August 12, 2019

SUBMITTED ELECTRONICALLY VIA www.regulations.gov

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: **CMS-6082-NC; Request for Information: Reducing Administrative Burden to Put Patients over Paperwork**

Dear Administrator Verma:

The undersigned members of the Coalition to Preserve Rehabilitation ("CPR") appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services ("CMS") request for information ("RFI") regarding reducing administrative burden through the Patients over Paperwork initiative. 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.

CPR recognizes the importance of the Patients over Paperwork initiative and CMS' broader efforts to decrease unnecessary regulatory burden on patients and providers. Specifically, patients with disabilities who need rehabilitative care, and the providers who serve them, face significant regulatory hurdles that often serve as a barrier to access for critical and medically necessary care. Additionally, these administrative hurdles can prevent health care professionals from tailoring care to individual patient needs. We have detailed some of these major burdens and potential solutions, and we urge CMS to act on the proposals outlined below.

I. Three Hour Rule Requirement

Current regulations narrowly restrict the types of skilled therapy countable towards the so-called "three hour rule" for Medicare beneficiaries admitted to inpatient rehabilitation hospitals. CMS should modify the rule to restore physician judgment in selecting other skilled therapies that can count toward the intensity of therapy requirement.

In order to qualify for coverage in an inpatient rehabilitation hospital or unit ("IRF"), a Medicare beneficiary with an injury, illness, disability, or chronic condition must require a "relatively intense" course of rehabilitation therapy. Beneficiaries must be able to participate in at least three hours of rehabilitation therapy per day, five days per week (or fifteen hours within a consecutive seven-day period in certain cases), the so-called "three hour rule." Prior to 2010, CMS regulations for IRFs explicitly stated that skilled therapies such as physical therapy ("PT"), occupational therapy ("OT"), speech language pathology ("SLP"), and/or orthotics and prosthetics ("O&P") could be counted toward the "intensity of therapy" requirement. CMS regulations also stated that "other therapeutic modalities" that were determined by the physician and the rehabilitation team to be needed by the patient "on a priority basis" would qualify toward satisfaction of the rule.

This language allowed neuropsychology services, recreational therapy, respiratory therapy and other skilled services to count toward satisfaction of the three hour rule for patients who required therapies other than those explicitly listed in the regulation. The mix of therapies was determined by the professional judgment of the treating physician and the rehabilitation team. This deference to physician judgment was removed by regulations issued in 2010, resulting in restricted access to skilled services other than PT, OT, SLP, and O&P. As a result, some IRFs eliminated their capacity to provide other skilled services that IRF patients often need as they progress through the course of their IRF stay.

The current interpretation of the three hour rule explicitly allows PT, OT, SLT and O&P to be counted toward the three hour rule but ultimately replaces physician judgment with a one-size-fits-all, bureaucratic approach to therapy prescription. Ensuring access to the appropriate mix of services in the IRF setting is essential to optimizing care for people with brain injuries, spinal cord injuries, individuals who have sustained strokes and amputations, individuals living with neurological disorders, and other beneficiaries with a wide range of medical conditions.

In addition to the four skilled therapies listed in the current regulation (ie., PT, OT, SLT, and O&P), CPR recommends that CMS update the three hour rule regulation to restore physician judgment and allow the treating professionals to determine the appropriate mix of skilled therapy services that best meet the patient's needs as they progress through their IRF stay. The current regulation is overly proscriptive and prevents physicians from fully implementing a patient-centered, intensive, interdisciplinary treatment program tailored to the needs of the individual patient.

II. Three-Day Inpatient Stay Requirement for SNFs

Current CMS regulation requires at least three consecutive days to be spent as an inpatient in an acute care hospital in order to qualify for coverage of Skilled Nursing Facility (SNF) care. CMS should modify this overly restrictive regulation to allow days spent in "observation" to be considered to satisfy the three-day requirement.

Beneficiary stays at SNFs are covered under Medicare Part A's SNF benefit for those who qualify for short-term, intensive stays and require skilled nursing and/or skilled rehabilitation care. Beneficiaries are generally eligible for payment of up to 100 days of SNF care, including

room and board, skilled nursing care, durable medical equipment ("DME"), and other accompanying services. In order to qualify for coverage of post-acute care in a SNF, however, most Medicare beneficiaries must have a prior inpatient hospital stay of at least three consecutive days, within 30 days of admission to a SNF.

This limitation has become increasingly burdensome for beneficiaries who require SNF care, and has acted as a barrier to coverage for critical skilled nursing services. For beneficiaries admitted under observation status which is provided on an outpatient basis, hospital stays may not qualify the patient for SNF admission, even if their condition makes SNF care medically appropriate. There are no clear standards as to when patients should be admitted under observation rather than as an inpatient, and in many cases beneficiaries may not even be fully aware of their status when they are in the hospital. This effectively directs many beneficiaries towards discharge and home health care, even when SNF admission may result in better outcomes. Worse yet, some beneficiaries are admitted to SNFs only to have coverage for the services denied.

CPR recommends that CMS modify the existing SNF three-day inpatient stay requirement to allow observation days to be considered for meeting the three day rule. This change would reduce burden on patients and providers and address confusion around eligibility for SNF care. The *Improving Access to Medicare Coverage Act of 2019* currently before Congress (S. 753/H.R. 1682) would accomplish this goal legislatively, but CMS can and should act under its regulatory authority to make this change and decrease the barriers facing observation patients in Medicare.

III. Prior Authorization

Prior authorization in Medicare Advantage (MA) plans often serves as a barrier to timely access to care for beneficiaries. CMS should require participating plans to ensure that their use of prior authorization does not create undue burdens on patients and providers.

Medicare Advantage plans routinely use prior authorization as a tool to rein in costs and combat overutilization. However, there are serious concerns with abuse of prior authorization by MA plans. The HHS Office of Inspector General found in October 2018 that MA plans may abuse prior authorization as a method to delay or deny coverage of—and payment for—care. Overuse and misuse of prior authorization compromises patient outcomes and denies beneficiaries the services they need to be healthy, functional, and independent.

Additionally, the expanded use of prior authorization has created a significant additional burden on providers. A recent survey conducted by the Regulatory Relief Coalition, a group of national physician specialty organizations, found that the vast majority (87% of respondents) of physicians report negative impacts on patient clinical outcomes from prior authorization. Nearly two-thirds of physician offices are forced to employ staff working exclusively on prior authorization requests and appeals.

Providers have to spend significant amounts of time submitting and following up on prior authorization requests, and when services are denied, providers are faced with a choice between spending even more time appealing the decisions, foregoing reimbursement, or being unable to provide critical patient care. In many cases, even when services are routinely approved and very

unlikely to be over-utilized, the lengthy prior authorization process prevents beneficiaries from receiving medically necessary care in a timely manner.

Delays caused by prior authorization can become outright denials of care. This is typical for Medicare patients awaiting approval of a referral to inpatient hospital rehabilitation following hospitalization for an illness or injury. When a Medicare patient must wait days for approval to an IRF, many acute care hospital discharge planners are forced to send the patient to a lower level of care, such as a skilled nursing facility or home health care, despite the fact that the patient qualifies for inpatient rehabilitation hospital care. This is one reason why MA beneficiaries have one third the access to IRFs that traditional Medicare beneficiaries have, according to MedPAC data.

There is currently legislation in Congress (H.R. 3107, the Improving Seniors' Timely Access to Care Act) which would implement important reforms in the MA program and streamline and automate the use of prior authorization. However, CMS can and should use its own authority to reduce the burden of prior authorization on both providers and patients.

CPR recommends that CMS instruct Medicare Advantage plans not to use prior authorization as a tactic to delay care, and should instruct plans to implement strict safeguards to protect patients while still combating overutilization and waste in the MA program. Prior authorization in the MA program should be timely, transparent, and streamlined wherever possible. For services that are routinely prescribed and approved, prior authorization should be either discontinued or automated in a manner that minimizes provider burden and speeds the approval process as much as possible. Additionally, MA plans should be required to review non-routinely approved requests in a timely manner, especially during periods that traditionally have slow response rates (e.g., over weekends and federal holidays).

IV. Redundant Documentation and Deadline Requirements in IRFs

Providers in IRFs face extensive and duplicative documentation requirements that take away from time spent caring for beneficiaries. CMS should address unnecessary documentation burdens on physicians and other providers by limiting redundancies and implementing reasonable deadlines for documentation.

Physicians and other professionals operating in IRFs are subject to extensive regulatory requirements that mandate completion of certain documents within specific timeframes, including the pre-admission screening, post-admission physician evaluation, patient medical history and physical examination, and the overall plan of care. These requirements are highly burdensome, contributing to physician burn-out and missed time deadlines that lead to claims denials for small documentation deficiencies. Additionally, much of the required documentation is redundant, covering the same or similar information about the patient and diagnoses as forms that may have been completed within days of each other. Removing these redundancies would greatly reduce provider burden without compromising patient care, and would provide physicians and other rehabilitation professionals more time to provide direct patient care to treat the complex needs of IRF patients.

CPR recommends that CMS modify existing IRF regulations to lessen unnecessary and duplicative documentation requirements and reduce burden on physicians and other professionals.

Many of the documents mandate completion within a specified time frame (such as the post-admission physician evaluation, which must be completed no later than 24 hours after a patient is admitted to an IRF). With the widespread adoption of electronic medical records, this requirement has become extremely burdensome on physicians and is unnecessary for the safe medical management of IRF patients. In many cases, submitting a signature mere minutes beyond the 24-hour deadline can result in a technical denial of the entire IRF stay. In turn, this contributes to the high number of unnecessary claim denials and the case backlog at the Office of Medicare Hearings and Appeals. Physicians are then forced to spend valuable time contesting the denial of appropriate medical care, simply because the regulation provides no reasonable leeway in the time stamp for required signatures.

CPR recommends that CMS allow documentation to be completed and signed by the end of the next calendar day, rather than the exact 24 hours determined by the time stamp of admission. Additionally, CPR recommends that when documentation deadlines fall on a weekend or federal holiday, CMS permit completion and signature by noon on the following business day. Implementing these regulatory adjustments would not impact the quality of patient care, but would significantly reduce unnecessary burdens on physicians and other rehabilitation professionals.

V. Certification and Recertification for Therapy Plans of Care

CMS currently requires providers of outpatient therapy services to develop plans of care that are certified and signed by a physician within 30 days of the initial treatment, and recertified and resigned every 90 days. While physician certification is important to ensure the plan of care is medically appropriate, the strictures of the regulation are onerous and take valuable time and resources away from patient care and can delay care while awaiting signatures. CMS should modify the requirement for a plan of care signature to reduce undue burden on therapy providers.

Medicare currently covers outpatient therapy services, including physical therapy, occupational therapy, and speech-language pathology, furnished under a written treatment plan of care. The plan may be established by a physician or nonphysician practitioner ("NPP"), or the therapist or speech pathologist who will provide the services under the plan. The plan of care contains information such as diagnoses, long-term treatment goals, and details about the type, amount, duration, and frequency of therapy services.

Current CMS regulation[1] ensures that Medicare Part B only pays for these services if a physician certifies the treatment plan and provides a dated signature affirming their approval. Ideally, the certification and signature is obtained as soon as possible after the plan is established, but regulations require the signature within 30 days of the initial therapy treatment. If a physician does not certify the plan, or if the physician does not provide a signature within the specified

[1] 42 C.F.R. § 424.24.

time frame, payment can be denied even if the services have already been provided and were medically appropriate under the plan. Medicare Administrative Contractors ("MACs") may consider evidence of the therapist's diligence in providing the plan to the physician for signature, but are not required to do so. Additionally, the plan must be reviewed by a physician or NPP at least every 90 days after initiation of treatment under that plan.

The certification requirement is important to ensure that the care provided is appropriate, but the current regulation is overly burdensome on therapy providers. Care may frequently be delayed while awaiting a physician signature, and therapists bear the full financial burden for any care provided if the plan is not certified on time, even if they have performed due diligence in requesting a physician signature. Though the regulations provide for remedies in the instance of delayed certifications, therapists are forced to bear additional burden in identifying and compiling evidence to justify the delay, taking away from time that could be spent providing direct patient care.

CPR *recommends that CMS modify the requirement for a plan of care signature to reduce unnecessary administrative burden on providers when seeking a signature on a treatment plan.* For example, CMS could treat an order or referral signed by a physician or NPP to a therapy provider as sufficient in lieu of a signed plan of care. Reducing the administrative burden for requesting treatment plan signatures will allow therapists to direct more resources toward patient care.

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CPR shares CMS' goal of reducing unnecessary administrative burden for patients and providers, and we appreciate CMS' commitment to achieving this goal. We believe that the proposals outlined above will have a significant impact on the ability of individuals with complex rehabilitative needs to receive truly patient-centered care. We urge CMS to consider adopting these proposals and to continue pursuing policies that decrease regulatory barriers to access and empower providers to maximize their time spent providing care to Medicare beneficiaries.

We greatly appreciate your attention to the proposals included in our comments. Should you have further questions regarding this information, please contact Peter Thomas, coordinator of CPR, at Peter.Thomas@PowersLaw.com or by phone at 202-466-6550.

Sincerely,

The Undersigned Members of the Coalition to Preserve Rehabilitation

ACCSES
American Academy of Physical Medicine & Rehabilitation
American Association on Health and Disability
American Congress of Rehabilitation Medicine
American Dance Therapy Association
American Medical Rehabilitation Providers Association

American Music Therapy Association
American Physical Therapy Association
American Spinal Injury Association
American Therapeutic Recreation Association
Amputee Coalition
The Arc of the United States
Association of Academic Physiatrists
Association of Rehabilitation Nurses
Center for Medicare Advocacy
Christopher and Dana Reeve Foundation
Clinician Task Force
Falling Forward Foundation
Lakeshore Foundation
National Association for the Advancement of Orthotics and Prosthetics
National Association of State Head Injury Administrators
The National Athletic Trainers' Association
National Multiple Sclerosis Society
Paralyzed Veterans of America
United Spinal Association