AARP
Real Possibilities

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June 20, 2018

Administrator Seema Verma
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1688-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically to: http://www.regulations.gov

Re: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2019

Dear Administrator Verma:

AARP appreciates the opportunity to provide comments on the inpatient rehabilitation facility (IRF) payment proposed rule. AARP, with its nearly 38 million members in all 50 States, the District of Columbia, and the U.S. territories, is a nonpartisan, nonprofit, nationwide organization that helps people turn their goals and dreams into real possibilities, strengthens communities and fights for the issues that matter most to families such as healthcare, employment and income security, retirement planning, affordable utilities and protection from financial abuse.

AARP's comments will specifically focus on two issues – telehealth and enabling IRFs to expand their use of non-physician practitioners to fulfill some of the requirements that rehabilitation physicians are currently required to complete.

CMS notes that the rehabilitation physician must conduct face-to-face visits with an IRF patient at least three days per week throughout the patient's stay in the IRF to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process. When the IRF coverage criteria were first implemented in 2010, CMS believed that the rehabilitation physician visits should be completed face-to-face to ensure that the patient receives the most comprehensive in-person care by a rehabilitation physician throughout the IRF stay. CMS is now seeking public comments on whether the

rehabilitation physician should have the flexibility to determine that some of the IRF visits can be appropriately conducted remotely via another mode of communication, such as video or telephone conferencing. CMS is also interested in feedback on whether it should allow a limited number of visits to be conducted remotely.

In 2010, videoconferencing technology was beginning its ascent. Face-to-face assessment was the norm. Since then, videoconferencing via expanded telehealth technology has become common in many medical settings and could be implemented in IRFs. Telehealth can serve as a method to link to a rehabilitation provider when time or distance is a barrier, especially in rural communities where there are physician shortages, or underserved communities where it is challenging to recruit and retain health care providers. In some cases, telehealth may also enable the participation of a family caregiver, as appropriate, in such a visit.

In addition, IRF regulations require documentation that a rehabilitation physician, defined as a licensed physician with specialized training and experience in inpatient rehabilitation, visited each patient admitted to an IRF and performed an assessment of the patient. CMS is seeking stakeholder feedback about potentially allowing IRFs to expand their use of non-physician practitioners to fulfill some of the requirements that rehabilitation physicians must complete.

All advanced practice registered nurses are educated and trained in physical assessment, including assessing functional status. Nurse practitioners and clinical nurse specialists also have expertise in transitional care, which is key to safe discharge from an IRF. Currently, some nurse practitioners and clinical nurse specialists have specialized training in rehabilitation services and work in IRFs. As federal regulations evolve, specialized rehabilitation training such as residencies and fellowships for nurse practitioners and clinical nurse specialists will likely increase.

Expanding the use of non-physician practitioners -- including advanced practice registered nurses and physician assistants -- in meeting the IRF coverage requirements can reduce costs, increase access especially in rural areas, and maintain or improve quality. This helps ensure program integrity and maximum value for the beneficiaries.

AARP appreciates the opportunity to comment on this proposed rule and these important issues. If you have questions, please contact me or have your staff contact Rhonda Richards (rrichards@aarp.org) on our Government Affairs staff at 202-434-3770.

Sincerely,

David Certner
Legislative Counsel & Legislative Policy Director
Government Affairs