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February 16, 2021

Elizabeth Richter
Acting Administrator
Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Attention: *Form Number:* CMS-10765; *OMB Control Number:* 0938–NEW
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: CMS-10765: Agency Information Collection Activities: Proposed Collection; Comment Request.

Dear Acting Administrator Richter:

On behalf of The Hospital and Healthsystem Association of Pennsylvania (HAP), which represents approximately 240 member hospitals and health systems, including nearly 70 inpatient rehabilitation facilities (IRF) and units across the Commonwealth of Pennsylvania, we appreciate this opportunity to comment about the Centers for Medicare & Medicaid Services' (CMS) Review Choice Demonstration for IRF Services ("RCD") Notice in the *Federal Register* (85 Fed. Reg. 81209 (December 15, 2020).

IRFs provide their patients with intense medical rehabilitation, therapy and services that are delivered through a multi-disciplinary, team-based approach to patient care. In IRFs, unlike other less-intense post-acute care settings, rehabilitation physicians drive the patient admission process and lead, advise, and work collaboratively with the multi-disciplinary team of nurses, therapists, and other clinicians in caring for IRF patients. IRFs always have played a unique role in the care continuum. However, more recently, we are learning that IRF services are a critical component of care continuum for some patients recovering from COVID-19. IRF care is an important part of the commonwealth's public health emergency response.

Under the IRF RCD, CMS proposes to subject all Medicare fee-for-service (FFS) claims for IRF admissions in Pennsylvania, as well as Alabama, California and Texas, to either pre-claim or post-payment review. While the program's stated purposes is to "improve methods for the identification, investigation, and prosecution of potential Medicare fraud," we believe the approach contemplated in this notice is more likely to adversely impact access to necessary IRF care and create substantial paperwork and operational burden for clinical staff in IRFs already facing significant patient care and operational challenges associated with the COVID-19 pandemic.

HAP has the following concerns with this proposal:

As designed, the IRF RCD mandates that Medicare contractors second guess rehabilitation physicians' medical judgments. Many of our IRF members experience questionable "medical necessity" claim denials from CMS contractors and medical audit programs that result from misunderstandings or misapplications of Medicare's regulations governing IRF care and services. Often, these denials are made by non-physician practitioners who do not have experience or familiarity with IRFs and caring for IRF patients, unlike the rehabilitation physicians required by Medicare to determine whether to admit a patient based on applicable IRF admission and coverage criteria. Many of these denials are reversed on appeal before administrative law judges, especially when the rehabilitation physician is able to participate in the hearing and explain her or his decision to admit and treat the patient.

As proposed, the IRF RCD would indiscriminately second guess 100 percent of the rehabilitation physicians who are charged with determining whether a Medicare patient should be admitted to an IRF. Second guess reviews will be conducted by nurse reviewers, not physicians who are experienced in caring for IRF patients and trained in medical rehabilitation. It is unlikely such reviewers will have the background, experience, or specialty knowledge in the field of complex medical rehabilitation that underlies the care provided in IRFs. Medicare contractors too often lack training and expertise with specialized rehabilitation care and Medicare's IRF coverage requirements. Any program that does not involve rehabilitation physician reviewers in chart and medical reviews will only result in harm to patients, excess burden, and large volumes of appeals. **Physician decisions to provide a patient with IRF care and services should not be denied without the review and approval of another experienced rehabilitation physician.**

As designed, the IRF RCD would limit access to necessary care. Because Medicare's IRF coverage criteria are not general in nature but, instead, must be applied to each patient and their unique conditions and circumstances, IRF RCD reviews likely will result in claims denials that are inappropriate under IRF regulations, e.g., they may misinterpret coverage requirements or utilize criteria that are not part of the IRF coverage regulations, such as impermissible diagnoses-based "rules of thumb" that deny IRF coverage based on a patient's diagnosis, or denials based on a reviewer's opinion that the patient could or should have been treated in another level of post-acute care. Invariably, these results will create more confusion about which patients are appropriate for IRF care, and will create additional administrative burdens on IRFs through the documentation resubmission and claims denials appeals processes.

Most concerning, if an inappropriate denial is not cured or successfully appealed by an IRF, other patients with similar diagnoses or clinical conditions may lose access to IRF care by virtue of the IRF adjusting their patient admission practices based upon

erroneous applications of Medicare's IRF coverage criteria by RCD reviewers. Risking patient access to IRF care is unacceptable and CMS must ensure that IRF RCD will avoid this outcome. The IRF RCD must not limit patient's access to IRF care by creating "de facto" new rules.

Proposed timing of the RDC imposes unwarranted administrative burden during a pandemic. The proposed IRF RCD's across-the-board approach would impose undue administrative burden on IRFs that have no history of noncompliance, yet would still be subjected to 100 percent review; this increased burden will divert critical resources away from patient care. The IRF RCD program would significantly increase the volume of communication and administrative work that Pennsylvania's IRFs would need to incorporate into their existing workflows. Burdening every Pennsylvania IRF with the additional and onerous tasks associated with a 100 percent pre- or post-claim review process, including efforts and resource allocations put forth in contemplation of preparing for the implementation of such a process, is not appropriate or useful at a time when local, regional, and national health care providers and systems are operating as the front line against the most significant public health risk to emerge in generations.

As long as the COVID-19 pandemic is impacting hospital utilization and increasing provider burden, IRF RCD should be shelved and reassessed.

Conclusion: For the above reasons, we firmly recommend that CMS not implement the IRF RCD program as currently envisioned. Our IRF and acute care members support education around IRF coverage criteria compliance, but not at the risk of unnecessarily burdening an important component of our COVID-19 response or curbing patient access to critically important IRF services.

We thank you for the opportunity to comment on this information collection proposal for an IRF RCD. If you have any questions concerning our comments, you are welcome to contact me at jjordan@haponline.org, or (215) 575-3741.

Sincerely,

Jennifer Jordan
Vice President, Regulatory Advocacy