



August 12, 2019

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

***Delivered Electronically***

***Re: Request for Information; Reducing Administrative Burden To Put Patients Over Paperwork [CMS-6082-NC], 84 Fed. Reg. 27070 (June 11, 2019)***

Dear Administrator Verma:

This letter is submitted on behalf of the American Medical Rehabilitation Providers Association (AMRPA) regarding the Centers for Medicare and Medicaid Services (CMS) Request for Information (RFI) on Reducing Administrative Burden to Put Patients Over Paperwork. AMRPA is pleased to see CMS' continued interest in evaluating its current regulations for ways to reduce unnecessary burden. We appreciate the opportunity to provide recommendations from our provider community on how CMS can remove regulatory obstacles, reduce provider burden and improve access to patient-centered care via regulatory changes.

AMRPA is the national voluntary trade association representing more than 650 freestanding rehabilitation hospitals and rehabilitation units of general hospitals (collectively referred to by CMS as inpatient rehabilitation facilities (IRFs)), outpatient rehabilitation service providers and several other types of rehabilitation providers. In 2017, IRFs served 340,000 Medicare beneficiaries with more than 380,000 IRF stays.<sup>1</sup> On average, Medicare Part A payments represent approximately 60 percent of IRF revenues.<sup>2</sup> AMRPA members help patients maximize their health, functional ability, independence, and participation in society so they are able to return to home, work, or an active retirement.

IRFs occupy a unique space in the settings of care available to patients. In addition to offering an intensive array of therapy modalities and other rehabilitation treatments, IRFs provide hospital-level medical care, which is significantly different from the rehabilitation or general medical supervisory services provided in non-hospital post-acute care (PAC) settings. As a result, there are vast differences in the outcomes of IRF patients when compared to those

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<sup>1</sup> Medicare Payment Advisory Commission (MedPAC), "Chapter 10: Inpatient Rehabilitation Facility Services," Report to the Congress: Medicare Payment Policy, March 2019.

<sup>2</sup> *Id.*

receiving PAC in non-hospital facilities. Medicare beneficiaries admitted to IRFs for their immediate post-acute care have significantly better outcomes across a range of quality indicators compared to clinically matched beneficiaries who received their immediate post-acute care in another setting. These indicators include returning home from their initial stay two weeks earlier, remaining home significantly longer, utilizing emergency visits at a lower rate and experiencing a lower all-cause mortality rate.<sup>3</sup>

Despite their position as a highly effective and efficient PAC delivery system for Medicare beneficiaries, IRFs are arguably the most heavily regulated provider in all of Medicare. As this letter details, IRFs are subject to regulations that impact the specific diagnoses that they can treat to qualify as an IRF, the timing and form of how clinical team members meet to discuss their patients, the modes and exact number of hours of therapy to be delivered, the soon-to-be 36 pages of assessment documentation that must be completed for every Medicare patient, and many others. These requirements exist in spite of the fact that IRF patients are supervised at all times by trained rehabilitation physicians, who may find their clinical judgement on the best course or method of treatment superseded by the need to meet these strict regulatory requirements.

AMRPA members wrestle daily with understanding and complying with the vast web of overlapping regulatory criteria governing IRF admissions and patient stays. It is not surprising, therefore, that our members report that they are often subject to audits where a contractor – who often does not have a background in rehabilitation medicine – may misapply or misinterpret classification, coverage and other regulations governing IRFs. IRFs are then in turn required to engage in lengthy and costly appeals, which are more often than not decided in the IRFs' favor. AMRPA adds that the complexity of the current IRF regulatory landscape makes it all the more important that IRF claim reviewers have appropriate background and expertise in an inpatient rehabilitation hospital or unit.

These extensive regulations, differing interpretations, conflicting contractor policies, regular audits and drawn-out appeals have all led IRFs to spend enormous amounts of time, resources and focus on administrative matters that are more appropriately spent on patient care. This enormous compilation of requirements is why AMRPA is fully committed to assisting CMS with its “Patients Over Paperwork” initiative, to better enable providers to deliver patient-centered care and the best possible outcomes for beneficiaries.

The recommendations contained in this letter reflect extensive feedback from the medical rehabilitation industry, including professionals involved in every aspect of the treatment of IRF patients who possess a thorough understanding of the impact that specific policies and regulations are having on IRFs and their patients. We have provided below a summary of recommendations which are followed by our substantive and detailed comments.

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<sup>3</sup> See DOBSON DAVANZO & ASSOCIATES, ASSESSMENT OF PATIENT OUTCOMES OF REHABILITATIVE CARE PROVIDED IN INPATIENT REHABILITATION FACILITIES (IRFS) AND AFTER DISCHARGE (July 2014).

## **Summary of Recommended CMS Actions to Reduce IRF Regulatory Burden and Put Patients Over Paperwork**

- CMS should eliminate or significantly amend the IRF classification criteria, namely the “60 Percent Rule”.
- CMS should eliminate or streamline redundant and burdensome clinician documentation requirements for coverage of IRF care.
- CMS should modernize the IRF intensity of therapy requirements.
- CMS should limit Medicare Advantage plan’s use of prior authorization which is used to deny beneficiaries’ access to necessary IRF care.
- CMS should reduce administrative burden in the audits and appeals system for Medicare program and for providers.
- CMS should revise the IRF Quality Reporting Program to remove unnecessary burden and to deliver meaningful quality information for beneficiaries.
- CMS should introduce more regulatory flexibility to allow for IRFs to fully participate in alternative payment models and other CMS efforts to create a more efficient Medicare system.
- CMS should improve the navigability of post-acute care to lessen the burden shouldered by patients and their family/caregivers during care transitions.
- CMS should reduce the regulatory burden associated with opening a new IRF subunit.
- CMS should amend the Conditions of Participations and provide flexibilities that enable specialty hospitals to focus on patient-centered care in a competitive manner.

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### **I. The Current IRF Classification Criteria Contains a Decades Old Rule That Overrides Physician Judgement and Modern Medical Practice and Should be Repealed or Modified.**

Unlike other hospitals participating in Medicare, in order for IRFs to receive payment under their prospective payment system, they must admit a patient mix that fits a very specific criterion. Known as the “60 Percent Rule,” the regulation mandates that 60 percent of all IRF patients must have diagnoses derived from 13 medical conditions.<sup>4</sup> These 13 conditions are extremely outdated, having been expanded only once since their inception in 1975 (from 10 to 13 conditions), and therefore limit IRFs’ ability to evolve with the ever-changing medical treatment landscape. As the following suggestions will detail, the 60 Percent Rule should be eliminated, or at the very least modified, if Medicare wants to enable its participating providers to have the flexibility to provide the most clinically advanced, individualized care for its beneficiaries.

#### **A. The 60 Percent Rule Is Inherently Flawed and Should Be Repealed to Allow Physicians and Modern Medical Standards to Dictate Treatment Decisions.**

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<sup>4</sup> 42 C.F.R. § 412.29(b)(2).

The existence of the 60 Percent Rule forces IRFs to meticulously monitor the diagnoses of admitted patients and screen those being considered for admission in order to comply with the rule's provisions, thereby disproportionately emphasizing diagnosis rather than the patient's rehabilitative and medical needs. In presupposing that patients with particular diagnoses require IRF services, the 60 Percent Rule creates an incorrect impression that patients whose diagnoses fall outside of its diagnostic categories and medical conditions do not require IRF services. CMS does this despite the fact that patients with the same diagnoses can have a wide range of functional deficits and number of comorbidities, which are some of the more appropriate factors a trained clinician considers when determining whether a patient is an appropriate candidate for an inpatient rehabilitation hospital.

**AMRPA recommends CMS eliminate the 60 Percent Rule as one of Medicare's classification criterion for IRFs.** The rule's arbitrary assumptions supplant the medical judgment of physicians discharging their patients from general acute-care hospitals to IRFs, as well as physicians in IRFs when deciding whether to admit patients into their hospital. The rule effectively forces physician judgment regarding a patient's rehabilitation placement to be secondary to Medicare regulations, and is therefore best characterized as top-down medical decision-making via regulation.

By replacing physicians' judgement with its own, CMS limits access to needed treatment for both Medicare and non-Medicare patients. Patients suffering with diagnoses derived from medical conditions outside the rule receive IRF care on what amounts to a rationed approach. IRF treatment is allocated via this "lottery system" because each IRF can only accommodate non-60 Percent rule patients by virtue of its status relative to the 60 Percent compliance threshold. This backwards result of distorted admission patterns and access barriers demonstrates that the 60 Percent Rule is outdated and an inappropriate criterion by which to classify IRFs and distinguish them from acute-care hospitals.

Further, the rule's original ten conditions, which still serve as the core of today's 13 conditions, were developed based on a technical review of treatments in IRFs in 1975.<sup>5</sup> In the 44 years since, and even since the addition of 3 more condition categories in FY 2005, medical treatment and outcomes have evolved significantly. Patients with medical conditions derived from the rule's 13 diagnoses who were once often in need of intensive rehabilitation, such as some orthopedic procedures, no longer require an IRF stay with as much frequency due to advancements in surgical techniques.

On the other side of the equation, diagnoses that could benefit from IRF treatment remain excluded from the list of 13 conditions, such as cardiac, pulmonary, oncology, and transplantation, among others. The majority of these excluded diagnoses have seen major advances in medical treatments, technology and patient outcomes in

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<sup>5</sup> Medicare Program; Prospective Payment for Medicare Inpatient Hospital Services, 49 Fed. Reg. 239 (Jan. 3, 1984)

recent years, leading to more patients in these categories becoming suitable for intensive rehabilitation. As an example, due to treatment advances and improved outcomes, the American College of Surgeon's Commission on Cancer now requires that rehabilitation services be included in order to certify a cancer program.<sup>6</sup> Yet despite rehabilitation services becoming the standard of care for oncology treatments, cancer/oncology remains excluded from the list of 13 conditions.

Put simply, medicine is constantly evolving. The fact that the 60 Percent Rule cannot reflect these constantly evolving medical standards, combined with the rule's effect of superseding physician judgment in order to meet an arbitrary patient mix, means that the 60 Percent Rule should be eliminated in favor of a more patient-centered approach.

**B. The 60 Percent Rule is Not Necessary to Distinguish IRFs from other Sites of Care and Repealing It Will Allow CMS to Focus on More Appropriate Criteria.**

When the 60 Percent Rule was implemented in 1984 (then as a 75 Percent Rule), a prospective payment system was just being implemented in general acute-care hospitals and cost-based reimbursement was still in effect for rehabilitation hospitals.<sup>7</sup> Under these very different dynamics, the 60 Percent Rule was used to classify IRFs and served the purpose of distinguishing the uniquely intensive medical rehabilitation services an IRF provides from general acute care hospitals.

Since then, CMS created a separate prospective payment system for IRFs, and revised and expanded other requirements to be classified and paid as an IRF, including licensure standards, a wide range of coverage and intensity of treatment requirements, mandatory patient screenings to determine suitability for intensive rehabilitation, required multi-disciplinary medical teams, and close medical supervision such as full-time physician coverage and 24-hour nursing.<sup>8</sup> CMS has also implemented extensive audits of IRF claims to ensure the medical necessity of admissions and the appropriate level of intensity of services delivered. These other criteria and requirements more than ensure that IRFs are treating patients who need their services and that IRFs are providing patients with an intensive rehabilitation treatment program.

The 60 Percent Rule, by contrast, is a holdover from a prior era when CMS needed a quick way to distinguish those providers that would be excluded from the new general acute care hospital prospective payment system. The rule does little to inform the type of treatment delivered or the complex needs of the patient, or describe the attributes of an IRF. Instead it uses broad strokes to attempt to define an outdated patient population as describing the provider. **Therefore, AMRPA recommends that if CMS eliminates the 60 Percent Rule, the agency should leave in place the**

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<sup>6</sup> See The Commission on Cancer's Cancer Program Standards: Ensuring Patient-Centered Care (2016 Edition).

<sup>7</sup> Medicare Program; Prospective Payment for Medicare Inpatient Hospital Services, 49 Fed. Reg. 239 (Jan. 3, 1984)

<sup>8</sup> 42 C.F.R. § 412.29(b)(2)

**already existing IRF classification criteria which focuses on the medical, rehabilitative, and nursing services within the hospital/unit and the manner in which they are provided, rather than the diagnoses of patients treated.**

If CMS were to adopt this recommendation to keep the majority of the IRF classification criteria, but eliminate the 60 Percent Rule, it would mean that physicians, and not CMS, would ultimately decide the best setting of care for patients. At the same time, the remaining classification criteria would mean that IRFs still would be required to deliver the same intensive and multi-disciplinary rehabilitative treatments in order to be paid under the IRF PPS. To put it bluntly, if the 60 Percent Rule were to be eliminated today, IRFs would continue to deliver intensive rehabilitation services under close the medical supervision of physicians and other specialists, albeit to a broader and more appropriate patient mix. The change would result in the best possible outcomes for beneficiaries and highest level of efficiency for Medicare.

***The 60 Percent Rule, based upon decades-old medical standards, usurps physician judgement and restricts patient access to needed medical rehabilitation services. AMRPA recommends the complete elimination of the 60 Percent Rule because of the detrimental effect the rule has on beneficiary access to intensive rehabilitation services. AMRPA recommends the continued use of other IRF classification criteria that relate to the services and program structure provided in the hospital, which will ensure that IRFs continue to produce superior health outcomes and to a broader population of patients today.***

## **II. If CMS is Unable to Completely Withdraw the 60 Percent Rule, The Agency Should Significantly Amend the Rule.**

As discussed in the previous section, CMS should undertake the long-overdue task of removing the antiquated 60 Percent Rule. If, however, CMS finds itself in a position of being unable to repeal the rule, CMS should at the very least significantly alter the rule to allow for a more patient-centered approach to care. These changes should include a significant expansion of the conditions permitted under the 60 Percent Rule, a lowering of the rule's threshold, and changes in compliance audit standards. CMS has the existing regulatory authority to make all of these changes in the absence of an act of Congress.

### **A. CMS Should Expand the Conditions Covered by the 60 Percent Rule.**

**Should CMS not be able to eliminate the 60 Percent Rule, AMRPA recommends the inclusion of several new diagnoses under the 60 Percent Rule – including cardiac, pulmonary, and organ transplant.** The new diagnoses should include conditions that have seen an increased need for intensive rehabilitation services due to changes in treatment norms and expected health outcomes. The table below demonstrates the evolving nature of medical rehabilitation care and how the field is continually advancing to improve the outcomes for new patient populations. For example, while Orthopedic conditions have seen a sharp decrease in need for IRF



stays due to advancing technologies, improved outcomes for Cardiac and Pulmonary conditions have increased the need for those patient groups to be treated in an IRF.

Clinical Condition	Change in Medicare FFS Volume, 2009-2017
Orthopedic conditions	31% decrease <sup>1</sup>
Cardiac	18% increase <sup>1</sup>
Pulmonary	41% increase <sup>2</sup>

Sources: <sup>1</sup> MedPAC Data Books, June 2010 and 2019; <sup>2</sup> eRehabData®

## **B. CMS Should Significantly Reduce the 60 Percent Rule’s Threshold.**

**Should CMS be unwilling to eliminate the 60 Percent Rule, the agency should lower the compliance threshold to a significantly lower percentage.** Although this change does not fully address the underlying problems with the rule itself, a lower threshold would result in considerably fewer Medicare and non-Medicare patients arbitrarily being denied access to medically necessary inpatient rehabilitation care due simply to their diagnosis. AMRPA notes that CMS has clear authority under statute to make this change, as the Medicaid, and SCHIP Extension Act of 2007 directs CMS to “require a compliance rate that is *no greater than the 60 percent* compliance rate that became effective for cost reporting periods beginning on or after July 1, 2006.”<sup>9</sup> Therefore, while CMS may not increase the compliance threshold above 60 percent, the agency can clearly reduce the threshold percentage through notice and comment rulemaking.

## **C. CMS Should Lower the Medicare Threshold for the 60 Percent Rule’s Presumptive Compliance Methodology and Other Suggestions**

IRFs must demonstrate compliance with the 60 Percent Rule via one of two compliance methodologies, a medical review (chart audit) or a more automated “presumptive methodology” calculated from patient diagnoses information submitted by the IRF to a Medicare contractor. AMRPA would like to offer several suggested changes to the presumptive compliance methodology, including ways to ensure that future updates are made in a more constructive and collaborative manner. These include: removal of the 50 percent Medicare patient threshold to qualify an IRF under the presumptive compliance methodology; creation of a Technical Expert Panel (TEP) to provide input before making proposed changes to the ICD-10-CM codes; and provision of data that would allow IRFs to review the data associated with their presumptive compliance calculations. These concepts are more fully detailed below:

### **1. Removal of the 50 Percent Threshold**

In order to qualify for the presumptive methodology, IRFs must demonstrate that 50 percent or more of its patients are Medicare beneficiaries. This requirement is outdated and imposes an undue burden on IRFs with a smaller proportion of

<sup>9</sup> Medicare, Medicaid, and State Children’s Health Insurance Program Extension Act of 2007, Pub. L. No. 110-173, § 115(b), *uncodified* 42 U.S.C. § 1395ww note.

Medicare patients. As CMS often notes, providers retain the ability to demonstrate compliance with the 60 Percent Rule through medical review chart audit. However, this review is a burdensome and resource-intensive process that places considerable strain on IRFs, especially smaller providers with limited resources, as well as the agency and its contractors. AMRPA believes that a statistically valid extrapolation for compliance could be determined for providers serving fewer than 50 percent Medicare patients, and we welcome the opportunity to work with CMS to develop such an approach. **CMS should therefore eliminate the 50 percent Medicare patient threshold for eligibility to use the presumptive compliance methodology.**

## **2. Technical Expert Panel**

AMRPA believes stakeholders should be permitted to provide feedback on potential changes to the presumptive compliance methodology and the 60 Percent Rule as early as possible. **AMRPA recommends that CMS establish a technical expert panel (TEP) comprised of at least 15 persons with clinical, operational, and policy expertise and experience in dealing with the 60 Percent Rule and its effects and consider much-needed reforms.**

The TEP should meet at least once annually with the staff of the Chronic Care Policy Group, as well as CMS medical and clinical personnel charged with overseeing and maintaining the 60 Percent Rule. One of the key issues for discussion during the meeting would be some of the transparency issues related to the 60 Percent Rule's administration, including the vague process through which determinations are made as to which ICD-10 codes "require" IRF services and which do not. IRFs have had little opportunity to gain insight into CMS' thinking and objectives in this area or to provide feedback, beyond submitting annual comment letters. A TEP, therefore, provides a much-needed transparent and comprehensive discussion about both the utility of the 60 Percent Rule itself and how it is currently being administered.

## **3. Provider Review of Data**

AMRPA has previously requested that CMS make available to IRFs the software specifications and data used by CMS' independent contractor to determine providers' 60 Percent Rule compliance under the presumptive methodology. Presumptive testing is based on assessment data submitted by IRFs via the IRF PAI, and CMS affords providers the opportunity to review and validate patient-level assessment data for other programmatic requirements such as the IRF QRP. In the interest of transparency and consistency, we request that CMS provide IRFs with access to the pertinent information (software specifications, claims and patient-level data, etc.) that would allow providers to review and compare internally generated presumptive compliance percentages with those generated by CMS' contractor. We believe this process would educate providers, streamline and enhance the precision of the presumptive methodology and reduce the administrative burden – to providers and to Medicare – of a medical record



review.

*If CMS declines to fully eliminate the 60 Percent Rule, it should revise the rule to allow for more deference to clinician judgement and to eliminate unnecessary barriers to care. These changes to the rule should include adding new conditions, lowering the compliance threshold, and allowing for more flexibility in the compliance determination methodology. CMS should also revise how it implements the 60 Percent Rule to reduce providers' administrative burden to remain compliant.*

### **III. CMS Should Eliminate Or Streamline Documentation Requirements for IRF Claims, Especially Those That Include Mostly Redundant Information.**

#### **A. Duplicative Documentation Requirements**

IRFs are subjected to significantly redundant documentation requirements that include a Pre-Admission Screen (PAS), a Post-Admission Physician's Evaluation (PAPE), and an Individual Overall Plan of Care (IOPC). IRFs are subject to strict submission requirements (down to the hour), as the PAS must be documented within 48 hours of admission; the PAPE must be documented within 24 hours of admission; and the IOPC must be documented within four days of admission.

Summary denials are issued for even a single missing piece of information from one of these assessments, despite the fact the same information is also included in one of the other two assessments. This not only evidences the redundancy of the information collection process, but also demonstrates the unfairness of a summary denial when the IRF has in fact provided that information through another assessment. For example:

- Both the PAS and the PAPE require an IRF to document the patient's level of function *prior to the onset* of the current illness. Given the fact that this information is retrospective, the reported level of function will be identical across the PAS and PAPE.
- The PAPE requires an IRF to document the patient's *current* function when it is the same as documented in the PAS. While it is reasonable that the PAPE include notation that there has not been any change in function, if there is no change, providing documentation to this effect is entirely redundant of the PAS.
- The IOPC requires a rehabilitation physician to support the patient's IRF plan of care using a synthesis of information obtained through various evaluations. Specifically, the IOPC must include sufficient information to justify the plan of care, including documentation of the needed therapy interventions, intensity, frequency and duration, the medical prognosis at the time of admission, the expected functional outcomes, discharge destination, length of stay, and other information submitted in the PAS and/or PAPE.<sup>10</sup>

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<sup>10</sup> Medicare Benefit Policy Manual (MBPM), CMS Pub. 100-2, Ch. 1, § 110

The time and administrative burden associated with documenting these duplicative requirements for the purpose of contractor claim review is substantial, as they require not just administrative staff, but extensive participation and certification by medical professionals.

CMS should eliminate this duplication (and for certain data, triplication) in one of two ways. First, and most effectively, the agency can simply eliminate the redundancies in the patient assessment documentation criteria. Although the patient would still be evaluated on each of these domains during each assessment, secondary documentation would only be required for a single assessment level. This would be a truly meaningful deregulatory action that would not just avoid technical claims denials, but would actually reduce the time and cost burden associated with submitting each claim. We ask that CMS be particularly mindful of new and effective ways to reduce providers' time burdens in light of the additional submission requirements tied to the IRF-PAI effective October 1, 2020. At the very least, we recommend that CMS restrict the overreaching practice of denying entire claims for technical documentation deficiencies, such as one missing piece of information in one of the assessments, when that information is readily available or discernible from another part of the documentation for that claim.

In the alternative, the agency could direct contractors to deem documentation for a single assessment to satisfy each of the assessments for that patient. Thus, if an IRF submitted documentation that satisfied identical requirements of the PAPE and IOPC for only one and not the other, the contractor would be required to accept the documentation for purposes of both assessments. CMS could issue a simple directive to its contractors requiring this administrative simplification. While this action would not reduce administrative burdens as effectively and meaningfully as eliminating assessment redundancies in the first place, it would at least help address issues with punitive and resource-consuming technical denials.

***The administrative burden of duplicative documentation requirements should be reduced by directing contractors to consider all information in a claim to satisfy each of the levels of assessment for that patient, or by eliminating redundancies in the patient assessment documentation criteria in the regulations.***

## **B. CMS Should Provide Additional Flexibility for Arbitrary Time Requirements, Especially on Weekends and Holidays**

The clinicians treating a patient in an IRF are in the best position to evaluate the patient and put into motion a plan of care. However, these specialized clinicians are forced to mold their approach to fit CMS' tight and subjective timeframes. There are two major unnecessary timeline burdens placed on IRFs that could be alleviated with small changes to the CMS regulations: (1) establishing time-related requirements in days, rather than hours, to avoid arbitrary cut-off periods during a workday, and (2) offering greater flexibility for documentation timeframes during weekends and holidays.

First, CMS uses a 48- and 24-hour standard for the PAS and PAPE, respectively. If CMS were to rephrase these regulations as a “day” standard, it would go a long way to alleviate pressure on IRFs to correctly time their documentation submissions. To illustrate, currently a physician must be aware of the specific time a patient was admitted to an IRF in order to ensure the PAPE is completed no later than that exact time the next day. **If CMS’ deadline for the PAPE were instead phrased as “midnight the next calendar day,” rehabilitation physicians would not be caught in the position of having to interrupt direct patient care in order to fill out and submit documentation by a rigid deadline having nothing to do with patient quality or outcomes.** CMS should implement this same change for the deadlines applicable to the PAS and IPOCs so providers are not required to fixate on exact times, and instead have flexibility within the next calendar day(s) to complete the requirements in a way that does not interfere with patient care, while maintaining the spirit of the regulation and ensuring patients are seen and tended to in a timely fashion.

Second, we ask CMS to allow certain flexibility for deadlines on weekends and holidays. As an example, if a patient is admitted to an IRF late on a Friday, the physician must complete the PAPE by late on a Saturday. **CMS could add a clause to its regulations to require that the documentation be completed within 24 hours, or by the end of the next business day, whichever is later.** This would allow providers to focus on the most pressing needs of patients and complete the PAPE during the next business day, if clinically appropriate. As another example, if the PAS took place on Friday, providers need to ensure that the patient is officially admitted on Monday no later than the time the PAS took place on Friday – an arbitrary timing point - or otherwise run afoul of the regulation. Adding an end-of-the-day standard would similarly provide appropriate flexibility for clinicians so they are free to finish admitting the patient by the end of the day Monday, rather than by a seemingly arbitrary time deadline. **Therefore, CMS should provide additional flexibility for timed requirements in the IRF regulations, such as by imposing day rather than hour requirements on hospitals.**

#### **IV. CMS Coverage Rules for the Delivery of Therapy in IRFs is Overly Restrictive and Confusing, Leading to Unnecessary Burden and Curbing Access to Needed Therapies.**

The hallmark of the care delivered in IRFs is the intensive therapy services combined with close, hospital level medical supervision. Despite these hospitals employing expert clinicians to deliver these therapy services, the Medicare coverage criteria for therapy services are extensive, confusing, and overly restrictive to the point that they limit providers’ ability to deliver the best outcomes for patients. CMS has prescribed very restrictive instructions for therapy services, detailing the modes and hours of therapy to be delivered, regardless of the clinical situation. There has also been variation in interpretations among contractors and CMS, with different standards being enforced by various entities, making it difficult for providers to comply and thereby leading to costly claim denials and appeals. CMS should vastly simplify and clarify the existing standards and take steps to permit other modes of therapy to be delivered to Medicare beneficiaries.

**A. The Therapy Intensity Requirements Should Be Updated to Allow For Patient-Centered Care Delivery.**

Currently, Medicare regulations dictate that an IRF must provide 3 hours of therapy per day, at least 5 days a week (known as the “3-hour rule”). The regulation states that under limited circumstances, instead of 3 hours per day, a patient may receive a total of 15 hour of therapy a week.<sup>11</sup> This regulation has been interpreted to hold IRFs to a general standard of providing 3 hours per day of some combination of individual physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy. Any deviation, including providing an additional type of therapy in lieu of the modes mentioned or staggering the therapy in some other manner than 3 hours per day, is very closely reviewed by Medicare contractors and providers are often denied payment on the basis of failure to meet the intensity of therapy requirements.

AMRPA understands the 3-hour rule is intended to reflect the specialized care required by rehabilitation patients and the distinguished services provided by IRFs, as these features distinguish IRFs from any other care setting. These rigid restrictions on the time and type of therapy delivery, however, are quite simply the opposite of patient-centered care. Clinicians, and not regulators, should dictate the manner, mode and timing of therapy services based on the individualized needs of a patient. The sole concern of Medicare should be the best possible outcomes for patients. Therefore, CMS should do away with the overly restrictive hour and mode requirements and instead require a generally intensive course of therapy to be delivered in the manner or mode decided by the clinician. This change could be accomplished by revising the current regulations or guidance to require 15 hours per week of therapy, delivered in the manner and mode justified by the clinician in the medical record.

This resolution would be considerably more manageable for rehabilitation providers than the policies and interpretations that do not allow for any variation for individual patient need. Making the 3-hour rule more flexible would not reduce the aggregate amount of therapy patients currently receive, but would allow therapy to be tailored to patients’ unique circumstances and individualized care plans. Moreover, this simplification would allow IRFs to forgo copious amounts of documentation or risk losing payment for the entire stay, simply because the therapy on a given day was less than three hours on one day for clinically valid reasons.

**B. The Restrictions on the Types of Therapy in an IRF Should Also Be Relaxed to Allow for the Best Possible Outcomes for Patients.**

As previously stated, current guidance states the therapy delivered in an IRF to meet the 3-hour rule should be some combination of individual physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy. This restricts clinicians from choosing from other types of appropriate therapies, such

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<sup>11</sup> 42 C.F.R. § 412.622 (a)(3)(ii).

as recreational therapy that might best meet the needs of patients. CMS should expand the types of therapy permitted to count towards the therapy intensity requirements so that clinicians, and not CMS, determine the best course of treatment for patients. Other types of skilled therapy, such as recreational therapy, should be counted as a qualifying modality when it is: (1) prescribed by the treating physician and the rehabilitation team as part of the patient’s plan of care; (2) considered active treatment; and (3) provided by a qualified therapist. Other services that should be considered include psychological and neuropsychological services. CMS should also explore how therapies furnished via new technologies can be accommodated and incorporated in the 3-hour rule.

This approach would preserve the intensity of therapy delivered in an IRF, while allowing more flexibility to individualize care for each patient’s need. Restricting the types of therapy that meet the intensity of therapy only serves to promote a one size fits all approach to care delivery. Moving to a more flexible approach to therapy would be a win-win-win for patients, CMS and providers, as patients will be sure their care is delivered in a manner best suited to them, CMS will be guaranteeing proper outcomes for patients and avoiding the cost of monitoring compliance with arbitrary therapy standards, and providers will no longer be forced to meet those arbitrary standards when a different approach is the better way to deliver care to a patient.

#### **V. Proposals to Reduce Burden Resulting from Medicare Advantage Practices**

IRFs find that Medicare Advantage (MA) plans are placing an untenable burden on IRFs through their prior authorization processes. According to membership reports, an inordinate number of prior authorization requests for IRF services are initially denied.<sup>12</sup> These denials set off an appeals process that is time consuming and takes physicians away from delivering patient care, thereby delaying access to needed care for beneficiaries.

Even the most expeditious MA plans take one to three business days to respond to a prior authorization request for IRF admission. This delay simply is not in the best interest of patients. In addition, if a patient becomes ready for discharge late in the week or on a weekend, the approval to transfer the patient from an acute-care hospital to an IRF will be further delayed since MA plans are closed for the weekend. Once an initial denial is issued on the medical record, a physician can then engage in a peer-to-peer discussion with the MA plan’s clinical personnel to attempt to justify the admission. However, despite hospitals having 24/7 operations, MA plans provide limited timeframes for these discussions. This forces either acute-care hospitals or the rehabilitation hospitals to rearrange their other duties to spend time justifying their judgement to an MA representative – who has never seen the patient and is seldom trained in rehabilitation

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<sup>12</sup> Medicare Payment Advisory Commission, Report to The Congress: Medicare Payment Policy 298 (Mar. 2017) (Finding that MA beneficiaries are admitted to IRFs at a rate nearly three times less than traditional Medicare beneficiaries).

medicine.

During this process, the acute-care hospital has the precarious and potentially untenable choice of either continuing to hold on to a patient who may have been ready for discharge days prior, or discharging the patient to another, perhaps less appropriate, PAC setting. This can be devastating to patients, their families, and caregivers who attempt to use their best medical judgment to place a vulnerable patient in the best site of care, only to have MA plans supersede their decision and ultimately delay or deny access to needed IRF care.

**To address this issue, we propose that CMS bar MA plans from using a prior authorization program for IRF services.** As described above, CMS regulations already dictate a thorough screening process for IRF services. CMS should require MA plans to align their requirements with the fee-for-service program and review claims on a post-service basis. In addition to lessening administrative burden, this would also ensure that MA beneficiaries are not inappropriately denied access to services to which they are medically qualified and legally entitled.<sup>13</sup> At the very least, we ask CMS to implement the following guardrails to both protect vulnerable rehabilitation patients and lessen burden on IRFs.

**1. Require a Physician with Specialized Training and Experience in Rehabilitation to Make Prior Authorization Determinations**

Rehabilitation physicians report they spend an outsized amount of their time on the phone with MA plans justifying admission decisions. Medicare regulations require IRFs to utilize a physician with specialized training and experience in rehabilitation.<sup>14</sup> Despite this requirement, MA plans utilize clinicians with lesser or no training in rehabilitation medicine to overrule rehabilitation physician admission decisions and deny prior authorization requests. In the appeal phase, rehabilitation physicians find that the title of “peer-to-peer” calls is a misnomer, since they are often not speaking to a rehabilitation physician with training and experience in IRF care. Instead, they are often speaking to physicians who have little or no experience in medical rehabilitation.

Making IRFs jump through administrative hoops to have MA plans without expertise overruling medical judgement is an unsound and clinically dangerous policy. **To save time and ensure accurate decisions are reached, CMS should require that only a clinician with specialized training in rehabilitation be utilized to review prior authorization requests.** For peer-to-peer discussions, this should include a physician that meets Medicare’s definition of rehabilitation physician and would be appropriately qualified to themselves serve the rehabilitation physician role. **CMS**

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<sup>13</sup> Medicare Managed Care Manual Chapter 4. Revision 121, Issued: 04-22-16 (“While an MA plan may offer additional coverage as a supplemental benefit, it may not limit the original Medicare coverage. MA plans must provide their enrollees with all basic benefits covered under original Medicare.”).

<sup>14</sup> 42 C.F.R. § 412.622(a)(3)(iv).



**should also require that for any denial or adverse appeal decision, the name and qualifications of the reviewer be included to ensure he or she is adequately trained and experienced.**

**2. Prohibit the Use of Proprietary Decision-Making Tools by MA Plans**

MA plans often utilize propriety guidelines, such as those marketed by Milliman and Interqual, to justify denying patients' access to IRFs. In our members' experience, these guidelines recommend upwards of 95 percent of cases qualifying for IRF care be directed to a lower intensity setting, such as a skilled nursing facility (SNF). This practice runs contrary to CMS coverage guidelines, which requires MA plans to offer the same level of care to its patients as traditional Medicare.<sup>15</sup> It also leads to additional strain on physicians who must justify their medical decision-making against algorithms that are often based on outdated or questionable published studies, and arguably inconsistent with Medicare coverage policy.

**3. Mandate MA Plans Issue More Timely Decisions and Be Staffed at All Hours to Handle Pressing Prior Authorization Requests**

As CMS knows, hospitals are 24/7 operations and a patient's condition does not pause during evenings and weekends. Despite the vulnerable state of patients in hospitals, MA plans typically take several days to render decisions, and their operations often cease in the early evenings and on weekends. This means that IRF personnel must block off large portions of their workday in order to go through the MA administrative processes. If private health plans choose to participate in the Medicare Advantage program, these plans should have 24/7 availability of qualified clinical personnel to timely consider prior authorization requests as well as appeals of negative prior authorization determinations.

Instead of spending precious weekday hours engaged in the delivery of care, IRF personnel are tied up in the bureaucratic MA prior authorization process. Not only is this a burden on the hospital's workflow, it is detrimental to patients. A typical example is a patient who receives a prior authorization denial on a Friday. At this point, they may have already been waiting a day or two for an IRF admission decision. Then, since the MA plan ceases operations over the weekend, a peer-to-peer appeal discussion may not be scheduled until Monday or Tuesday, where the IRF personnel must yet again take time out of their busy weekday schedule to speak with the MA physician representative. Once that occurs, and the patient has finally been moved, the patient may have spent an extra week unnecessarily in an acute-care hospital and their needed intensive rehabilitation services are delayed accordingly. This pattern is a lose-lose for all stakeholders – patients are adversely impacted by treatment delays, physicians are diverted from patient care, and the extended hospital stay results in avoidable costs and Medicare expenditures.

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<sup>15</sup> Medicare Managed Care Manual Chapter 4. Revision 121, Issued: 04-22-16.

**To address this urgent issue, MA plans should be required to render IRF admission decisions and appeals in a timely fashion reflecting the immediate needs of patients requiring inpatient rehabilitation services.** While AMRPA believes all patients would benefit from this change, hospitalized patients are especially in need of expedited decision timeframes. **CMS should also require MA plans to always have a specialized physician on call, just as the hospital is required to do.** This would allow IRFs to focus their resources on participating in patient care and not on the phone with MA plans. It would also speed up the appeals process to avoid further delays, which would be beneficial to patients and their outcomes as well as to the rehabilitation physicians.

**VI. HHS and CMS Should Revamp Audit, Denials and Appeals Procedures.**

The aggregate burdens of Medicare’s various audit and appeals programs have become intolerable for health care providers, including IRFs, not only due to the arduous processes, but because of the increasing number of items that have become subject to audit. Reining in contractor use of minute omissions to deny claims, as well as providing more deference to practicing physicians’ judgement, would over time, substantially reduce the strain that Medicare claims appeals are placing on our administrative law system, judicial system, taxpayers, providers, and patients.

**A. CMS Should Take Steps to Eliminate Technical Denials.**

CMS should include a statement in regulations governing IRF coverage rules and contractor audits declaring that isolated technical deficiencies in documentation shall not constitute the sole basis for denial of a claim. Alternatively, the agency could establish a “totality of the circumstances” test for determining whether coverage criteria are met. This change would prevent entire claims from being denied for many of the more perfunctory reasons, such as one missing signature next to a note or documenting the post-admission evaluation one hour late (unless they are systemic or can otherwise be shown to impact patient care). Either approach would create a much more equitable standard of review as applied by Medicare contractors. Moreover, either approach represents a vast improvement over the status quo.

As CMS is aware, contractors can deny an entire claim - withholding tens of thousands of dollars to patients for IRFs – based on a single, small technical omission in the medical record. A prohibition on technical denials would reduce financial strain on providers, as well as significantly lessen the total number of claims that are appealed. It would also alleviate one of the most frustrating aspects of providing services to Medicare beneficiaries—delivering high-quality care that restores a patient’s physical and cognitive function only to be denied payment for an arguably insignificant paperwork error. Addressing these issues is precisely aligned with the goals of the “Patients Over Paperwork” initiative.

**B. CMS Should Improve Audit Processes To Facilitate Improved Performance and Lessen Burden on Providers.**

AMRPA appreciates that CMS recently issued a set of standardized denial codes to

be used by all contractors when reviewing claims from facilities being paid under the IRF PPS.<sup>16</sup> These standardized codes may alleviate confusion and will be helpful in providing a specific citation to a regulation or section of the Medicare Benefit Policy Manual (MBPM) for a provider to reference.

However, AMRPA remains concerned that without a requirement that contractors cite the specific deficiency found in the medical record, providers may still be unable to determine their error and thus not be able to improve performance. As an example, one of the denial statements reads (IRF8B) in full: “Documentation does not support the patient received intensive rehabilitation therapy services.” Without a more specific and precise explanation, a provider would not be able to discern exactly what about the therapy services delivered were insufficiently intensive.

Further, we also recognize that CMS has implemented the Targeted, Probe and Educate audit procedures, which are geared towards providing education to providers to explain the reasons for denials of specific claims. However, it has been AMRPA providers’ experiences that the education portion of this process is lacking. Specifically, contractors performing the education are often not the ones who reviewed and denied the chart, so they are unable to answer specific questions about the deficiency in the chart. In other instances, the contractors are attempting to educate about multiple patients at once, each one of which was a complex and varying situation, and the hour provided for the call is not nearly sufficient.

Beyond the deficiencies in the education sessions, it is unclear that these probes are truly as “targeted” as they are meant to be. There have been a high number of IRFs receiving these probes, which seem to focus on no particular area of the claim. At the very least, CMS should provide more transparency as to how providers are chosen for the probe and focus on one problem area in particular (for example, physician visit documentation or on therapy notes). This would be consistent with the cyclical approach of the probes – where a provider is audited, and then educated on their mistakes.

Finally, the frequency of audits creates an unreasonable burden on providers. Providers report that they usually have just finished responding to the last set of Additional Documentation Requests (ADRs) and first stages of appeals when they are hit with another audit request. Providers report that they spend approximately 10 hours per case on the ADRs and first levels of appeal. They frequently receive 20-40 ADRs per audit. This means they are spending 200 hours, conservatively, per probe, which is happening multiple times per year. All of this time is spent just to reach a years-long backlog at the third level of appeal (ALJ hearing) – the first level of independent review - where providers’ claims are most often overturned in their

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<sup>16</sup> *Inpatient Rehabilitation Facilities Reason Codes and Statements* (Updated December 8, 2017). Retrieved from: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/ESMD/Downloads/Inpatient-Rehabilitation-Facilities-IRF.pdf>.

favor. Resources are again devoted to responding to arduous audit requests and responses through this process, rather than improving performance, which is the purpose of these audits. Therefore, CMS should limit audits to once per year per provider, and longer for providers who have demonstrated high compliance rates.

**C. There are Simple Ways HHS Could Streamline the Appeals Process to Alleviate Provider Burden.**

In order to shorten the lengthy Medicare appeals process, reduce provider burden, and hasten the time to final resolution, CMS should consolidate the redetermination and reconsideration stages of the appeals process. At a minimum, providers should be allowed to opt out of the reconsideration stage before proceeding to ALJ review.

Notably, Qualified Independent Contractor (QIC) reconsiderations rarely result in a different outcome than the original redetermination and are rightfully perceived as a “rubber stamp” of the initial denial. A 2012 HHS Office of the Inspector General (OIG) report found that ALJs reversed QIC decisions and decided fully in favor of Part A hospital providers in 72 percent of appeals.<sup>17</sup> This posture is likely based on the information and circumstances that QICs are empowered to take into consideration, as well as their general orientation to the bases for denials, including technical denials and contractor errors. CMS likely has authority to modify the procedure by consolidating the first two levels of appeal at the provider-appellant’s request. Although the Medicare statute entitles claimants to the reconsideration stage,<sup>18</sup> CMS could nonetheless issue policies to allow providers to opt out.

Should CMS conclude that any modifications to the stages of Medicare appeals process require legislation, we believe a legislative solution would be well warranted to address the unacceptably long and costly process to obtain payment for medically necessary care. This proposal is designed to reduce the amount of time and resources a provider is forced to expend on the obligatory lower levels of appeal, which do not offer a meaningful opportunity to overturn the initial denial, and thus simply add expense and time—which is of course itself a cost—to the appeals process. This also advances HHS’ ongoing efforts to reduce the appeals backlog, signaling the widespread recognition that the current appeals process results in unacceptable delays for providers.

**D. CMS Should Halt Recoupment of Claims Denied Post-Payment through the Issuance of an ALJ Decision.**

In order to lessen the financial strain imparted by the current appeals process, and to spare CMS compounding interests costs, CMS should expand the current limitation on recoupment related to post-payment denials through the date an ALJ decision is issued. Under current policy, claims that are denied and reaffirmed on

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<sup>17</sup> DEPARTMENT OF HEALTH AND HUMAN SERVICES OFFICE OF THE INSPECTOR GENERAL, IMPROVEMENTS ARE NEEDED AT THE ADMINISTRATIVE LAW JUDGE LEVEL OF MEDICARE APPEALS, OEI-02-10-00340 (Nov. 2012).

<sup>18</sup> 42 U.S.C. § 1395ff.

redetermination must be paid back pending appeal. As noted above, however, it is not until the ALJ phase that there is a meaningful opportunity to review the medical necessity of care. Therefore, this proposal would alleviate some of the financial burden borne by providers stuck in the years-long appeals backlog by allowing them continued access to reimbursement for care already furnished.

This proposal would also benefit CMS by taking some of the pressure off the ALJ backlog and reducing the amount of interest that must be paid back to providers at the conclusion of the appeals process in the case of overturned denials. Although this policy admittedly does not address the concerns raised by the extended appeals backlog for those providers pursuing pre-payment denied claims, it is nevertheless an improvement on the status quo.

**E. CMS Should Create an Audit “Circuit Breaker” to Stop Unnecessary Audits.**

Medicare contractors should be barred from conducting payment reviews based solely on statistical analyses when a provider demonstrates why its caseload is at variance with the applicable regional or national analyses. In recent years, Medicare contractors have increasingly audited cases citing statistical analysis as their rationale. For example, the contractor’s letter may state that documents are requested because the provider exceeds the regional average for the particular types of cases audited, such as stroke. In reality, the multitude of factors that influence individualized post-acute care placement decisions are not conducive to an oversimplified audit-by-number approach. Providers may exceed the averages stated in the letters for any number of valid reasons, which may not be apparent in simple statistical analyses. For instance, the IRF may be the only teaching program in the state or region; other nearby IRFs may have closed and it has assumed all of the closed providers patients; or the IRF may be renowned for a specific rehabilitation subspecialty or may be attached to a trauma center, cancer center, or cardiac center. In the end, such statistical analyses simply demonstrate variation from a mean, and can signal exceptional clinical performance - not improper practices. Audits on this basis alone are therefore harassing, unwarranted, and add to the overall burden of a flawed recovery audit program. The data will show that they are often fruitless, to boot. CMS should direct contractors not to launch reviews on the basis of statistical analyses alone.

**F. CMS Should Require Recalculation of Error Rates for Providers Under Pre-Payment Review.**

Medicare Administrative Contractors (MACs) that institute ongoing pre-payment reviews against a provider should be required to recalculate providers’ error rates on a quarterly basis (and include the results of any favorable appeals in the calculation) for purposes of determining whether it is appropriate to continue pre-payment review or revise the percentage of claims to be reviewed. Since prior regulations limiting the use of recalculation were rescinded, there has been a noticeable increase in its use by the MACs with virtually no rules restricting these contractors. While pre-payment review can help identify improper payments before they are made, it also creates

significant administrative inefficiencies if it fails to account for appeal outcomes, continuously shuttling new denials into the appeals system.

**G. CMS Should Deem Appealed Claims as Payable if They Remain Pending for Five Years or More After the Initial Determination.**

If any appeal is still pending five years after the date of the initial determination on the claim, the claim should be deemed payable. By presuming that after a certain period of time a claim should be considered finally decided, this proposal is consistent with reopening regulations treatment for claims not involving allegations of fraud or similar fault. A five-year period accounts for the typical year it should ordinarily take an appeal to work through the ALJ level of appeal (at most), plus the four years permitted for reopening. But for the extensive appeal backlog, this five-year period would typically account for the maximum amount of time reimbursement for a claim could be at issue.

*As demonstrated, there are many redundant and minimally effective processes in the current audit and appeals system. CMS should take the steps outlined above which would lower administrative burden on providers as well as on CMS, while still maintaining high levels of program integrity within the Medicare program.*

**VII. Elements of The IRF Quality Reporting Program (IRF QRP) Should Be Revised to Provide the Most Clinically Relevant Data and Ensure Minimal Provider Burden.**

The IRF QRP seeks to improve performance and transparency in the quality of care being delivered by Medicare providers. However, there are several areas of the IRF QRP that impose unnecessary burden while not always reflecting the most clinically valuable information. As CMS continues to implement the quality measures and data collection requirements of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act, we urge it to do so in a practical and minimally burdensome manner that adds value to post-acute care providers and to patients. This approach would be consistent with the goals of “Patients Over Paperwork” and “Meaningful Measures” to reduce provider administrative burden (specifically with regard to burden from quality measures) and ensure that federal reporting mandates prioritize actionable, patient-centered information.

**A. CMS Should Prioritize Clinical Utility and Patient-Facing Value in Developing New Standardized Patient Assessment Items Pursuant to the IMPACT Act.**

While our member hospitals support the goals of the IRF QRP, it is critical to evaluate the burden of additional IRF QRP measures and reporting requirements such as the standardized patient assessment data elements (SPADEs). AMRPA is concerned that the SPADEs add significant provider burden and it is unclear how many of the data items would actually improve the efficiency and quality of post-acute care. AMRPA supports the IMPACT Act and appreciates the desirability of collecting standardized PAC patient assessment data. However, CMS’ implementation of the Act has added burdens to the IRF QRP at an incredibly aggressive pace, with the most recent IRF PPS rule doubling the length of the patient assessment that IRFs must complete for each Medicare patient. Furthermore, many



of the SPADEs are nearly identical to existing hospital assessment and care practices that are already in place in IRFs and thus are unnecessarily repetitive and burdensome.

The SPADEs also add to provider burdens by significantly affecting clinical workflow. Providers are not simply completing a longer assessment form for each patient, but they must also build additional assessment practices into their existing workflows; this entails working with vendors to modify electronic health record (EHR) systems and investing in staff education and training, to start. To paint a picture, CMS and the RAND Corporation conducted a National Field Test to beta test the SPADEs with a limited sample of PAC providers, and one of challenges CMS grappled with is the sustained training and education of the clinical staff at the test sites. This example is but a small taste of the logistical and administrative challenges that providers face whenever new mandatory assessment practices are introduced to PAC settings.

**To meet the IMPACT Act's requirements, CMS should consider an approach by which it implements a core set of non-duplicative standardized patient assessment items across all PAC settings, upon which it builds and supplements setting-specific assessment items as needed.** AMRPA urges CMS and its contractors to prioritize and consider in concert both the administrative burden to providers of collecting data and the data's clinical effectiveness and utility. CMS should also be mindful of the impact that numerous assessment or patient-reported items could have on the patient-provider relationship. We believe this aspect has been an unevaluated, yet critical, component to successful implementation of PAC assessment items. To some elderly and other patients, so many questions can seem intrusive and they may respond negatively to an exhaustive battery of assessment minutiae.

#### **B. CMS Should Account for the Added Reporting Burden in FY 2021**

CMS estimates that the new SPADEs will add approximately 20 minutes to each patient assessment, at a minimum. AMRPA thinks CMS' estimates significantly underestimate the provider burden associated with training, assessing, and reporting these new items. For one, while the proposed items underwent time testing, the IRFs participating in those tests received training directly from CMS and/or its contractors and also had access to CMS/contractor guidance throughout the test period. These simply are not benefits afforded to all IRFs despite CMS' commendable efforts with providing IRF QRP training events and the IRF QRP Technical Helpdesk. Furthermore, several assessment items require clinical information that can be obtained only through a detailed chart review, and it is unclear if CMS' tests accounted for that additional time in the reported results.

Most notably, the new SPADEs double the length of the IRF-PAI. CMS must recognize that any addition, revision, or adjustment to the IRF-PAI has a considerable ripple effect in terms of increased burden on providers' operations. Changes to Medicare's mandatory patient assessment instruments not only add more time to

every patient assessment, but also consume provider resources to adapt to these changes in their clinical practice, administrative workflow, not to mention working with their EHR and IRF-PAI vendors to update IT systems. **AMRPA urges CMS to account for the costs associated with the finalized IRF QRP additions by upwardly adjusting the IRF PPS payment update in the FY 2021 rulemaking to reflect higher provider resource use (and therefore costs).**

**C. CMS Should Lower the IRF QRP Completion Threshold in FY 2021**

In the FY 2018 IRF PPS rulemaking, CMS adopted a policy to apply the IRF QRP data completion threshold to the submission of standardized patient assessment data beginning with the FY 2019 IRF QRP. The IRF QRP completion threshold is 95 percent, meaning that at least 95 percent of an IRF's required IRF-PAI submissions (Medicare Parts A and C patient assessments) must have 100 percent completion of the required data elements. In contrast, the SNF QRP and LTCH QRP completion thresholds are 80 percent, a dichotomy that seems unfair.

In the FY 2018 IRF PPS final rule, CMS signaled a willingness to consider an alternative data completion threshold, due to AMRPA and others' objection to the agency perpetuating discrepant standards in QRP reporting requirements across PAC settings. To AMRPA's disappointment, however, the FY 2020 IRF PPS proposed rule did not propose a reduced IRF QRP completion threshold. In fact, CMS wholly neglected to address the completion threshold in this year's rulemaking, despite finalizing changes that dramatically increase providers' IRF QRP compliance burden starting in October 2020. **AMRPA urges CMS to propose a reduced IRF QRP threshold percentage that is aligned with other PAC QRPs (i.e., 80 percent) in FY 2021 rulemaking and prior to the October 2020 implementation of the new SPADEs.** At a minimum, the IRF QRP completion threshold should be lower than 95 percent in the first year providers are required to report the new SPADEs. It is critical for CMS to afford providers the flexibility needed to adapt to this increased reporting burden.

**D. The Two Percent Payment Penalty for Failure to Successfully Submit Required Quality Data Should Provide Flexibility for Providers Who Make a Good-Faith Effort to Submit.**

AMRPA continues to ask CMS to provide flexibility in its application of the IRF QRP payment penalty for IRFs that make a good-faith effort to comply and submit quality reporting data. AMRPA and our member hospitals recognize the importance of timely submission of IRF QRP data. However, due to the volume of mandatory reporting items, the unreasonably high likelihood of reporting errors (particularly through the National Healthcare Safety Network (NHSN)), and lack of a confirmatory checkpoint, the inflexible and outsized financial penalty should be reexamined. If data are not properly submitted, IRFs have insufficient notice before CMS imposes the two percent financial penalty through a reduction to the provider's annual payment update. These financial penalties can be very significant.

The IRF QRP relies in part on data reported to the NHSN which is maintained by the Centers for Disease Control and Prevention (CDC), and the CDC separately transmits the data to CMS for IRF QRP compliance purposes. Unfortunately, the NHSN portal incorporates a complicated, multi-step reporting mechanism that is prone to system and user error and which does not provide any mechanism for confirming accurate and complete data submission to CMS.

### ***CMS Should Take Steps to Reduce NHSN Reporting Burdens***

IRFs currently report three quality measures via the NHSN's attestation portal. Although NHSN was originally designed as a voluntary system for acute-care hospitals to report quality data, it is now used to report mandatory quality measures to CMS for multiple reporting programs, including the IRF QRP. Due in part to its original voluntary use, NHSN requires more data and reporting than CMS requires for the IRF QRP. The NHSN legacy system was not designed for its current purpose or use, and certain features of the NHSN that might have made sense for a voluntary reporting program create additional burdens for reporting mandatory QRP data. We present below several examples of how the highly burdensome NHSN reporting requirements jeopardize IRFs' compliance with CMS' quality reporting program:

- NHSN will not count as “complete” any data submissions that do not contain all of the data required by NHSN, even though these requirements can be beyond CMS' requirements. If NHSN does not count a submission as “complete” (even if the submission reflects all of the information required for a particular CMS quality measure), NHSN will not “pass on” the data to CMS and “tells” CMS that no data has been received at all. This results in the IRF being out compliance with IRF QRP requirements.
- NHSN requires IRFs to declare what they are planning to report to NHSN via submission of a “monthly reporting plan,” before they actually report it. NHSN also requires different monthly reporting plans for different reporting modules. When the NHSN was a voluntary system, these monthly reporting plans were a way for hospitals to indicate their intention to report data for a specific time period. However, now that data reporting is predominantly mandatory, this additional step takes significant time to complete and creates an additional and arbitrary way for an IRF to become out of compliance with regulatory requirements. If a hospital does not complete an initial monthly reporting plan, NHSN will not transmit the hospital's data to CMS, even if all the requisite data has been submitted for that month. A frustrating challenge for many IRFs is a failure to set up a monthly reporting plan, even if they have entered the actual quality data required.
- Although NHSN is now able to receive certain data via an electronic submission, not all of NHSN's required data (which again, are over and above the data required for the CMS IRF QRP) can be accepted electronically. Monthly reporting plans currently cannot be submitted electronically. As another example, if an IRF has no infections in a given reporting period, they are still required to check a box when no events (*i.e.*, infections) occur. Hence, even if an IRF submits its data electronically, staff must still

log into the NHSN system every month, create a complete monthly reporting plan for infections, and check additional boxes indicating “no events,” in order for its data to be transmitted to CMS and avoid the financial penalties of IRF QRP noncompliance. Enabling a full transmission of all required information electronically would alleviate a significant burden and provide more accurate and complete, real-time information for IRFs.

- Most recently, in order to report monthly summary data for certain multidrug resistant organisms, hospitals have been required to report their primary laboratory testing method data once per quarter. This information is not required by CMS in order to calculate any quality measure performance, but without entering this information made mandatory by NHSN, IRFs’ regulatory QRP data that is required by CMS cannot not be saved and will not be submitted to CMS.
- Most frustratingly, if NHSN has not transmitted the data to CMS, it fails to provide any notification to hospitals that there is an issue which requires redress in order to satisfy NHSN’s reporting requirements and “pass on” the data to CMS.

Given its complicated nature, the potential for data transmission issues between the CDC and CMS, and the absence of a data receipt confirmation process, the NHSN system and CMS’ reliance on it creates an unnecessarily high likelihood that providers may encounter a problem in submitting some of their required quality information. Without confirmation of successful data submission to notify IRFs, there is no opportunity to correct any data submission issues. Despite their good faith efforts to report all of the data, due to clerical errors while inputting the information to the NHSN or the unknown software problems mentioned above, many IRFs have been hit with a payment reduction of hundreds of thousands of dollars, which would be devastating to any provider.

As the CDC collects more and more data at agency discretion via NHSN, IRFs become further bound not only by their regulatory requirements from CMS, but also from the requirements of the CDC, which has little regard for the burden on IRF providers. Since IRFs are financially penalized for incomplete QRP data, any elements outside of CMS’ regulatory requirements should be minimized.

**AMRPA urges CMS to provide more flexibility in its application of the noncompliance penalty to allow providers an opportunity to correct any errors when a good faith effort to submit data is undertaken.** Correspondingly, we ask that CMS reserve harsher penalties for egregious offenders who fail to consistently submit IRF QRP data in a timely or thorough manner. **We also respectfully request CMS to revisit the way that NHSN reporting requirements are creating mounting administrative burdens for all IRFs and consider less burdensome alternatives.**

**E. CMS Should Remove Measures That Are Not Clinically Relevant to IRF Quality of Care from Mandatory Reporting and from Public Display**

As described above, the NHSN measures in particular are administratively taxing to report and the provider costs associated with these measures can be severe and disproportionate to the limited value these measures bring. **Therefore we recommend that CMS act to remove the following measures from the IRF QRP:**

- **NHSN Catheter Associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138);**
- **NHSN Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure (NQF #1717); and**
- **Influenza Vaccination among Healthcare Personnel (NQF #0431), which is also submitted via CDC/NHSN.**

Like the MRSA and patient flu vaccine measures that CMS has recently removed from the IRF QRP, these measures also do not produce meaningful quality information to providers or patients. According to CMS data on IRF Compare, 97 percent of IRFs display a “Not Available” or “No different than the National Benchmark” score on IRF Compare for the CAUTI measure, and 88 percent of IRFs display those scores for the CDI measure.<sup>19</sup> The CAUTI measure is not relevant to the IRF QRP because rehabilitation hospitals and units generally have a very low number of indwelling/Foley catheter days. Furthermore, because the denominator is so small, the CAUTI incidence rate can swing wildly from just one additional infection day and thus can be interpreted unfairly in public reporting. These measures are simply not relevant to IRFs and they do not produce meaningful information for consumers who use IRF Compare data.

IRF QRP measures should be relevant to IRFs’ patient care and generate robust, discriminating data, especially when the data is reported on IRF Compare. Resources expended by providers for collecting measures are resources not available for other patient-centric activities. CMS should regularly assess the value versus burden of its mandatory measures and focus quality measurement on those domains that truly improve patient care instead of adding provider burden.

*Currently, many aspects of the IRF QRP impose unnecessary burden while not always reflecting the most clinically valuable information. We urge CMS to be more flexible in determining IRFs’ compliance with the IRF QRP reporting requirements, and to reserve the two percent payment penalty for egregious offenders who are flouting their responsibilities under the IRF QRP. The IRF QRP and the public display of provider performance on IRF Compare should be updated based on the best available clinically meaningful measures and streamlined to improve efficiency.*

**VIII. CMS Should Allow IRFs the Flexibility to Maximize Their Participation in Alternative Payment Models (APMs) to Innovate Care Delivery.**

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<sup>19</sup> IRF Compare, June 5, 2019 Refresh.



AMRPA shares CMS' vision of creating a more efficient Medicare system that rewards patient-centered care. However, IRFs are currently restrained from fully participating in several Medicare APMs due to a lack of regulatory flexibility. CMS should make the following adjustments to allow for IRFs to take part in the transition to more value-based care.

**A. CMS Should Allow IRFs to Implement Alternative Pricing within APMs.**

An increasing number of APMs hold provider entities, such as acute care hospitals or broader networks of providers, responsible for post-acute spending. These models encourage IRFs, like other post-acute care providers, to produce high-quality outcomes at a reduced cost. However, unlike other post-acute providers such as nursing homes, IRFs are paid on a flat per-discharge basis for patients. Because Medicare rules do not allow IRFs to “charge less” in this context, existing bundling programs typically incentivize bundle-holders to steer patients away from receiving inpatient medical rehabilitation, even when it is imperative to their recovery. This phenomenon is exacerbated by these programs' failure to penalize for stinting on medically necessary care or otherwise measure long-term functional outcomes. **For IRFs to be able to compete alongside other providers in these models, CMS should allow willing providers permitted to receive reduced reimbursement, a per diem payment, or offer a discount from the IRF PPS amount, if they so choose.** Although this likely means that IRFs will be paid below cost for treating patients in these programs, the alternative—that patients are denied access to inpatient rehabilitation altogether—is far worse for IRFs, and especially for patients. Since margins are very small or negative for the majority of IRFs, pricing flexibility must be voluntary, as should all alternative payment and delivery models being tested.

**B. CMS Should Offer Regulatory Waivers for IRFs in APMs**

CMS should afford IRFs the option of including patients admitted under an APM as counting towards the IRF's compliance with the 60 Percent Rule. Innovations and advances in medicine over the past four decades have enabled patients with other serious diagnoses to not only survive acute care hospitalizations, but to also benefit tremendously from the intensive and multidisciplinary rehabilitation program provided in IRFs. However, these patients are often denied admission because they do not meet 60 Percent Rule compliance. **Hence, CMS should grant IRFs the option of counting patients admitted under APMs towards their satisfaction of the 60 Percent Rule; to do so would afford IRFs the much-needed regulatory flexibility to more fully participate in alternative care and payment delivery models.** The 60 Percent Rule is an antiquated utilization control mechanism that is unnecessary in today's environment of risk-based APMs, as we detail extensively in earlier sections of this submission.

This approach is consistent with CMS' recent emphasis on expanding provider access to APMs, and has been favorably discussed by the Medicare Payment Advisory Commission (MedPAC) in the context of reforming and advancing Medicare's post-



acute care payment systems. CMS has the authority to permit such flexibility, and to waive these bureaucratic requirements without Congressional approval; therefore the agency should do so when promulgating any future models or changes to the current programs.

**C. CMS Should Allow for an Administrative Presumption of Coverage under APMs.**

All patients admitted to IRFs from acute care hospitals participating in an APM, regardless of whether the provider is receiving IRF PPS payment or reduced reimbursement, should be presumed to be covered in the IRF setting. Acute hospital “bundle holders” are responsible for the cost and quality of care for their bundled patients. If acute care physicians choose to discharge patients to an IRF, they should have full discretion to do so without Medicare contractor interference as their performance metrics and outcomes in the APM will be impacted by the placement decision. **CMS should instruct its contractors to respect post-acute care referrals and admission determinations under APMs. Specifically, CMS’ contractors should not be permitted to deny payment for cases treated under APMs based on pre-payment review or post-payment reopening, unless there is evidence of fraud.**

**D. CMS Should Test APMs that Aim to Directly Demonstrate the Clinical and Financial Value of Regulatory Flexibility**

AMRPA urges CMS, via the Center for Medicare and Medicaid Innovation (CMMI), to test a model specifically designed to show how relief from certain regulatory requirements applicable to IRF physicians that could both reduce Medicare expenditures and improve patient care – precisely in line with the goals of all CMMI models. To that end, AMRPA asks that CMS consider developing a new set of billing codes that would be used by an attending rehabilitation physician for daily care for an entire inpatient rehabilitation episode. As constructed, the rates would reflect the estimated total amount of charges that are, on average, submitted for these stays (the rates would take into account, for example, patient diagnosis and length of stay). Through this bundled or “batched” payment system, rehabilitation physicians would be paid at a discounted Medicare rate (to be set at a later time), *in exchange for being exempt from claims review or denials tied to documentation (e.g., the IOPC)*. Physicians would benefit from immunity from medical necessity reviews and audits, and Medicare would see an immediate benefit through the reduced payment rate. This change would also allow physicians to expend more of their time and resources on patient care, in line with the goals of CMS’ initiative.

**E. CMS Should Voluntarily Test Any Unified PAC Payment System Before Submitting a Prototype to Congress.**

The IMPACT Act of 2014 directs the Secretary of HHS to develop a technical prototype for a unified PAC PPS and submit it to Congress along with accompanying policy recommendations. *Before* such a prototype and policy recommendations are submitted to Congress, HHS must pilot or test the prototype payment system in order

to ascertain the feasibility of its implementation and use within the PAC sector, including its capacity to predict patients' PAC resource needs and impact on patients' quality of post-acute care and outcomes. Such a pilot or test should be voluntary, should be designed to accommodate the testing of multiple payment and reimbursement methodologies (including episodic and stay-based payment reimbursement approaches) and provider reimbursement rates contemplated under the prototype, and should include waivers or rescissions of site-specific regulations and policies that define current post-acute provider settings.

***CMS should introduce more regulatory flexibility, such as allowing alternative pricing and presuming IRF coverage, to allow for IRFs to fully participate in CMS efforts to create a more efficient Medicare system. CMS must also properly utilize its demonstration authority and test any unified PAC PPS model before a prototype payment system is submitted to Congress.***

#### **IX. CMS Should Change Its Policy on New IRFs to Reduce Undue Administrative Burden**

Many AMRPA members perceive CMS' current policy for paying new rehabilitation units as placing a sizable and unnecessary burden on hospitals attempting to open a new IRF subunit. Currently, if a unit opens before the first day of a cost report period, the unit is paid on the basis of an acute hospital's diagnosis-related group (DRG) instead of the corresponding IRF case-mix group (CMG) for the remainder of the cost-reporting period. Because the lower reimbursement rate from DRGs is not adequate for an IRF to sustain itself, new hospital-based rehabilitation units are all but required to open on, or a day or two prior to, the hospital's cost report year.

If the hospital encounters an unanticipated construction delay or a delay in receiving state certification (for which some states are notorious), missing the deadline by even a few days would result in the IRF unit being stuck with the DRG rate for nearly a full year. The payment differential can be significant, imposing what is in essence a multi-million dollar penalty. More broadly, it does not make sense for an arbitrary Medicare policy to essentially force rehabilitation units to open on one specific day of the year. Freestanding rehabilitation hospitals do not face this problem because they have no pre-existing cost report year. The hospital can thus open whenever ready and will be paid according to the appropriate CMG rate beginning on day one.

When confronted with these concerns in the past, CMS personnel have indicated that there is nothing that can be done to address the problem because a hospital unit is actually paid an outlier payment upon opening based on the division of cost (as evidenced by its filed cost report) and the number of patients it treats. However, in addition to confusing providers, this convoluted approach to new units results in outlier payments that exceed the annual cap, and thus by the start of the next cost report year, CMS recoups approximately 90 percent of the outlier payment.

Many AMRPA members believe that the policies that apply to new IRF units create arbitrary regulatory burdens that often result in financially devastating consequences for providers. Paying hospital-based rehabilitation units under the IRF PPS' CMGs from the outset, the same as a freestanding rehabilitation hospital is a simple fix that harmonizes the payments across all new IRFs.

***AMRPA recommends that hospital-based rehabilitation units should be paid a CMG from the outset regardless of whether the unit opens on or after the first day of the hospital's cost reporting period.***

**X. Recommendations to Reduce Patient and Family/Caregiver Burden in Navigating Post-Acute Care**

Many consumers are unfamiliar with PAC services and settings, yet patient and their families/caregivers are often forced to make a quick decision at the acute-care hospital discharge, with only limited assistance of hospital staff or clinicians and often under cost and time pressures. These swift decisions and the lack of information can lead to patients being placed with PAC providers that are not high-quality and/or do not meet the patient's needs. This "PAC awareness gap" leaves patients and their families without sufficient guidance at an incredibly vulnerable point in their care trajectory.

**CMS should encourage earlier discussions in the acute-care hospital setting that educate beneficiaries and their families/caregivers about discharge planning needs and post-acute care.** This decision should also include educating the patient's family or caregiver about post-discharge needs, such as assistance with activities of daily living, as assessing caregivers' ability to support these needs is highly informative to PAC discharge planning. Many families and caregivers would benefit from being more aware of PAC patient needs and potential options earlier in the patients' care trajectory. **CMS should also revise hospital discharge planning requirements to facilitate more transparent dialogue between hospitals discharge planners and patients about PAC.** These revisions could, for example, allow hospitals to provide more detailed information about high-quality PAC providers and permit hospital discharge planners to recommend a specific PAC provider. While patients and families are told they are able to choose the PAC provider, the provider options, and information on said providers, are often very limited. As a result, the "choice" of provider often becomes a burden of research and decision-making with patients and families frequently choosing a provider based on distance, access to transportation, or where the first bed becomes available as opposed to quality of care.

**Finally, CMS should enhance transparency and improve beneficiary education regarding what Medicare covers for post-hospital care, the difference in covered services across PAC settings, and the differences in beneficiary cost-sharing responsibilities across settings.** Many beneficiaries are not aware of Medicare's 100-day lifetime cap for coverage of SNF services or of their coinsurance responsibilities for days 21-100. For some patients, this leads to a scramble to find an alternate care setting when on or immediately before day 20. There is a significant and unfortunate gap in

public awareness about PAC and knowledge of Medicare's coverage thereof – and it is patients who suffer.

*CMS should take steps to minimize the burden that patients and their family/caregivers experience when choosing a high-quality PAC provider during the acute-care hospital discharge process, and to ensure that beneficiaries understand their financial responsibilities for various PAC settings.*

## **XI. CMS Should Amend Hospital Conditions of Participation and Enrollment Requirements**

### **A. Recent Changes by CMS Have Put IRFs in an Untenable Competitive Disadvantage**

In the last several years, CMS has made a number of changes to its Hospital-Within-Hospital (HwH) regulations as well as its excluded-unit regulations. Beginning in 2018, CMS changed its HwH requirements so that two co-located, Inpatient Prospective Payment System (IPPS) excluded hospitals would no longer need to comply with the HwH regulations pertaining to separation of hospital operations and staff.<sup>20</sup> In addition, even HwHs that were co-located with an IPPS-hospital would no longer need to meet the “basic functions” tests in the HwH regulations.<sup>21</sup> CMS said it made these changes because these restrictions were relics of former payment systems, created to prevent patient shifting to excluded units when these units were still paid under the reasonable cost-based reimbursement system.

The following year, CMS eliminated its prohibition on an IPPS-excluded hospital operating an IPPS-excluded unit.<sup>22</sup> Similar to when it made changes to the HwH regulations, CMS stated that due to the creation of prospective payment systems for excluded hospitals and units, the concerns that prompted this restriction (patient shifting) were no longer a concern. AMRPA agrees with CMS' conclusion that these excluded unit provisions are no longer necessary. However, removal of this restriction had the unintended consequence of creating a dysfunctional imbalance among post-acute care (PAC) hospitals. This is because among the two types of PAC hospitals – long-term care hospitals (LTCHs) and IRFs – only an LTCH is able to host a unit of IRF, but the reverse is not possible.

As CMS knows, while Medicare allows for operation of an IRF unit, no such unit equivalent exists for an LTCH. An LTCH must be its own, separately licensed

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<sup>20</sup> Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2018 Rates, Final Rule, 82 Fed. Reg. 37990, 38293 (Aug. 14, 2017).

<sup>21</sup> *Id.*

<sup>22</sup> Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2019 Rates, Final Rule, 83. Fed. Reg. 41144, 41513 (Aug. 17, 2018).

hospital.<sup>23</sup> This means that an LTCH can host an IRF unit, but an IRF cannot host an LTCH in its hospital. Since an LTCH can now add an IRF unit, and also house other elements, such as a distinct SNF as well as outpatient services, the LTCH can essentially host most of the PAC continuum under one roof. This allows the LTCH to operationalize significant efficiencies in the management and care of patients throughout the PAC continuum of care. Existing IRFs, by contrast, are offered no such ability. While AMRPA has long supported breaking down these silos of care, doing it in a way that favors one sector but adversely impacts another within the post-acute field – and leaves existing IRFs unable to be competitive – may present unintended and potentially harmful consequences to patients and the Medicare program.

The rehabilitation hospital sector has long been at the forefront of care innovation and improvement for PAC patients. Among the sites of care in the PAC continuum, which include LTCHs, IRFs, SNFs and home health agencies (HHAs), IRFs enjoy the unique distinction of being the site of care that delivers both intensive rehabilitation services and hospital-level medical care.<sup>24</sup> In addition, IRFs deliver care through a unique interdisciplinary team approach, with CMS requiring physical therapists, occupational therapists, speech-language pathologists, rehabilitation nurses, rehabilitation physicians, and other clinician types to work in a highly coordinated manner in order for a patient with a serious debility to regain function and quality of life.<sup>25</sup>

LTCHs, by contrast, are only held to the standards of acute-care hospitals, other than the requirement to exceed a certain length of stay threshold. Therefore, if the silos of PAC begin to break down through these changes, IRFs should be afforded an opportunity to continue to lead the way with their expertise in delivering intensive rehabilitation care. Instead, CMS is essentially leaving them in an untenable competitive position, risking beneficiaries' access to this care as well as Medicare's access to the long-term cost savings achieved from timely intensive rehabilitation interventions.

AMRPA understands that the inability to create an LTCH unit may require a statutory technical correction and for CMS to create parity through creation of an LTCH unit. However, AMRPA has several recommendations that would lessen provider burden and allow IRFs to remain competitive in spite of these recent changes. These would involve changes to the Medicare Conditions of Participation (CoPs) and HwH regulations to facilitate an existing IRF incorporating an LTCH into an existing hospital site.

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<sup>23</sup> See 42 U.S.C. § 1395ww(d)(1)(B)(iv)(I) (defining a LTCH as “a hospital which has an average inpatient length of stay (as determined by the Secretary of Health and Human Services) of greater than 25 days”).

<sup>24</sup> See 42 C.F.R. § 412.622 (CMS Regulations Require IRFs to deliver at least 3 hours of therapy per day, in addition to providing close physician supervision of all patients and treatments, a feature unique to all sites of care).

<sup>25</sup> See Medicare Benefit Policy Manual § 110.2.5 - Interdisciplinary Team Approach to the Delivery of Care.



## **B. CMS Should Amend the Medicare Conditions of Participation to Alleviate Burden on Existing IRFs**

Under current policy, the only way for an IRF to add LTCH beds at its existing site would be for an IRF to add a second hospital and operate as an HwH. As previously noted, CMS did away with several of the HwH requirements for co-located, IPPS-excluded hospitals. However, for several reasons, the HwH option is far more burdensome and costly to pursue than the option available to LTCHs, which only requires adding of a unit to the existing hospital. Therefore, CMS should amend the existing CoP regulations to afford flexibility to allow existing IRFs to add an LTCH to their site, akin to how LTCHs can now operate IRF units.

In the FY 2018 IPPS final rule, when removing the aforementioned HwH requirements for IPPS-excluded hospitals, CMS asserted that these changes would not “result in a practical change to how HwHs are currently operated because the performance of basic hospital functions requirements at § 412.22(e)(1)(v) are currently addressed under CMS’ Interpretative Guidance for the hospital [Conditions of Participation].”<sup>26</sup> Further, CMS stated in the subsequent year’s rule that “All hospitals, regardless of payment status, must always demonstrate *separate and independent* compliance with the hospital CoPs, even when an entire hospital or a part of a hospital is located in a building also used by another hospital.”<sup>27</sup> In short, CMS has made clear that in order to remain compliant with the Medicare CoPs, the HwH arrangement is not to function in any way, shape or form as a unit in a host hospital, and should remain as a separately and independently functioning hospital.

It is clear that the separateness interpretation of the CoPs leaves existing IRFs with no comparable option to compete with an existing LTCH that is able to incorporate an IRF unit into its facility. The IRF would need to seek out a license for an entirely new hospital, which may not be possible due to state certificate of need restrictions or space limitations in the current building. Even if the IRF is able to create a separate hospital, it cannot share resources and create efficiencies the same way an LTCH and IRF unit would be permitted to do. While the LTCH hosting an IRF unit can move staff and resources freely between the IRF unit and LTCH patients, the IRF hosting an LTCH as an HwH would need to duplicate staff and resources.

These arbitrary restrictions exist despite the fact that IRF units and IRF hospitals are held to the exact same certification, payment, quality and intensity of services standards. If one were standing inside an IRF, there would be no way to distinguish whether the IRF was a unit or a separately licensed hospital, due to the identical regulatory requirements. Yet, CMS imposes two entirely different standards for how an IRF hospital can integrate with a co-located hospital compared to how an IRF unit

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<sup>26</sup> Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2018, 82 Fed. Reg. 37990, 38293 (Oct. 1, 2018).

<sup>27</sup> Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2019, 83 Fed. Reg. 20164, 20451 (May 7, 2018) (emphasis added).



can integrate with its host hospital. CMS recognized the arcane and outdated HwH and excluded-unit regulations, and wisely eliminated them in favor of allowing providers to focus more resources on patients, rather than administrative roadblocks. CMS should take the same approach for co-located, IPPS-excluded hospitals.

AMRPA recommends CMS amend these regulations to allow for more parity across PAC hospitals and to eliminate outdated co-location standards that serve no clinical purpose. The changes CMS makes should include allowing for more lenient separateness standards for co-located hospitals when both hospitals are IPPS-excluded hospitals. Additional changes should also include permitting medical staff and other clinicians, such as therapists, to move more freely between the two hospitals, especially when patients are transitioned from one hospital to the next during the course of the patient's recovery. CMS should also allow other crossovers, including integrated medical records and other clinically related services that benefit a patient when they remain consistent through the patient's course of treatment. Administrative functions such as billing, payroll, and accounting should also be permitted to be shared between the two entities. In addition, the agency should loosen shared space restrictions, permitting families to share specialized treatment areas and other clinical areas that may benefit patients at both hospitals.

These changes would clearly be beneficial to patients and the Medicare program. If an IRF is interested in integrating sites of care under one roof, they would no longer be required to either convert their host hospital to an LTCH to incorporate an LTCH unit, or operate as separate hospitals under burdensome CoP separateness requirements. Instead, an existing IRF could create a co-located LTCH and integrate services across the continuum of care, reducing inefficiencies as patients transition from one site to the next, and also allowing for clinical integration to ensure patient's caregivers and information travel with them as they progress.

#### **C. CMS Should At Least Create a Grandfather Exception for Previously Existing HwHs**

Co-located arrangements, such as HwH, have existed for decades. It is only in recent years that CMS has started to promulgate interpretations of the CoPs that proscribe such strict separateness standards. Many currently existing HwH are housed in buildings built long before these new interpretations. As such, AMRPA requests that if CMS cannot amend the CoPs as described in the above subsection, that CMS at the very least include a narrow "grandfathering" exception for specific cases where the current configuration does not meet CMS standards for HwH separateness.

This exception process is necessary where the ability to reconfigure a hospital building may be cost prohibitive, and hospitals would be closed if not provided an exception. Providers are more than capable of addressing privacy, quality and safety concerns in shared space, and should be permitted to do so when granted grandfather status. **Therefore, we request CMS, if it does not exercise its regulatory authority to more broadly amend the CoPs to provide parity for IRFs, to provide an exception to separateness requirements for HwHs that have been in existence for at least five years.**

In conclusion, IRFs offer life-changing care to patients that have been afflicted with a serious injury or illness. The recent regulatory changes – as well intentioned as they may be – have put IRFs in a precarious situation. ***In order to lessen the regulatory burden on IRFs to allow them to devote maximum resources to patient care, while still remaining financially viable, CMS should amend the Medicare CoPs to allow for more flexibility when two specialty, IPPS-excluded hospitals co-locate with one another.***

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AMRPA appreciates the opportunity to participate in CMS' important efforts to streamline Medicare policies to prioritize patient care. We are also eager to provide any technical assistance or further information on our recommendations at your convenience and look forward to continuing to collaborate on creating a more patient-centered health care delivery system. If you have any questions, please do not hesitate to reach out to Kate Beller, AMRPA Executive Vice President for Policy Development and Government Relations (202-207-1132, [kbeller@amrpa.org](mailto:kbeller@amrpa.org)).

Sincerely,



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