is capable of measuring what it is supposed to measure or is predictive on its own of cost or length of stay. Analyses of both the unweighted and weighted motor scores has shown little to no correlation with the prior FIM® item-based weighted motor score and produces patient-severity levels that differ significantly from information that has been proven to be reliable and valid for over twenty years.

Additional testing must be conducted in order to make sure that the motor score is proven a reliable and valid measure for use in defining a payment model. Specifically, UDSMR recommends that CMS provide evidence that any calculated value used for payment models is reliable and valid. This should require that each of the following measures for reliability and validity be met:

1. Test-retest reliability: This will address whether the calculated value (such as a motor score) is consistent across time. In order to assess this, CMS/RTI should examine the correlation between the motor score at two different points in time (perhaps admission and discharge) to determine whether the measure value is consistent over time.
2. Internal consistency: This will address whether there is reliable consistency between responses to the items that make up a measure, such as a motor score. UDSMR suggests using a split-half correlation or providing a Cronbach's alpha value.
3. Construct validity: This will address whether the measure (such as a motor score) is capable of measuring what it claims to measure. CMS should provide evidence that

the resulting measure is highly correlated with an existing measure of its intended construct.

4. Predictive validity: This will address whether the measure (such as a motor score) is capable on its own of predicting outcomes or other values of importance—in this case, providing evidence that the measure can predict length of stay or cost or other outcomes.

ii. The continued use of the functional data collected alongside another similar but different set of functional data calls into question the integrity of the data used to make changes to the payment system.

The creation of the motor score and resulting CMGs for FY 2020 utilized limited analyses from the first two years of functional quality indicator data collected alongside another similar but different set of functional data. Changes to the CMG relative weights and LOS values for FY 2021 utilize FY 2019 claims data. In FY 2019, claims and the underlying CMGs for those claims utilized the FIM® instrument for payment purposes. The integrity of the underlying data and analyses is in question, as the payment system for FY 2019 represents a period of confusion among providers caused by the duplicative nature of functional assessment data with different guidelines and scales, producing values that may not properly represent patient severity.

UDSMR recommends that CMS freeze the FY 2020 CMGs and associated relative weight and LOS values until it completes the following:

1. Provide a limited data set that matches patient-level IRF-PAI assessment data to claims/cost data in order to allow stakeholders to analyze and potentially model alternative recommendations.
2. Conduct monthly or quarterly stakeholder or technical expert panel (TEP) payment model meetings for the purposes of providing additional transparency and discussing and reviewing payment model–related analyses and information.
3. Resolve the remaining issues related to the admission assessment guidelines by working with clinical industry experts to establish clear and concise examples and instructional materials that remove the need for "clinical judgement."
4. Collect two to three years of "clean" quality indicator data, unless there is a need to increase the resources available for a certain CMG. In other words, CMGs and their associated relative weights and LOS values should not be adjusted or reduced until two to three years of standardized patient assessment data elements have been collected without any confusion resulting from the collection of similar but slightly different items that measure the exact same construct.

1b. The proposed refinements to the FY 2021 IRF PPS CMG relative weights and LOS will negatively affect patients' access to resources and an IRF level of care.

Although UDSMR supports the approximately 2.2% increase in the proposed FY 2021 standard payment conversion factor (SPCF), it does not support changes to the proposed CMG relative weights and LOS values. UDSMR believes that the increase in the SPCF is actually hiding underlying issues with the construction of the CMGs that utilize quality indicator data.

Table 3 in section IV of the proposed rule provides the percentage of patients who may experience changes in their relative weight value. This table has three issues that influence the ability to provide transparency related to the actual changes that IRFs might experience:

1. As we detailed previously, the data used for this analysis is from a time when CMGs were based on FIM® instrument data, which was collected alongside the quality indicator data. The FY 2019 data is not representative of current patient severity and does not represent the training and education IRFs have engaged in leading up to the FY 2020 CMGs. More recent data from FY 2020 suggests a different distribution of cases and projections of the proposed changes to the CMG relative weights. Although there are a higher percentage of cases whose relative weight values have increased, the use of data that is not reliable, valid, or representative of current IRF practice to decrease relative weight values on over 40% of IRF cases should not occur.
2. The comparison of relative weight values does not consider the payment effects of changes to LOS values and the potential for early transfers. Instead of using relative weights, CMS should provide projections of changes to the resulting payment weight, which accounts for the effect of early transfers. Using payment weight instead of relative weight not only would more adequately project the effects of changes to the relative weight values, but also would include the effect of changes made to the LOS values.
3. The use of percentage change in projecting potential effects hides the underlying payment changes. CMS should instead utilize the actual relative weight or payment weight differences to project effects. For example, in the proposed rule, CMG 1603 in tier 1 has a proposed relative weight value of 1.3534 for FY 2021, but for FY 2020 the relative weight value for this CMG is 1.6234. This is a reduction of 0.2700, which represents a 16.6% reduction. Comparatively, in the proposed rule, CMG 1806 in tier 2 has a proposed relative weight value of 2.6481 for FY 2021, but for FY 2020 the relative weight value for this CMG is 2.9109. This is a reduction of 0.2628, which represents a 9.0% reduction. Even though the actual change in the relative weight value is nearly the same, the percentage change for CMG 1603 would place it in the "15% or more" category in table 3, while the percentage change for CMG 1806 would place it in the "5 to 15%" category. In both CMGs, the decreases in relative weight values represent a decrease of at least $4,400 in payment.

In order to more accurately represent the changes resulting from updates to relative weights and LOS, UDSMR recommends that CMS consider modifying table 3 to examine changes to payment weight to consider the effects of LOS changes and relative weight changes. We also ask that CMS change table 3 from a percentage change table to an actual change table, with categories displaying the following:

- Decreases of 0.2 or more (decrease of approximately $3,000 or more)
- Decreases of 0.1 to less than 0.2 (decrease of between approximately $1,500 and less than $3,000)
- Decreases of more than 0.0 to less than 0.1 (decrease of between $0.01 and approximately $1,500)
- Increases of more than 0.0 to less than 0.1 (increase of between $0.01 and approximately $1,500)

- Increases of 0.1 to less than 0.2 (increase of between approximately $1,500 and less than $3,000)
- Increases of 0.2 or more (increase of approximately $3,000 or more)

UDSMR is also concerned about the potential effects on very severe populations. Although major multiple trauma (MMT) patients are only 3% of IRF cases, they have severe medical and functional deficits requiring IRF care. Of the forty-four CMGs for MMT, only ten appear to have a projected increase in their payment weight, but the payment weight for the other thirty-four will decrease. Although the increase in the SPCF may provide a small increase for some of these cases, cases in RIC 18, Major multiple trauma with brain or spinal cord injury, are projected to experience at least a 1% decrease in payment, representing a decrease of nearly $300 per patient. UDSMR does not believe that MMT cases should be subject to a decrease in payment that results from the analysis of data that lacks integrity, reliability, and validity.

We also would like to point out inconsistencies within the CMG relative weights and LOS values. These inconsistencies create circumstances in which IRFs receive fewer resources for higher-severity cases than for similar cases in less severe categories. For example, for CMG 1604, Pain syndrome with a motor score < 43.50, the relative weight values are the same for patients with a tier 1 (highest additional cost) comorbidity and a tier 2 (medium additional cost) comorbidity. Continuing with this CMG, the average LOS for patients with a tier 1 comorbidity is thirteen days; by contrast, patients with a tier 2 comorbidity have an average LOS of fifteen days, and patients with a tier 3 (lowest additional cost) comorbidity have an average LOS of seventeen days. How does CMS reconcile a similar relative weight and shorter LOS for patients who have higher additional costs due to the presence of more severe comorbidities? Is CMS suggesting that more severe patients are to be paid the same as, or discharged sooner than, less severe patients? We believe that issues associated with the integrity, reliability, and validity of underlying data available for analysis are the cause of these inconsistencies.

CMG 1604 is not the only CMG that illustrates inconsistencies with the CMG average LOS. In all twenty-one rehabilitation impairment categories (RICs), the CMG average LOS for patients with a tier 1 comorbidity appear to be the same as, or smaller than, the CMG average LOS of patients in lower-cost comorbidity tiers. UDSMR appreciates that CMS appears to be providing additional payment for these patients through higher relative weight values, but we do not agree with the proposal to suggest shorter stays for patients who are receiving additional services in an IRF to care for paralysis of vocal cords and larynx, tracheostomy, or the need for renal dialysis services. UDSMR reiterates our belief that issues with the integrity, reliability, and validity of underlying data available for analysis are the cause of these inconsistencies.

To summarize these comments about the proposed refinements to the FY 2021 IRF PPS CMG relative weights and LOS values, UDSMR does not support any reductions in resources to provide IRF care until CMS provide evidence that analyses that meet basic standards for integrity, reliability, and validity. UDSMR and our subscribers would appreciate the opportunity to work with CMS to identify a way of ensuring that any updates to the payment system accurately account for patient severity and provide the necessary resources for patient care.

2. UDSMR supports the codification of certain preadmission screening requirements but is concerned about the following:

a. The inclusion of preadmission screening elements that are not clearly defined or are not relevant to determining medical necessity prior to admission

b. The expansion of denials of access to IRF care due to erroneous interpretations of these requirements by Medicare contractors

As stated in section VIII.A of CMS-1729-P.

As noted previously in the executive summary, UDSMR supports regulatory relief efforts that would prevent Medicare contractors from inventing restrictive definitions or other criteria that go beyond Medicare law and regulations, ultimately denying access or payment to IRFs for patients who meet medical necessity standards and would benefit from the care provided by an IRF. Erroneous denials are harmful to patients and to the inpatient rehabilitation infrastructure. Patients and providers should have confidence that Medicare covers any care provided consistent with the criteria for medical necessity under Medicare without argument or delay. We believe that these determinations are currently suited more for IRFs than for Medicare contractors. In an effort to provide more clear and consistent expectations for IRFs, we are supportive of the proposal related to the codification of the specific preadmission screening requirements with the removal of a few required elements. Although we agree that CMS should create consistent requirements between CFR and the *MBPM*, we are concerned that codification of preadmission screening requirements may increase the number of patients denied access to IRF care due to erroneous interpretations of these requirements by Medicare contractors.

To address our concerns, UDSMR recommends that CMS:

1. Amend § 412.622(a)(4)(i)(B) to include detailed requirements for the preadmission screening documentation, with the exception of the following:
    a. The frequency and duration of treatment
    b. Anticipated postdischarge services
2. Amend § 412.622(a)(4)(i)(D) to include the need for a rehabilitation physician to review and concur with findings prior to the IRF admission.
3. Amend chapter 1, section 110.1.1, of the *MBPM* to remove the following requirements for the preadmission screening:
    a. The frequency and duration of treatment
    b. Anticipated postdischarge services
4. CMS should resolve any instances where the incorrect interpretation of the existing CFR has resulted in a denial of an IRF claim.
5. In order to avoid erroneous denials of access to IRF care, CMS should also convene meetings or technical expert panels with industry stakeholders to consider any further changes to requirements in the CFR or *MBPM* related to preadmission screening requirements.

3. UDSMR supports removing the PAPE but is concerned about any historical or future denials of IRF claims based on the requirements in § 412.622(a)(4)(ii).

As stated in section VII of CMS-1729-P.

As part of CMS's "Patients over Paperwork" initiative, UDSMR supports the proposal to remove the PAPE. We agree that similar or duplicative information may exist as part of the preadmission screening documentation or in other physician documentation produced upon a patient's admission to the IRF.

UDSMR supports this proposal but remains concerned about Medicare contractors denying access or payment to IRFs for patients who meet medical necessity standards and would benefit from the care provided by an IRF. Given that CMS is proposing to remove the PAPE under the suggestion that it contains similar or duplicative information to other physician documentation, UDSMR recommends that CMS should resolve any instances where denial of an IRF claim was based on the documentation requirements in § 412.622(a)(4)(ii). If IRF documentation for a prior claim meets all other documentation requirements, there is no reason for CMS and its contractors to deny access or withhold payment for services provided to patients when medical necessity is appropriate and clearly documented.

4. Any proposal that has the potential to diminish the role of a rehabilitation physician as the leader of IRF care would negatively affect the quality care and would unnecessarily put patients at risk.

UDSMR strongly supports the role of the rehabilitation physician role within the IRF and, more specifically, the need for the rehabilitation physician to lead and direct the care provided in the IRF. UDSMR does not support proposals that would potentially harm patients by reducing the quality of care provided by IRFs. Although we believe there are opportunities to reduce the administrative burden for rehabilitation physicians, we do not support proposals that would diminish the lead role of the rehabilitation physician in the IRF.

———

In closing, UDSMR appreciates both the opportunity to comment on this proposed rule and CMS's careful consideration of the concerns and issues raised in this letter. With over thirty years of experience providing coding, clinical, and quality improvement services to IRFs and other PAC providers, UDSMR welcomes the opportunity to work with CMS to provide ongoing feedback regarding refinements to the IRF PPS and to discuss how to reduce the administrative burden on rehabilitation physicians and other clinicians who provide IRF care. If you have any questions about these comments or require additional information, please contact us at 716-817-7800.

Sincerely,

Kathy Dann
Executive Director/CEO

Troy Hillman
Vice President of Government Affairs

Cc: Alex Azar, Secretary of Health and Human Services