CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

June 15, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 314-G
Washington, D.C. 20201

SUBJECT: CMS-1729-P, Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2021; Proposed Rule, Federal Register (Vol. 85, No.77), April 21, 2020

Dear Administrator Verma:

On behalf of our more than 400 member hospitals and health systems, including approximately 80 inpatient rehabilitation facilities (IRFs), the California Hospital Association (CHA) is pleased to submit comments on the Centers for Medicare & Medicaid Services (CMS) IRF prospective payment system (PPS) proposed rule for federal fiscal year (FFY) 2021.

CHA supports and appreciates CMS' proposals to:

- Limit the scope of regulatory changes in the context of the current COVID-19 public health emergency (PHE)
- Permanently remove the requirement for the post-admission physician evaluation (PAPE)
- Codify existing requirements for pre-admission screening documentation

CHA strongly opposes CMS' proposal to allow non-physician practitioners (NPPs) to perform certain required activities in place of the rehabilitation physician. While CHA is generally supportive of changes that provide additional flexibility and reduce regulatory burden, we believe the current proposal is overly broad and would undermine the unique value and effectiveness of the IRF setting.

PAYMENT AND CASE-MIX UPDATES

CHA supports CMS' efforts to improve the accuracy of post-acute care payment, including the development of standardized patient assessment items and associated changes to the IRF PPS case mix methodology. **CHA reiterates our prior request that CMS conduct assessment of the reliability and validity of the data collection efforts and related case-mix changes, including additional provider engagement, education, and training.**

The current FFY 2020 represents the first full fiscal year of the implementation of revised case-mix methodology used to determine a patient's case mix group (CMG) for purposes of payment. Effective October 2019, the CMG classification is calculated using data items collected on admission and recorded in Section GG section of the IRF-Patient Assessment Instrument into the CMG classification system, rather than on the previous Functional Independence Measure instrument. In association with this

change, CMS also modified the functional status scores used in the case-mix system, revised the CMGs, and updated the associated relative weights and average length of stay values.

The COVID-19 PHE has severely impacted our health care system. CHA supports and appreciates CMS' rapid response, as evidenced by the implementation of multiple waivers to provide flexibility and to assist hospitals and other health care providers in responding to the needs of their communities. The resulting disruption to the health care system will impact the mix of patients seen in the various settings, as well as associated data collection and reporting and patient outcomes. All these factors underscore the need to allow additional time for data collection and analysis and to slow down the process of post-acute care payment reform.

REMOVAL OF THE POST-ADMISSION PHYSICIAN EVALUATION REQUIREMENT

CMS proposes to permanently remove the current requirement for a PAPE. The PAPE is completed by the rehabilitation physician within 24 hours of the patient's admission to the IRF and documents the patient's status on admission to the IRF as compared to the information noted in the preadmission screening. It also serves as the basis for developing the overall individualized plan of care.

CHA appreciates the rationale CMS provided and its recognition that IRFs are knowledgeable in determining — prior to admission — whether a patient meets the coverage criteria for IRF services. While we understand that many IRFs will continue the practice of completing a comprehensive assessment shortly after IRF admission for the purposes of care planning, we appreciate the increased flexibility that this change represents. **CHA supports this change**.

PREADMISSION SCREENING DOCUMENTATION INSTRUCTIONS AND GUIDANCE

CMS proposes to codify certain existing requirements for preadmission screening in order to improve clarity and reduce administrative burden. Additionally, CMS requests comments on additional changes to pre-admission documentation requirements.

CHA appreciates CMS' ongoing efforts to clarify and identify additional changes that will reduce regulatory burden, while continuing to ensure that services provided are medically necessary. In this context, CHA suggests that CMS consider an additional change to the documentation of the physician review and concurrence with the findings of the preadmission screening.

The preadmission screening is a key component in the IRF admission process and ensures that prospective patients meet medical necessity guidelines and will benefit from IRF admission. As noted in §412.622(a)(4)(i)(D), "the comprehensive preadmission screening must be used to inform a rehabilitation physician who must then review and document his or her concurrence with the findings and results of the preadmission screening prior to the IRF admission." The rehabilitation physician is ultimately responsible for reviewing and approving all admission decisions, based on information collected and provided by the clinical liaison conducting the preadmission screening.

We agree that the review and concurrence of the rehabilitation physician must occur prior to the IRF admission and that his/her recommendation regarding admission/non-admission must be clearly documented in a timely manner. We are concerned, however, that this requirement has been interpreted to require that the rehabilitation physician must access the medical record and affix his/her signature to the preadmission screening document with a time stamp prior to the time of the patient's

admission. This rigid interpretation had led to denials of reimbursement for cases that otherwise meet all requirements for admission.

It is not unusual for a prospective patient's preadmission screening to take place at a different facility or location than that of the IRF. In such instances, the clinical liaison will initiate a remote discussion and review with the rehabilitation physician, who can then make a determination about admission or non-admission and allow transfer to the IRF to proceed on a timely basis. However, it may not be possible for the physician to immediately access the record to formally sign — either because the patient's record is not yet available at the IRF, or because the physician is off-site at the time of the review.

CHA encourages CMS to clarify that the requirement for the rehabilitation physician to review and concur with the result of the preadmission screening can be met by documenting, in the medical record, the discussion between the clinical liaison who conducted the screening and the rehabilitation physician, and that the physician may provide a verbal order for IRF admission.

ALLOWING NPPS TO PERFORM CERTAIN IRF COVERAGE REQUIREMENTS CURRENTLY REQUIRED OF A REHABILITATION PHYSICIAN

CMS proposes to allow NPPs to perform certain IRF coverage requirements. Specifically, the proposed rule would provide that an NPP who is determined by the IRF to have specialized training and experience in inpatient rehabilitation may perform any of the duties required of a rehabilitation physician, provided that the duties are within the NPP's scope of practice under applicable state law.

CHA strongly opposes this proposal. We believe that such a change would compromise the unique value of the IRF setting and its role and value within the continuum of care.

The four distinct levels of care in the post-acute care continuum — long-term acute care hospitals, IRFs, skilled-nursing facilities, and home health agencies — each evolved to provide specific types of services that meet patients' varied post-hospitalization needs. Matching patients to the right level of post-acute care improves their ability to achieve sustained medical and functional recovery without unnecessary cost or utilization. It is imperative, as reform of our health care system proceeds, that we do not standardize care to the point that we lose sight of each setting's unique contributions and roles in ensuring patients' needs are met.

This is particularly true of the acute rehabilitation care provided in inpatient rehabilitation units and hospitals. A hallmark of the care provided in IRFs is that a rehabilitation physician is responsible for the care provided to the patient — including medical and functional assessment; development, implementation, and monitoring of the care plan; and coordination of the interdisciplinary care team. The rehabilitation physician's unique perspective and training enables the team, under his or her leadership, to help individuals recovering from disabling injury or illness return to the highest possible level of independence and to effectively manage chronic conditions and impairments.

CHA recognizes and appreciates CMS' commitment to reducing regulatory burden for providers at all levels of the care continuum and applauds CMS' efforts to investigate the implications of possible changes. The limited use of NPPs may extend the rehabilitation physician's reach and allow for greater flexibility and access to care, particularly in rural areas. However, we are concerned that implementation

of such provisions without limitation may compromise the unique nature of the specialized IRF care provided to patients, which is possible only with the rehabilitation physician's leadership.

CHA appreciates the opportunity to comment on the FFY 2021 IRF PPS proposed rule. If you have any questions, please contact Megan Howard, senior policy analyst, at mhoward@calhospital.org or (202) 488-3742, or Pat Blaisdell, vice president continuum of care, at pblaisdell@calhospital.org or (916) 552-7553.

Sincerely,
/s/

Anne O'Rourke
Senior Vice President, Federal Relations