American Hospital Association™
Advancing Health in America

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June 15, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Room 445-G
Washington, DC 20201

CMS—1737—P: Medicare Inpatient Rehabilitation Facility Prospective Payment System for Inpatient Rehabilitation Facilities for Federal Fiscal Year 2021

Dear Administrator Verma:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including approximately 1,000 inpatient rehabilitation facilities, and our clinician partners – including more than 270,000 affiliated physicians, 2 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) 2021 proposed rule on the IRF prospective payment system (PPS).

The AHA appreciates CMS's streamlined proposed rule, which allows IRFs and their partners to focus on local COVID-19 responses.

In addition, we appreciate the substantial measures taken by CMS to optimize the IRF field's contribution to the national pandemic response. The agency's ongoing support is helping IRFs provide critical aid to beneficiaries and communities battling COVID-19 through direct treatment of patients with the virus as well as indirect support to allow other local settings to create additional space to treat COVID-19 patients.

The AHA is concerned, however, that CMS proposes to allow IRFs to use non-physician practitioners (NPP) to fulfill the clinical and leadership roles that are currently filled exclusively by rehabilitation physicians. We urge CMS to withdraw this proposal to ensure that the scope of services provided in IRFs remains at the highest levels and consistently delivered across the field. In addition, we support alternative ways to streamline IRF care in order to preserve and enhance the

physician-directed care required by beneficiaries and other patients treated in IRFs.

Finally, we note that the pandemic response has highlighted the relative strengths of each post-acute care setting. This raises concerns with the ongoing effort to develop a unified post-acute care PPS, specifically with regard to its questionable underlying principle that one payment system can accurately and reliably accommodate patients receiving care in these disparate provider settings, given their uneven clinical capacity and patient populations.

PROPOSED REDUCTION IN THE SCOPE OF INPATIENT REHABILITATION FACILITY CARE

The AHA is concerned about CMS's proposal to allow IRFs to use non-physician practitioners (NPP) to fulfill the clinical and leadership role that is currently filled exclusively by rehabilitation physicians. Specifically, we are concerned that under this proposal, beneficiaries who meet IRF admissions criteria – especially those with greatest clinical complexity – could receive medical guidance and treatment that is only a portion of that provided by rehabilitation physicians. We believe that care in IRFs should be directed by these highly trained physicians in order to maintain both quality and consistency.

As such, the AHA urges CMS to withdraw this proposal, which would inappropriately reduce the minimum qualifications of the lead clinicians in IRFs.

Instead, we support alternative ways to streamline IRF care in order to preserve and enhance the physician-directed care required by beneficiaries and other patients treated in IRFs.

Rehabilitation Physicians Should Continue to Direct IRF Care. Clinical care and leadership by rehabilitation physicians should not be made optional in IRFs. **Rather, we urge CMS to uphold existing Medicare coverage criteria that clearly establish rehabilitation physicians as central to all IRF patient care and other leadership functions; this includes directing, advising, and working collaboratively with the multi-disciplinary team of IRF nurses, therapists, and other clinicians and caregivers.**

In fact, Medicare coverage criteria explicitly state that each patient must require and receive face-to-face physician care throughout the week. **These IRF patient-centered standards should not be compromised in order to advance the rule's paperwork reduction goals.**

The current rehabilitation physician role includes:

- managing the complicated interplay between patients' primary diagnosis, medical stability, the multiple comorbidities that are typical in the IRF patient population, and restoration of their physical and cognitive function;

- evaluating each patient through at least three face-to-face visits per week throughout the patient's stay to assess progress and make the interventions needed to advance improvements of patients' medical and functional status;
- directing an interdisciplinary team, including weekly team meetings that are required to coordinate all facets of care, including medical management and restorative therapy;
- leading a comprehensive preadmission screening within the 48 hours immediately preceding IRF admission;
- conducting a post-admission clinical evaluation within 24 hours of admission; and
- developing an individualized plan of care with input from the interdisciplinary team within four days of the patient's admission to the IRF.

While NPPs have extensive medical training, it does not substitute for that of rehabilitation physicians. NPPs undoubtedly play a valuable role in IRFs – especially in rural areas and other locations experiencing rehabilitation physician shortages – however, the scope of IRF services would be reduced under this proposal. Specifically, rehabilitation physicians' extensive medical education and specialized training focus on restoring functional ability following surgery and physical impairment.

Physicians complete four years of physician-level medical education, at least three years of formal clinical training, and achieve board certification. In addition, many rehabilitation physicians undergo specialized training in the field of physiatry. Their qualifications are not replicated by any other clinician type, including NPPs with years of experience in an IRF setting. NPPs receive less and more varied advanced nursing education and clinical training.

For example, some physician assistant programs require approximately 25 months of instruction and one year of clinical training. Nurse practitioner and clinical nurse specialist designations require two or more years of graduate level nursing education and 500 hours of clinical training. Moreover, many clinical nurse specialists have advanced training that may be limited to a particular subfield. These variances can be magnified by licensure parameters that differ not only across the NPP subcategories, but from state to state.

As such, the AHA opposes the proposal to allow NPPs to assume physician-level diagnostic-and-care duties or the leadership of an IRF inter-disciplinary team, which poses even greater concerns for high-acuity patients such as those with traumatic brain injury and spinal cord injury.

Preserving Quality of Care. To avoid diminishing the quality of care in IRFs, CMS should preserve, as is, the critically important and unique rehabilitation physician role. Under this proposal, quality of care – especially for high-acuity IRF patients – could be reduced in the following ways:

- missed or incorrect diagnoses;

- the under or over-prescribing of IRF diagnostics and treatments in a patient's plan of care;
- incorrect interpretations of diagnostic test results;
- an increase in avoidable complications;
- an increase in preventable readmissions to general acute-care hospitals; and
- for the most complex IRF patients, including those with or recovering from COVID-19, difficulties managing the inter-disciplinary care – medical care in combination with, often, multiple forms of physical and cognitive therapy – required to facilitate the greatest level of return to home, work and society.

In addition, some of these consequences would affect referring general acute-care hospitals.

Further, should CMS continue to explore the feasibility of this proposal in the future, we call upon the agency to develop and incorporate evidence on the comparative outcomes of IRF care overseen by rehabilitation physicians in contrast to that of NPPs – per rehabilitation impairment category and per key rehabilitation physician function.

Certainly a proposal of this magnitude warrants no less than an evidence-based foundation to avoid any inadvertent reductions in quality of care.

Risk of Inconsistent IRF Levels of Care. **Allowing IRFs to replace rehabilitation physicians with NPPs would result in qualitative inconsistencies in the scope of IRF services provided across the nation.** Specifically, while we expect that many IRFs would continue using rehabilitation physicians to lead their clinical program, those IRFs led by an NPP would offer a narrower range of clinical service.

In addition, even among the subset of NPP-led IRFs, we would expect an uneven range of service delivery since the NPP category is comprised of several types of providers with licensure restrictions that vary by state. We also should anticipate that such inconsistencies would cause confusion as uncertainty among referring hospitals and patients grows with regard to each IRF's relative scope of services. This inconsistency would also present an oversight challenge for CMS, auditors and other payers and policymakers. Further, **AHA is concerned with this and any policy that could result in inconsistent standards of hospital-level care.**

Alternative Ways to Streamline IRF Regulatory Burden. CMS's proposal to allow NPPs to fulfill the role of rehabilitation physicians is, in part, fueled by the agency's stated desire to reduce administrative burden and costs in IRFs. We strongly support the pursuit of this goal through reductions in unnecessary paperwork and reporting requirements, which, unfortunately, would not be accomplish by this proposal. Further, in addition to our concerns about diminishing the quality and scope of care, this change could actually increase administrative burdens for CMS and providers, along with costs associated with increased IRF audits and appeals.

Instead, to reduce regulatory burden, we call on CMS to look to alternative streamlining strategies, such as this rule's proposal to permanently remove the requirement for a post-admission physician evaluation. This patient assessment has been found by the agency and providers to be redundant to the pre-admission patient screening mandated for every potential IRF patient. In fact, as part of its response to the COVID-19 public health emergency, CMS waived this evaluation, and other policies, to help IRFs focus on their pandemic response. Our members report that this particular waiver is helping IRFs focus on maintaining a high level of quality during the upheaval and strain caused by the pandemic.

Given the positive feedback on what has effectively served as a pilot test of the proposed elimination of this particular patient evaluation, AHA supports CMS's proposal to permanently eliminate the post-admission patient evaluation, and encourages CMS to pursue similar approaches to increase the efficiency and quality of care in IRFs.

IRF QUALITY REPORTING PROGRAM

The AHA appreciates CMS using the IRF QRP's extraordinary circumstances exception (ECE) policy to make data reporting optional for the fourth quarter of 2019 and the first two quarters of 2020. This policy provides some administrative burden relief while ensuring that data from the time of the COVID-19 public health emergency that are not representative of true performance are not used in public reporting.

As the pandemic evolves, we encourage CMS to consider whether applying the ECE policy for additional quarters may be warranted. Furthermore, we urge CMS to consider excluding Medicare claims data from the first two quarters of 2020 in calculating the IRF QRP's claims-based measures.

CMS's March 27 memorandum on quality reporting programs made it clear that the measures derived from the patient assessment data in the IRF-PAI would be exempt from reporting, but it does not specify whether the agency also is applying an exception to claims-based measures like readmissions and Medicare spending per beneficiary. CMS is excluding Q1 and Q2 2020 claims from the claims-based measures in its hospital quality reporting and value programs. We believe it also may be appropriate to do so for IRFs.

Lastly, exempting quarters of data from reporting has implications for measure reliability and accuracy in future public reporting. We urge CMS to conduct measure reliability analyses using truncated performance periods to ensure it has sufficient data to calculate performance accurately, and to make any results of such an analysis public. Basing public reporting on unreliable data would be highly problematic.

Thank you for the opportunity to comment on this proposed rule. Please contact me if you have questions or feel free to have a member of your team contact Rochelle Archuleta, AHA's director of policy, at rarchuleta@aha.org.

Sincerely,

Thomas P. Nickels
Executive Vice President