



**CONSORTIUM FOR CITIZENS
WITH DISABILITIES**

October 8, 2021

Submitted Electronically

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Center for Program Integrity

The Honorable Shalanda Young
Acting Director
Office of Management and Budget
Office of Information and Regulatory Affairs

RE: **Proposed Review Choice Demonstration for Inpatient Rehabilitation Facility Services;
CMS-10765**

Dear Administrator Brooks-LaSure and Acting Director Young:

We, the undersigned members of the Consortium for Citizens with Disabilities Health Task Force, appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed Review Choice Demonstration (RCD) for inpatient rehabilitation facilities (IRFs). The RCD would impose 100% medical review by CMS contractors on every Medicare beneficiary admitted to an IRF in up to 17 states over a five-year demonstration period. The premise of this expansive audit demonstration is to help ensure that Medicare beneficiaries admitted to IRFs are appropriate patients to be served in that setting of care.

The Consortium for Citizens with Disabilities (CCD) is the largest coalition of national organizations working together to advocate for federal public policy that ensures the self-determination, independence, empowerment, integration, and inclusion of children and adults with disabilities in all aspects of society. CCD members represent a broad range of stakeholders – people with disabilities and their families, older adults, disability service providers and workers, health care professionals, and state systems that provide disability services – who advocate on behalf of adults and children with all types of disabilities, including people with physical, intellectual, developmental and mental health disabilities, chronic health conditions, and older adults.

The individuals that the Health Task Force members represent already face significant barriers in accessing care to improve their health and independent function as a result of disabilities and chronic conditions. Many, if not all, of these pre-existing barriers and related health care disparities have been severely exacerbated by the COVID-19 pandemic. For many individuals with significant disabilities and medical needs, such as those with brain or spinal cord injury, multiple sclerosis, stroke, amputation or numerous other conditions, inpatient rehabilitation provided in a hospital setting is necessary to achieve improved health outcomes with the goal of returning to the home and community after illness or injury. In addition to the 58 million

seniors on Medicare, the program also covers health care services for 8 million people with disabilities below the age of 65.

Unfortunately, the Review Choice Demonstration (RCD) project proposed by CMS would likely lead to a significant reduction in access to appropriate care for certain disability populations and other individuals in need of inpatient rehabilitation care. We therefore urge CMS to withdraw this proposal and meet with stakeholders to discuss ways to help ensure the integrity of the Medicare program in a way that does not compromise patient access to care.

CMS Must Prioritize Access to Rehabilitation Care

We believe the RCD proposed demonstration will lead to more people with disabilities who need intensive, coordinated, interdisciplinary rehabilitation care getting turned away from IRFs and sent to less appropriate settings that may not meet their medical and functional needs. Under this proposal, IRFs would be required to either submit all patients' clinical files to Medicare Administrative Contractors (MACs) for pre-claim approval or be subjected to 100% post-payment audits. Either approach would empower CMS contractors to supersede the medical judgments of treating rehabilitation physicians in making decisions about the need for inpatient rehabilitation care. Given the massive scope of this demonstration project, we find this highly problematic.

Though CMS states that the RCD will help to address technical problems with claims more quickly (such as missing or incomplete documentation), the agency also states that the MACs will be reviewing claims based on medical necessity as well. We believe that medical decision-making should be left in the hands of the patient and their provider(s), and that allowing the MACs to second-guess the evaluations of rehabilitation physicians in IRFs will result in a significant negative impact on IRF patients. In addition, options for rehabilitation therapies are limited outside of IRFs, because CMS has recently implemented changes to payment systems in other post-acute settings that deemphasize access to rehabilitation therapy services as well. CCD is concerned that Medicare beneficiaries will be hard-pressed to gain access to the rehabilitation care they qualify for and to which they are entitled under the Medicare program.

We also believe that as MAC denials increase under the RCD demonstration, IRFs will be forced to change their admissions policies – not based on the medical needs of patients, but due to the resources that will be required to challenge systematic denials of certain groups of patients (such as stroke patients or those with so-called “mild” brain injuries) through the lengthy administrative appeals process. As denials increase under the RCD, providers will be able to dedicate less and less time to defending these claims and will likely have to begin preemptively denying admission to those patients who do not fit into the MACs' interpretations of medical necessity, even if the treating physician considers them in need of IRF care. This will create a “gatekeeper” effect that will bar access to this setting of care for certain types of patients.

This ripple effect will most severely impact patients with complex disabilities that are not easily categorized as “typical” IRF patients. While CMS states that the agency does not expect beneficiary access to be impacted by this demonstration, the increased involvement of Medicare contractors and especially non-physician reviewers who make medical necessity

decisions off a paper record and trump the decisions of treating physicians who directly examine patients will almost certainly lead to increased denials for certain types of patients. While there are certain conditions that will be considered typical IRF patients, there are many more individuals with injuries, illnesses, chronic conditions, and disabilities who cannot be easily categorized but may require the intensive, coordinated, interdisciplinary services provided in IRFs.

Individuals who require hospitalization often do not arrive with one, discrete diagnosis. Their conditions may vary greatly in severity, there may be one or more comorbid conditions that make treatment more complex and influence outcomes, and social determinants of health may play a significant role in the individual's plan of care. For example, many individuals may sustain what appears to be a "mild" brain injury or "incomplete" spinal cord injury. Others, such as COVID-19 survivors, may have "debility" as a result of weeks-long hospital stays spent on ventilators. The fact is that certain conditions, regardless of how they initially appear, can have significant, long-term effects on a person's ability to function and live as independently as possible in their home and community, and these may require the kind of intensive, coordinated therapy program available in an IRF.

All of these elements are precisely the kinds of factors that a treating rehabilitation physician, who actually screens each patient and often conducts an in-person evaluation, is prepared for and qualified to assess to determine the most appropriate setting for that individual. Conversely, these potentially complicated components of a patient's circumstances are ill-suited for sufficient consideration and potential reversal by mostly non-physician, MAC reviewers. We are particularly concerned that complex patients with disabilities, representing some of the most vulnerable populations in the Medicare program, are most at risk under this demonstration.

CMS Must Consider the Continuum of Post-Acute Care

The fact that some people with disabilities and chronic conditions are likely to lose access to IRF care is reason enough to withdraw this proposal and explore other ways to achieve CMS' goals without limiting patient access. However, when people qualify for an IRF stay but are turned away, they do not simply disappear from the health care system. Rather, they are likely to spend additional time in an acute care hospital, where they are unlikely to receive the intensive and comprehensive rehabilitation care they need to help regain their health and function. This is particularly problematic during the ongoing public health emergency, where many hospitals are facing severe capacity issues and need the space to accept new patients.

When these patients are transferred out of the hospital, and if they cannot gain admission to an IRF, they are likely to be sent to another setting that may be less appropriate for their needs. These settings may be perfectly appropriate for some patients, but for those who qualify for and require IRF care, they should be able to access the appropriate setting. One of IRFs' primary goals is to discharge the individual back to their home and community to live as independently as possible, and this is completely consistent with the current administration's disability policy agenda. Home health care, skilled nursing care, and outpatient therapy can assist a wide variety

of Medicare beneficiaries, but when Medicare beneficiaries qualify for an IRF level of care, there ought to be no systemic barriers to them gaining admission to this setting.

Conclusion

The CCD Health Task Force recognizes the importance of CMS' role in protecting the integrity of the Medicare program and ensuring that Trust Fund dollars are spent appropriately in keeping with the programs' benefits as established in statute and regulations. This is a critical responsibility, which protects the long-term viability of Medicare and ensures the long-term availability of services for beneficiaries, especially individuals with disabilities and chronic conditions.

However, this responsibility must be balanced with sufficiently providing the benefits to which Medicare enrollees are entitled and for which they are qualified. The proposed RCD will have the effect of limiting access to IRF care for certain Medicare beneficiaries. It is a misguided demonstration project and would disproportionately impact some of the key populations we represent, including those who already face serious inequities in health care. Especially given the Biden Administration's focus on advancing equity and support for underserved communities, including people with disabilities, we urge CMS to reconsider this approach. The Health Task Force and our members stand ready to offer assistance to CMS in developing processes that appropriately protect program integrity while ensuring access to care is not compromised.

Thank you for the opportunity to comment on this important issue. If you have further questions, please contact Caroline Bergner, American Speech-Language-Hearing Association, at cbergner@asha.org and Peter Thomas, Brain Injury Association of America, at peter.thomas@powerslaw.com.

Sincerely,

American Academy of Physical Medicine & Rehabilitation
American Music Therapy Association
American Occupational Therapy Association
American Speech-Language-Hearing Association
American Therapeutic Recreation Association
Association of University Centers on Disabilities
Brain Injury Association of America
Christopher & Dana Reeve Foundation
Disability Rights Education and Defense Fund
National Association of State Head Injury Administrators
National Disability Rights Network
National Multiple Sclerosis Society
Paralyzed Veterans of America
United Spinal Association