June 26, 2018

SUBMITTED VIA REGULATIONS.GOV

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

RE: (CMS-1688-P) Medicare Program: Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2019

Dear Administrator Verma:

The undersigned members of the Steering Committee of the Coalition to Preserve Rehabilitation (CPR) appreciate the opportunity to comment on the proposed rule entitled, *Medicare Program: Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2019*. CPR is a coalition of more than 50 national consumer, clinician, and membership organizations that advocate for policies to ensure access to rehabilitative care so that individuals with injuries, illnesses, disabilities and chronic conditions may regain and/or maintain their maximum level of health and independent function.

Overview

The proposed rule adopts a market basket update specific to Inpatient Rehabilitation Hospitals and Units (IRFs), and updates quality measures and reporting requirements under the IRF Quality Reporting Program (QRP), among other things. CPR does not intend to comments on these sections of the proposed rule. CMS also proposes ways to reduce provider burden, particularly with respect to excessive documentation requirements. This burden impacts consumers because time spent documenting care for the file is time that cannot be spent directly addressing the clinical needs of Medicare beneficiaries in need of inpatient hospital rehabilitation. We will address some of our concerns with these proposals later in this letter.

The proposed rule also suggests switching from use of the Functional Improvement Measure set (the FIM™) to use of Quality Indicator measures for purposes of the IRF Patient Assessment Instrument (IRF-PAI) and case-mix group (CMG) assignment, which ultimately determines the amount of payment for each claim. This may have an impact on patient access to IRF care. The proposed rule would accelerate transition to these Quality Indicators and away from the FIM measurement tool

beginning in federal Fiscal Year (FY) 2020. The reason for this change is the reduction of provider burden by eliminating overlapping and duplicative reporting requirements. The Improved Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 establishes the timeline for this transition and links it to fiscal year 2023. The proposed rule would accelerate the elimination of the FIM to FY 2020. Because of the importance of this issue in terms of access to IRF care, we begin our comment letter with this issue.

Transition from FIM™ Instrument Measures to Quality Indicators for the IRF-PAI

CPR believes that making the proposed transition from use of the FIM instrument to use of the Quality Indicators (as reported in Sections GG, H, BB, and C of the IRF-PAI) effective for FY 2020 is premature. CPR acknowledges that the IMPACT Act ultimately requires this transition, but the timeline for this proposed transition is not in line with the requirements of the IMPACT Act. CPR opposes this acceleration due to the fact that CMS is basing its proposal (including proposed scoring methodology and changes to CMG classification) on only one year of data collected by the IRF field. This relative dearth of data and the inability to compare the data across time to identify any trends is concerning in isolation, but there is also the possibility that the data available may not be reliable given IRFs' unfamiliarity with the Quality Indicators and the related scoring and reporting processes for that single year of reporting.

Given that CMS proposes to use the Quality Indicators to assign CMGs, which establishes the basis for the amount of payment due, it is critically important that the assessment, scoring, and subsequent reporting of these measures be accurate. Unfortunately, little training has been provided to date to IRFs on scoring and reporting of the Quality Indicators. This creates a substantial degree of uncertainty that IRFs are accurately completing the relevant sections of the IRF-PAI and that the data reported to date is reliable.

Inaccurate or otherwise improper scoring and reporting on the Quality Indicators under the proposed rule will necessarily impact CMG assignment and payment to IRFs. The resulting changes in payment may create financial disincentives for IRFs with respect to some CMGs and, therefore, impact patient access to IRF care. For these reasons, CPR opposes CMS' proposal to implement this transition in FY 2020. Instead, we encourage CMS to continue to use the FIM instrument measures while it collects adequate amounts of data under the Quality Indicators to develop a reliable scoring methodology. In this manner, we believe the methodology will more accurately reflect the functional status of IRF patients, allow for appropriate CMG assignment, and limit the risk of negative impacts on patient access to IRF care.

Requests for Comment on Remote Face-to-Face Physician Visits and Use of Non-Physician Practitioners

The key to effective inpatient hospital rehabilitation is the team approach led by a physician with expertise in rehabilitation. Along with the intensity of therapy and the coordination of medical and rehabilitation services, the interdisciplinary team led by an experienced physician is what defines IRF care. CPR believes that an IRF-level of care necessitates a level of physician involvement and direction that is often lacking in sub-acute care settings. CPR believes that rehabilitation physicians must retain their critical role in directing IRF care along with the rehabilitation team and has some reservations about the possibility of (1) allowing rehabilitation physicians to conduct face-to-face patient visits (which are required to occur at least three times a week during an IRF admission) via some form of remote access or communication and (2) allowing non-physician practitioners to fill the role of the rehabilitation physician at times throughout an IRF admission.

CPR understands the heavy burden placed on rehabilitation physicians under the Medicare coverage criteria for IRF care, especially with respect to documentation. CPR supports CMS' attempts to reduce this burden where feasible so that physicians can maximize their time directly treating Medicare beneficiaries. Reduction of this burden will help combat physician fatigue and burnout and help retain high quality physicians in the field of inpatient hospital rehabilitation. With this in mind, CPR recognizes the utility of allowing remote face-to-face visits (i.e., telemedicine) and allowing some relief on physician duties through the use of non-physician practitioners, particularly in rural and other settings dealing with a shortage of rehabilitation physicians.

However, policy changes that may lead to the dilution of the role and value of the rehabilitation physician in the IRF setting are concerning. We therefore ask CMS to proceed very carefully in this policy area. Furthermore, the effectiveness (and even safety) of telemedicine is unproven in such a setting, where the patient's functional status is as important as his or her laboratory values and comorbidities. These considerations serve as the source for CPR's reservations about allowing physician visits to IRF patients to occur remotely.

CPR also has reservations about the potential use of non-physician practitioners to temporarily satisfy requirements otherwise required to be met by rehabilitation physicians. These concerns are grounded in the distinctions between the training and experience of rehabilitation physicians, who are frequently Board-certified specialists, and non-physician practitioners with no such specialized training or certification (e.g., physician assistants; nurse practitioners). Certainly non-physician practitioners already play a critical role in IRF care, and can gain crucial experience in rehabilitation medicine over time. But these practitioners must be used in a manner that does not undermine direct physician-patient engagement in the IRF. CPR believes the IRF level of care must continue to be defined by the rehabilitation team concept, led by a physician with expertise and experience in rehabilitation.

Thus, any future proposals to allow the practice of telemedicine by rehabilitation physicians in an IRF setting or the use of non-physician practitioners for roles and tasks usually filled by a rehabilitation physician must carefully bear in mind the unique nature of IRF care and the impact on patients of the rehabilitation physician's work in such settings.

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Thank you for the opportunity to submit these comments on the proposed IRF PPS for FY 2019. If you have any questions, please contact Peter Thomas or Christina Hughes at (202) 466-6550 or at Peter.Thomas@PowersLaw.com or Christina.Hughes@PowersLaw.com.

Sincerely,

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