

DATE

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-1729-P
Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for
Federal Fiscal Year 2021 Proposal to Allow Non-physician Practitioners to Perform
Certain IRF Coverage Requirements that Are Currently Required to Be Performed by
a Rehabilitation Physician**

Dear Administrator Verma:

The undersigned organizations write in response to a proposal included in the Fiscal Year (FY) 2021 Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) proposed rule. In this rule, the Centers for Medicare and Medicaid Services (CMS) proposes to amend regulations to allow the use of non-physician practitioners (NPPs) to perform the IRF services and documentation requirements currently required to be performed by rehabilitation physicians under 42 CFR § 412.622. As representatives of the patients who require high-quality IRF-level care, as well as the clinicians and institutions that furnish services to the broader Medicare population, the undersigned organizations write to express our concerns that this proposal will undermine delivery of and access to physician-led team-based care in the IRF setting, which is critical for both ensuring the health and safety of patients receiving specialized rehabilitation care and differentiating the services that IRFs provide. We also are concerned that this sets a dangerous precedent for removing physician supervision requirements across all health care settings. ***For the reasons we further outline below, we strongly oppose this proposal to expand the scope of services NPPs furnish in IRFs, and we urge CMS to uphold the role of the rehabilitation physician in delivering and overseeing care for patients in IRF settings.***

Rehabilitation physicians are leaders of the interdisciplinary care teams¹ that provide comprehensive medical and rehabilitative care to high acuity patients with chronic illnesses or disabilities, and/or who are in recovery from devastating physical traumas – that is, those who comprise the typical patient population in IRFs. Rehabilitation physicians lead the interdisciplinary rehabilitation team that optimizes patients' medical and functional status. This is necessary for the patient population typical to IRFs who are extraordinarily vulnerable, complicated, and require comprehensive and multilayered care.

Relying on physician leadership – including in the IRF setting – is the most effective approach to maximizing the unique and complementary skill sets of all health care professionals on the team to

¹ The interdisciplinary rehabilitation team typically includes rehabilitation physicians, consultant physicians, nursing staff, therapists, neuropsychologists, social workers, as well as NPPs and others.

help patients achieve their care goals. While we recognize and appreciate the role that NPPs, such as nurse practitioners and physician assistants, play in providing care to IRF patients as part of an interdisciplinary care team, *NPPs' skill set is not interchangeable with that of fully-trained rehabilitation physicians.*

To appropriately manage patient care and meet the current IRF coverage requirements, rehabilitation physicians are currently responsible for:

- evaluating and managing patients' conditions, not only with respect to medical status but also to functional status, as well as assessing changes in status and adjusting treatment consistent with patients' goals of care;
 - managing medication changes that must be made to accommodate exercise, including anti-hypertensive and diabetic medications;
 - managing the use of psychoactive medications including anxiolytics and anti-depressants;
 - managing complex care for high-acuity patients that includes medical management of:
 - changes in neurological status that may warrant imaging or transfer to an alternative level of care,
 - cardiovascular changes that occur with exercise, and
 - neurogenic bowel and bladder management,
 - coordinating pain management interventions;
- reviewing and concurring with findings of a comprehensive preadmission screening, which requires medical knowledge of the patient's principal diagnosis in conjunction with their co-morbidities and biopsychosocial factors to determine prognosis for recovery;
- prescribing durable medical equipment;
- engaging in complex medical decision-making; and
- advocating for the many unforeseen needs newly disabled patients may have.²

In addition, IRF patients require rehabilitation physicians to manage devastating chronic issues resulting from spinal cord injuries, traumatic brain injuries, and a number of other illnesses and disabilities. Such complex patients have multiple co-morbidities that need to be managed concurrently. Most recently, rehabilitation physicians have been called upon to manage COVID-19 positive patients due to their unique experience in exercise and rehabilitation for patients who have cardiopulmonary instability.

To gain the expertise required to complete these activities, the rehabilitation physician develops a skill set through several avenues, including extensive medical education, residency, and often fellowship training and board certification; direct patient care experience in inpatient rehabilitation settings; and mentoring by physicians who offer guidance and share important lessons from their own experiences. Together, these provide rehabilitation physicians with a unique set of tools to use in treating IRF patients. Indeed, many physicians spend over 11 years in their undergraduate education and medical training and garner more than 10,000 hours of clinical experience in order to ensure they are properly trained and educated to diagnose and treat patients. In addition, many rehabilitation physicians complete training to achieve board certification, with some completing additional years of

² This list encapsulates just some of the responsibilities required to ensure IRF patients are appropriately managed. For a full list of the CMS coverage requirements of a rehabilitation physician, please see 42 CFR § 412.622.

subspecialty board requirements in Spinal Cord Injury Medicine, Brain Injury Medicine, and Neuromuscular Medicine and at least one year in medical management of patients in IRFs. By sharp contrast, the education and training of NPPs is significantly less. For example, nurse practitioners must complete only 2-3 years of graduate level education and 500-720 hours of clinical training. Physician assistant programs are two-years in length and require 2,000 hours of clinical care. The level of acumen obtained by physicians throughout their extensive education and training is simply not comparable to the education and training of nurse practitioners or physician assistants. Given the highly complex needs of the patient population in IRFs, the more extensive education and training of physicians equips them to lead the health care team responsible for these patients.

Furthermore, we believe that CMS' proposal could reduce the standard and quality of care IRF patients receive. Rehabilitation physicians are the most highly educated and trained health care professionals within IRFs and should be maintained as the authorized leaders of the health care team. Allowing NPPs with comparatively less education, training, and experience to take on rehabilitation physician responsibilities, increases the risk of significant, problematic unintended consequences for IRF patients. Such action threatens the health and safety of this uniquely complex patient population and could result in inappropriate care plans, poor or sub-optimal patient outcomes, and inappropriate and unnecessary use of limited resources, potentially including inappropriate admissions, prolonged delivery of high-cost services, high-cost complications of mismanaged co-occurring conditions, and inappropriate and unnecessary use of equipment and supplies. ***We strongly disagree that the potential cost savings estimated by CMS and purported reductions in burden outweigh these risks. Indeed, we are concerned that the risks to patient care outlined above may even contribute to increased health care costs, rather than savings.***

Finally, while we understand and concur with CMS' desire to increase access to post-acute care services in rural areas, ***we do not believe services led by NPPs will rise to the level of services that IRFs are designed and paid to provide.*** To the contrary, in cases where NPPs are allowed to independently complete IRF coverage requirements currently completed by rehabilitation physicians, we believe there could be meaningful risk that patients would not be receiving IRF-level care. Patients for whom IRF-level care is appropriate require the specialized training and expertise of rehabilitation physicians to manage their care. We believe it is this critical element of specialized physician leadership that differentiates IRFs from other settings. We are concerned, therefore, that the CMS proposal would compromise the value proposition that IRFs offer. Not only would this lead to payments that do not align with the care that IRFs furnish, but – at a time when policymakers are considering major reforms to post-acute care including unified payment proposals – it could also place at risk the future viability and availability of traditional IRF care. These facilities would simply no longer be IRFs if NPPs replaced rehabilitation physicians, because they could not meet the needs of the highly complex patients that are increasingly in IRFs. ***Furthermore, we question whether CMS' policy will achieve its stated goal of increasing access in rural areas.*** In reviewing the actual practice locations of NPPs, such as nurse practitioners, it is clear that nurse practitioners tend to work in the same areas as physicians, including in large urban areas, regardless of the level of autonomy they are granted at the state level, harboring sincere doubts that this proposal would have a significant, positive impact on access to care.

For the reasons outlined above, we urge CMS not to finalize its proposals to expand the scope of services NPPs furnish in IRF settings. 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