June 2, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services (CMS)
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: CPR Coalition Comments on the Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2024 and Updates to the IRF Quality Reporting Program; File Code 1781-P

Dear Administrator Brooks-LaSure:

On behalf of the Steering Committee members of the Coalition to Preserve Rehabilitation (CPR), we appreciate the opportunity to submit comments on the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) for Fiscal Year (FY) 2024 Proposed Rule, published in the Federal Register on April 3, 2023. CPR is a coalition of 57 national consumer, clinician, and membership organizations with the goal of preserving and expanding access to medical rehabilitation services in a variety of settings. CPR advocates for policies that ensure access to rehabilitative care so that individuals with disabilities, illnesses, injuries, and chronic conditions may regain and/or maintain their maximum level of independent function.

I. The FY 2024 Proposed Rule

The IRF proposed rule for FY 2024 proposes a number of payment updates, quality measure adjustments, and other policies that we generally view as non-controversial. While we generally support the rule, we offer a specific set of comments on the proposed adjustments to the Case Mix Groups (CMGs) that form the basis for the IRF PPS and ultimately create financial incentives that may impact care to certain types of Medicare beneficiaries. We address two additional issues as well, one in response to the proposed rule's solicitation of other policies, namely, ensuring that future quality measures are directed, first and foremost, at improving patient care, and expressing our continued concern with the impending implementation of the IRF Review Choice Demonstration (RCD) project.

1. Case Mix Group (CMG) Adjustments: In the context of updating the CMG and tier relative weights using claims data and cost report data, the proposed rule estimates that the vast majority of the proposed CMG changes (99.4% of cases) will result in a change in weight of less than 5 percent. The remainder of cases will receive greater increases or decreases in weight. However, our understanding is that certain complex cases will be disproportionately affected by the proposed reductions in weight, specifically, the CMGs

for a traumatic spinal cord injury patient (CMG 0404) and patients with major multiple trauma with brain or spinal cord injury (CMG 1801). We also note that these particular CMG adjustments may implicate health equity concerns, given that the conditions described by these CMGs are more common in minorities and patients of lower socioeconomic status compared to others. These data were collected during the height of the public health emergency which had a profound impact on availability of IRF care, availability of other settings of post-acute care, lengths of stay, and other relevant factors. CPR Coalition therefore requests CMS to consider the impact of these distorting factors when finalizing the weights for these types of patients treated by IRFs in the final IRF rule so as not to underserve Medicare beneficiaries with spinal cord and brain injuries.

II. Solicitation of Comments on Quality Measures

In the proposed rule, CMS invites general comments on the principles for identifying future quality measures under the IRF Quality Reporting Program (QRP). The CPR Coalition appreciates the opportunity to provide comments related to the IRF QRP and focuses its comments on one key quality issue: Patient-Centric quality measurement. Like all quality measurement requirements under the Medicare program, the intent of new quality measures is not to burden providers and patients with collection of data that does not serve a compelling purpose. The reason quality data is collected is to ultimately lead to improvements in care that benefit patients through better outcomes. Yet, a review of the current measures within the IRF QRP to date raises questions about whether this is being achieved.

The CPR Coalition strongly urges CMS to focus all new quality measures, first and foremost, on patient-focused measures that are designed to genuinely improve care with the least amount of burden on patients and providers. One way to achieve this is to more purposefully request this information from patients themselves, as well as the patient organizations that represent various patient constituencies. In addition to publication of this annual proposed rule, we urge CMS to think creatively about obtaining patient perspectives through roundtables, Open Door forums, focus groups, and other creative mechanisms for public feedback.

II. IRF Review Choice Demonstration

The FY 2024 IRF proposed rule omits any mention of a program that CMS is poised to implement in the coming months known as the IRF Review Choice Demonstration or "RCD." Ironically, the RCD is, by far, the most impactful change to IRF care that will befall the IRF community this year and, likely, for years to come. Yet, the proposed rule completely omits any mention of it. The CPR Coalition is on record as having serious reservations about the IRF RCD and how it will likely create a gatekeeper effect that will restrict access to IRF care over time. The CPR believes that the IRF RCD has the potential to significantly restrict CMS coverage criteria for IRF care without going through proper regulatory procedures that include public notice and comment.

The IRF RCD is a five-year demonstration project that is scheduled to begin in the State of Alabama on August 21, 2023, before expanding to Pennsylvania, Texas and California and eventually other states in several Medicare Administrative Contractor (MAC) jurisdictions. When fully implemented, CMS estimates that IRF RCD will apply to 526 freestanding rehabilitation hospitals and hospital-based inpatient rehabilitation units across the United States.

The demonstration would require all IRFs in those states to submit *all* Medicare fee-for-service claims for review throughout the demonstration or until they have a 90% claim approval rate. At that point, they could forgo these constant reviews but would still be subject to so-called "spot checks" on 5% of their claims. IRFs would have the choice between pre-claim review or post-payment review but the result would be the same: Every admission would be scrutinized and second-guessed by their MACs. The medical judgment of treating rehabilitation physicians will be systematically challenged on every patient. It will not take long for IRFs to anticipate which types of patients their MACs will deny, and it will take a financially strong IRF to continue admitting those types of patients and providing them with intensive rehabilitative care only to have those claims denied and subject to lengthy, costly, and time-intensive appeals that take away frontline providers from the current provision of patient care.

IRFs provide intensive medical rehabilitation care and services to thousands of Medicare beneficiaries and other patients who have sustained a serious illness or injury, such as stroke, neurological impairment, hip fracture, amputation, spinal cord or brain injury. These are serious, complex conditions that require medical rehabilitation expertise to accurately assess these patients. Because of this, it is imperative that CMS and its contractors thoroughly educate and train the clinicians who will be tasked with reviewing IRF claims under the RDC. Under the CMS regulations, a physician with training and experience in rehabilitation must determine whether an IRF stay is medically necessary for a Medicare beneficiary. The CPR believes that only a rehabilitation physician should be empowered to deny such claims on behalf of a Medicare contractor.

For these and other reasons, the CPR Coalition continues to have serious concerns with the impact the IRF RCD will have on patient access to care. Accordingly, we urge CMS to take a methodical approach to implementation of the RCD, extensively educate and train the MACs in charge of the program in each state in which it is implemented, and closely monitor the impact of the RCD on access to patient care. We also urge CMS to remain open to input from IRF stakeholders, including the CPR Coalition, as it designs and implements this program. If access issues are revealed, as we expect, we strongly urge CMS to take aggressive steps to prevent this from happening on an ongoing basis and we look forward to working with CMS to help assist in this endeavor.

We appreciate your leadership and the work that CMS is pursuing to ensure that Medicare continues to be viable for tens of millions of beneficiaries who depend upon this important program for their healthcare services and benefits, particularly for IRF care. Please contact Peter Thomas, CPR Coalition Coordinator, for any questions or additional information at 202-607-5780 or at Peter.Thomas@PowersLaw.com.

Sincerely,

The Coalition to Preserve Rehabilitation Steering Committee:

Brain Injury Association of America
Center for Medicare Advocacy
Christopher & Dana Reeve Foundation
Falling Forward Foundation
United Spinal Association