



June 15, 2020

SUBMITTED ELECTRONICALLY VIA www.regulations.gov

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS-1729-P: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2021 Proposed Rule

Dear Administrator Verma:

On behalf of the Association of Rehabilitation Nurses (ARN) – representing approximately 4,800 rehabilitation nurses and more than 14,000 Certified Registered Rehabilitation Nurses (CRRN) that work to enhance the quality of life for those affected by physical disability and/or chronic illness – we appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed rule implementing the Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) for Fiscal Year (FY) 2021. Our comments focus on the proposed revisions to IRF coverage requirements for FY 2021.

Overview of Rehabilitation Nursing

Rehabilitation nursing is a philosophy of care, not a work setting or a phase of treatment. We base our practice on rehabilitative and restorative principles by: (1) managing complex medical issues; (2) collaborating with other specialists; (3) providing ongoing patient/caregiver education; (4) setting goals for maximum independence; and (5) establishing plans of care to maintain optimal wellness. Rehabilitation nurses practice in all settings, including freestanding rehabilitation facilities, hospitals, long-term subacute care facilities/skilled nursing facilities (SNFs), long-term acute care facilities, comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHAs), and private practices.

Rehabilitation nurses take a holistic approach to meeting patients' nursing and medical, vocational, educational, environmental, social, spiritual, and safety needs. We lead and coordinate rehabilitation, restorative care, and community reintegration for populations across all age groups and ethnicities across the care continuum, from ambulatory care to hospice. Rehabilitation nurses begin to provide care to individuals, their families, and caregivers soon after the onset of a disabling injury or chronic illness and continue to provide specialty care, patient and family education, and care transition planning that empowers these individuals to return home, work, and/or school. Rehabilitation nurses, in collaboration with interdisciplinary

teams, provide comprehensive, population-specific care management to access health care services, adaptive technology and equipment, and community resources.

ARN supports efforts to ensure persons with disabilities and chronic illnesses have access to the appropriate level of rehabilitation services to maximize functional outcomes, independence, and quality of life. Specifically, as a part of its mission, ARN stands ready to work with policymakers at the local, state, and federal levels to advance policies and programs that promote maximum independence for all persons in need of rehabilitation.

Use of Non-Physician Practitioners to Perform IRF Coverage Requirements

In the proposed rule, CMS includes a significant proposal to allow non-physician practitioners (NPPs) to perform the IRF coverage requirements that are currently required to be performed by a rehabilitation physician. These expanded duties for NPPs would include nearly all facets of IRF care, including conducting CMS-required face-to-face medical visits with the patient, leading interdisciplinary team meetings, and developing the patient's plan of care. If finalized, this proposal would allow NPPs to essentially take over the role of the rehabilitation physician in an IRF.

CMS states that this proposal would reduce regulatory burden on physicians in IRFs, decrease expenses, and increase access to post-acute care (PAC) services, especially in rural and underserved areas. However, this proposal goes far beyond allowing NPPs to complete documentation requirements and would have a far-reaching impact on the operations of IRFs and the provision of inpatient rehabilitation care.

While ARN appreciates CMS' efforts to ease regulatory burdens on IRF providers, we have significant concerns about this proposal's apparent treatment of NPPs and rehabilitation physicians as interchangeable. As representatives of rehabilitation nurses, ARN is concerned that physician assistants (PAs) and nurse practitioners (NPs) do not have the same rehabilitation knowledge, experience, and training as a physiatrist and therefore should not be allowed to fulfill the requirements for rehabilitation physicians in IRFs. Equating these providers could present a significant challenge to the quality of care provided in IRFs.

NPPs are a valuable part of the care team in IRFs across the country. However, we do not believe that NPPs have the specialized medical training in rehabilitation that is needed to assess IRF patients both medically and functionally in order to replace the rehabilitation physician's role in an IRF. While some NPPs may have significant experience in IRF settings and caring for patients in need of rehabilitation, there are no standardized requirements or criteria outlined in the proposal to ensure that these practitioners have sufficient knowledge to treat patients with spinal cord injury, stroke, traumatic brain injury, amputation, or other significant disabilities and chronic illnesses that require IRF care. The complex patient populations treated in IRFs are at high risk of serious secondary complications and comorbidities, and it is crucial to ensure that the providers managing their care have the medical expertise to address such comorbidities and complications of disability as they arise.

IRF patients are, by definition, highly complex patients in need of intensive rehabilitation treatment along with an acute care hospital level of integrated medical management. If a facility or care team determines that patient care in an IRF can be completed by an NPP, we worry this is instead recognition that the level of care required to treat a patient may not rise to the level of care provided in the IRF setting. Services provided in the IRF setting are not intended to be the same level of care provided in SNFs, and the distinction between these and other PAC settings is crucial to the appropriate treatment of patients who need IRF-level care. Although ARN supports efforts to align care across PAC settings, we do not agree that the care provided in an IRF should be akin to that which can be provided in a SNF.

We appreciate CMS' commitment to reducing regulatory burden on post-acute care providers and stand ready to work with the agency to develop and implement policies that achieve this and other critical goals. However, the proposal to expand the role of non-physician practitioners in IRFs has the potential to seriously impact the quality of care provided in these settings as well as potentially increase costs due to avoidable readmissions, longer lengths of stay, and unnecessary provision of services. ***We urge CMS not to finalize this proposal and to instead work with stakeholders across the spectrum of post-acute care to identify solutions that will benefit providers and patients alike.***

Conclusion

ARN appreciates the opportunity to provide comments to CMS regarding the proposed rule implementing the FY 2021 IRF PPS. We are available to work with you, your colleagues, the rehabilitation community, and other stakeholders to develop and implement payment policy changes that ensure access to quality care for Medicare beneficiaries with physical disabilities and/or chronic disease. If you have any questions, please contact me or ARN's Health Policy Associate, Jeremy Scott (Jeremy.scott@PowersLaw.com or 202-466-6550). We thank you for your consideration of our comments.

Sincerely,

A handwritten signature in cursive script that reads "Barbara J. Lutz".

Barbara J. Lutz, PhD, RN, CRRN, PHNA-BC, FAHA, FAAN

President