REHABILITATION & COMMUNITY PROVIDERS ASSOCIATION

June 15, 2020

The Honorable Seema Verma
Administrator
The Centers for Medicare and Medicaid Services
US Department of Health and Human Services
Attention: CMS-1729-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Delivered Electronically

Re: CMS-1729-P; Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2021, Proposed Rule 85 Federal Register 22065 (April 21, 2020)

Dear Administrator Verma:

With well over 350 members, the majority of who serve over 1 million Pennsylvanians annually, Rehabilitation and Community Providers Association (RCPA) is among the largest and most diverse state health and human services trade associations in the nation. RCPA advocates for those in need, works to advance effective state and federal public policies, serves as a forum for the exchange of information and experience, and provides professional support to members. RCPA provider members offer mental health, drug and alcohol, intellectual and developmental disabilities, children's, brain injury, medical rehabilitation, and physical disabilities and aging services, through all settings and levels of care. Visit www.paproviders.org for more information.

RCPA appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) fiscal year (FY) 2021 proposed rule for the inpatient rehabilitation facility prospective payment system (IRF PPS).

RCPA also greatly appreciates CMS' recognition of the demands that have been placed on the medical field, including the inpatient rehabilitation facilities (IRFs) as they provided care during the COVID-19 public health emergency (PHE) and assisted acute care hospitals during surge demands. This recognition is demonstrated by CMS providing a more limited rulemaking for fiscal year (FY) 2021.

One area that this PHE displayed was the differences in personnel, equipment, etc. in hospitals that provide post-acute care (PAC), such IRFs, compared to other PAC settings. The differences in patient treatment, outcomes, and safety in IRFs compared to other settings are tied directly to those characteristics that distinguish IRFs from other settings. One of these characteristics that sets IRFs apart is that the physicians direct and provide the care given to the patients in IRFs and the rehabilitation physician plays a critical role in determining the diagnosis, prognosis, and treatment of IRF patients. As a result, there is great concern about the proposal to allow non-physician practitioners (NPP) to perform

services currently required to be performed by a rehabilitation physician, also known as a physiatrist. Additional information surrounding this concern will be provided in our detailed comments below. A summary of our recommendations follows.

1. Proposal to Allow NPPs to Perform Certain IRF Coverage Requirements that Are Currently Required to be Performed by a Rehabilitation Physician

RCPA strongly recommends that CMS **not permit** Non-Physician Practitioners (NPPs) to perform any of the currently required roles of a rehabilitation physician, including those functions involving the Pre-Admission Screening (PAS), Post-Admission Physician Evaluation (PAPE), the Individualized Overall Plan of Care (IOPC), or the interdisciplinary team meetings. RCPA believes that such a substantial policy change creates a serious risk to quality of care and patient outcomes, as well as a likely increase to unnecessary program spending in the form of acute hospital readmissions, missed or incorrect diagnoses, and avoidable complications. These outcomes would not only have the likelihood of increasing unnecessary spending in the Medicare program, but would also detract from the physician-led, patient-centered care provided uniquely by IRFs.

The acuity of patients admitted to IRFs has increased. Rehabilitation physicians are specially trained to handle the distinctive needs of highly complex medical rehabilitation patients. Additionally, only rehabilitation physicians have the expertise and training to appropriately evaluate and order durable medical equipment (DME) — such as prosthetics, orthotics, and custom wheelchairs — for patients that incur new onset disabilities. Having proper DME utilization is a critical component of an intensive rehabilitation program for many patients and is directly related to their recovery and outcomes.

While RCPA recognizes the helpful supporting role that NPPs play, these providers simply do not have the experience, medical knowledge, training, or education to substitute for a rehabilitation physician in tasks involving the exercise of medical judgment around decisions pertaining to the admission and treatment of IRF patients or direct oversight of care. RCPA encourages CMS to work with IRFs to find more significant ways to alleviate existing administrative burdens.

2. Proposal to Eliminate the Post-Admission Physician Evaluation (PAPE)

a. RCPA supports CMS' proposal to eliminate the PAPE and appreciates the agency's efforts to reduce duplicative and unnecessarily burdensome reporting in the IRF PPS. RCPA appreciates CMS' waiver of this policy during the COVID-19 PHE, and RCPAs members' positive experience with this regulatory flexibility speaks to the soundness of the policy and justification for permanent implementation.

b. RCPA urges CMS to continue to address redundant documentation requirements in conjunction with the PAPE elimination, and streamline documentation requirements as much as possible.

3. Proposed Revisions to Certain IRF Coverage Documentation Requirements

a. Proposals Related to the Pre-Admission Screening

i. RCPA urges CMS not to codify the elements of the pre-admission screening (PAS) included in the Medicare Benefit Policy Manual (MBPM), and instead to allow IRF physicians to rely on their training and expertise to determine which information best supports the appropriateness of the admission. Such an

approach would reduce provider burden, facilitate appropriate and timely patient admissions to IRFs, and improve the post-admission review process for both IRFs and Medicare Administrative Contractors (MACs).

ii. If CMS does not finalize a policy that would grant IRFs broader discretion with respect to the PAS, RCPA requests CMS to, at minimum, streamline the PAS and eliminate some of the unnecessary elements currently included in the MBPM.

iii. RCPA encourages allowing rehabilitation physicians to offer verbal approval of the PAS (with corresponding documentation) as a simple way of reducing administrative burdens and allowing rehabilitation physicians to spend additional time on patient care.

b. Proposal to Clarify the Definition of a "Week"
CMS proposes to amend the regulatory text to clarify that a week is defined as "a 7 consecutive calendar day period, beginning with the date of admission to the IRF." RCPA supports CMS' efforts to clarify this definition and utilize consistent language throughout the regulatory text.

4. Proposals Related to the FY 2021 Case Mix Groups

a. RCPA recommends CMS to closely evaluate how the COVID-19 PHE will impact future reimbursement under current practices, and work with stakeholders to make appropriate adjustments.

b. RCPA encourages CMS to consider using its discretionary authority to modify the 60 percent rule to include other conditions – such as pulmonary and cardiac conditions – in light of the impact of the COVID-19 PHE.

c. RCPA recommends that CMS further investigate cognitive function and resource use in IRFs, and work to identify appropriate cognitive function status items suitable for IRF patients.

5. Finance and Labor Proposals

a. Proposed Market Basket Update and Productivity Adjustment

i. RCPA supports CMS updating the market basket and productivity amounts using the latest available data in the IRF PPS final rule.

ii. RCPA recommends that CMS continue to research productivity factors for health care providers and hospitals, and partner with Congress to implement a more appropriate, health care specific productivity adjustment.

b. Proposed FY 2021 Wage Index Policies
RCPA continues to support the use of the concurrent year's inpatient prospective payment system (IPPS) wage index to ensure uniformity in wage-index adjustments among different provider types. However, RCPA urges CMS to apply any other applicable changes it makes to the IPPS wage index to the IRF PPS as well, to avoid creating any additional disparities.

c. Proposed Update for Payments for High-Cost Outliers
RCPA recommends that CMS include historical outlier reconciliation dollars in its IRF outlier threshold projections as it now does for IPPS hospitals.

d. Facility-Level Adjustment Factors for FY 2021 and Beyond
RCPA recommends CMS conduct a review to evaluate the appropriateness of the current facility-level adjustment factors at a minimum interval of once every three years.

6. Proposed Revisions and Updates to the IRF Quality Reporting Program (QRP)

a. Method for Applying the Reduction to the FY 2021 IRF Increase Factor for Providers that Fail to Meet the Quality Reporting Requirements
RCPA urges CMS to provide more flexibility in its application of the two percent noncompliance penalty, to allow providers an opportunity to correct any errors when a good faith effort to submit data is undertaken, and reserve such harsh penalties for flagrant offenders.

RCPA appreciates the opportunity to comment on this proposed rule. Questions about these comments may be made to Melissa Dehoff, Director, Rehabilitation Services Divisions, at 717-364-3284.

Sincerely,

Richard S. Edley, PhD, President and CEO