Rehabilitation Hospitals: A Critical Part of America’s Response to COVID-19

Inpatient Rehabilitation Facilities (IRFs) are federally regulated as hospitals and issued licenses to operate as hospitals by their states. This is because traditional patients in IRFs face a wide range of medical comorbidities beyond rehabilitation needs that require hospital-level attention. As such, IRFs have the capabilities and experience to treat a broad range of inpatients beyond their traditional rehabilitation care mission. In light of the current pandemic, IRFs in many areas need to help acute-care hospitals handle the overflowing admissions they are experiencing with COVID-19, and require the regulatory flexibilities to be able to fully do so. In fact, many IRFs already are – without assurance of coverage or payment – caring for acutely ill patients because IRFs in many communities are the safest option for many patients during this public health emergency (PHE).

Through the Coronavirus Aid, Relief, and Economic Security (CARES) Act and subsequent agency action, Congress and the Centers for Medicare and Medicaid Services (CMS) have already relaxed certain criteria, but additional action is needed. Given the need for urgent and uniform relief for IRFs treating or preparing to treat the surge of inpatients, we ask Congress to immediately address the following:

1. Congress should provide adequate fiscal relief to ensure that IRFs will be equipped to lead the long-term recovery of COVID-19 patients given unique medical complexities and likely longer-term rehabilitation needs.

   - Many IRFs are facing dire financial situations as patients avoid the hospital setting and forgo elective procedures. Hospitals must continue to receive fiscal relief from CARES Act funding (and other sources) to ensure they can maintain a robust workforce and operational capacity in order to play a vital role in the long-term patient recovery effort.

   - Furthermore, CMS has helpfully expanded the Accelerated/Advance Payment programs to ensure all Medicare providers are temporarily eligible for these payments, but IRFs are limited in the amount they can receive and must repay the government sooner than other hospitals. This policy should be rectified so that IRFs are eligible for the same amount of payment, for the same duration, and on the same terms as other IPPS-exempt hospitals.

2. Congress should explicitly authorize acute care hospitals to directly transfer inpatients to freestanding IRFs if needed to assist with surge capacity. Further, IRFs should be able to directly admit medical patients during the PHE regardless of their need for rehabilitation services if there are no appropriate acute-care beds available for those patients.

   - CMS has authorized acute care hospitals to transfer inpatients to IRF units – or to transfer patients to other facilities via “under arrangements” agreements. Providers do not have the capacity under current circumstances to design and implement these arrangements. Furthermore, acute care hospitals retain treatment and oversight obligations through these “under arrangements” agreements, limiting their practicality in COVID-19 hotspots. Given the volatile situation in various areas of the country, the only practical solution that will enable IRFs to provide surge capacity is to allow freestanding IRFs to receive or directly admit inpatients, and be paid pursuant to their own payment system, on an as-needed basis to respond to the needs of their community.

3. Congress should direct CMS to waive IRF coverage rules during the PHE based on hospital needs.

   - In the CARES Act, Congress categorically waived the so-called “3 Hour Rule” requiring IRFs furnish intensive therapy at least 15 hours per week. While this was a critical first step, IRFs may require additional coverage regulatory relief, and it is unclear at this point whether CMS will exercise its discretionary authority. To ensure IRFs can continue to respond to the pandemic in a timely and comprehensive way, further direction from Congress is necessary. As such, IRFs need to be able to access the following blanket waivers as their clinical situations warrant during the PHE, including:

     - The pre-admission screening, which delays the transfer of patients from acute-care hospitals to IRFs;
The interdisciplinary team-meeting requirement, which requires the therapy team to convene physically to coordinate patient care (and, at a minimum, needs to be permitted by remote participation). Patients are still being seen by physicians and nurses, but the specific utilization of the therapists in the rehabilitation team varies widely, depending on the clinical need; and

- The requirement of three patient visits by a rehabilitation physician who documents the rehabilitation program status each week. The physicians who see these patients daily in a rehabilitation hospital may be from a variety of disciplines – infectious disease, internal medicine, pulmonary medicine, rehabilitation medicine or other. For patients not engaged in a rehabilitation program, there is no rationale for requiring physician documentation in this way. For similar reasons, the individualized overall plan of care requirement must also be waived, as there is no practical reason to require documentation of a program that is not needed or being utilized. The same rationale applies to the requirement that a medical director provide 20 hours of services per week in rehab unit.

- CMS has encouraged providers to seek individual waivers, but those can be burdensome for the most inundated providers and the approval process remains slow. In addition, it is difficult for providers to predict in advance when their surge capacity will be needed. As such, the aforementioned policies should be addressed via blanket waivers to ensure timely and critical regulatory relief, and providers should be directed to document appropriately when they need to avail themselves of these waivers.

4. Congress or CMS should clarify that any licensed rehabilitation professional be allowed to furnish services via telehealth in the hospital to help an IRF and its patients address exigent circumstances.

- Congress has given a number of disciplines flexibility to furnish in-person services via telehealth. More clarity is needed, however, to ensure IRFs can fully leverage telehealth to furnish a comprehensive rehabilitation program while protecting the health and safety of IRF staff and patients. While therapists are not currently recognized under statute as providers that can furnish services via telehealth, it is imperative that therapists be able to treat COVID-19 patients via telehealth to protect the hospital’s workforce. Congress should allow all members of a rehabilitation team (ranging from physical therapy to rehabilitation neuropsychology) to be able to furnish and bill for their services via telehealth for the duration of this PHE.

5. Congress should ensure that IRFs and other providers have the financial capacity to invest in infrastructure and operational upgrades needed to confront the pandemic.

- The CARES Act included billions in funding “for building or construction of temporary structures, leasing of properties, medical supplies and equipment including personal protective equipment and testing supplies, increased workforce and trainings, emergency operation centers, retrofitting facilities, and surge capacity,” but to date, CMS has distributed funds to health care providers based on prior Medicare payments and irrespective of these needs.

  - Many IRFs on the frontline are incurring these types of operational expenses – such as creating “on-demand” accommodations for COVID-19 (e.g., creation of negative air pressure private rooms and construction of isolation barriers and other accommodations for infection control)

  - To get through the COVID-19 PHE as swiftly as possible, and to be prepared for the next global pandemic, Congress should invest in both short- and long-term infrastructure to support critical upgrades for hospitals and other institutional providers – something that has not been taken on since the Hill-Burton Act of 1946 – particularly IRFs.

COVID-19 patients are likely to face prolonged medical rehabilitation needs and challenges extending long beyond the end of the immediate pandemic crisis. Congress, CMS and IRFs must prepare now for potentially extraordinary post-acute patient needs and not prematurely and arbitrarily declare the PHE resolved until these long term needs of patients are fully addressed. In the next phase of COVID-19 response legislation, Congress must ensure that IRFs have all of the above-mentioned resources and flexibilities so that they can utilize them as their situation warrants. These actions are critical to help the nation overcome this PHE.

Dr. Robert Krug · Chairman, AMRPA Board of Directors
President & Medical Director, Mount Sinai Rehabilitation Hospital
529 14th Street NW, Suite 1280, Washington, DC 20045 · Phone: 202-591-2469 · Fax: 202-591-2445