**Congressional Sign-on Letter**

**DRAFT**

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: Support for Patient & Physician Group Opposition to Certain Inpatient Rehabilitation Facility (IRF) Coverage Requirements in 2021 Medicare IRF Prospective Payment System Proposed Rule**

Dear Administrator Verma:

We stand strongly in support of patients who require high-quality IRF-level care and clinicians and institutions that furnish these services to Medicare patients. We write today to align ourselves with these groups’ comments objecting to the Centers for Medicare and Medicaid Services’ (CMS) Fiscal Year (FY) 2021 Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) proposed rule. Specifically, we object to the proposed rule’s change of policy that would allow the use of non-physician practitioners (NPPs) to perform the Inpatient Rehabilitation Facility (IRF) services now performed by rehabilitation physicians.

**Patient Acuity and Complexity Requires Unique Physician Skills and Leadership**

We understand that patients requiring IRF services are extraordinarily vulnerable and require comprehensive and multilayered care; they are often facing devastating medical complications and chronic issues resulting from spinal cord injuries, traumatic brain injuries, cardiorespiratory illnesses, and other seriously debilitating illnesses and disabilities. In the IRF setting, these patients are cared for through a delivery model required by CMS that works well – physician-led, team care. We understand that through physician-led, team-based care, rehabilitation physicians maximize the unique and complementary skill sets of all health care professionals in the team. In addition, IRF patients require specialized rehabilitation physicians to treat their complex medical issues. Our constituent physicians tell us that rehabilitation 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 these particularly vulnerable patients.

**Existing CMS Rules for IRF Patient Eligibility, Physician-Led Care Should Remain Intact**

By CMS regulation, IRF-level care is defined as “intensive rehabilitation services using an interdisciplinary team approach in a hospital environment.” These regulations include strict rules about providing medically reasonable and necessary care as well as detailed documentation requirements to show that certain medical criteria are met at admission and that the patient is receiving “active and ongoing intervention in multiple therapy disciplines.” The purpose of the interdisciplinary teams, according to CMS’ published documents, is “to foster frequent, structured, and documented communication among disciplines to establish, prioritize, and achieve treatment goals.” All these rules and guidelines are tied to a long-standing, specific CMS requirement that these coordinated interdisciplinary teams must be led by rehabilitation physicians.

**Policy Proposal is a Risky Proposition, Threatens to Decrease Quality of Care, Increase Costs**

We question the wisdom of removing the physician supervision requirement at this time and for these uniquely and especially vulnerable patients. Such a policy experiment is a dangerous proposition especially now with the current turmoil in our healthcare system. While we recognize and appreciate the role that NPPs play in providing care to IRF patients, we understand that the vast majority of NPPs do not have the same or even similar education and training to treat these complex patients, co-manage several co-morbid conditions, or lead interdisciplinary teams. This rule would not only risk the future viability and access to intensive rehabilitation, but also sets the very dangerous precedent of removing physician supervision requirements across all health care settings. We should not gamble on new rules that could inadvertently result in lowering the standard of care for these patients or risking an increase in inappropriate and unnecessary use of limited, often high cost services.

**To protect vulnerable patients in inpatient rehabilitation settings and to preserve sound, patient-centric policy, we strongly urge CMS not to finalize its proposal to expand the scope of services for NPPs in IRFs.**

Sincerely,