ALABAMA HOSPITAL
ASSOCIATION

October 8, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Attention: Office of Strategic Operations and Regulatory Affairs
7500 Security Boulevard, Room C4–26–05
Baltimore, MD 21244–1850

RE CMS – 10765: Medicare Program. CMS 10765; Review Choice Demonstration for Inpatient Rehabilitation Facilities (IRF) Services: Information Collection Activities: Submission for OMB Review.

Dear Ms. Brooks-LaSure:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, the Alabama Hospital Association (AlaHA) appreciates the opportunity to respond to the agency's most recent information collection notice proposing an IRF review choice demonstration (RCD). We ask the Centers for Medicare & Medicaid Services (CMS) to withdraw this proposed demonstration, which would implement new program integrity audits for all IRFs in four states, including Alabama.

Our main concern is the timing of these new audits, which would begin during the ongoing COVID-19 public health emergency (PHE) and thus would divert critical resources from the IRF field's efforts to help fight the pandemic.

Being one of the 4 target states, along with California, Pennsylvania and Texas, Alabama is in a unique position to comment on the burdens that will be created by this RCD. Our providers are very concerned and do not feel that it will benefit the patients. Rather than resulting in improvements for Medicare beneficiaries and the Medicare program, we continue to be concerned that the approach contemplated in this paperwork reduction Notice and supporting documents is more likely to adversely impact patients' access to IRF care and services. It is also more likely to create substantial paperwork and operational burdens for clinical and administrative staff in freestanding rehabilitation hospitals and hospital-based inpatient rehabilitation units. IRF caregivers and other staff are already facing significant patient care and operational challenges associated with the COVID-19 pandemic, including in the state of Alabama where the demonstration is proposed to start.

AlaHA continues to have serious concerns about the timing of this demonstration, given both the duration of the pandemic and the number of intense surges the country has experienced. Alabama continues to be a hotspot. Reports from this week show that Alabama has less than ten percent of its ICU beds available statewide and the added stress of this demonstration would be too much for our providers. Throughout the pandemic, IRFs have continued to treat patients with and recovering from COVID-19, as well as those transferred from overwhelmed general acute-care hospitals. These pandemic-driven admissions often include "long-haul" COVID patients who, because of the virus, face a longer-term and often complex recovery trajectory requiring specialized care to address pulmonary and other complexities and debilities. Furthermore, at this point, we are confident that the pandemic will continue into 2022. Specifically, the hospital field writ large is very concerned about a forthcoming winter surge, due to persistently low vaccination rates in certain parts of the country and cold temperatures, which are expected to increase COVID-19 rates due to increased indoor interaction.

The PHE waivers for IRFs have increased the flexibility to collaborate with general acute-care hospital partners, including IRF units that were, in whole or in part, repurposed to accommodate patients that exceeded the host hospital's capacity. Given the continuing emergence of COVID-19 hotspots, the varying resources across communities, and the complex needs of some COVID-19 patients, these waivers remain instrumental in enabling IRFs to help fight against the virus.

However, despite the waivers, IRFs located in hotspots like Alabama are still experiencing operational challenges. Providers are facing unprecedented staffing shortages, shifts in case-mix, inadequate testing supplies and personal protective equipment, and fill-in personnel for infected staff. COVID-19 demands such as these, which are currently straining the entire health care system, were neither discussed nor addressed at all in the IRF RCD notice.

If CMS does proceed with this demonstration, it should require every potential IRF auditor to demonstrate that they possess comprehensive knowledge of relevant IRF coverage and other key policies in the statute, as well as Medicare regulations and sub-regulatory guidance. Given these auditors' ability to second-guess and overturn the medical opinion of the treating physician, we believe this is a reasonable requirement. Additionally, we urge CMS to require that rehabilitation physicians with credentials consistent with those for physicians practicing in an IRF provide ongoing oversight of IRF auditors.

We share CMS' interest in ensuring that Medicare resources are sensibly used and reimburse services that are medically necessary. However, AlaHA is concerned that the proposed IRF RCD's across-the-board approach would impose undue administrative burden on IRFs that have no history of noncompliance. These IRFs would still be subjected to 100% review, which will increase burden and divert critical resources away from patient care. This is a problem for patient access during the PHE. There is simply little justification for imposing such burdens on patients and providers in this way, particularly at this time in the COVID-19 crisis. If CMS wishes to proceed with this demonstration, it should rely on data-driven evidence to narrow the program's scope by reducing the number of affected providers and claims for those providers.

AlaHA appreciates the opportunity to comment on CMS' Notice for the IRF RCD paperwork reduction requirement. While we support CMS' efforts to be a prudent steward of Medicare dollars, given the significant concerns about timing and provider burden we recommend that CMS not move forward with the IRF RCD. CMS can instead make improvements to its medical review approach for IRFs to address longstanding flaws which will benefit both patients and the Medicare program.

Sincerely,

Donald E. Williamson, MD
President/CEO

Cc: The Honorable Kay Ivey, Governor
The Honorable Richard Shelby, United States Senate
The Honorable Tommy Tuberville, United States Senate
The Honorable Jerry Carl, United States House of Representatives
The Honorable Barry Moore, United States House of Representatives
The Honorable Mike Rogers, United States House of Representatives
The Honorable Robert Aderholt, United States House of Representatives
The Honorable Mo Brooks, United States House of Representatives
The Honorable Gary Palmer, United States House of Representatives
The Honorable Terri Sewell, United States House of Representatives