June 25, 2018

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 314-G
Washington, D.C. 20201

SUBJECT: CMS-1688-P, Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2019; Proposed Rule, Federal Register (Vol.82, No. 84), May 8, 2018

Dear Administrator Verma:

On behalf of our more than 400 member hospitals and health systems, including approximately 75 inpatient rehabilitation facilities (IRFs), the California Hospital Association (CHA) is pleased to submit comments on the Centers for Medicare & Medicaid Services (CMS) IRF prospective payment system (PPS) proposed rule for federal fiscal year (FFY) 2019.

In summary, CHA supports and appreciates CMS’ proposals to:

- Make limited changes to rehabilitation physician supervision requirements, while preserving necessary intensity and quality of rehabilitation physician supervision given IRFs’ unique services.
- Expand exemptions to separateness and control requirements for long-term care hospitals co-located with another inpatient prospective payment system (IPPS)-excluded hospital, including IRFs.

Additionally, CHA supports and appreciates CMS’ ongoing efforts to improve payment accuracy, including aligning reimbursement more closely with patient characteristics. However, changes to the IRF case-mix classification system, proposed for FFY 2020, have not — in our view — been sufficiently vetted by interested stakeholders to allow for meaningful input. Implementation of such significant changes on the proposed timeline is problematic for a number of reasons, articulated below. CHA urges CMS to engage with providers and other stakeholders to address specific concerns raised in comments to ensure that, as these changes proceed, patient access to medically necessary inpatient rehabilitative care is not jeopardized. Therefore, CHA urges CMS not to finalize this proposal, and instead proceed with additional evaluation and development in close collaboration with key stakeholders and providers.

CHA supports the objectives of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, including the development of standardized patient assessment data elements (SPADE) and data collection across all levels of post-acute care. On behalf of our member organizations, CHA has been actively engaged in supporting the act’s implementation. We recognize the interdependence of the four distinct levels of post-acute care and their respective payment systems, and believe strongly in the need for robust and transparent analysis of data across the continuum.
Key to supporting meaningful changes in payment systems across the continuum is access to data, so that stakeholders may replicate CMS’ analysis to inform comments and educate providers on the potential impact. As implementation continues, we urge CMS to make publicly available, on an ongoing basis, the SPADE currently being collected from providers across all settings of care so that they can be compared and evaluated as part of the proposed changes to the case-mix classification systems. Absent a transparent process, it is nearly impossible to provide meaningful input on such significant changes.

CMS’ Approach to PPS Changes for Post-Acute Care Providers
Noting its long-term goal of a unified payment system for all post-acute care providers, CMS proposes a series of changes for both the IRF PPS and skilled-nursing facility (SNF) PPS beginning in FFY 2020. CMS notes that its proposals, outlined in each of the respective rules, will begin to align the payment systems across settings with the intent of paying based on the patient’s clinical characteristics, rather than the setting in which he or she receives care. CHA appreciates and supports CMS moving forward to ensure that patients receive the appropriate level of care to address their needs. However, we are struck by the divergent approaches CMS has taken in its outreach on the quality measures and SPADE data collection effort, compared to the process undertaken to propose such significant payment changes utilizing the new patient assessment items. In addition, the agency was proactive in seeking input on the SNF proposed changes through an advance notice of rulemaking and previous comment period prior to proposing an implementation date. We are disappointed that we have not yet seen a similar approach for the IRF setting. Keeping in mind our shared goals of providing high-quality care to patients as they move from the acute to post-acute care setting, we offer the following thoughts for your consideration.

Establish Technical Expert and Stakeholder Advisory Panels for the Continuum of Care, Specific to Payment Changes
Understanding how changes will impact a broad spectrum of providers is vital to ensuring successful implementation. In 2011, CHA made a conscious decision to develop the CHA Center for Post-Acute Care, a governing body representing the full continuum of care: hospital case management, IRFs, SNFs, long-term care hospitals, home health agencies and hospice providers. The center provides input and analysis for CHA’s policy development process, allowing us to better understand the implications of policy changes for our patients across the care continuum. This has been key in helping California providers understand and prepare for anticipated changes in post-acute care payment.

CHA urges CMS to create a similar technical advisory group, or groups, to advise the agency on payment changes it is considering. This multi-disciplinary group (or groups) could be modeled after Medicare Technical Advisory groups of the past to dive in on very technical issues, and/or advise CMS on the more strategic and operational implications that should be considered as these changes go forward. More specifically, having the full continuum of providers meet would foster shared learning and understanding, and allow for discussion of a common analysis framework, while still allowing CMS to engage in a dialogue with providers across the continuum on how changes — whether to their respective system or to another PPS in the continuum of care — would impact patient care. We believe such a group (or groups) would be helpful to the agency over the long term in meeting its goals. More specifically, we believe that stakeholder engagement conducted only in our respective payment silos when the goals are to have more alignment going forward is counter-intuitive and should be rethought.
It is our understanding that CMS has established an internal multi-disciplinary team; such a stakeholder group could also liaison with this group, the SPADE group and others. We believe as this process moves forward, additional stakeholder engagement that looks beyond one payment system would help this transition and further assist in developing field understanding and support. Such an approach would not prevent CMS from establishing the very specific, task-oriented technical expert panels that may be needed to inform agency work. This group could also be connected to the U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation, as that office is charged with developing a unified PPS report due to Congress in 2022.

**Comparable Analytic Approaches to PPS Changes**

While we understand that the SNF PPS and IRF PPS are significantly different, CMS seems to have proposed the changes to each PPS absent any crossover analysis. More specifically, CMS has proposed to use the functional assessment items and scales as the underpinning for major revisions to the IRF and SNF case-mix classification systems. Notably, CMS has used two separate contractors with differing analytic approaches. In our view, the technical report provided for review with the proposed SNF changes is far superior to that provided for the IRF changes. We attribute the more robust analysis of the SNF PPS proposed changes to the agency’s commitment to engaging with providers through advanced rulemaking prior to release of its proposed rule this year. We are disappointed that CMS has not chosen the same path for engaging with the IRF community and are even more concerned to see no crossover analysis or consistent analytic approach. Given CMS’ stated goal is to begin to align the two systems, it would be helpful to have more robust, overarching analysis with supporting data for each PPS system.

**Reliability and Validity Testing of SPADE in Both Prospective Payment Systems**

Unfortunately, CHA believes CMS has missed an opportunity to direct contractors to look more closely at the reliability and validity of the new SPADE across the two settings prior to proposed use. While CMS has previously noted that these items have been tested, we now have a small data set that could be looked at more closely. We urge CMS to begin to look at the data collected across the two settings and again test for reliability and validity. These data are fundamental to standing up a unified PAC PPS and, as such, must be reliable and valid for purposes of payment. CMS may wish to consider a sample audit of SPADE items and more qualitative interviews with providers to inform this work. Ongoing evaluation of the implementation of this work is as critical, if not more— so, to development of the SPADE items through the BETA test and should be treated as such.

**TRANSPARENCY**

As previously stated, CHA urges CMS to withdraw its proposal due to the inability to access data to fully replicate, understand and provide meaningful comment on the proposed changes. CHA appreciates CMS’ efforts to take bold steps in aligning the current post-acute care prospective payment systems to pay more accurately based on patient characteristics rather than the setting of care. However, the speed of this change — absent a fully transparent process — is of significant concern and should be corrected.

While any change is difficult, it is made significantly more so if providers are not given adequate information to make informed strategic and operational decisions. In our view, CMS continues to woefully underestimate the time providers need make the kinds of cultural and organizational changes that are being requested, while simultaneously ensuring beneficiary access is not limited. CHA urges CMS to look for additional ways — outside a very limited rulemaking process — to engage providers and make
data available for analysis on an ongoing basis. We acknowledge that this is a time-consuming and
difficult task. However, we believe it is critical and fundamental as CMS proceeds. Resources and
personnel should be dedicated to this process. CHA stands ready to work with CMS to help inform next
steps.

**Changes to the IRF PPS Case-Mix System for FFY 2020**

Beginning in FFY 2020, CMS proposes to make a series of changes to the case-mix classification system,
including removing the FIM™ instrument and associated function modifiers from the IRF-Patient
Assessment Instrument (PAI).

IRFs are required to complete the IRF-PAI upon the admission and discharge of each Medicare Part A
fee-for-service patient and each Medicare Part C (Medicare Advantage) patient. IRF-PAI data are used to
classify patients into payment groups based on clinical characteristics and expected resource needs, as
well as to monitor the quality of care furnished in IRFs. The IRF-PAI was originally based on a modified
version of the Uniform Data System for medical rehabilitation patient assessment instrument,
commonly referred to as the FIM™. Since the implementation of the IRF PPS, FIM™ data reported in
the IRF-PAI have contributed to case-mix classification and payment.

Going forward, CMS proposes to incorporate the data items collected on admission and located in the
Quality Indicators section of the IRF-PAI into the case-mix group (CMG) classification system and remove
the FIM™ instrument entirely from the IRF-PAI. CMS also proposes to update the functional status
scores used in the case-mix system, revise the CMGs and update the relative weights and average length
of stay values associated with the revised CMGs.

**CHA is concerned that the proposed timeline for implementation, absent more complete and
transparent analysis, could create additional burden and confusion in the provider community and
ultimately limit patient access to medically necessary inpatient rehabilitative care.** CHA supports the
goal of developing standardized patient assessment data elements across post-acute care that would
support a more robust payment system. However, we do not believe that CMS has made available the
analysis showing that these changes promote adequate payments for providers to assist patients in
reaching optimal medical and functional outcomes by supporting access to the right care, at the right
time and in the right setting. **We urge CMS not to finalize the current proposal and instead continue
meaningful assessment and development — including additional provider engagement, education and
subsequent training.**

**Validity and Accuracy of Proposed Data Elements**

CMS proposes to utilize SPADE for functional assessment items currently collected in the Quality
Indicators section of the IRF-PAI, in lieu of the FIM™ instrument, for the purposes of case-mix
classification and subsequent payment.

**While the SPADE associated with function have been in place since October 2016, we believe IRFs’
accurate and consistent reporting of these elements has been significantly hampered by many factors,
some outside of their control. While the new SPADE capture many of the same mobility and activities
of daily living items as the established FIM™, they do so using a significantly different scale,
definitions and performance standards. Moreover, reports from our members indicate that many**
providers encountered evolving — or even conflicting — interpretations of scoring guidelines that left them confused and frustrated.

Unfortunately, CMS’ implementation guidance, issued on a rolling basis, has undermined providers’ ability to develop a shared understanding of scoring criteria and subsequently provide adequate and consistent training to all staff. To ensure that the SPADE associated with functional status are reported accurately across all providers over time, CMS must provide adequate guidance in a timely way. Subsequently, the field needs additional time to come to a shared understanding with CMS on how best to proceed, so that provider training supports implementation.

A related concern is that some of the proposed changes in the SPADE proposed for use in payment do not fully reflect the individual’s functional limitations, and thus may understate their need for IRF services. For example, some members have expressed concern that elimination of the wheelchair metric from the case-mix classification will provide a limited picture of certain patients, with respect to their rehabilitation needs and goals for an IRF admission. Additionally, by transitioning to a scale that does not recognize or capture the individual’s lowest level of care, critical information about a patient’s ongoing care needs and associated costs is lost. As CMS continues to evaluate and seek input on the proposed changes, including adding and removing specific SPADE from the case-mix determination, CHA urges CMS to share additional information about the clinical rationale and basis for such changes.

Modification of CMG Classification

CMS proposes to modify the methodology for updating the CMGs used to classify IRF patients for payment under the IRF PPS to reflect the conversion from use of FIM™ items to SPADE from the Quality Indicators section of the IRF-PAI. As noted above, hospitals relate the continued challenges of reporting on two different scales — one for payment purposes and the other for quality measurement. As previously stated, we have identified limitations related to the accuracy and quality of the data of the SPADE associated with the quality measures. As such, we urge CMS to withdraw its proposal to implement a revised case-mix classification system until a more robust data set is available for testing. One year of data, looked at in one setting rather than across settings, is not sufficient to assess its reliability and validity — particularly if the data are to be used for payment purposes. CMS has stated its intent to use this data going forward and, therefore, must invest resources to ensure its accuracy.

Transparency/Access to Data

As detailed above, CHA and its member IRFs are constrained in their ability to assess the impact of the proposed changes to the case-mix classification due to the lack of access to comprehensive data and analysis, including aggregate SPADE elements from the IRF-PAI. Further, we believe the technical report provided by CMS is woefully inadequate to help us understand the rationale behind some of the analytical choices made in the development of the refined case-mix classification system. Without additional information, coupled with meaningful stakeholder input and sufficient time to review and engage in discussions, CHA is concerned that neither providers nor CMS can adequately evaluate how this change will affect IRF services and patients and avoid unintended negative consequences. We urge CMS to provide adequate opportunity for key stakeholders to access data that would allow them to provide more meaningful input to the agency.

Changes to IRF Coverage Requirements
CMS proposes changes to the physician supervision requirement for FFY 2019 and requests feedback on additional changes under consideration for the future.

**Background**
The distinguishing characteristics of the care provided in an IRF are the medical supervision and coordination of the care plan by the rehabilitation physician. Upon admission, the rehabilitation physician must complete a post-admission physician evaluation (PAPE) that documents the patient’s need for IRF care and that meets specified regulatory requirements. Throughout the patient’s stay in the IRF, the rehabilitation physician must conduct face-to-face visits with the patient at least three days per week and lead a weekly interdisciplinary team meeting.

**Changes to Physician Supervision Requirement**
CMS proposes that the PAPE may count as one of the three weekly face-to-face physician visits for all IRF discharges beginning on or after October 1, 2018. CMS notes that it continues to believe that the evaluations and the face-to-face physician visits are two different types of assessments. However, the agency also believes that the rehabilitation physician should have the flexibility to assess the patient and conduct the PAPE during one of the three visits required in the first week of the IRF admission, and determine whether the patient needs to be seen more than three times in the first week of the IRF admission.

CHA is pleased that CMS is taking steps to assess the continued value of existing regulations and to propose changes that provide additional flexibility while preserving the unique characteristics of the IRF setting. **CHA supports the proposed changes to allow the PAPE to be counted as one of the three required face-to-face visits during the first week of the IRF stay.** We appreciate CMS’ recognition that the decision about need and frequency of rehabilitation physician visits is most appropriately made by the rehabilitation physician, based on each patient’s needs.

**Changes to Requirements for the Interdisciplinary Team Meeting**
CMS proposes to amend current regulatory language to specify that the rehabilitation physician may lead the interdisciplinary meeting remotely, without any additional documentation requirements. The proposed change would not apply to other members of the interdisciplinary team, although CMS says that it may consider expanding the policy in future rulemaking.

CHA appreciates the increased flexibility that this proposed change provides, particularly for smaller rehabilitation units or those located in rural areas. **CHA supports CMS’ proposal to allow the rehabilitation physician to lead the team meeting remotely.** However, CHA encourages CMS to proceed cautiously in extending this provision to other members of the rehabilitation team. Our members have concerns that over-reliance on remote communication may undermine the care planning and coordination process that is the hallmark of IRF care.

**Changes to the Admission Order Documentation Requirement**
CMS proposes to remove regulatory language that requires an IRF to have physician orders for a patient’s care during the hospitalization, noting that it believes this regulatory requirement is duplicative and unnecessary because IRFs must satisfy other requirements that address this issue. **CHA supports this proposed change.**
Solicitation of Comments on Additional Changes

CMS seeks additional comments on two additional changes under consideration. First, CMS seeks feedback on whether the rehabilitation physician should have the flexibility to determine that some IRF visits can be appropriately conducted remotely via video or telephone conferencing. Secondly, CMS asks whether it should enable IRFs to expand the use of non-physician practitioners (physician assistants and nurse practitioners) to fulfill some of the duties that currently must be carried out by rehabilitation physicians.

While we welcome changes that support the ongoing transformation of the delivery system to one that delivers greater value, we are also mindful that the four distinct levels of care in the post-acute care continuum — long-term acute care hospitals, IRFs, SNFs and home health agencies — each evolved to provide specific types of services that meet patients’ varied post-hospitalization needs. Matching patients to the right level of post-acute care improves their ability to achieve sustained medical and functional recovery without unnecessary cost or utilization. It is imperative, as reform of our health care system proceeds, that we not standardize or streamline care to the point that we lose sight of each setting’s unique contributions and roles in ensuring patients’ needs are met.

This is particularly true of the acute rehabilitation care provided in inpatient rehabilitation units and hospitals. A hallmark of the care provided in IRFs is that a rehabilitation physician is responsible for the care provided to the patient — including medical and functional assessment; development, implementation and monitoring of the care plan; and coordination of the interdisciplinary care team. The rehabilitation physician’s unique perspective and training enables the team, under his or her leadership, to help individuals recovering from disabling injury or illness return to the highest possible level of independence and effectively manage chronic conditions and impairments. We urge CMS to ensure that future regulatory changes support the continued central role of the rehabilitation physician in the post-acute setting. We are concerned that, if not designed and implemented carefully, too many changes to rehabilitation physicians’ presence may undermine their critical role in the IRF setting or in a future unified PPS.

CHA recognizes and appreciates CMS’ commitment to reducing regulatory burden to providers at all levels of the care continuum and applauds CMS’ efforts to investigate the implications of possible changes. The limited use of remote visits and non-physician practitioners may extend the rehabilitation physician’s reach and allow for greater flexibility and access to care, particularly in rural areas. However, we are concerned that implementation of such provisions without limitation may compromise the unique nature of the specialized IRF care provided to patients, which is possible only with the rehabilitation physician’s leadership.

As these and other provisions are considered in the future, we encourage CMS’ rulemaking to continue to ensure that the rehabilitation physician maintains clear accountability for care coordination, including direct management of the interdisciplinary care team and leading the team’s meetings. We also urge CMS to monitor utilization of such changes, including any potential or perceived impact on care, and to share the results of its assessment with others.

INPATIENT REHABILITATION FACILITY QUALITY REPORTING PROGRAM AND STANDARDIZED PATIENT ASSESSMENT DATA ELEMENTS
CMS continues implementation of requirements of the Affordable Care Act and the IMPACT Act, including development and implementation of a quality reporting program and quality measure domains using standardized data elements nested within patient assessment instruments. Similar changes are being implemented in other post-acute levels of care, including long-term care hospitals, SNFs and home health agencies. The changes provide a basis for CMS’ stated goal of developing standardized patient assessment items across all levels of care coordination.

**CHA supports the currently proposed changes to the IRF Quality Reporting Program**, and recognizes that these changes are part of a multi-year process to reform patient assessment and quality reporting across multiple levels of care. CHA is committed to participating in this ongoing process, but notes that additional transparency from CMS — including access to patient assessment data — is essential.

CHA supports the IMPACT Act’s objectives. However, as we have previously stated in numerous forums, we are concerned that the rapid development and implementation of the SPADE used to develop these quality measures have not provided sufficient time to evaluate their accuracy, consistency and clinical efficacy — in particular, how their application may differ between provider types. **We urge CMS to prioritize the evaluation of data collection across settings.**

**Changes to Regulations Governing Satellite Facilities and Excluded Units**

To ensure that a “hospital within a hospital” (HwH) — defined as a “hospital that occupies space in a building also used by another hospital, or in one or more separate buildings located on the same campus as buildings used by another hospital” — is separate and distinct from the hospital that it is within, CMS has established “separateness and control (S&C) requirements.” Effective October 1, 2017, CMS only requires HwHs to meet the separateness and control requirements when the IPPS-excluded hospital (such as a long-term care, children’s or cancer hospital) is within an IPPS hospital.

In the FFY 2019 IPPS/long-term care hospital PPS proposed rule, CMS proposes to extend exemption from S&C requirements to satellite units when co-located with an IPPS-excluded hospital. CMS also proposes that, for cost reporting periods beginning on or after October 1, 2019, an IPPS-excluded hospital would no longer be precluded from having an excluded psychiatric or rehabilitation unit. CMS proposes to revise regulatory language to specify that an IPPS-excluded hospital may not have an IPPS-excluded unit of the same type as the hospital (for example, an inpatient rehabilitation facility may not have an inpatient rehabilitation facility unit).

**CHA strongly supports the proposal to exempt certain co-located HwHs and satellite facilities from the S&C criteria.**

IRFs operate as one component of the post-acute care continuum, along with long-term care hospitals, SNFs and home health agencies. As health care reform continues and our health care delivery system evolves to one that emphasizes value over volume, greater coordination and collaboration are needed among and between individual levels of the post-acute care continuum. Alternative payment models, such as bundled payment for episodes of care, hold great promise for controlling costs while also supporting optimal patient outcomes. IRFs and other post-acute care providers play a critical role in this process, but are often limited by outdated provider-specific regulations — including the separateness criteria. CHA appreciates CMS’ willingness to consider greater flexibility for co-location of IPPS-excluded
hospitals, and believes that this change will provide an opportunity for post-acute care facilities and providers at all levels to work together more effectively.

**REQUEST FOR INFORMATION ON PROMOTING ELECTRONIC INTEROPERABILITY**

CMS seeks feedback on promoting interoperability and, specifically, how it could use the Medicare and Medicaid Conditions of Participation (CoPs) to advance electronic exchange of health information in support of care transitions between hospitals and community providers. As an example, CMS says it might consider revising the hospital CoPs to require that hospitals electronically transfer medically necessary patient information to the other facility when a patient is transferred. Similarly, the agency might require that hospitals electronically send discharge information to a patient’s community provider when possible, and provide discharge instructions electronically to patients or a third-party application, if requested.

CHA appreciates the work undertaken by CMS in recent years to promote a regulatory framework for the Medicare CoPs that supports our collective goals of high-quality, patient-centered care in a rapidly changing health care delivery system. The hospital CoPs in particular are still in need of updating, as many have not kept pace with changes in care delivery or hospital and health system organization and integration. Recent changes in law have demanded more fully integrating health care services, putting the patients’ health, safety, well-being and preferences at the forefront. Our regulatory framework must more fully address these changes in both the acute and post-acute care settings. Should CMS proceed down this path, we urge the agency to look more broadly at all the CoPs and prioritize all contemplated revisions. A piecemeal approach that does not consider implications across the delivery system will likely lead to the need for additional revisions sooner rather than later. The CoPs must be looked at in total, through a shared lens of overarching and agreed-upon principals — not in silos.

To that end, we request that CMS take this opportunity, under a relatively new administration, to demonstrate leadership in this area and consider a more formal stakeholder engagement process as part of its Patients over Paperwork Initiative. With the initiative’s goals as the framework for engagement, working with providers across the continuum of care on a more refined set of guiding principles will assist the agency in prioritizing its work so that providers can anticipate and prepare for what will likely be significant revisions to the CoPs — along with anticipated payment and other regulatory changes that, if not timed sequentially, will pose significant operational and financial challenges. An opportunity to share our perspectives, offer suggestions and participate in an ongoing dialogue about these and other changes with the agency would help foster better understanding and shared expectations, and would allow the field adequate preparation time.

Any revisions, additions or removal of CoPs — regardless of the care setting to which they apply — must address not only the current way care is delivered, but also future care delivery. It is imperative that the development of interpretive guidance be done in consultation with revisions to the CoPs. Surveyor training and oversight of the process must be a top priority for the agency. CHA looks forward to working with CMS on these and other CoP changes.

In response to CMS’ more specific request for comments, CHA has previously noted that we support policies and practices for effective and sustainable transitions of care, and commend CMS’ previous efforts to update existing CoPs to align with current practices and to clarify expectations of providers.
However, we continue to believe appropriate oversight must be balanced with the need for flexibility and innovation, and keeping pace with the current state of health information technology (HIT).

Before CMS considers revisions to the CoPs that would require electronic transfer of health information, it must survey the HIT landscape of the entire health system — not just that of acute care hospitals. While hospitals and health systems have made great strides in the adoption of EHRs under the Medicare and Medicaid EHR Incentive programs, and continue the work under the Promoting Interoperability programs, the use of EHRs is not as widespread in other care settings. Some of the most critical junctures for the exchange of health information are during transitions to care settings such as post-acute and behavioral health providers, who were not incentivized to adopt certified EHR technology under the meaningful use programs. As a result, it is often not possible to effectively exchange electronic information with these providers.

CMS must also understand additional operational challenges that currently present barriers to interoperability. Due to a lack of standardized patient identifiers, hospitals continue to have challenges in patient matching. Hospitals experience major challenges in transferring health information for medically indigent patients, who often do not have a primary care provider and may not have a permanent address.

Hospitals also often lack the appropriate contact information when transferring health information to community providers or payers. Section 4003 of the 21st Century Cures Act requires the Health and Human Services Secretary to “directly or through partnership with a private entity, establish a provider digital contact information index for providers and facilities.” To date, this digital contact information index has not been established. **CHA urges CMS to work with the Department of Health and Human Services to develop this directory as soon as possible.** Until the government helps providers solve the problems of patient matching and fully implements a system of accurate provider and payer contact information, hospitals must choose between complying with federal requirements and opening themselves up to risk of penalty under state and federal law for a privacy breach if protected health information is inadvertently sent to the wrong place or provider. That penalty, in California, comes with a significant fine.

Any future changes to requirements for electronic transfer of health information must also consider the various legal barriers to increased sharing of health information. In comments on CMS’ previously proposed changes to the regulations at 42 CFR §482.13, CHA noted that we believe proposed revisions to the CoPs on patients’ right to access their own health information are unnecessary and further confuse the body of law surrounding health information privacy. The Health Insurance Portability and Accountability Act (HIPAA) currently requires hospitals to provide patients access to their medical information with limited exceptions, including certain medical records related to research; prisoners’ records where access might jeopardize the health or safety of the patient or other inmates; mental health records where access is reasonably likely to endanger the life or physical safety of the patient; and psychotherapy notes.

**Portions of existing regulation (42 CFR Part 2) restrict sharing of substance use disorder (SUD) information, which further complicates the exchange of health information in some cases. Clinicians treating patients for any condition need access to their complete medical histories — including information related to SUD — to ensure their patients’ safety and delivery of the highest quality care.**
Partitioning a patient’s record to keep SUD diagnoses and treatments hidden from the clinicians entrusted to care for them, as required by 42 CFR Part 2, is dangerous for the patient, problematic for providers and contributes to the stigmatization of mental and behavioral health conditions. To ensure compliance with 42 CFR Part 2, clinicians must maintain two separate computer systems and two separate medical records. This requirement adds burden and expense, but without benefit. CHA supports efforts to make statutory changes that would amend 42 CFR Part 2 to align with HIPAA for the purposes of treatment, payment and health care operations. Such changes are required before hospitals and other community providers can meaningfully share health information.

These and other issues must be considered both through notice and comment rulemaking as well as through stakeholder dialogue. CHA stands ready to work with the agency to identify challenges and opportunities, and to solve problems together. Our goals are shared, and we urge CMS to make this a priority going forward. There is a tremendous opportunity to advance the regulatory framework in which care is provided, lower costs and decrease burden and — most importantly — make our health care system more patient-friendly.

CHA appreciates the opportunity to comment on the FFY 2019 IRF PPS proposed rule. If you have any questions, please do not hesitate to contact me at akeefe@calhospital.org or (202) 488-4688; or my colleague Pat Blaisdell, vice president continuum of care, at pblaisdell@calhospital.org or (916) 552-7553.

Sincerely,

/s/
Alyssa Keefe
Vice President Federal Regulatory Affairs