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Advancing Health in America

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May 24, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1804-P
P.O. Box 8016
Baltimore, MD 21244–8016.

Re: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2025 and Updates to the IRF Quality Reporting Program; 89 Fed. Reg. 22,246 (March 29, 2024).

Dear Administrator Brooks-LaSure:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including approximately 900 inpatient rehabilitation facilities (IRF), and our clinician partners — more than 270,000 affiliated physicians, two million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2025 IRF prospective payment system (PPS) proposed rule.

The AHA is appreciative that CMS did not propose any major payment or coverage changes to the IRF PPS; this predictability will be valuable to IRFs as they continue to serve their patients and communities while facing mounting financial pressures. To that end, we continue to be concerned about shortcomings in the annual payment updates for IRFs — in particular, the market basket forecasts and updates. For example, the forecasts on which CMS relies have been consistently under-forecasting cost growth for IRFs. In addition, the actual market basket increases seem to be falling well short of inflation. **Therefore, AHA encourages CMS to consider whether adjustments are necessary in its approach to annual market basket updates.**

MARKET BASKET UPDATE

CMS proposes a 3.2% market basket increase, reduced by a 0.4% productivity adjustment. However, this update is inadequate given that, like all hospitals, IRFs have seen dramatic increases in their costs over the last four years. The inflation seen by hospitals, particularly those who care for severely impaired patients like IRFs, has created novel challenges. At the same time, Medicare payment updates for IRFs have shown a consistent pattern of failing to not only forecast, but also eventually capture this growth. **Therefore, we urge CMS to consider whether adjustments are necessary in its approach to annual market basket updates.**

IRFs Have Faced Unprecedented Inflation in Recent Years. Employee and labor costs continue to strain IRFs. For example, a recent report from the AHA finds that hospital employee compensation has grown by 45% since 2014.[1] This contrasts with total inflation, which only grew by 28.7% in that time. Labor-related inflation has been driven in large part by a severe workforce shortage, which the Department of Health and Human Services (HHS) says will persist well into the future.[2] Indeed, McKinsey finds that resignations per month among health care workers grew 50% from 2020 through 2023.[3] Because of this, hospitals are turning to pricey contract labor to sustain operations. Indeed, contract labor costs increased by 258% from 2019 through 2023.[4] These increased costs are felt acutely by IRFs as they struggle to maintain highly skilled staff in the form of rehabilitation nurses, physical, occupational and speech-language therapists, rehabilitation physicians and other critical personnel.

Drug and supply costs have also pressured hospital operations due to disruptions in the supply chain and other factors. In fact, HHS found that prices for nearly 2,000 drugs increased an average of 15.2% from 2017 through 2023, notably faster than the rate of general inflation.[5] Further, the American Society of Health System Pharmacists has found that numerous drug shortages are having a critically negative impact on hospital operations.[6] Further, IRFs and other hospitals rely on a wide-range of medical supplies

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[1] https://www.aha.org/system/files/media/file/2024/05/Americas-Hospitals-and-Health-Systems-Continue-to-Face-Escalating-Operational-Costs-and-Economic-Pressures.pdf
[2] ASPE Office of Health Policy, *Impact of the COVID-19 Pandemic on the Hospital and Outpatient Clinician Workforce*, HP-2022-13 at 1 (May 3, 2022).
[3] McKinsey & Company. (Sept. 2023). How Health Systems and Educators Can Work to Close the Talent Gap. https://www.mckinsey.com/industries/healthcare/our-insights/how-health-systems-and-educators-can-work-to-close-the-talent-gap
[4] Syntellis and AHA, *Hospital Vitals: Financial and Operational Trends.* (Last visited May 8, 2023), https://www.syntellis.com/sites/default/files/2023-03/AHA%20Q2_Feb%202023.pdf.
[5] ASPE. (Oct. 2023). Changes in the List Prices of Prescription Drugs, 2017-2023. https://aspe.hhs.gov/reports/changes-list-prices-prescription-drugs
[6] https://news.ashp.org/-/media/assets/drug-shortages/docs/ASHP-2023-Drug-Shortages-Survey-Report.pdf

ranging from protective equipment to robotic machinery. The AHA has found that supply costs for hospitals increased by $6.6 billion in 2023 alone.[7]

Administrative costs have also risen sharply for IRFs in recent years due to burdensome and unnecessary Medicare Advantage (MA) and commercial insurer practices. For example, a study by the HHS Office of Inspector General found that post-acute care prior authorization requests were being denied inappropriately and that IRFs and other hospitals were being forced to appeal erroneous denials.[8] Supporting this, McKinsey estimated that hospitals spent $10 billion annually dealing with insurer prior authorizations, and a 2023 study by Premier found that hospitals are spending just under $20 billion annually appealing denials.[9] Despite recent efforts by CMS, IRFs report there has not been any relief from these practices in 2024, and hospitals and systems will need to continue to devote considerable resources toward them for the foreseeable future.

In addition to payer requirements, another mounting administrative cost for hospitals pertains to cybersecurity. As CMS knows, the recent cyberattack on Change Healthcare is deemed the most significant attack ever on the nation's health care system. In addition to the immediate disruption to hospitals' cashflow and operations, hospitals have devoted considerable resources to protecting patient and hospital information. Therefore, while they are expected to share more and more information with each other and with payers, they are also being forced to do so with increasing levels of security, which will continue to require more financial resources.

These escalating costs for essential clinicians, personnel, drugs, supplies and other items have put a strain on the entire health care continuum. In all, Kaufman Hall found that overall expenses have risen 18% for hospitals compared to 2021.[10] This is felt keenly by IRFs, who care for high-acuity patients with unique rehabilitation needs.

Adjustments to Market Basket Forecasts and Updates May Be Needed. During this period of significant cost growth, Medicare payment updates for IRFs have shown a consistent pattern of failing to not only forecast correctly, but also eventually capture this cost growth. In fact, despite the high rates of medical inflation, IRF payments have not

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[7] https://www.aha.org/system/files/media/file/2024/05/Americas-Hospitals-and-Health-Systems-Continue-to-Face-Escalating-Operational-Costs-and-Economic-Pressures.pdf

[8] DHHS OIG. (2023). High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care. https://oig.hhs.gov/oei/reports/OEI-09-19-00350.pdf

[9] McKinsey & Company. (2021). Administrative Simplification: How to Save a Quarter-Trillion Dollars in US Healthcare. https://www.mckinsey.com/~/media/mckinsey/industries/healthcare%20systems%20and%20services/our%20insights/administrative%20simplification%20how%20to%20save%20a%20quarter%20trillion%20dollars%20in%20us%20healthcare/administrative-simplification-how-to-save-a-quarter-trillion-dollars-in-us-healthcare.pdf

[10] https://www.kaufmanhall.com/sites/default/files/2024-05/KH-NHFR_2024-04.pdf

even kept up with general inflation. Since fee-for-service Medicare patients make up more than half of all IRF discharges, and other insurers adjust payment relative to Medicare reimbursement, these missed forecasts compound the obstacles facing IRFs.[11] **CMS should therefore closely evaluate its current forecasting and market basket practices for further refinement.**

Specifically, since the COVID-19 public health emergency, IHS Global Inc. ("IGI's"), forecasted growth for the IRF market basket has shown a consistent trend of under-forecasting actual market basket growth. As demonstrated below, there has now been four consecutive years of missed forecasts to IRFs' detriment, beginning in FY 2021. Based on the market basket adjustments alone, this has resulted in underpayments to IRFs of almost four percentage points. However, combined with the productivity adjustments, the shortfall rises to 5.1 percentage points. While AHA is cognizant of the fact that forecasts will always be imperfect, in the past, they have been more balanced. However, with four straight years of under-forecasts, AHA is concerned that there is a more systemic issue with IGI's forecasting.

Table 1: IRF Market Basket Updates, FY 2021 through FY 2024

Year	FY 2021	FY 2022	FY 2023	FY 2024	Total
Market Basket Update in Final Rule	2.4%	2.6%	4.2%	3.6%	12.8%
Actual/Updated Market Basket Forecast	2.8%	5.3%	4.8%	3.8%	16.7%
Difference in Net Market Basket Update and Actual Increase	**-0.4%**	**-2.7%**	**-0.6%**	**-0.2%**	**-3.9%**

The missed forecasts have a significant and permanent impact on IRFs. At current levels, cumulative underpayment of 5.1 percentage points totals approximately $450 million in underpayments annually. Further, and as CMS knows, future updates are based on current payment levels. Therefore, absent action from CMS, these missed forecasts are permanently established in the standard payment rate for IRFs and will continue to compound. In addition, these underpayments also influence other payments, including the growing Medicare Advantage patient population, as well as commercial insurer payment rates.

In addition to inaccurate forecasts, the underlying market basket itself may have shortcomings that fail to properly capture growth. As explained above, there has

[11] https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch8_MedPAC_Report_To_Congress_SEC.pdf

been very large growth in IRF and other hospitals' costs in the last several years. This has exceeded even general inflation, which totaled 16.8% from 2021 to 2023 according to the CPI-U.[12] However, even the actual market basket growth (not forecasts) totaled only 12.9% during this time. **It is confounding to AHA how hospitals, and especially labor-intensive IRFs, could have a change in the market basket that is significantly below general inflation.**

There may be many and overlapping contributing factors to the market basket failing to capture inflationary factors. As AHA noted in prior comment letters, one such factor may be CMS' use of the Employment Cost Index (ECI) to measure changes in labor compensation in the market basket.[13] By design, the ECI cannot capture changes in costs driven by shifts between different categories of labor, which CMS itself recognizes.[14] Yet, one major change over the last several years has been increased utilization in contract labor. Therefore, the ECI may not be adequately capturing growth in the costs of employment and labor. However, this is just one example of a potential issue, and we encourage CMS to thoroughly reexamine the market basket and its recent shortcomings to identify other potential areas for refinement. AHA stands ready to work with CMS to assist with such an endeavor.

To summarize, IRFs and other hospitals have faced steep inflation across numerous cost areas in recent years, many of which have exceeded general inflation. However, CMS' forecasts have consistently failed to accurately predict this growth. Moreover, the actual growth in the market basket has fallen well short of general inflation and the actual costs facing IRFs. This has resulted in ongoing and permanent (unless rectified) underpayments to IRFs in the billions of dollars, both through direct Medicare payments and through the influence on other payers. Consequently, AHA urges CMS to evaluate and refine its approach to market basket forecasts and the underlying construction of the market basket. Doing so would ensure continued access to IRFs for severely debilitated Medicare patients who rely on these specialized hospitals.

Proposed Adjustment to High-Cost Outlier Payments

AHA continues to support CMS' policy of setting outlier payments at 3% of total payments. However, we are concerned about recent volatility in the outlier threshold, including the proposed threshold for FY 2025. Since the inception of the payment system, CMS has adjusted the outlier threshold annually to reach its 3% target.

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[12] https://www.bls.gov/regions/mid-atlantic/data/consumerpriceindexannualandsemiannual_table.htm
[13] 86 Fed. Reg. 25401 (May 10, 2021). "We use the ECI because it reflects the price increase associated with total compensation (salaries plus fringes) rather than just the increase in salaries. In addition, the ECI includes managers as well as other hospital workers. This methodology to compute the monthly update factors uses actual quarterly ECI data and assures that the update factors match the actual quarterly and annual percent changes."
[14] 86 Fed. Reg. 25421 (May 10, 2021). CMS stated that ECI measures "the change in wage rates and employee benefits per hour… [and are superior] because they are not affected by shifts in occupation or industry mix."

However, there has been substantial volatility in the outlier threshold over the last several years. Specifically, from FY 2021 through FY 2025, the smallest year-over-year change was 15% (FY 2021), and the largest was 32% (FY 2023). In comparison, the largest year-over-year change in the previous six years was less than 9%. Large annual changes in recent years are consequential adjustments that create a lack of predictability for providers.

In order to avoid such dramatic swings in the outlier threshold, AHA recommends that CMS explore changes to its methodology. For example, CMS could use a three-year rolling average methodology in setting its outlier threshold. Along with additional adjustments, such an approach may lead to smaller annual adjustments that allow for greater predictability for providers. To that end, AHA would be happy to work with CMS to explore methodologies that would fairly and consistently reimburse IRFs for outlier cases.

Proposed Wage Index Policies

CMS proposes to apply to the wage index the most recent labor market areas issued by the Office of Management and Budget in the July 2023 Bulletin No. 23-01. As CMS states in the proposed rule, this would result in wage index decreases for 16% of IRFs. CMS does not propose a specific policy to address this, and instead intends to rely on its existing policy of applying a 5% year-to-year cap on any reductions in an individual IRF's wage index.

AHA continues to support the existing 5% cap policy. However, AHA also notes than the budget neutrality factor being applied due to wage index changes is -0.72%. This notably reduces the already small market basket update for IRFs. Further, combined with the budget neutrality adjustment for the relative weights, the cut reaches 1.1%. This substantial cut, combined with a proposed market basket update of only 3.2% and smaller than appropriate increases in past years would further contribute to the financial strain on many IRFs. **For this reason, AHA urges CMS to implement wage index adjustments, including the 5% cap on decreases and new wage index figures, in a non-budget-neutral manner.**

CMS also proposes a transition policy for IRFs in geographic areas that are being reclassified from rural to urban. Specifically, CMS would phase in the elimination of the IRF rural add-on payment over three years. **AHA supports this proposal, and appreciates CMS' consideration of this issue.**

IRF QUALITY REPORTING PROGRAM

Proposed Adoption of Four New Standardized Patient Assessment Data Elements. Beginning with the FY 2028 IRF Quality Reporting Program (QRP), CMS proposes to require IRFs to report four new standardized patient assessment data elements (SPADEs) under the social determinants of health (SDOH) domain. In its

proposal, CMS states that the new SPADEs address health-related social needs (HRSN) not already captured by the existing SDOH elements and include food security, living situation and utility difficulties. The AHA shares CMS' goal of advancing health equity and recognizes the value that screening for HRSNs can play in identifying barriers to achieving the best outcomes for all patients. However, we are concerned that the proposed new SPADEs are not well-aligned with similar HRSN reporting requirements across the care continuum. We also believe the proposed SPADEs need further testing and refinement to ensure they work as intended in the IRF setting.

In its proposal, CMS states that it believes these new requirements would "further standardized the screening of SDOH across quality programs," citing the recently adopted quality measures in the Inpatient PPS and Inpatient Psychiatric Quality Reporting Programs (IPFQR) that assess whether facilities have screened patients for housing instability, food insecurity, utility difficulties, transportation needs and interpersonal safety. Indeed, CMS states that it believes "using common standards and definitions for new items is important to promote interoperable exchange of longitudinal information between IRFs and other providers to facilitate coordinated care, continuity in care planning, and the discharge planning process."

While the proposed SPADEs do address some (but not all, like interpersonal safety) of the same HRSNs addressed by the screening measures, the proposed requirements are hardly standardized with those in the IQR and IPFQR. The proposed SPADEs are adapted from the Accountable Health Communities (AHC) HRSN Screening Tool developed for the AHC model; CMS is dictating precisely when and how (that is, asking questions with specific wording during the initial admission assessment) IRFs are to assess patients for these HRSNs. However, inpatient acute care hospitals and psychiatric facilities may use any "standardized HRSN screening" and are only asked to document that a patient was screened, not when or how. In other words, these proposals are unlikely to produce the interoperable data CMS believes they will.

Further, the AHA is concerned with the elements themselves. In implementing the AHC HRSN screening tool in the AHC model, CMS directs users to follow particular protocols to determine a patient's eligibility for completing the tool, select domains for use in their communities, and score patient responses to determine next steps. In this proposed rule, CMS merely picks a few questions from the tool and plants them in the MDS without much guidance. The AHA is concerned that it will be challenging to glean accurate responses to the AHC items from the IRF patient population in particular, considering that IRF patients and residents are more severely ill than the average Medicare beneficiary for which the screening tool was developed. For example, the food security questions ask patients to rate the frequency of food shortages using a three-point scale, whereas other questions on the MDS, such as the resident mood (PHQ-9 tool), behavioral symptoms and daily preferences items, use a four-point scale to determine frequency. These discrepancies might make it difficult for staff to administer the SPADEs and given the inconsistency with the scales used in other MDS items, it may lead to confusion for staff and patients alike. In addition, there is no skip logic

included for these questions as there are for other MDS items. If a patient reports that they do not have a stable place to live in response to the living situation item, it seems inappropriate to subsequently ask them about their utility difficulties.

Overall, the AHA questions the utility of including these items in the MDS. While we agree that IRFs — and other healthcare facilities and providers — should consider their patients' and residents' HRSN in their care, CMS' evaluation of the use of the AHC HRSN screening tool in the model showed that it "did not appear to increase beneficiaries' connection to community services or HRSN resolution."[15] At a minimum, we believe the proposed new SPADEs need further testing and clearer implementation guidance before CMS adopts them for the IRF QRP.

Lastly, we also request that CMS articulate its vision of how HRSN information collected in the SPADEs will be used in its quality and payment programs. While CMS appears to be focused for now on HRSN screening, there is evidence that CMS is considering even farther-reaching approaches to holding IRFs and other health care providers accountable for addressing HRSNs. For example, CMS is also considering measures that assess connections to community providers and the resolution of HRSNs following care.[16] We believe that those measures would inappropriately hold IRFs and other health care providers solely accountable for social drivers of health that require resources and engagement across an entire community to address. We are concerned that CMS may implement such measures in the IRF QRP in the future, using its SPADE collection process as the mechanism to collect measure data. Holding IRFs solely accountable for community-based outcomes is far outside the scope of these facilities.

Proposed Removal of Admission Class from IRF Patient Assessment Instrument (PAI). CMS proposes to remove Item 14, Admission Class, from the IRF-PAI beginning Oct. 1, 2026. The item, completed only at admission, has been included in the tool since its inception; however, it is not used in the calculation of quality measures or for other purposes (such as payment, survey or care planning) and thus CMS believes it is unnecessary. **The AHA supports this removal and recommends that CMS perform additional analysis of the IRF-PAI and other post-acute care patient assessment tools to identify additional elements that may be removed.**

Request for Information: Future IRF Star Rating System. CMS seeks public comment on the development of a five-star quality rating methodology for IRFs. Specifically, CMS requests feedback on any specific criteria CMS should use to select measures for an IRF star rating system, and how the agency should present IRF star rating information in a way useful to consumers.

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[15] https://www.cms.gov/priorities/innovation/data-and-reports/2023/ahc-second-eval-rpt-fg
[16] http://mmshub.cms.gov/news-events/2023-measures-under-consideration-list-now-available

As longstanding supporters of quality transparency, the AHA shares CMS' goal of giving patients meaningful, accurate and understandable information about the quality of care in IRFs and other health care facilities. Our response to this RFI is heavily influenced by our experience with the Hospital Star Ratings Program, which has undergone significant changes over the past few years due to inadequacies in its initial design. This program, as it would be the future IRF Star Rating System, is just one of a number of sources of data and rankings on facility performance. As with any report cards or ratings, each must be interpreted in context, and it is unlikely that any one particular rating will provide a robust and reliable portrait of quality in a facility.

The premise of a star rating, or any other composite quality ranking or rating, is that available measures lend themselves to a fully representative quality score relevant to all patients. Yet, the measures available in the IRF QRP were never selected to create this holistic picture. The measures reflect highly specific aspects of care delivered in IRFs, and have been added to the program to achieve disparate goals, ranging from agency priorities to statutory requirements (e.g., the Improving Medicare Post-Acute Transformation Act directive for standardized and interoperable measures across post-acute care settings). As a result, an overall rating may reflect performance on measures that are irrelevant to the reasons a patient is seeking care.

Furthermore, we are concerned that issues regarding statistical validity with the Hospital Star Ratings Program, as well as the ability for consumers to use it to inform decision-making, would be exacerbated due to the nature of the IRF QRP measures. CMS quality measure data that goes into the Star Ratings is often several years old, which lessens its utility in evaluating the quality of care in the present. The limited scope and breadth of measures available in the IRF QRP — and the often low volumes that IRFs report — would make data reliability and developing a truly representative overall star rating even more challenging for IRFs. The IRF QRP will consist of just 16 measures beginning FY 2025, and IRFs provide about 400,000 stays per year (according to the Medicare Payment Advisory Commission), whereas the Hospital Star Ratings Program uses data from over 40 measures across more than 7.5 million inpatient stays and 78.1 million outpatient visits. In other words, if we and others have concerns about how well the Hospital Star Ratings Program represents the totality of care delivered in hospitals, it is hard to conceptualize the utility of an IRF star ratings program based on a small fraction of measures and patient episodes.

If CMS does develop an IRF star rating methodology, we do have a few recommendations. First, we recommend CMS provide IRFs with feedback reports on claims-based measures on a quarterly basis, as it does for hospitals. Currently, IRFs are not able to review this information at the patient level, and thus are limited in their ability to implement tailored improvements to the care they provide. Second, we would recommend CMS not include a rating of patient-reported experience of care in an IRF Star Ratings program because implementing such a survey in the IRF setting presents both conceptual and statistical reliability challenges. Patient experience during an IRF stay is difficult to glean for this population, many of whom have undergone traumatic

brain injuries and are relearning basic function. These patients may not be able to respond to patient experience questions in the same way as in general acute care. As a result, the reliability of a patient experience survey based on such a small number of responses would be extremely low. This was demonstrated when CMS contracted with RTI International to develop an experience of care survey for IRF patients in 2015, which has not been further developed or promoted by the agency.

Request for Information: Measure Concepts Under Consideration for Future Years. CMS seeks public comment on the importance, relevance, appropriateness and applicability of certain quality measure concepts for future use in the IRF QRP.

Composite measure of overall immunization status. The AHA does not support this measure concept. The AHA strongly supports the vaccination of health care providers and communities against vaccine-preventable communicable diseases. However, the use of measures of immunization status — including the recently adopted COVID-19 Vaccination Among Patients or Residents measure — is inappropriate in the IRF setting. Vaccination status among patients or residents is subject to many patient-level factors outside of the control of providers. For post-acute facilities and providers, it may be infeasible or inappropriate to offer vaccination for patients due to length of stay, ability to manage side effects and medical contraindications, or other logistical challenges to gathering information from a patient who may have received care from multiple proximal providers. Even without these challenges, however, patients or residents may choose to forgo vaccination despite a provider's best efforts. It is possible that a post-acute care facility could have a robust effort to encourage vaccination among their patients or residents but still have a relatively low rate of vaccination. As the health equity subcommittee of the National Quality Forum Measure Applications Partnership noted in its review of this measure, cultural norms often play a large role in vaccine confidence. While post-acute providers will always seek to counsel vaccination in a culturally sensitive way, they also want to honor the choice of their patients once they have offered their clinical advice.

Clinical Screening and Follow-up for Depression. In its request for information, CMS notes that it is considering a measure concept related to depression, which "may be similar" to a measure in CMS' Universal Foundation. We assume the agency is referencing the measure used for the Hospital Inpatient QRP, Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan, which assesses the percentage of patients aged 12 years and older who are screened for clinical depression using an age-appropriate standardized depression screening too and, if positive, a follow-up plan is documented. Considering that the IRF-PAI already contains the Patient Health Questionnaire (PHQ)-9, which serves to screen, diagnose, monitor and measure the severity of depression, an additional quality measure regarding depression screening would be redundant.

Pain management. CMS does not provide any details regarding the measure concept of pain management, so it is difficult to provide feedback on whether this would be an

appropriate measure for the IRF QRP. However, if the measure is like other pain management measures in CMS quality programs (that is, a patient-reported measure of the experience of pain), we would not support its inclusion in the IRF QRP. Patients in an IRF are undergoing physical rehabilitation for extremely serious conditions or injuries; the experience of pain and discomfort is an unavoidable reality of this process. That is why IRF providers are already sensitively attuned to the ongoing process of assessing and managing the pain of the patients they treat. Unlike pain management in general acute care, where patients may receive continuous infusions of analgesics, IRFs aim to emulate the environment in which patients will manage pain at home (often with a preference for non-opiate and multimodal therapies). Further, patients may be unable to express pain in the same ways as patients in other settings. CMS is considering this measure concept for other post-acute care settings as well, which would invariably lead to inappropriate comparisons in pain management across settings. If CMS is looking to address whether pain is managed *adequately*, it should take and review feedback from multiple stakeholders to identify what aspects of pain management are of most interest and relevance to the IRF population, such as staff responsiveness to pain, and determine if there is sufficient available information to develop a meaningful quality measure.

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We appreciate your consideration of these issues. Please contact me if you have questions or feel free to have a member of your team contact Jonathan Gold, AHA's senior associate director for policy, at (202) 626-2368 or jgold@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development