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Advancing Health in America

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June 2, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1781–P
P.O. Box 8016
Baltimore, MD 21244–8016.

Re: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2024 and Updates to the IRF Quality Reporting Program; 88 Fed. Reg. 20,950 (April 7, 2023).

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 address the fiscal year (FY) 2024 IRF prospective payment system (PPS) proposed rule.

As CMS is aware, IRFs played a critical role during the COVID-19 public health emergency (PHE) by providing additional hospital capacity to communities struggling to meet demand, as well as by rehabilitating COVID-19 patients who are encountering serious deficits. In meeting this challenge, IRFs have utilized their unique capabilities as hospital-level providers who also specialize in caring for patients with challenging post-acute care needs, such as stroke, spinal cord and brain injury, amputation, cancer, and other complex conditions and comorbidities.

That said, we wish to impress upon CMS that the COVID-19 PHE's end does not mean that hospitals' operations are returning to "pre-COVID-19" status. IRFs, along with their counterparts throughout the entire continuum of care, continue to face a myriad of challenges in meeting the needs of their patients. For this reason, AHA appreciates that CMS has not proposed any major changes to the payment or coverage dynamics of the

IRF PPS. This predictability will allow IRFs to continue to adapt to the "new normal," and therefore maximize their ability to provide the best care possible to their communities. Still, AHA does have concerns that CMS' historical approach to annual payment updates may not be well-suited to capture the extraordinary challenges facing hospitals due to the effects of inflation and labor shortages. **As such, we urge the agency to consider deviating from its usual update to properly calibrate the IRF PPS with present-day costs and operations.**

In addition, the AHA has concerns about certain proposals related to the IRF Quality Reporting Program (IRF QRP). While we appreciate CMS' goals to continue monitoring incidence of COVID-19 in post-acute care settings, we are unsure whether the two measures proposed in this rule will be operational for IRFs as currently specified. In addition, the proposed Discharge Function Score measure lacks clarity, especially as a purported "cross-setting" measure. We urge CMS to consider our recommendations on updates to the IRF QRP to ensure that it is focused on high-priority areas and measures that are based upon reliable clinical evidence.

Annual Payment Updates for IRFs Have Under-forecasted Cost Growth

Hospitals, including IRFs, have been facing unprecedented inflation. The most recent analysis from Kaufman Hall in its *National Hospital Flash Report* indicates that from 2020 to present, overall expenses have risen by 18% for hospitals.[1] This has been driven in large part by labor costs, including contract labor costs, which have risen 258% since 2019.[2] These increases have been felt sharply by IRFs, which must not only meet hospital-level requirements, but also are mandated to have specialized personnel such as rehabilitation nurses and therapists. These requirements are why CMS estimates that labor-related costs account for nearly three quarters of IRFs expenses.

Indeed, inflationary and labor shortage pressures on IRFs and other hospitals will continue, with the Department of Health and Human Services (HHS) finding that health care workforce shortages will persist well into the future.[3] As these pressures continue to mount, IRFs will be increasingly challenged to provide the highly skilled personnel needed to care for their complex patient mix.

Labor is not the only expense experiencing large growth in recent years. Hospital supply costs per patient have risen 18.5% between 2019 and 2022.[4] Drugs, and especially

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[1] Kaufman Hall | *National Hospital Flash Report* (April 2023) https://www.kaufmanhall.com/sites/default/files/2023-05/KH-NHFR_2023-04.pdf.
[2] Syntellis and AHA, *Hospital Vitals: Financial and Operational Trends* at 2 (last visited May 8, 2023), https://www.syntellis.com/sites/default/files/2023-03/AHA%20Q2_Feb%202023.pdf.
[3] 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).
[4] American Hospital Association, *Cost of Caring* at 4 (Apr. 2023), https://www.aha.org/costsofcaring.

specialized drugs, make up a large portion of this increase, with an HHS study finding that many commonly used drugs have had their price increase by more than 30% in recent years.[5] Again, these increases are felt acutely by IRFs, which are caring for patients with some of the most complex post-acute care needs. And, unfortunately, these financial pressures on IRFs have upstream effects on their acute-care partners, as shown in a December 2022 AHA study that revealed a 14% increase since 2019 in the average length of stay of hospital patients awaiting discharge to an IRF.[6] This is due to staffing shortages in IRFs as they navigate the aforementioned challenges.

While these pressures have continued to mount, CMS' annual market basket updates have been inadequate to meet these rising costs. For FY 2024, the agency proposes a market basket update of only 3.2%. In FY 2021, 2022 and 2023, it provided only 2.4%, 2.6% and 4.2% market basket increases, respectively.

CMS' updated figures have demonstrated the deficiency in these figures, with more recent estimates showing the market basket for these years to be 2.7%, 5.3%, and 4.6%, respectively.[7] The missed projections are tantamount to permanent underpayments to IRFs, since future payment adjustments continue to be built off of these market basket updates. **We are deeply concerned about increased costs to hospitals that are not reflected in the recent market basket adjustments and ask CMS to discuss in the final rule how the agency will account for these increased costs.**

AHA also continues to be concerned about CMS's proposed application of a 0.2% productivity cut to the market basket update for FY 2024. Particularly in the IRF space, patients are provided time-intensive, hands-on skilled therapies and care. These types of services simply do not lend themselves to the proxy used by CMS, which is intended to capture new technologies, economies of scale, business acumen, managerial efficiencies and other changes in production. AHA therefore requests that CMS more closely examine this adjustment and how it may be negatively impacting IRFs and provide such analysis to the relevant stakeholders.

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[5] Arielle Bosworth, et al., Assistant Secretary for Planning and Evaluation, *Price Increases for Prescription Drugs*, 2016-2022, HP-2022-27 at 1 (Sep. 30, 2022), https://aspe.hhs.gov/sites/default/files/documents/d850985c20de42de984942c2d8e24341/price-tracking-brief.pdf.

[6] AHA, Issue Brief: *Patients and Providers Faced with Increasing Delays in Timely Discharges*; December 2022 (https://www.aha.org/system/files/media/file/2022/12/Issue-Brief-Patients-and-Providers-Faced-with-Increasing-Delays-in-Timely-Discharges.pdf).

[7] These figures reflect the market basket update prior to reductions due to the productivity adjustment.

Rebasing of the IRF Market Basket

AHA supports and appreciates CMS' proposal to update the market basket using the most recently available data. Rebasing the market basket no less than every four years ensures that IRF payments are updated to accurately reflect the mix of goods and services provided by IRFs. However, AHA is concerned that, while the labor market and input costs are now very different than they were pre-pandemic, as discussed above, the proposed new market basket does not differ substantially from the current market basket. More specifically, the proposed FY 2021-based market basket produces almost identical updates as the current, FY 2016-based market basket.

Therefore, while AHA supports moving forward with an updated market basket using 2021 as a base year, we urge CMS to continuously evaluate whether an additional rebasing when FY 2022 data become available would be appropriate. Although this would deviate from CMS usual cadence for rebasing the market basket, it is clear from the data presented earlier that the cost structure of IRFs and other hospitals underwent a dramatic shift in 2022 and into 2023. Therefore, rather than have IRFs operate under an increasingly inaccurate market basket, the extraordinary and unusual circumstances of the past several years warrant exploration of a more frequent update, perhaps again as early as next year.

In addition to a subsequent update to the market basket, **AHA encourages CMS to explore other changes to the composition of the market basket to better capture evolving dynamics in the labor force.** More specifically, CMS uses the Employment Cost Index (ECI) to measure changes in labor compensation in the market basket. Unfortunately, the ECI may no longer accurately capture the changing composition and cost structure of the hospital labor market given the large increases in short-term contract labor use and its growing costs. By design, the ECI cannot capture changes in costs driven by shifts between different categories of labor, such as shifts to use of contract labor.

Indeed, CMS itself recognizes that the ECI does not capture these shifts in occupation.[8] This is because the ECI holds the composition of labor fixed between salaried and short-term contract based on a point in time using weights.[9] When an alternative labor cost index, the Employer Costs for Employee Compensation (ECEC), is examined, it shows just how much bias is created by ECI's lag in updating the labor composition. The ECEC uses current employment weights, as opposed to fixed employment weights

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[8] Proposed Rule. Pg. 20,967. 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."
[9] U.S. Bureau of Labor Statistics. National Compensation Measures. https://www.bls.gov/opub/hom/ncs/calculation.htm#computing-the-employment-cost-index-eci.

used in the ECI, to reflect the changing composition of today's labor force.[10] Since 2014, ECEC-based costs rose 16 percentage points more than ECI-based costs (43% vs. 27%) with more than 5 percentage points of the gap attributable to 2022 Q4 alone. This all suggests that, because it does not account for the change in labor composition, the ECI fails to accurately capture the changing dynamic of the current health care workforce.

Proposed Wage Index Policies

AHA is appreciative of recent changes to wage index policies that have helped provide stability to IRF payments, including the application of a 5% cap on any reduction in an IRF's wage index from one year to the next. As discussed last year, we also encourage CMS to implement these caps in a non-budget neutral manner. AHA believes this is the only way to mitigate volatility caused by wage index shifts. **Therefore, we respectfully encourage the agency to modify its methodology to ensure these adjustments are made in a non-budget-neutral manner.**

Proposed Adjustment to High-Cost Outlier Payments

AHA continues to support CMS' policy of setting outlier payments at 3% of total payments. Consistent with prior comments, AHA encourages CMS to explore modifications to its methodology in setting the outlier threshold to improve the accuracy of the payments. For example, this year CMS projects that outlier payments will be approximately 2.3% of total payments for FY 2023. For FY 2022, CMS estimated that outliers would account for approximately 3.8% of total payments. This resulted in CMS proposing and finalizing notable adjustments (both upwards and downwards) to the outlier thresholds each year.

Rather than having large swings in the outlier threshold from year-to-year, CMS may want to consider exploring alternative methodologies that could yield more stability. For example, AHA would be interested in any analysis CMS could provide of what the effects of using a rolling average of outlier payments over several years would yield. To that end, AHA would be happy to work with CMS to explore methodologies that would fairly and consistently reimburse IRFs for outlier patients.

Modification of Regulation on Excluded Units Paid under the IRF PPS

CMS proposes to revise existing regulations to allow hospitals to open a new IPPS-excluded rehabilitation unit at any time within the cost reporting period (as long as the hospital meets certain notification requirements), rather than requiring hospitals to wait

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[10] U.S. Bureau of Labor Statistics. National Compensation Measures. https://www.bls.gov/opub/hom/ncs/calculation.htm#employer-costs-for-employee-compensation-ecec.

until the start of a new cost reporting period. **The AHA supports this proposal and believes it will allow for additional flexibility to open needed rehabilitation beds.**

IRF Quality Reporting Program (IRF QRP)

The Affordable Care Act mandated that reporting of quality measures for IRFs begin no later than FY 2014. The Improving Medicare Post-Acute Care Transformation (IMPACT) Act requires that, starting FY 2019, providers must report standardized patient assessment data elements and quality measures as part of the QRP. Failure to comply with IRF QRP requirements will result in a 2.0 percentage-point reduction to the IRF's annual market-basket update. For FY 2024, CMS requires the reporting of 18 quality measures by IRFs.

CMS proposes to adopt two new measures as well as a modified version of an existing measure while removing three measures. CMS also proposes to begin public reporting for four measures.

Modified COVID-19 Vaccination Coverage among Health Care Personnel (HCP) Measure. Beginning with the FY 2025 IRF QRP, CMS would adopt a modified version of the COVID-19 Vaccination Coverage among HCP currently used in the IRF QRP. While the current measure assesses the number of HCP "who have received a complete vaccination course against COVID-19," CMS would replace this term with "who are up to date" with their vaccination as recommended by the Centers for Disease Control and Prevention at the time of the reporting period.

The AHA supports the vaccination of health care personnel and communities against COVID-19. We also agree with CMS' rationale underlying the proposal to adopt this modified measure that measures in use in its quality reporting programs should reflect the current science.

However, the evidence around the optimal cadence for booster doses of COVID-19 vaccines, as well as the seasonality of the virus itself, is evolving rapidly. Over the past several months, CDC and FDA have indicated they are seriously considering adoption of a once-yearly regimen for COVID-19 vaccinations, comparable to the well-established approach used for influenza vaccination. In addition, the AHA is concerned that the administrative complexity of collecting CDC's current definition of "up-to-date" status may outweigh its benefit. For these reasons, **we recommend CMS continue to collect up-to-date vaccination status on a voluntary basis and implement required reporting of up-to-date status after FDA and CDC have completed their recommendations on an updated vaccination schedule.**

We encourage CMS to learn from the experience of implementing the previous version of this measure and anticipate logistical challenges of data collection and reporting when considering this new version for inclusion in its various quality reporting programs.

As CMS notes in the proposed rule, health care facilities are collecting and reporting data on "up-to-date" COVID-19 vaccination status on a voluntary basis.

However, facilities have reported that this collection process is quite administratively burdensome under CDC's current "up-to-date" definition. This is because the collection protocol uses a reference time-period for determining up-to-date status that changes every quarter. Practically speaking, this means that HCPs who counted as "up-to-date" in a given quarter may no longer be up-to-date in the next quarter.

Furthermore, CDC's vaccination guidance suggests that some individuals with certain risk factors should consider receiving an additional booster dose within four months of receiving their first bivalent dose. Yet, hospitals usually do not have routine access to data to know which of their HCPs may need an additional booster. In fact, collecting accurate data on HCPs underlying risk factors likely would require hospitals to both obtain permission to have such data, and a mechanism to keep the data fully secure. The AHA is concerned that the resource intensiveness of collecting data under CDC's current definitions may outweigh its value.

The AHA believes that the adoption of a once-yearly vaccination regime would alleviate much of the administrative complexity of collecting up-to-date vaccination status. While we do not yet know the precise timing, recent discussions from the FDA and CDC's vaccination advisory committees, as well as public statements from the agencies and White House, suggests that such a schedule could be adopted as soon as Fall 2023. By delaying the required reporting of "up-to-date" vaccination status, CMS could align its reporting requirements around this more efficient approach. In practical terms, we believe the soonest facilities could report up-to-date status based on a once-yearly vaccination regimen is the second quarter of 2024, but we recognize that more time may be needed.

As CMS continues to implement the HCP COVID-19 vaccination measure across its programs, we also urge it to consider other important implementation issues. For example, we continue to urge that CMS get the measure endorsed by a consensus-based entity (CBE). A CBE endorsement process will enable a full evaluation of a range of issues affecting measure reliability, accuracy and feasibility. Given the urgency of addressing the COVID-19 pandemic, the current version of the measure never went through a CBE endorsement process and is relatively new to the CMS quality reporting programs. As a result, we have not yet had a holistic evaluation regarding whether the measure is working as intended (e.g., reflecting vaccination rates accurately, achieving CMS's stated goals of encouraging vaccination).

Finally, CMS needs to consider how to implement this measure in a way that is consistent and logical with other sources of information regarding vaccination among health care personnel. The time lag between data collection and the publicly reported rate will result in a mismatch between the true rate of health care personnel who are up-

to-date with their vaccinations and the rate that is displayed on Care Compare; CMS needs to clearly communicate what publicly reported data reflects.

Similarly, the measure under consideration is inconsistent with the CMS Condition of Participation requiring vaccination among health care personnel in terms of its exceptions for sincerely held religious beliefs. We understand that CMS intends to sunset the CoP shortly. However, to maintain continuity with the CoP and align with Office of Civil Rights guidance, we recommend that CMS develop an additional exclusion for this measure to account for sincerely held religious beliefs.

Discharge Function Score Measure. Beginning with the FY 2025 IRF QRP, CMS proposes to adopt this assessment-based outcome measure that estimates the percentage of IRF patients who meet or exceed an expected discharge score during the reporting period. The agency issues the same proposals for the Skilled Nursing Facility (SNF) and Long-term Care Hospital (LTCH) QRPs as well in their respective rules, terming the measure a “cross-setting” measure.

While this cross-setting discharge function score measure appears to fulfill requirements of the IMPACT Act better than the current, setting-specific self-care and mobility discharge score measures used in the SNF, LTCH and IRF quality reporting programs (which CMS proposes to remove in this same rule), we continue to doubt the cross-setting applicability of this measure considering the different patient populations served by the various post-acute care settings. **We urge CMS to wait until this measure has undergone endorsement review by a CBE and demonstrates that it gleans useful information for patients and providers before adopting it for use in the IRF QRP.**

The measure uses information from Section GG items that appear on all four of the patient assessment instruments across the various post-acute care settings. While patients are assessed using the same or similar items, the capabilities and goals of patients differ widely by setting. The measure developer notes that the measure is risk adjusted and calculated individually by setting; then, the calculation for measure performance “rolls up” information from several items to calculate an overarching score. Risk adjustment takes many variables into account, and denominators vary by setting (for example, the denominator for the measure when calculated in the IRF and LTCH QRPs includes all eligible stays, regardless of payer, while for the SNF QRP the denominator consists of patients/residents under Medicare fee-for-service only).

While we appreciate the work the developer has done to attempt to account for the myriad of differences in patient populations across the various settings – including demographics, case mix, severity of illness, length of stay and comorbidities – at some point these variables alter the underlying calculation of the cross-setting measure and result in four different measures. In other words, discharge function is calculated in a way that is not truly standardized, as the IMPACT Act intended.

It is at this point we ask whether it is necessary to force a measure that is “cross-setting” in name only into CMS quality programs; perhaps if testing of the measure demonstrates that this measure produces statistically meaningful information that can be used to inform improvements in care processes, it is. But until we have that information from the endorsement review process by a CBE, the AHA has doubts about this measure’s utility.

In addition, the measure uses a statistical imputation approach to account for “missing” assessment elements when codes on the assessments note that the “activity was not attempted” (ANA). In the event of an assessor coding an item as “not attempted,” the imputation approach inserts variables based on the values of other activities that were completed; in other words, the calculation makes assumptions about what the patient would have scored on that item if it had been attempted based on their performance on other, similar activities that were scored. CMS argues that this approach “increases precision and accuracy and reduces the bias in estimates of missing item values.”

While we understand that scores would be influenced more heavily by individual assessment items if there are fewer included in the calculation, CMS errs in labeling items coded ANA as “missing.” When an activity is not attempted, it is likely because it would be clinical inappropriate or dangerous for a patient to attempt it; for example, it would be ill-advised (and painful) for a patient with a healing wound on one side to roll left to right. In such a case, making assumptions about the patient’s function based on other activities would, in fact, not improve the precision of the score.

We also question whether it is precise and accurate to generically apply an “expected” discharge score based on statistical regressions to unique patient populations, and whether the comparison of observed to “expected” function could wholly be attributed to the facility’s quality of care. The calculation approach for the “expected” discharge score is opaque, which makes it difficult for providers to know what they’re working towards. In reality, providers strive to help each individual achieve their own specific goals related to function, independence and overall health. These goals are not based on statistical regressions.

The AHA understands the purpose of this measure and agrees that the discharge function measures currently in use in the IRF QRP (Change in Self-Care Score for Medical Rehabilitation Patients, Change in Mobility Score for Medical Rehabilitation Patients, and Application of Percent of Long-term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function) do not meaningfully evaluate comparative performance across post-acute care settings. **However, without further testing and review of the proposed Discharge Score measure by a CBE, we are not certain that this measure brings value to the QRP and thus cannot support it for adoption.**

Patients/Residents who are Up to Date with COVID-19 Vaccination Measure. Beginning with the FY 2026 IRF QRP, CMS proposes to adopt this assessment-based process measure that reports the percentage of stays in which patients in an IRF are up-to-date with their COVID-19 vaccinations per the CDC's latest guidance. The agency reasons that the measure would, when publicly reported, provide useful information for patients and their caregivers when choosing a facility, and "would be an indirect measure of IRF action" since the IRF would, according to CMS, have the opportunity to administer the vaccine to patients during their stay, coordinate a follow-up visit for the patient to obtain the vaccine at their physician's office or local pharmacy, or educate the patient about the importance of staying up to date with vaccinations. CMS also proposes to adopt this measure for the SNF and LTCH QRPs in their respective rules.

The AHA supports the vaccination of health care providers and communities for COVID-19 and acknowledges the importance of up-to-date vaccinations. However, this measure has not been tested for validity and reliability and thus we cannot support it without knowing that it is, at minimum, feasible to report and likely to produce statistically meaningful information.

Furthermore, we are not clear that the conceptual construction of the measure is the best way to encourage vaccination, especially in post-acute settings where care is delivered in episodic rather than longitudinal fashion. When reviewed by the National Quality Forum (NQF)'s Measure Applications Partnership (MAP) during the 2022-2023 review cycle, the Post-acute/Long-term Care Workgroup voted "Do Not Support" for this measure, meaning that a multi-stakeholder panel of experts representing providers, patients and payers do not support this measure for inclusion in the IRF QRP.

Vaccination status among patients/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/residents may choose to forgo vaccination despite a provider's best efforts.

It is possible that post-acute care facilities could have a robust effort to encourage vaccination among their patients/residents, but still have relatively low rates of vaccination. As the Health Equity subcommittee of the NQF MAP 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.

We reiterate that we understand the importance of vaccination in protecting patients from the most serious outcomes of COVID-19. However, it is unclear whether the use of this measure will produce those results or if it is feasible for post-acute care facilities to

collect and report the information necessary. The measure consists of a single yes or no item on the IRF-PAI without any requirements for documentation or validation of vaccination status; while we acknowledge that additional documentation would be unduly burdensome for providers to collect, without it the measure is a mere checkmark in a box with no evidence that it leads to improved quality of care (since, as stated above, the measure has not been fully tested).

For these reasons, **we do not support the adoption of this measure in the IRF QRP.** CMS also may want to consider whether alternative measure constructions focused on the actions providers take in encouraging vaccination might be better suited to achieving the goal of higher vaccination rates.

Disclosures Of Ownership And Additional Disclosable Parties Information

CMS currently requires disclosure of certain ownership, managerial and other information regarding Medicare skilled-nursing facilities and Medicaid nursing facilities. In a Federal Register notice published Feb. 15, 2023, CMS proposed definitions of "private equity company" (PEC) and "real estate investment trust" (REIT) for purposes of ownership disclosure in the CMS 855A Medicare enrollment form. Previously, CMS had issued a Paperwork Reduction Act submission to require all owning and managing entities listed on any provider's or supplier's Form CMS 855A submission to disclose whether they are a PEC or REIT. In the FY 2024 IPPS and LTCH proposed rule, CMS is proposing that all providers and supplies that enroll in Medicare using CMS 855A enrollment disclose PEC and REIT information; it also seeks feedback on whether CMS should consider collecting any other types of private ownership besides PECs and REITs as part of the enrollment process.

The agency states that it is concerned "about the quality of care furnished by PEC-owned and REIT-owned SNFs and the consequent need for transparency regarding such owners," and that "these concerns about PEC and REIT are not limited to SNFs but extend to other provider and supplier types."[11] Therefore, the agency believes that it is important to "collect this information from all providers and suppliers that complete the Form CMS-855A so as to: (1) determine whether a similar connection exists with respect to non-SNF providers and suppliers; and (2) help us take measures to improve beneficiary quality of care to the extent such connections exist."

The AHA is concerned by this unnecessary and burdensome requirement. With little actual basis in fact, CMS appears to impugn the integrity of private equity owners based on loose analogies and suppositions. Private equity ownerships, including for-profit hospital arrangements, do not inherently indicate lower quality care or lesser care than any other ownership type. The agency should *not* finalize this requirement. At the very least, it should explain (1) how it will

[11] 88 Fed. Reg. 27190 (May 1, 2023).

determine if a connection exists between quality and ownership type for non-SNF providers and suppliers; and (2) how quality is impacted if the requested date shows that such a connection exists.

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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/

Stacey Hughes
Executive Vice President, Government Relations and Public Policy