

June 17, 2019

Ms. Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically

Re: File Code CMS – 1710 – P
Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for
Federal Fiscal Year 2020

Dear Administrator Verma:

The undersigned organizations write in response to a proposal included in the Fiscal Year (FY) 2020 Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) and Updates to the IRF Quality Reporting Program proposed rule. In this rule, the Centers for Medicare and Medicaid Services (CMS) proposes to amend regulations to specify that the decision as to whether a physician qualifies as a Rehabilitation Physician is determined by the IRF. As representatives of the patients who require high-quality IRF-level care, as well as the clinicians who provide or refer patients to such care, the undersigned organizations are concerned with the long term impact this proposal may have on future access to an intensive, coordinated, interdisciplinary level of care currently provided by inpatient rehabilitation hospitals and units. For the reasons outlined below, **we urge CMS not to finalize at this time its proposal to change the definition of rehabilitation physician at 42 CFR 412.622, thereby allowing rehabilitation stakeholders to discuss this important issue with the intent of returning to CMS with a consensus approach for protecting the quality and integrity of IRF care.** Stakeholders need significantly more time beyond a 60-day comment period to convene and establish consensus guidelines to better define the qualifications of a rehabilitation physician.

Under current regulations, IRFs are subject to certain requirements for delivering care to admitted patients, including requirements related to the qualifications and responsibilities of Rehabilitation Physicians. Specifically, current regulations state that a Rehabilitation Physician must be a “licensed physician with specialized training and experience in inpatient rehabilitation.”¹ Such specialized training and experience equips Rehabilitation Physicians to successfully undertake the following activities, as required by regulations:

- Review and concur with findings of a comprehensive preadmission screening;
- Complete a post-admission physician evaluation within 24 hours of a patient’s IRF admission;
- Develop an individualized overall plan of care for the patient;

¹ 42 CFR 412.622 (a)(3)(iv)

- Conduct face-to-face visits with patients at least 3 days per week throughout the patient stay; and
- Lead interdisciplinary team meetings at least once per week throughout the patient stay to implement appropriate treatment services, review the patient’s progress toward stated rehabilitation goals, identify any potential problems, and as necessary reassess goals and revise treatment plans for the patient.

Together, the required qualifications and responsibilities of Rehabilitation Physicians maximize their ability and likelihood to provide optimized rehabilitation care that best supports patients in achieving their rehabilitation goals in IRF settings, while also enabling effective management of co-occurring conditions and promoting efficient utilization of limited health care resources. The expertise of the Rehabilitation Physician also differentiates IRFs from other settings and will be critical to preserving access to IRF level care as Congress and CMS move toward development of a unified payment system for post-acute care.

In the FY 2020 IRF PPS proposed rule, however, CMS proposes to revise the definition of Rehabilitation Physician to specifically state that “Rehabilitation physician means a licensed physician **who is determined by the IRF** to have specialized training and experience in inpatient rehabilitation.” [Emphasis added.] Under this proposal, CMS explicitly defers in regulation to the IRF to determine who is qualified to act as a rehabilitation physician in an IRF, and thereby, eliminates its oversight responsibility to ensure that IRF patients are being served by appropriately trained and experienced rehabilitation physicians. Given there is typically no ongoing oversight other than the initial IRF accreditation, the lack of specific standards is especially troubling. This policy has the potential to compromise the value proposition IRFs – with their rehabilitation expertise – offer at a time when policymakers are considering major reforms to post-acute care, potentially placing at risk the future viability and availability of traditional IRF care.

CMS’ proposal could result in significant problematic unintended consequences that could ultimately reduce quality of care for IRF patients and place them at risk for poor or sub-optimal outcomes. Moving forward, patients seeking IRF care may experience vastly different quality of care, which may vary by factors such as geographic location or IRF ownership. This policy could increase the likelihood that physicians without specialized training and experience in inpatient rehabilitation will take on the role of Rehabilitation Physician in IRF settings and engage in practices that increase the improper and inefficient utilization of limited healthcare resources, potentially leading to prolonged delivery of high-cost services, high-cost complications of mismanaged co-occurring conditions, and inappropriate and unnecessary use of equipment and supplies.

Existing regulations maintain a standard for Rehabilitation Physician qualifications that ensures that CMS retains sufficient oversight authority to protect patient care, and nothing under the existing regulations prevents IRFs from making good faith decisions regarding hiring and granting admission privileges to licensed physicians who otherwise have specialized training and experience in inpatient rehabilitation. At the same time, existing regulations help ensure that IRFs in the future will not push the boundaries of the rehabilitation physician definition with impunity, thereby eroding a key element of what constitutes an

inpatient rehabilitation hospital. Without an opportunity to engage the rehabilitation stakeholders in a dialogue on this important issue, we do not believe that finalizing CMS's proposal at this time is in the long term interests of rehabilitation physicians, IRFs, Medicare beneficiaries in need of intensive, coordinated, interdisciplinary inpatient hospital rehabilitation, or the Medicare program itself.

For the reasons outlined above, we urge CMS not to finalize at this time its proposal to change the definition of rehabilitation physician at 42 CFR 412.622, thereby allowing rehabilitation stakeholders to discuss this important issue with the intent of returning to CMS with a consensus approach. Please feel free to contact Melanie Dolak, Associate Executive Director, Health Policy and Practice Services, American Academy of Physical Medicine and Rehabilitation, at (847) 737-6020 or mdolak@aapmr.org. Thank you for your consideration of our comments.

Sincerely,

American Academy of Physical Medicine and Rehabilitation

ALS Association

American Academy of Orthotists and Prosthetists

American Academy of Pediatrics

American Association of Neurological Surgeons

American Association of Orthopaedic Surgeons

American Board of Physical Medicine and Rehabilitation

American College of Surgeons

American Congress of Rehabilitation Medicine

American Music Therapy Association

American Orthotic & Prosthetic Association

American Occupational Therapy Association

American Physical Therapy Association

American Society of Anesthesiologists

American Society of Clinical Oncology

American Therapeutic Recreation Association

Amputee Coalition

Association of Academic Physiatrists

Bacharach Institute for Rehabilitation

Brain Injury Association of America

Center for Medicare Advocacy

Child Neurology Society

Christopher & Dana Reeve Foundation

Congress of Neurological Surgeons

Disability Rights Education & Defense Fund

Frazier Rehab Institute

Mary Free Bed Rehabilitation Hospital

Mayo Clinic

MossRehab

National Association of State Head Injury Administrators
National Health Council
North American Spine Society
NYU Langone Health
Rush University Medical Center
Shirley Ryan AbilityLab
Schwab Rehabilitation Hospital/Sinai Health System of Chicago
Spaulding Rehabilitation Network
The Institute for Rehabilitation and Research (TIRR) – Memorial Hermann Houston TX
The Society of Thoracic Surgeons
University of Texas Southwestern Medical Center
UW Medicine