



May 31, 2022

SUBMITTED ELECTRONICALLY VIA www.regulations.gov

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2023 and Updates to the IRF Quality Reporting Program (CMS-1767-P; RIN 0938-AU78)

Dear Administrator Brooks-LaSure:

The undersigned members of the Coalition to Preserve Rehabilitation (CPR) appreciate the opportunity to comment on the Fiscal Year (FY) 2023 Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) proposed rule.

CPR is a coalition of more than 50 national consumer, clinician, and membership organizations that advocate for policies to ensure access to rehabilitative care so that individuals with injuries, illnesses, disabilities, and chronic conditions may regain and/or maintain their maximum level of health and independent function. CPR is comprised of organizations that represent patients – as well as the clinicians who serve them – who are frequently in need of the rehabilitation care provided in IRFs and other settings of post-acute care (PAC), such as home health.

The proposed rule adopts a market basket and payment update specific to IRFs and revises relative weights for the IRF case-mix groups. It also addresses quality measurement and reporting as well as other aspects of the IRF payment system. CPR does not intend to comment on these sections of the proposed rule. Instead, our comments focus on CMS' Request for Information (RFI) regarding potential application of the home health transfer policy to IRFs, as well as broader concerns with access to appropriate rehabilitation for complex conditions in the Medicare IRF benefit.

Home Health Transfer Policy RFI

Overview of RFI

CMS is seeking feedback from stakeholders on a potential change to the existing IRF transfer payment policy. Currently, when IRFs discharge a patient to certain other post-acute care settings (other IRFs, inpatient hospitals, nursing homes, or long-term care hospitals) before the

patient has reached the average length of stay (LOS) for their respective case-mix group, the IRF payment for that patient is reduced. This policy was implemented in the early 2000s and was intended to provide a financial disincentive to inappropriately shortening courses of IRF treatment in order to increase profit margins. At the time, the home health prospective payment system (PPS) was new, and so this policy was not expanded to include discharges to home health. CMS cites a recent Department of Health and Human Services (HHS OIG) report that found that the Medicare program could have reduced its expenses by approximately \$993 million in 2017 and 2018 if this policy were applied to so-called “early” discharges to home health care as well as other settings. CMS is now considering this recommendation, and is seeking additional information about how such a policy could impact patient access to appropriate post-acute care services.

Notably, CMS is not currently proposing a change to the IRF transfer payment policy, simply asking for additional information from the public.

CPR Response

We appreciate that CMS is opening a dialogue with stakeholders about potential future changes to this policy, rather than immediately proposing a change. While we recognize CMS’s mandate to guard against overpayments and protect the fiscal solvency of the Medicare program and have broader concerns about trends toward shorter lengths of stay in IRFs (detailed below), ***we do not believe that expanding the IRF transfer payment policy to home health discharges would be in the best interest of IRF patients.***

As a guiding principle, we believe that decisions about settings of care, lengths of stay, courses of treatment, and other medical considerations must be made based on clinical factors, not financial criteria or incentives. Simply put, patients should receive the medically necessary care to which they are entitled for the length of time that is appropriate for their individual clinical circumstances, in the setting or settings most appropriate to meet their specific medical and functional needs. ***Patient care in any setting should be patient-centered and physician-directed.***

Extending the transfer policy to home health care when beneficiaries are discharged from IRFs to home health before the average LOS is achieved omits consideration of those patients whose stay in an IRF exceeds the average. The nature of prospective payment systems assumes that some patients are discharged before, and some patients are discharged after, the average LOS. Applying a financial penalty to patients discharged before the average LOS and not expanding payments for those discharged after the average LOS seems inequitable and could produce perverse incentives in the provision of post-acute care for Medicare beneficiaries.

A proposed financial penalty for IRFs that discharge patients to home health prior to the average LOS implies that such a discharge is inappropriate, premature, or that the IRF has not sufficiently completed the rehabilitation treatment program for which CMS is providing payment. On the contrary, these decisions are made by treating rehabilitation physicians in consultation with the entire rehabilitation team. Home health should be considered the primary intended destination of rehabilitation care for all IRF patients, with limited exceptions for those with particularly complex conditions. “Discharge to community” is, in fact, a measure of IRF

quality and this usually means a discharge of the patient to their home setting. Approximately 75% of IRF patients are discharged to their homes, a strong indicator of quality care.

The intensive therapy and medical management provided in an IRF may be necessary to address their initial rehabilitation needs, and outpatient/home health care can provide the ongoing support necessary in the longer term while allowing the patient to begin to reintegrate into their community and resume their daily lives and life roles. A return to home is the most preferable outcome in many rehabilitation cases, and IRFs should not be disincentivized from facilitating these outcomes when the patient has achieved their individualized rehabilitation goals and can benefit from this type of care, which is often preferable for patients that desire a return to normalcy rather than elongated inpatient stays away from their families and longer-term caregivers.

Unfortunately, the OIG's proposed home health transfer policy would create a significant incentive to keep patients longer in an IRF setting than is necessary. The policy would make it more difficult for patients to return home when they are ready to do so. As stated above, a transfer to home health is not only often necessary but should be considered as an expected goal of a successful course of inpatient rehabilitation treatment. Such transfers are critical for reintegrating patients into their community after an injury or illness, especially for many of the populations that our members represent. ***Thus, we do not support an expansion of the IRF transfer payment policy to home health discharges.*** We welcome additional dialogue with CMS on how to ensure appropriate access to care for Medicare beneficiaries in need of post-acute care.

Lengths of Stay and Other Patient Access Concerns in IRFs

Separate and distinct from the IRF transfer payment policy discussion, CPR would like to again raise our long-held concerns that some patients are finding it increasingly difficult to access the full range of medically necessary rehabilitation services across the spectrum of post-acute care providers to which Medicare beneficiaries are entitled under Medicare coverage guidelines. In particular, our members have heard from patients, especially those with severe and complex rehabilitation needs, that they are unable to achieve a full inpatient stay long enough to address their myriad needs. This occurs across post-acute care settings and does not seem to be limited to any one type of condition or discharge location. In many cases, Medicare Advantage plans place great pressure on post-acute care providers to discharge their patients as soon as possible. Some patients under Medicare are even told that the Medicare coverage policies are dictating early discharge, even when the treating physician or lead provider believe the patient could achieve a better outcome with a longer length of stay.

We recognize that the nature of a prospective payment system will clearly incentivize shorter lengths of stay; however, this issue seems to be accelerating in recent years. This also appears to be one symptom of a broader trend towards limiting access to post-acute care – CPR has long expressed to CMS our concerns with the misuse of prior authorization and other utilization management techniques, the use of proprietary guidelines to overrule physician judgment, the barriers to access created by the Patient-Driven Payment & Groupings Models (in the Skilled Nursing Facility and Home Health payment systems, respectively), and other policies that result

in patients being denied the medically necessary care they need. While we do not support a home health transfer payment policy as detailed above, we urge CMS to delve deeper into the trends of *underutilization* in the Medicare post-acute care benefit and work with stakeholders to identify ways to improve patient access to care, not further restrict such access.

We greatly appreciate your consideration of our comments on the FY 2023 IRF PPS proposed rule. Should you have any further questions regarding this information, please contact Peter Thomas or Joe Nahra, coordinators for CPR, by e-mailing Peter.Thomas@PowersLaw.com or Joseph.Nahra@PowersLaw.com, or by calling 202-466-6550.

Sincerely,

The Undersigned Members of the Coalition to Preserve Rehabilitation

ACCSES

American Academy of Physical Medicine and Rehabilitation

American Association on Health and Disability

American Occupational Therapy Association

American Physical Therapy Association

American Spinal Injury Association

American Therapeutic Recreation Association

Amputee Coalition

Association of Academic Physiatrists

Brain Injury Association of America *

Christopher & Dana Reeve Foundation *

Disability Rights Education and Defense Fund

Falling Forward Foundation *

Lakeshore Foundation

National Association for the Advancement of Orthotics and Prosthetics

National Association of Rehabilitation Providers and Agencies

National Association of State Head Injury Administrators

Rehabilitation Engineering and Assistive Technology Society of North America

Spina Bifida Association

United Spinal Association *

**** CPR Steering Committee Member***