October 8, 2021

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services,
U.S. Department of Health and Human Services
Attention: CMS–10765
P.O. Box 8016
Baltimore, MD 21244-8016
Delivered Electronically

RE: CMS-10765: Agency Information Collection Activities; Proposed Collection; Comment Request; Review Choice Demonstration for Inpatient Rehabilitation Facility (IRF) Services

Dear Administrator Brooks-LaSure,

On behalf of Kindred Healthcare, LLC (Kindred), Select Medical Corporation (Select), and Vibra Healthcare (Vibra) we appreciate the opportunity to comment on the second Information Collection Request proposing an Inpatient Rehabilitation Facility Review Choice Demonstration (IRF RCD) as published in the Federal Register on September 8, 2021. .

Under the proposed IRF RCD, contractors would perform a pre-claim or post-payment review on all Medicare fee for service (FFS) claims in certain states (starting first with Alabama, expanding next to California, Pennsylvania and Texas, and then expanding into numerous other states). Once the demonstration commences, IRFs would remain subject to the demonstration until they receive a compliance rate of at least 90% and would then move to a more limited review process. In the second notice, the Centers for Medicare and Medicaid Services (CMS) restates that the demonstration is intended to "improve methods for the identification, investigation, and prosecution of potential Medicare fraud." However, the notice includes no detail or explanation of the fraudulent behavior justifying this demonstration.

Despite a significant number of thoughtful comments and legitimate issues raised in response to the first IRF RCD notice issued in December 2020, CMS did little to address the grave concerns raised by our organizations and many other stakeholders. We are concerned that the agency did not take the time to reflect on the feedback and adjust the notice accordingly in its second iteration. For the reasons outlined in this letter, **we respectfully request that CMS fully withdraw this proposal, delay any issuance of a formal proposed rule with comment period until well after the public health emergency (PHE) has ended, and alternatively engage with our three organizations and other stakeholders to identify more effective and significantly more patient-centered ways to assure Medicare program integrity.**

As the nation's leading specialty hospital companies, Kindred, Select and Vibra provide high-quality patient outcomes for the most medically complex patients. Collectively, our three companies, own and operate 180 Inpatient Rehabilitation Facilities (IRFs), 98 hospital-based inpatient rehabilitation units (IRFs), 195 Long-Term Care Hospitals (LTCHs), 2,100 outpatient clinics, and 6 acute behavioral health

locations. We help our patients reach their highest potential for health and healing with intensive medical, behavioral, and rehabilitative care through a compassionate patient experience. Our collective mission is to transition patients safely from the general acute setting, prioritize their recovery, and send them home. Our 80,000 dedicated and caring employees deliver healthcare services to more than 1.5 million patients annually across the nation.

Inpatient rehabilitation hospitals are for patients in need of intensive therapy provided through a rehabilitative, physician-led, team-oriented approach to care. Many inpatient rehabilitation hospital patients are recovering from the debilitating effects of traumatic injuries, strokes, spinal cord injuries, brain injuries, orthopedic and neurological conditions, and other serious injuries. Inpatient rehabilitation hospitals are licensed by the state as general acute care hospitals, with additional specialized services and expertise that enable recovery for the most medically-complex patients, and discharges to lower levels of care, if not directly to home.

Our hospitals have played an important and clinically valuable role in the public health response to the COVID-19 pandemic. We believe our nationwide presence comes with many responsibilities, including demonstrating leadership during times of crisis. Throughout the public health emergency, our combined specialty hospitals have cared for tens of thousands of critically-ill, medically complex patients with, or recovering from, COVID. Our dedicated clinicians delivered essential medical and rehabilitative care to patients including those reliant on ventilators, in medically-induced comas, or with substantial post-intensive care needs. Throughout the PHE, our hospitals partnered with hospital systems across the country to address capacity constraints and provide relief for overwhelmed intensive care units and community hospitals.

We count among our successes: establishing more efficient lines of communication outside of typical care silos, helping acute-care hospital partners handle unprecedented surge capacity, converting rehabilitation units to COVID-19-dedicated units, and delivering vital rehabilitative care to patients during their recovery who exhibit unique and challenging clinical presentations.

In regard to our request to withdraw the IRF RCD proposal, we offer the following rationale:

- *Timing Compromises PHE Response*. The timing, speed, and magnitude of IRF RCD will jeopardize public health goals and contradict the intent of PHE waivers, which in large part were put in place to relieve Short-Term Acute Care Hospital (STACH) capacity constraints. The waivers have proven successful, as they have enabled fluid transitions and Post-Acute Care (PAC) hospitals such as IRFs to work hand-in-glove with STACHs, which has had important implications for patient safety from COVID-19 infection and patient care.

  Further, we believe CMS has failed to accurately estimate the incremental burden that the notice and proposed demonstration will place on our employees – both clinicians and administrative personnel – during this challenging time. Our healthcare and public health systems cannot afford to divert these resources, which have been become even more limited due to critical labor shortages.

  The current care delivery environment with temporary waivers, makes it impossible for CMS to proceed with IRF RCD until after the IRF industry is returned to normal operating order.

Additionally, it is imperative that when CMS proceeds with a revised and improved IRF RCD, that it allows time for IRFs and our nation's entire health delivery system to recover from the ongoing PHE. The COVID-19 pandemic continues to devastate the healthcare industry and it will take a protracted, but unknown, period of time for the healthcare industry to stabilize and return to normal. Therefore, CMS should wait at least 1-2 years after the end of the declared PHE before determining if it is appropriate to proceed with the demonstration.

- *New Post-Acute Care Landscape Must Be Addressed First*. The PAC continuum prior to the PHE looks very different from the one serving our health system today. Skilled Nursing Facilities (SNFs), which had previously accounted for the largest share of post-acute volume, have had significant decreases in volume and faced challenges in infection control, and at the same time, hospitals such as ours have stepped in to manage an increasingly more complex patient mix.

  We ask for CMS to recognize the role that our hospitals have been playing during this critical time, the implication being that the demonstration will exacerbate PHE-induced constraints to PAC, especially vital rehabilitative services. Importantly, the constituents most affected will be patients and families, who already experience significant stress at the point of hospital discharge to a PAC setting. IRF RCD – and the possibility of a prior authorization requirement in the future – have the potential to place even more undue responsibility on patients and families, unnecessarily create barriers to PAC, and disregard new systems we have been operating under during the pandemic. The latter is especially important as we believe these changes present an opportunity for policymakers to re-assess the path forward for Post-Acute Care.

- *IRF RCD Does Not Reflect Specialty Nature of Inpatient Rehabilitation*. We have concerns about the reliability of CMS' method for calculating potential payment errors. CMS has contended that IRFs were targeted for IRF RCD due to their high potential for improper payments and fraud. We believe this position is based on output from Comprehensive Error Rate Testing (CERT), a program under which Medicare contractors conduct a small (approximately one tenth of one percent of all Medicare IRF claims) sampling of claims to identify potential payment errors. The combination of reviewers who are not licensed rehabilitation physicians and massive inconsistencies in payment error rates year to year suggest elements of the CERT program (which will largely be replicated in the IRF RCD) may not be reliable to support such a large-scale demonstration that will affect patient care and access to our specialty hospitals.

- *Refinements are Needed with Respect to Reviewer Qualifications.* Only specialized rehabilitation physicians – physiatrists – can approve an admission to an IRF under Medicare regulations. Audit contractors typically employ nurses or therapists to second-guess the admissions decisions of rehabilitation physicians who actually treat Medicare patients. While it may be appropriate for nurses or therapists with experience in IRF care to review documentation to ensure all required elements are included, under IRF RCD or any other program integrity effort, it is only appropriate for a physician who meets the Medicare definition of a rehabilitation physician be allowed to determine that a claim was not medically necessary.

- *Inappropriate Use of Statutory "Fraud Authority".* We believe the authority (section 402(a)(1)(J) of the Social Security Amendments (SSA) of 1967)1 under which CMS has cited to conduct this

demonstration does not align with circumstances specific to the IRF industry, the implication being that the intention of the statute does not match the issue at hand. There is no documented history of significant fraud within the IRF sector, while other provider and supplier settings targeted under this same authority in the past had significant documented cases of fraudulent activities. We do not believe the demonstration as it stands will achieve CMS's goals given this misalignment, and recommend CMS review other ways to address concerns that are commensurate with the existing, rigorous rules and regulations for licensed IRF hospitals.

- *CMS Underestimates Burden Under Paperwork Reduction Act of 1995 (PRA).* CMS has solicited comments on the proposed collection of information under the demonstration in order to comply with the PRA. Even independent of a pandemic that has continued to strain our internal resources, we believe CMS has significantly underestimated the additional resources required to implement and operate a demonstration of this magnitude. We urge CMS to consider these items as we believe it may be possible that initial estimates did not take into account what would be required in practice to undertake the proposed demonstration.

We are committed to assisting CMS in its efforts to identify and address improper behavior, but believe the IRF RCD as it stands – and importantly, implemented at this precarious time – will not achieve these goals, and risks undermining other important public health goals and beneficiary access to care. Below, we have outlined our concerns in more detail and have highlighted areas we recommend CMS consider before moving forward with any demonstration. We hope this letter serves as an opening to collaborative conversations about the best way to approach this area of concern.

What Our Companies Are Already Doing

We believe that it is important for CMS to understand and reflect upon the many existing initiatives and protocols our companies have in place in order to proactively identify and address issues around patient admissions that could lead to improper payments. We welcome further discussion with CMS about these activities.

1. IRFs are specialty hospitals appropriate for only the most critical patients. Our respective staffing structures and investment in compliance programs reflect this belief. We have skilled, dedicated staff that focus on documentation review and admission criteria, and their work is supported by technology-enabled programs that consistently distinguish appropriate from inappropriate patients. This is evidenced by the fact that rehabilitation physicians actually turn away a high percentage of referrals.

2. Ensuring that medically appropriate patients are admitted to our hospitals is a key priority, and top-down communication from leadership at our companies has ensured that our employees are regularly briefed on not only patient profiles, but also are provided the tools to make the right decision.

3. We have coordinated with our referral sources to develop consistent transition processes, this communication has facilitated strong partnerships that focus on patient placement in the right setting, at the right time.

4. Our significant technology investments (e.g., electronic medical records and secure sharing practices with our partner STACHs) have enabled us to drill down into patient details that are necessary for the evaluation of the complex patient types we assess for appropriateness of admission..

We look forward to being a strong partner in assisting CMS in its efforts to refine and improve perceived error rates within IRFs and to develop more appropriate, and targeted initiatives that better address program integrity. If you have any questions about these recommendations, please contact us directly. Sincerely,

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