June 27, 2017

SUBMITTED VIA REGULATIONS.GOV

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: (CMS-1671-P) Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2018

Dear Administrator Verma:

The undersigned members of the Coalition to Preserve Rehabilitation (CPR) appreciate the opportunity to comment on the proposed rule entitled, *Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2018*. CPR is a coalition of national consumer, clinician, and membership organizations that advocate for policies to ensure access to rehabilitative care so that individuals with injuries, illnesses, disabilities and chronic conditions may regain and/or maintain their maximum level of health and independent function.

Overview

The proposed rule adopts a market basket update specific to Inpatient Rehabilitation Hospitals and Units (IRFs), and updates quality measures and reporting requirements under the IRF Quality Reporting Program (QRP), among other things. Due in part to enactment of the Improving Medicare Post-Acute Care Transformation ("IMPACT") Act of 2014, the proposed rule focuses heavily on implementation of quality reporting measures.

Notably, the rule does not include any pilots, demonstration projects, or more significant implementation of bundling of post-acute care, so-called "site-neutral" payment policies between IRFs and other settings of care, or other post-acute care proposals contained in recent MedPAC reports. CPR is grateful to CMS for choosing not to include these types of provisions in this rule, considering the serious reservations CPR members have with many of these proposals and the challenges they create for Medicare beneficiaries in need of an intensive, coordinated inpatient hospital level of medical rehabilitation.

CPR thanks CMS for its proposed solution to the unintended consequences of transitioning to the ICD-10 code set and the impact this transition is having on access to IRF care for select patients, particularly Medicare beneficiaries with brain injuries and other orthopedic impairments. Because of the importance of this issue in terms of access to IRF care, we begin our comment letter with this issue.

Refinements to the Presumptive Compliance Methodology ICD-10-CM Diagnosis Codes

On October 1, 2015 all providers were required to start using the ICD-10-CM code set in their documentation of health care services. In previous rulemaking, CMS translated the ICD-9 codes that would qualify under the ICD-10 code set for purposes of meeting "presumptive compliance" with the 60% Rule, the IRF requirement that at least 60% of IRF patients must have one of 13 specified diagnoses in order for a hospital to qualify as an IRF. The new ICD-10-CM codes were effective on or after October 1, 2015.

Soon after this coding transition, rehabilitation stakeholders began to notice a decrease in the number of patients with certain conditions who could be admitted to an IRF and counted toward the presumptive compliance methodology. This had the effect of creating a major disincentive for IRFs who were close to the 60% margin to admit patients whose conditions are described by codes that were no longer accepted by CMS for presumptive compliance with the 60% Rule. Medicare beneficiaries with brain injuries and hip fractures, as well as a number of other conditions, were greatly impacted by this unintended coding change. Led by the Brain Injury Association of America, one of CPR Coalition's Steering Committee members, CPR sent multiple letters to the CMS Administrator since 2015 requesting the agency to correct the unintended consequences of this transition to ICD-10 coding.

CPR Coalition is grateful that CMS finally included provisions in the proposed rule to attempt to correct this coding problem so that beneficiaries with brain injuries, hip fractures and other conditions will once again have appropriate access to inpatient hospital rehabilitation. We commend CMS for attempting to address in this Proposed Rule the number of ICD-10-CM codes that have not been accepted under presumptive compliance since October 2015—these codes had been routinely accepted under the ICD-9 code set.

While CPR commends CMS in large part for its proposed refinements to the presumptive compliance methodology ICD-10-CM diagnosis codes, we continue to have concerns with the following:

Traumatic Brain Injury under IGC 2.21 and IGC 2.22

CMS proposes removing some of the traumatic brain injury codes listed as exclusions on the Impairment Group Code (IGC) list, thereby allowing them to count toward the presumptive compliance criteria. However, CPR wishes to comment on several of the codes that will remain on, or are being added to, the exclusion list.

a. *S06.9X9A, Unspecified intracranial injury with loss of consciousness of unspecified duration, initial encounter*

CMS did not provide a specific reason for excluding this code from presumptive compliance, but CPR suspects it is because the term "unspecified" is used in the code name. CMS should consider that IRFs are not typically Medicare patients' first site of care. IRFs end up relying on medical records from the acute care hospital or other referral source in order to code the patient's injury. Therefore, the fact that the cause of injury cannot be specified should not impact a determination of clinical appropriateness for IRF care, especially for cases including loss of consciousness (which indicate a severe injury). Otherwise, beneficiaries will be denied access to IRFs without a sound clinical basis. CPR recommends that CMS retain this code on the presumptive compliance list as it indicates a condition that falls squarely within 60 Percent Rule requirements.

b. *S02.101B + A, S02.102B + A, S02.101A + A, S02.102A + A, Fracture of base of skull, right/left side, initial encounter for open/closed fracture*

CMS does not justify why it removed these codes from the presumptive compliance code list in the proposed rule. These codes indicate serious injuries, for which IRF care is often medically necessary. CPR therefore recommends that they be retained on the presumptive compliance list as they indicate conditions that fall under the 60 Percent Rule.

<u>Unspecified codes</u>

CPR is also concerned that CMS wishes to eliminate unspecified codes from the list of presumptive compliance codes. A patient may need an unspecified code for many clinical reasons, and often these reasons do not have anything to do with a particular patient's suitability for IRF services. First, many such codes are unspecified because the cause of the original injury is unknown, as discussed above regarding the code specifying "Unspecified intracranial injury with loss of consciousness of unspecified duration."

As already stated, IRFs rely on referring providers such as acute care hospitals for information on the original injury. Therefore, oftentimes there is not enough information (or the information is unascertainable, *e.g.*, as in the case of patients with memory loss) to assign a more specific code to a particular patient. In this way, the unspecified nature of the original injury should not be held against the patient in assessing the patient's current functional status or need to receive IRF services, and therefore should not be considered for purposes of determining whether an "unspecified" code should "count" under the 60% Rule's presumptive compliance framework.

<u>Publication of Code Changes</u>

CMS' proposed new, complete list of codes to be included under the presumptive methodology does not include an explanatory "crosswalk" or other mechanism for beneficiaries and other stakeholders to easily identify proposed changes from existing policy. To decipher the precise changes CMS is proposing, stakeholders must perform an intensive comparison to the previous list of codes. CPR recommends that CMS publish a list of only the codes proposed for revision, designating whether each code has been added to or removed from a particular list. CMS has done so in the past, including in the FY 2014 IRF PPS proposed rule, which included a list of "Proposed ICD-9-CM Codes To Be Removed From Appendix C: ICD-9-CM Codes That Meet Presumptive Compliance Criteria." Such

transparency would provide a better reference point for stakeholders and allow them to provide meaningful comments on CMS' proposed changes.

IRF Experience of Care Survey

With regard to the IRF Experience of Care survey, several beneficiaries from the test sites for the survey report that the survey's "experience during the IRF stay" portion does not adequately address the therapy the beneficiaries received during their stay. The provision of therapy is an essential element of IRF care. CPR therefore recommends that CMS include questions that better address therapy services in an IRF experience of care survey.

CPR also recommends that CMS make the draft survey and survey implementation process publicly available and allow an opportunity for stakeholder input well in advance implementing it in the IRF Quality Reporting Program (QRP). While this survey has been under development since 2015, there have been few opportunities for wide stakeholder involvement since that time.

IRF Compare Measures and Performance Ratings Should Report Clinically Meaningful Information

CPR believes that decision-making by beneficiaries and other stakeholders will only benefit from IRF Compare measures and performance ratings if such ratings are discernable and relevant to the general public. Minor variations in all-case readmissions rates, for instance, though they may derive from statistically significant data, are not meaningful for consumers to truly compare differences in quality between similarly situated IRF providers. Patients and other public users cannot discern a practical difference between an IRF with a 13% readmission rate versus one with a 12% readmission rate. Measures should be selected that truly discern meaningful differences in quality and outcomes and there must be clinically meaningful differences in the gradations between a high-quality/well-performing provider and others.

Medicare PAC Reform Requires Serious Deliberation and Reliable Data

All Medicare post-acute care (PAC) reforms that CMS considers should, first and foremost, preserve access to quality rehabilitation services provided at the appropriate level of intensity, in the right setting, and at the right time to meet the individual needs of Medicare beneficiaries. This is, of course, much easier said than done. Meeting this challenge, while making Medicare post-acute care payment policy more efficient, requires serious deliberation and should be based on reliable data that is comparable from one post-acute care (PAC) setting to another. Standardized data need to be collected across a variety of PAC settings with a major emphasis on appropriate quality standards and risk adjustment to protect beneficiaries against underservice. Implementation of the IMPACT Act is beginning to serve this data collection purpose, but it needs time to produce reliable results.

CPR favors payment and delivery models that are based on sound evidence with fully developed quality measures and risk-adjusters so that savings are achieved through genuine efficiencies, not achieved by stinting on patient care. Implementing the same set of quality measures across PAC settings, as the IMPACT Act requires and the rule proposes, helps facilitate meaningful comparisons between settings of post-acute care.

Standardized data and quality measures across PAC settings can be used to develop a uniform quality assessment instrument to measure outcomes across PAC settings and design appropriate risk adjustment methodologies that protect against underserving beneficiaries with the most significant medical and functional needs. Such tools would be invaluable to developing and enacting PAC

reforms that do not compromise care for people with disabilities and chronic conditions. This is a critical step in both adopting appropriate—and sufficiently granular—quality metrics to ensure PAC beneficiaries under a bundled Medicare payment system achieve good outcomes and to ensure that risk adjusters accurately capture the unique needs of individual beneficiaries.

Until these and other beneficiary protections are in place, we do not support regulating or legislating PAC reforms that bundle episodes of care, impose financial incentives to treat beneficiaries in the least intensive setting, or otherwise limit rehabilitation benefits under the Medicare program. Therefore, we thank CMS for refraining from proposing PAC policies through regulation that are simply not well developed at this stage.

Request For Information on Regulatory Flexibilities and Efficiencies in the IRF Setting

The RFI invites public comment regarding ideas for regulatory or sub-regulatory, policy, practice, and procedural changes to better accomplish flexibility and efficiency in Medicare, including reducing unnecessary burdens for clinicians, other providers, and patients and their families. These suggestions are intended to increase quality of care, lower costs, improve program integrity, and make the health care system more effective, simple and accessible. The RFI states that this is an important opportunity for providers and patients alike to offer regulatory relief suggestions that could significantly streamline the program and improve access to patient care while reducing provider burden with existing regulatory requirements.

Regulatory relief is particularly necessary in the IRF regulations and sub-regulatory guidance. In 2010, CMS sought to clarify coverage and documentation standards for inpatient rehabilitation hospitals and units by issuing a regulation at 42 C.F.R. § 412.622. CMS believed that this new regulation would limit the number of denials being issued by Medicare Administrative Contractors and Recovery Audit Contractors. The result was a highly regulated Medicare setting with strict timelines and detailed documentation requirements. However, this enhanced regulation did not result in greater clarity in IRF admission criteria and a steady flow of claims denials continue to this day. This creates extensive burdens on IRF providers, feeds the unconscionable backlog of Administrative Law Judge appeals, creates tremendous inefficiencies for both providers and the Medicare program, and does nothing to improve or advance patient care.

In fact, the uncertainty that pervades the provision of care to IRF beneficiaries is resulting in IRF clinical personnel self-policing their admission patterns, not based on the best medical judgments to meet patient needs, but on estimations of which cases are most likely not to be audited and recouped in the longer term. This has the effect of tightening coverage criteria even though IRF providers believe certain patients require IRF care and meet medical necessity criteria. The lengthy delay in the appeals backlog at the Office of Medicare Hearings and Appeals simply intensifies this problem.

CMS should conduct a comprehensive review of a wide variety of IRF regulations to ensure that the regulatory and sub-regulatory language that governs the 60% rule, the 3-hour rule, the intensity of therapy requirement, the group and concurrent therapy requirements, and the requirements for documentation of medical necessity are redesigned to be most efficient and targeted toward appropriate access to the IRF setting for patients who need that level of intensive inpatient hospital rehabilitation.

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Thank you for the opportunity to submit these comments on the inpatient rehabilitation hospitals prospective payment system. If you have any questions, please contact Peter Thomas or Steve Postal at (202) 466-6550 or at peter.thomas@powerslaw.com or steve.postal@powerslaw.com.

Sincerely,

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Supporting Organizations

Academy of Spinal Cord Injury Professionals
American Academy of Physical Medicine and Rehabilitation
American Association on Health and Disability
American Congress of Rehabilitation Medicine
American Dance Therapy Association
American Music Therapy Association
American Occupational Therapy Association
American Physical Therapy Association
American Spinal Injury Association
American Therapeutic Recreation Association
Amputee Coalition
Association of Academic Physiatrists
Association of University Centers on Disabilities
ACCSES
Brain Injury Association of America
Center for Medicare Advocacy
Christopher and Dana Reeve Foundation
Disability Rights Education and Defense Fund
Easterseals
Falling Forward Foundation
Lakeshore Foundation
National Association for the Advancement of Orthotics and Prosthetics
National Association of Social Workers (NASW)
National Association of State Head Injury Administrators
National Multiple Sclerosis Society
National Rehabilitation Association
Paralyzed Veterans of America
United Spinal Association