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AMRPA in an Unprecedented Year

In most years, August is generally considered a slower time for AMRPA, particularly as Congress generally goes into a month-long recess. However, 2020 continues to be an unprecedented year, and with it comes a more hectic summer than we would have otherwise anticipated.

Numerous policy developments have occurred since the last AMRPA Magazine, our COVID-19 Special Edition. Most notably, the fiscal year (FY) 2021 Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) final rule was released on August 4, with several positive developments included for our industry. AMRPA advocated zealously against the non-physician practitioner (NPP) provision in the proposed rule that would have allowed NPPs to perform certain services currently required to be performed by a rehabilitation physician. In the final rule, the Centers for Medicare and Medicaid Services (CMS) significantly scaled back the proposal and will only allow NPPs to complete one of the three required face to face weekly visits beginning with the second week of care. Additionally, CMS finalized the policy to permanently remove the Post-Admission Physician Evaluation (PAPE), consistent with AMRPA’s advocacy efforts. A full summary on the rule is available in the Special Edition: Off the Record distributed earlier in the month, as well as in this issue of the AMRPA Magazine. I want to thank all of our members who contributed through committee meetings and feedback to staff about the proposal, as your efforts helped ensure that the Association was able to adequately and effectively advocate for the industry’s needs.

Other developments within AMRPA include the launch of the new blog, AMRPA Access, numerous comment letter submissions and the re-launch of the COVID-19 industry calls. AMRPA Access is intended to provide membership with timely legislative and regulatory updates, association news, conference and webinar updates, patient success stories and more, and I look forward to enhancing our membership-wide engagement and education through this new tool. I also hope members will join us at future COVID-19 industry calls and encourage your network of industry stakeholders to join as well.

On the legislative front, there’s a great deal of uncertainty as to what the remaining months of the 116th Congress will look like. Through virtual meetings with regulators and Congressional offices, AMRPA has continued to engage with policymakers on some of our most important policy issues, such as prior authorization reform and resetting the IMPACT Act implementation timeframe. We have and will continue our collaboration with other post-acute care groups as the public health emergency continues to warrant a reevaluation of these policy issues.

Looking ahead, it is hard to believe we are less than two months away from the Fall Educational Virtual Conference and Expo. While I had hoped to see each of you in-person following last year’s successful event in San Diego, I am excited for all that is being offered this year in virtual content. I want to personally encourage you to make sure your staff is aware of the discounted rates and register in the coming weeks.

In closing, I want to thank you all for your ongoing dedication and involvement with the association. Despite all of the pressing demands on your time right now, we have continued to have excellent turnout for webinars, COVID-19 industry calls and committee meetings. I hope everyone finds some time to relax and recharge as summer comes to a close, as we certainly have a busy fall ahead of us as an association.

Robert Krug, MD
President and CEO
Mount Sinai Rehabilitation Hospital
Medical Director, PM&R Service Line
Find new and exciting opportunities in AMRPA’s Career Center.

Our Career Center provides services and resources to help the medical rehabilitation field meet their professional goals. All rehabilitation professionals may browse and apply for jobs at no cost, and AMRPA members will receive discounted rates for posting positions.

Begin by creating your free Career Cast account, which can be found on the top right hand corner of the website. From there, you can upload and manage multiple resumes, browse through hundreds of job postings, and even research salaries of the positions in question! AMRPA members and affiliates may also purchase Posting Packages at a standard, premium, or platinum level.

AMRPA members will receive a 50% discount on all job postings.

For questions about our Career Center, please contact Elizabeth Katsion, AMRPA Member Services Associate, at ekatsion@amrpa.org or 202–207–1102.
Phase 4 Outlook

The legislative calendar continues to march forward as Members of Congress (and staff!) adapt to their new work environments and routines. The House and Senate resumed July 20 with Senate Republicans beginning intense negotiations with the Administration on a Phase 4 proposal and additional COVID-19 relief.

Following a delay due to intraparty disagreements, Senate Republicans released the Health, Economic Assistance Liability Protection & Schools (HEALS) Act on July 27. The HEALS Act is comprised of several proposals. The packages focus on liability protection, children, jobs and health care. The initial Republican offer is substantially smaller in size and scope than the $3 trillion House-passed Health and Economic Recovery Omnibus Emergency Solutions (HEROES) Act, which the House passed on May 15 by a vote of 208 to 199 (H.R. 6800) and reflects the House Democrats’ Phase 4 priorities.

The $1 trillion Republican proposal includes an additional $25 billion for the Provider Relief Fund, as well as stipulations on not increasing the Medicare Part B premium in 2021. Providers will not have to begin repaying their “advance payments” until January 1, 2021, and the interest free repayment period is also extended. The HEALS Act does not amend the interest rate (9.5%), whereas the HEROES Act reduced it to 1 percent. Telemedicine reimbursement policies enacted because of the pandemic, will be extended through 2021, or the end of the public health emergency (PHE), whichever is the later. The Medicare Payment Advisory Commission (MedPAC) is directed to provide a report on the impact of telehealth flexibilities on access, quality and cost by July 1, 2021. Further, the Department of Health and Human Services (HHS) is required to release telehealth data collected during the pandemic in order provider legislative recommendations to Congress before flexibilities expire. Among other provisions, the HEALS Act includes provisions that establish nursing home “strike teams” to respond COVID-19 outbreaks and supports infection control training for nursing facilities.

The appropriations section includes an additional $25 billion for the Provider Relief Fund (for a total of $200 billion), $150 million for the Centers for Medicare and Medicaid Services (CMS) to increase survey frequency of skilled nursing facilities and nursing facilities, and over $15 billion for the National Institutes of Health. The bill also includes $16 billion for testing, contact tracing, and surveillance in states.

A priority for Leader McConnell (R-KY), the HEALS Act includes liability provisions that would broadly shield hospitals and medical professionals from COVID-19 malpractice lawsuits, while capping damages.

Additionally, the package includes a second round of economic impact payments for individuals; a supplemental unemployment benefit of $200 per week through

Highlights:

» According to data from Johns Hopkins Coronavirus Resource Center, over 16 million coronavirus cases have been confirmed as of August 14, 2020.

» On August 4, CMS released the final CY 2020 IRF PPS regulation, increasing overall payment rates by 2.8 percent.

» The House continues to move forward with passage of FY21 “minibus” packages, but the appropriations process has come to a halt in the Senate over controversial policies, such as policing reform and coronavirus funding.

» On July 23, HHS Secretary Alex Azar renewed the public health emergency for another 90-day period. This also extends many of the provider waivers and flexibilities that the Centers for Medicare & Medicaid Services announced during the pandemic.

» On July 27, Senate Republicans introduced the $1 trillion Health, Economic Assistance Liability Protection & Schools Act, commencing the negotiation process for an additional coronavirus economic relief package.

» The President signed three Executive Orders on July 24 aimed at bringing down drug prices, and an additional order on August 3 improving rural health and telehealth access. He signed four additional orders on August 8 due to stalled negotiations on a Phase 4 coronavirus relief package.
September 2020; a second round of Paycheck Protection Program (PPP) loans for small businesses; an increased Employee Retention Tax Credit (ERTC); and over $300 billion in emergency appropriations.

The HEALS Act also includes a number of supply chain proposals, such as requiring the Strategic National Stockpile (SNS) to purchase only domestically produced personal protective equipment (PPE) and other medical supplies and establishing a 30% investment tax credit for US manufacturers of PPE. The Act includes several provisions to create and expand state stockpiles of critical supplies.

Phase 4 negotiations dominated Congressional activity for the remainder of the work period, which concluded on August 13, when the Senate adjourned for the August recess. Meanwhile, the House adjourned for the August recess on Friday, July 31, but Members were given a 24-hour vote notice should negotiators come to a compromise. Despite the expiration of unemployment benefits, Congressional Democrats and the Trump Administration have remained deadlocked in negotiations over the next COVID-19 package. Senate Minority Leader Chuck Schumer (D-NY), House Speaker Nancy Pelosi (D-CA), White House Chief of Staff Mark Meadows, and Treasury Secretary Steven Mnuchin have met several times to discuss a way forward on the “Phase 4” package, but as of August 14 talks remain at a standstill.

Citing the lack of progress on a legislative package, President Trump on August 8 signed four executive orders that aim to provide limited economic relief to Americans. The policies consist of an order on unemployment insurance extends the CARES Act benefit while lowering the weekly enhancement from $600 to $400 and requiring states to cover 25 percent of the cost; a housing order directs federal agencies to review existing authorities and resources that could be used to prevent evictions and foreclosures; an order on student loans extends until December 31 the CARES Act policy that waives interest and temporarily halts payments on federal loans; and finally, an order on payroll taxes allows employers to defer collection of payroll taxes through December 31 for employees making less than $100,000 annually.

With no COVID deal imminent, lawmakers left Washington and will be called back if votes are needed on a package. The Democratic National Convention will be held August 17-20 in Milwaukee, Wisconsin; with Vice President Joe Biden and his running mate, Sen. Kamala Harris (D-CA), present virtually from Wilmington, DE. Many of the activities will be conducted remotely at venues across the country. The Republican National Convention will be held August 24-27. The RNC’s official business will take place in Charlotte, North Carolina. The main convention and other events that were scheduled to take place in Jacksonville, Florida have been cancelled as Florida grapples with a surge in COVID-19 cases. As we go to print, President Trump is considering holding political convention activities from the White House grounds and other government property, which is stoking considerable controversy.

**CMS Moves Forward with IRF PPS Final Rule**

CMS on August 4 released its Fiscal Year (FY) 2021 Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) Final Rule. For FY 2021, CMS is updating the IRF PPS payment rates by 2.8 percent. The final rule also makes permanent the regulatory change to eliminate the requirement for physicians to conduct a post admission visit since much of the information is included in the pre-admission visit. This flexibility is offered during the COVID-19 public health emergency and the rule would make the flexibility permanent beyond the end of the PHE. CMS is also finalizing that a non-physician practitioner may perform one of the three required visits in lieu of the physician in the second and later weeks of a patient’s care, when consistent with the non-physician practitioner’s state scope of practice.

**FY 21 Appropriations Minibuses Move Along**

Following the July 4 recess, the House Appropriations Committee began considering FY21 funding bills. The Committee approved all twelve of its funding bills, which will now head to the House floor where they may be further amended. The House passed its first minibus of FY21 appropriations bills on July 24, H.R. 7608, which includes: State-Foreign Operations, Agriculture-Rural Development-FDA, Interior-Environment and Military Construction and Veterans Affairs. The remaining eight bills, including the bill that funds HHS will be considered “en bloc” in late July. As we head toward the August Congressional recess, the Senate appropriations schedule remains stalled due to a partisan dispute regarding potential amendments related to COVID-19 and police reform.

**President Signs Executive Order on Rural Health and Telehealth**

On August 3, President Trump signed an Executive Order that directs HHS to review the Medicare telehealth flexibilities offered during the PHE and to propose a regulation to extend some of these policies beyond the end of the PHE. The order also calls for HHS to announce a new model to test innovative payment mechanisms in support of rural health care. According to the order, this model “should give rural providers flexibilities from existing Medicare rules, establish predictable financial payments, and encourage the movement into high-quality, value-based care.” On August 11, CMS officially announced the Community Health Access and Rural Transformation (CHART) Model, which aims to address health disparities in rural communities leveraging innovative financial arrangements and community partnerships to improve the health care delivery system. CMS will be providing funding for up to 15 entities to participate in a Community Transformation Track and up to 20 entities to participate in an Accountable Care Organizations (ACO) Transformation Track. The agency confirmed that regulatory flexibilities will be considered.

CMS expects the Notice of Funding Opportunity for the Community Transformation Track will be available in September, and the Request for Application for the ACO Transformation Track will be available in early 2021.
Congress Addresses Supply Chain Domestication in Defense Authorization Legislation

The annual “must-pass” defense authorization legislation (known as NDAA) contains provisions to address supply chain domestication during the COVID-19 pandemic, which could have far reaching implications on the American economy and global trade agenda. While Members of Congress and the Administration have expressed concerns regarding supply chain vulnerabilities, the recent significant shortages of medical equipment to combat the COVID-19 pandemic has refocused policy-makers’ attention on the issue. The shortages, along with growing economic competition with China and other foreign actors across a wider range of sectors, including technology, energy, aviation, minerals, financial services and agriculture catapulted taking action on supply chain domestication to a matter of national security.

After returning from a multi-week recess, the US House of Representatives and Senate considered their versions of the National Defense Authorization Act (NDAA) (S. 4049 and H.R. 6395), both of which contain numerous provisions that expand domestic defense manufacturing and address supply chain vulnerabilities. The House passed their version of the legislation by a vote of 295-125, while also accepting several amendments related to supply chain domestication on July 21. The Senate passed its version by a vote of 86-14 on July 23. During the amendment process on the Senate floor, Sen. John Cornyn's (R-TX) amendment to authorize a federal grant program for states to build or modernize domestic semiconductor manufacturing facilities was approved by a vote of 96-4, showing a bipartisan effort to further secure America’s supply chain.

While differences in the legislation must be reconciled during conference before final legislative passage and a signing into law, it is most likely that the supply chain provisions will find bicameral support and remain a critical component of the final bill.

Provider Relief Fund Update

HHS continues to allocate targeted distribution of funding to providers in areas particularly impacted by the COVID-19 outbreak. On July 17, HHS announced a second round of funding of $10 billion for hospitals impacted by COVID-19. According to HHS, funding is based on a formula for hospitals with over 161 COVID-19 admissions between January 1 and June 10, 2020, or one admission per day, or hospitals that experienced a disproportionate intensity of COVID admissions (above the average ratio of COVID admissions/beds). The Department confirmed that hospitals will be paid $50,000 per eligible admission. On July 22, it was announced that $5 billion would be allocated to Medicare-certified long-term care facilities and state veteran nursing homes to build nursing home skills and responses to COVID-19, including enhanced infection control.

According to a recently posted HHS notice document, health care providers that receive more than $10,000 from the Provider Relief Fund will have to account for all of the grant funds they spend in 2020 by February 15, 2021. HRSA anticipates providing additional information on or around August 17, 2020. The reporting system is set to open on October 1. The CARES Act requires providers that receive a minimum of $150,000 from the Provider Relief Fund to report on the funds, but HHS lowered the threshold. The Health Research and Services Administration, which is administering the Provider Relief Fund, plans to hold a webinar for providers in the near future to review the submission process and requirements.

Telehealth Expansion Bill Introduced by House Telehealth Caucus Members

On July 16, members of the House's Congressional Telehealth Caucus introduced the Protecting Access to Post-Covid-19 Telehealth Act (H.R. 7663) that would extend the expanded use of telehealth in Medicare beyond the coronavirus pandemic. Specifically, the bill would:

- Eliminate most geographic and originating site restrictions on the use of telehealth in Medicare and establish a patient’s home as an eligible distant site so that telehealth care can be provided at home and allow physician reimbursement for televisits.
- Avoid a sudden loss of telehealth services for Medicare beneficiaries by authorizing CMS to continue reimbursement for 90 days beyond the end of the PHE.
- Make the HHS disaster waiver authority permanent, permitting HHS to expand telehealth in Medicare during all future emergencies and disasters.
- Require a study on the use of telehealth during COVID-19, including its costs, uptake rates, measurable health outcomes, and racial and geographic disparities.

The bipartisan legislation was introduced by Rep. Mike Thompson (D-CA), founder and co-chair of the Congressional Telehealth Caucus, along with caucus co-chairs Peter Welch (D-VT), Bill Johnson (R-OH), David Schweikert (R-AZ) and caucus member Doris Matsui (D-CA).

On July 23, members of the House Telehealth Caucus and leaders of digital health groups hosted a virtual rally to discuss newly introduced legislation. AMRPA participated in this event.

Rep. Mike Thompson (D-CA) stated that expanded access to telehealth services has improved health outcomes and saved money. He reviewed H.R. 7663, noting it would eliminate geographic restrictions on telehealth and make permanent flexibilities for federally qualified health centers (FQHCs) and rural health clinics (RHCs). He noted that Centers for Medicare and Medicaid Services (CMS) Administrator Seema Verma and Senate Finance Committee leaders have expressed interest in extending some flexibilities beyond the end of the pandemic.

Rep. David Schweikert (R-AZ) urged stakeholders to provide data on telehealth utilization and costs to help the sponsors understand how to score the bill.

Rep. Doris Matsui (D-CA) noted that in the last Congress, she and Rep. Bill Johnson (R-OH) succeeded in getting a telehealth proposal related to substance use disorder (SUD) treatment included in the SUPPORT Act. In addition, the House Energy and Commerce Committee recently advanced a temelitarian health
bill. She thanked stakeholders for their continued support for telehealth expansion.

Rep. Bill Johnson (R-OH) stated that telehealth is the “way of the future” and noted that it can be helpful even in normal times, especially for mental health providers. He added that COVID-19 has exposed an urban/rural digital divide with respect to broadband access.

Rep. Peter Welch (D-VT) stated that Vermont residents have been very pleased with the quality of their telehealth visits.

Ann Mond Johnson, CEO of the American Telemedicine Association (ATA), expressed her support for the legislation and stated that the measure has the potential to transform health care. In particular, she touted the proposal to eliminate geographic/originating site restrictions.

Joel White, Executive Director of the Health Innovation Alliance, expressed hope that the bill will be signed into law “sooner rather than later.” He added that the waiver of originating site requirements is helpful for patients with mobility issues and particularly important during an infectious disease outbreak.

Hal Wolf, President and CEO of the Healthcare Information and Management Systems Society (HIMSS), stated that telehealth functions as a “great equalizer” in access to quality care. He spoke favorably of the proposal to extend flexibilities for FQHCs and RHCs and discussed the importance of mobile technology. Mr. Wolf added that telehealth is needed to address the worsening physician shortage in the US.

Krista Drobac, Executive Director of the Alliance for Connected Care, encouraged participating organizations on the call to sign onto a stakeholder letter in support of H.R. 7663, and to urge other members of Congress to cosponsor the bill.

Ms. Covich Bordenick asked the panelists to discuss the importance of broadband access for telehealth. Ms. Mond Johnson stated that ATA is supportive of efforts to expand broadband access in the US. Mr. Wolf also discussed the need for mobile technology. Ms. Drobac noted that members of Congress have also called on the Federal Communications Commission (FCC) to provide more support to telehealth providers in this space.

As we go to print, we strongly encourage AMRPA members to use the time between now and Labor Day to get in front of their members of Congress and Congressional candidates to educate and inform them about your COVID-19 experiences, the needs of your hospitals and the patients and Medicare and Medicaid beneficiaries you serve.

To meet the longer-term needs of COVID survivors, and for the future of rehabilitation medicine and hospitals, it is critically important for members of Congress to understand your needs and challenges as you care for the most medically complex patients and serve your community. Town meetings and candidate campaigning may offer new virtual and personal opportunities. Plan to participate! AMRPA staff are available to assist and support your outreach and advocacy. Just pick up the phone or email us. (mkendrick@akingump.com; 202-262-4373)

Your relationships and proactive advocacy voice are vital to AMRPA’s effectiveness and success, and we thank you in advance for engaging on behalf of your patients and hospitals.

Along with AMRPA staff, we are here to work with and assist you.

Stay healthy and stay well – you are needed! ★
Between the federal response to COVID-19 and the proposed rule for inpatient rehabilitation hospitals and units (IRFs), there have been a number of important developments impacting audits, appeals, and rehabilitation physician involvement in IRF care in recent weeks.

**CMS Announces Plan to Resume Medicare Fee-for-Service Audits**

In July, the Centers for Medicare and Medicaid Services (CMS) announced by updating an online Frequently Asked Questions (FAQ) document that Medicare fee-for-service audits will resume beginning on August 3, 2020. On March 30, CMS suspended most Medicare fee-for-service medical reviews—including pre-payment audits conducted under the Targeted Probe and Educate program and post-payment audits conducted by the Medicare Administrative Contractors (MACs), Supplemental Medical Review Contractor (SMRC), and Recovery Audit Contractor (RAC)—due to the COVID-19 public health emergency. Despite the rise in cases of COVID-19 throughout the country since that time, CMS concluded that it is necessary to lift the suspension of audits given the “importance of medical review activities to CMS’ program integrity efforts.”

CMS advised providers selected for review to discuss with their contractor any COVID-19-related hardships they are experiencing that could impact the audit response. The agency’s statement suggests that contractors may extend some flexibility to providers experiencing COVID-19-related hardships. CMS also noted that contractors will observe waivers and flexibilities in effect on the dates of service when evaluating claims.

CMS subsequently heard from multiple Medicare stakeholders and reportedly clarified that the August 3rd rollout of medical review activities is delayed and limited to post-payment audits conducted by the MACs. CMS told stakeholders that, at this point, the MACs will review claims prior to March 1, 2020, before the main impact of the pandemic. The agency reportedly indicated that it has not established a timeframe for restarting Targeted Probe and Educate, SMRC, and RAC audits.

However, the published report asserting that most audits are still suspended did not come from CMS. Instead, this information was included in an industry article that reported on verbal conversations with CMS on these issues and, at the time of this writing, cannot be verified. AMRPA is working with its sister organization, the Fund for Access to Inpatient Rehabilitation (FAIR), to respond to this situation and is urging CMS to delay all Medicare audits at least through 2020 and reassess as the new year approaches.

**New Data Available on Status of Global IRF Settlement**

CMS has released the first data on the global IRF settlement reached in 2019. On June 26, 2020, CMS filed its quarterly status report with the federal court in the American
Hospital Association lawsuit on the Administrative Law Judge (ALJ) backlog. As part of the decision in that case, the court has ordered CMS to meet annual targets to reduce the backlog. CMS has now added a line item to their report in that case showing the impact of the IRF global settlement. As of March 31, 2020, CMS settled 1,106 IRF appeals. It is not clear whether this represents all of the settled cases or whether additional settlements will be reported in the next status report, which is due in September and will show data through June 2020.

CMS continues to make overall progress toward reducing the ALJ backlog. As of March 31, 2020, the backlog is down to 242,995 appeals. Although this is a significant number of undecided appeals, it is far less than the 886,418 appeals that were in the backlog at the beginning of federal fiscal year 2016. The federal district court ordered CMS to reduce the backlog to 217,563 appeals by September 30, 2020, and it must be eliminated entirely by September 30, 2022. During the first half of the current federal fiscal year (October 1, 2019 through March 31, 2020), CMS lowered the backlog by 49,522 appeals. At this pace, CMS seems likely to meet its target of 217,563 appeals by September 30, 2020.

Progress on the OIG Physician Review of IRF Cases

In response, AMRPA embarked on an aggressive campaign to challenge those findings. The association worked in coalition with the American Academy of Physical Medicine and Rehabilitation (AAPM&R) and the Federation of American Hospitals (FAH) on a comprehensive written response at the time, met with senior CMS and Office of Management and Budget (OMB) officials, and met directly with the OIG. What came out of the meeting with OIG was a commitment to jointly review a sample of claims from the report in order to see whether this sample could be used to try to achieve a meeting of the minds on medical necessity standards for IRF admission.

After lengthy delays in obtaining a sample of case files and then further delays due to COVID-19, this project is moving forward. A panel of expert IRF physicians has been assembled by AMRPA, the Federation, and the Academy, and review of the files is getting underway. A direct meeting with OIG to discuss the findings of this expert panel is being planned for the coming months. Although the specific claims in the sample are not recent, the concepts at issue in this review are just as relevant today as they were when those services were actually provided. AMRPA’s hope is that this review will provide important guidance to the IRF field, as well as the OIG, as this federal agency continues to audit specific IRF providers now and into the future.

Regulatory Relief in the Wake of COVID-19
Throughout the Trump administration, the various federal agencies have been encouraged to seek ways of reducing the regulatory burden on their respective stakeholders. On May 19, 2020, President Trump doubled down on his approach to regulatory relief, issuing an Executive Order directing all federal agencies, including the Department of Health and Human Services, to ease regulatory burdens in order to promote economic recovery in light of the impacts of COVID-19. Specifically, Section 1 of the Executive Order states that “[a]gencies should address this economic emergency by rescinding, modifying, waiving, or providing exemptions from regulations and other requirements that may inhibit economic recovery.”

The FAIR Fund worked with AMRPA to take the opportunity to reach out to HHS Secretary Azar and the Director of the Office of Management and Budget (OMB) on behalf of IRFs, seeking to address the significant burden posed by the detailed documentation requirements contained in the regulations and the soon-to-be-codified Medicare Benefit Policy Manual (MBPM) provisions. In particular, the FAIR Fund requested that the requirement for a preadmission screening and a post-admission history and physical will decrease documentation burdens, allow physicians to document needed care more efficiently, and reduce unnecessary and extremely onerous denials based on minor deficiencies in current documentation requirements. Unfortunately, the final rule also elevates the currently unenforceable IRF guidance in the MBPM to binding regulation. Accordingly, the FAIR Fund had also requested that the proposed codification of the MBPM be eliminated due to the provider burden this will undoubtedly cause.

In fact, the recent regulatory changes, on the whole, actually increase the burden on IRFs rather than lessen them—an action in diametric opposition to the Executive Order. The FAIR Fund argued that replacing the preadmission screening and post-admission physician evaluation with the traditional history and physical will decrease documentation burdens, allow physicians to document needed care more efficiently, and reduce unnecessary and extremely onerous denials based on minor deficiencies in current documentation requirements. This approach would also align IRF admissions procedures with acute care hospital admission procedures and actually align with the Trump Administration’s goals of reducing regulatory burden.

Coalition to Preserve Rehabilitation Joins AMRPA in Highlighting Patient Perspective in NPP Debate
As AMRPA members are aware, CMS recently released the final rule detailing IRF payment rates and other policies for Fiscal Year 2021. The proposed rule, released in April, included a variety of proposed changes to the IRF coverage requirements, most notably a proposal to allow non-physician practitioners (NPPs) to perform all of the duties in an IRF currently required to be performed by a rehabilitation physician. AMRPA, among many other stakeholders in the field, strongly opposed this proposal on the basis that it could detract from the unique care provided in IRFs and result in worse patient outcomes. AMRPA’s full comments on the rule can be found here.

In June, towards the end of the public comment period on the IRF rule, healthcare news journal Modern Healthcare published an article detailing the stakeholder response to the proposed rule, titled, “Physicians, non-physicians at odds over inpatient rehab rule.” This article portrayed the controversy around the rule (which garnered more than 2,500 public comments, the vast majority of which were opposed to the NPP provision) as a “turf war” between provider groups. However, the article largely omitted the voice of IRF patients, who could have the highest risk of negative impact from this proposal.

In response to this article, the Coalition to Preserve Rehabilitation (CPR, of which AMRPA is a member) drafted a letter to the editor to highlight the patient perspective in this debate. CPR is a coalition of more than 50 national organizations that represent patients – as well as the clinicians who serve them – who are frequently in need of the intensive level of medical rehabilitation care provided in IRFs. In the letter, the CPR Steering Committee emphasized that IRFs are a unique setting of post-acute care, far different than skilled nursing facilities. CPR argued that IRFs are traditionally populated by the most complex rehabilitation patients, who have illnesses, injuries, disabilities, and comorbidities that require intensive, coordinated, team-based rehabilitation and medical management. The letter also stated that these rehabilitation teams are led by highly trained rehabilitation physicians, who typically have board certification and long-term, specialized experience in medical rehabilitation.

CPR believes that opening the door for IRF care to be solely provided by non-physician clinicians with limited or no specific training in rehabilitation could have dire consequences for IRF patients, whose course of recovery, functional outcomes, and lifelong health status is often decided by the initial care provided in an IRF following their injury or illness. The CPR letter was published in Modern Healthcare on August 1. CPR also sent the same letter under separate cover to CMS and the Office of Management and Budget (OMB), the agency currently preparing the final rule for publication. Fortunately, CMS heeded the concerns of stakeholders in the final rule and did not finalize the bulk of the agency’s proposal regarding NPPs. A full overview of the provisions in the final rule relevant to AMRPA members can be found on page 15.

Answers to AMRPA’s Most Frequently Asked Questions

Visit our regularly updated webpage for answers to questions about:

- Blanket waivers across the Medicare program
- Flexibilities granted to IRFs
- Financial relief available to providers
- Coding and billing issues

www.amrpa.org/FAQ
Be part of this exciting educational and networking opportunity!
Register for AMRPA’s 18th Annual Educational Conference & Expo.

Due to public health concerns presented by the COVID-19 pandemic, this year’s AMRPA Fall Educational Conference & Expo will be presented virtually.

New for 2020: Facility Registration
You can register for the conference as an individual, or as a facility with others from your respective rehabilitation hospital or unit. Hospitals and units sending more than one employee attendees may register under the Facility Registration Rate. Learn more.

Medical Directors’ Symposium
We’ve added the Medical Directors’ Symposium to this year’s program! Usually offered at the AMRPA Spring Conference & Congressional Fly-In, this is a unique opportunity for all conference attendees, including medical directors and physician leadership to gain invaluable information about running a medical rehabilitation hospital or unit for no extra cost. You don’t want to miss it.
Physician Documentation Tips

Recently, a reminder was sent to providers with results of an Office of Inspector General (OIG) audit, which found non-compliance in a large percentage of inpatient rehabilitation claims. I do not know if there was an implied message behind the warning, or if it was just a friendly reminder. In either case, it seems like the right time to dust off the cobwebs and review the Medicare documentation requirements for inpatient rehabilitation providers.

The OIG report, states that a large percentage of requested records did not meet eligibility requirements for an inpatient rehabilitation stay due to missing documentation. In the past, these were referred to as technical errors or lack of proof of medical necessity. The following list of requirements can be shared with physicians to ensure awareness of the requirements for Medicare patients.

CMS Requirements
1. Sign the pre-admission screening no more than 48 hours prior to the patient’s admission.
2. Assess the patient within 24 hours of admission and complete the H&P.
3. Complete the overall plan of care by the end of the fourth day of rehab.
4. Complete at least three documented face-to-face visits per week (in addition to the H&P).
5. Include updates on medical and functional progress and participation in your progress notes at least three times per week.

Medical Necessity
1. Thoroughly document the conditions that will be managed.
2. Discuss the strategies and interventions necessary to manage those conditions.
3. Be explicit about the patient’s need for medical management by stating what you saw, thought, and did during your exam.
4. Mention function and state whether the patient’s progress or lack of progress is meeting your expectations.
5. Note all order changes and tests in the progress notes to reflect close medical management. An auditor may not put these items together or read far enough into a record to see orders.

Lisa Werner, MBA, MS, SLP
Director of Consulting Services, Fleming-AOD, Inc.
Team Conference
Per CMS, the purpose of team conference is four-fold:
1. Discuss progress made.
2. Note barriers to discharge.
3. Identify interventions necessary to remove barriers.
4. Update the plan of care.

Ways to achieve this:
• Discontinue repeating the admission, current, and goal function, which is already stated in the team progress notes.
• Solicit barriers to discharge from staff.
• Document interventions that will be attempted to remove barriers.
• Note if staff indicate that the plan of care needs to be modified.

Team conference must take place weekly. No more than seven days should elapse between team conferences, regardless of whether the conference day falls on a holiday. All members of the treatment team must be present for conferences, or have a designee attend on their behalf.

Remember that the timelines for completion of the CMS requirements are firm. If your medical record does not strictly adhere to these time frames, you risk denial of the record when it is reviewed. The quality of the documentation is equally as important, as it establishes the need for close medical supervision and an intense rehabilitation program. Less is not more in physician documentation. Careful and thorough documentation is critical to proving that an inpatient rehabilitation stay was reasonable and necessary. Use these tips to ensure that documentation reflects the stellar care provided in your rehabilitation hospital or unit. ★

JOIN TODAY!
AMRPA: Working Together to Preserve Access to Medical Rehabilitation
Elizabeth Katsion, AMRPA Member Services Coordinator, ekatsion@amrpa.org, 202-207-1102.
Looking Ahead to October: AMRPA’s Recommendations Related to Coverage, Payment & Patient Outcomes Were Incorporated in the FY 2021 IRF Payment Final Rule

On August 4, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FY) 2021 Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) Final Rule and accompanying Fact Sheet. The rule will go into effect on October 1, 2020, and is scheduled to be published in the Federal Register on August 10, 2020.

Most notably, CMS significantly scaled back its proposal to allow non-physician practitioners (NPPs) to perform certain IRF services that are currently required to be performed by a rehabilitation physician (for example, completing the pre-admission screening). AMRPA raised serious concern about the proposal’s potential impact on patient care and safety, and we conveyed our concerns through our comprehensive comment letter and discussions with CMS and other post-acute care stakeholders. AMRPA therefore supports CMS’ decision to significantly limit this proposal to only allow NPPs to conduct 1 of the three required face-to-face physician visits with the patient per week, beginning with the second week of the patient’s admission to an IRF. Numerous arguments raised by AMRPA in our letter – such as the fact that the role and judgment of rehabilitation physicians are central to the successful outcomes of complex IRF patients – were cited by CMS in the final rule. Additional detail on this provision is included in the summary section below.

In addition to the NPP provision, CMS also finalized the removal of the Post-Admission Physician Evaluation (PAPE) consistent with AMRPA’s recommendation. The PAPE requirement was temporarily waived as an IRF coverage requirement under the April 6, 2020, interim final rule in response to the COVID-19 public health emergency (PHE). With the PHE being extended in late July, AMRPA anticipates that the PAPE will remain waived until its permanent removal on October 1, 2020.

AMRPA is closely reviewing some other provisions of the rule, including CMS’ decision to codify most

“CMS’s decision to directly respond to many of our leading concerns in its final rule constitutes a big win for AMRPA and, most importantly, the quality of care provided to our patients and their outcomes. We applaud CMS for this action and are gratified that CMS leadership recognized the immense value that IRFs and direction under rehabilitation physicians offer.”

— Dr. Robert Krug, AMRPA Board Chair
of the existing documentation instructions and guidance located in the Medicare Benefit Policy Manual (MBPM) related to the pre-admission screen. AMRPA had encouraged CMS to allow physicians to rely on their training and expertise to determine which information best supports the appropriateness of the admission, arguing that such an approach would reduce provider burden, facilitate appropriate and timely patient admissions to IRFs, and improve the post-admission review process for both IRFs and Medicare contractors. At the same time, CMS partially acted on AMRPA’s recommendation to eliminate duplicative reporting requirements for the pre-admission screen that are currently included in the MBPM, including the expected frequency and duration of treatment in the IRF and any anticipated post-discharge treatments. We will closely monitor the impact of this change in the upcoming payment year.

With respect to payment, CMS finalized changes to the weights and average lengths of stays for the IRF PPS Case Mix Groups (CMGs), an increase in the standard payment conversion factor due to growth in the IRF market basket, and an increase to the labor-related share. Overall, CMS estimates payments to IRFs will increase by 2.8%, or approximately $260 million nationwide in FY 2021. For reference, CMS finalized a 2.5% update in its final FY 2020 IRF PPS rule. CMS also finalized its proposal to use new statistical regional areas for purposes of IRF wage index adjustments, which will result in notable changes for some providers.

Additionally, CMS finalized the method for applying the 2 percentage point reduction (i.e., penalty) to the FY 2021 IRF increase factor for IRFs that fail to meet Quality Reporting Program (QRP) requirements. This is the only provision impacting the QRP in the FY 2021 rule, given CMS’ asserted intent to limit the scope of rulemaking in light of the PHE’s impact on our industry.

CMS also notes that it received comments on some issues that AMRPA is closely tracking – such as IMPACT Act data availability – but noted that such issues are also outside of the scope of the rulemaking and not subject to a response from CMS.

While the IRF PAI v. 4.0 was initially scheduled to take effect in conjunction with the effective date of the FY 2021 payment rule, CMS announced the delay of the IRF PAI update (until at least one full fiscal year after the public health emergency is declared over) in its separate COVID-19 interim final rule.

We will continue to analyze the rule and assess potential impact on our future efforts related to burden reduction, post-acute payment reform, and other Association priorities. Please reach out to staff with any questions or concerns you have on the final rule.

We’ve copied below the Highlights section that was included in our AMRPA Special Edition: Off the Record analysis, which was distributed to members hours after the rule’s release:

HIGHLIGHTS

A. FY 2021 Case Mix Revisions and Payment Changes

CMS finalized its yearly updates to the IRF PPS CMGs, the standard payment conversion factor, and the labor-related share. CMS also finalized its proposal to use updated statistical regions to assign wage indexes to hospitals, which will result in payment changes in some areas, along with a transition policy.

1. FY 2021 Case Mix Groups and Average Lengths of Stay

Consistent with previous annual updates, CMS used the most recent claims and cost report data to update the CMG relative weights and average lengths of stay (ALOS) for FY 2021. Table 2 on page 18 of the display version of the final rule presents the proposed relative weights for all CMGs and tiers, as well as the new proposed ALOS. These finalized CMG weights are consistent with CMS’ proposal, and CMS estimates that 99.3% of all IRF cases are in CMGs and tiers that would experience less than a 5% change (either increase or decrease) in its assigned weight.

2. Standard Payment Conversion Factor

In the proposed rule, CMS stated that it forecast a growth in the market basket of 2.9% for FY 2021. However, CMS typically uses updated data and creates a new forecast for the final rule. This year, using updated data, CMS and its contractor forecast the market basket to grow at just 2.4%, which it has now finalized as the market basket update for FY 2021. CMS also finalized a 0% productivity adjustment and a standard payment conversion factor of $16,856.

3. Wage Index and Labor Related Share Changes

CMS proposed a labor-related share for FY 2021 of 72.9%, up from the FY 2020 share of 72.7%. After using its updated forecasts for the final rules, CMS finalized a labor-related share of 73.0%. This will correspondingly lead to a slight increase in variations in payments across regions as a higher percentage of IRF payments are adjusted according to their local wage index.

CMS has also finalized its proposal to re-assign geographic regions to new designated areas. These new designations will be based upon updated delineations called Core-Based Statistical Area (CBSA) market definitions from the White House Office of Management and Budget (OMB). The changes to the CBSAs will result in some hospitals being grouped into a different region, potentially with a different rural, urban or other designation, and/or with a different wage index figure. CMS estimates approximately 5% of IRFs will see a decrease in their wage index value as a result of these changes. To address this, CMS has finalized a transition policy to implement the new wage indexes over a two-year period. CMS will cap any decreases in wage index values at 5% for FY 2021, and any remaining change will be realized in FY 2022.

4. Outlier Threshold

CMS proposed to reduce the outlier threshold amount from $9,300 for FY 2020 to $8,102 for FY 2021 in the proposed rule to ensure outlier payments account for 3% of total payments. In the final rule, using updated data, CMS finalized an even lower outlier threshold of $7,906 for FY 2021. If CMS correctly forecast the outlier threshold, CMS estimates there will be a
$40 million increase in aggregate payments to IRFs (rising from 2.6 to 3.0% of total payments).

5. Total Estimated Payment Changes
Overall, CMS estimates an increase of $260 million in aggregate payments to all IRF providers over FY 2020 payments, or about 2.8%. $220 million of this is attributable to the market basket increase (including adjustments for budget neutrality factors) with the remainder attributable to the potential for an increase in outlier payments. In addition, CMS also estimates urban IRFs would see a 2.8% increase overall and rural IRFs would see a 3% increase overall.

B. Removal of the PAPE Requirement from the IRF Coverage Requirements
As part of its Patients Over Paperwork initiative, CMS proposed and finalized the provision to remove the PAPE documentation requirement from both the coverage regulation and the MPBM. CMS provided several grounds for this change, including that “if IRFs are doing their due diligence while completing the pre-admission screening … by making sure each prospective IRF patient meets all of the requirements to be admitted to the IRF, then the post-admission physician evaluation is unnecessary.” CMS says the proposal received unanimous support from commenters, with many commenters stating the information included in the PAPE is duplicative of the information already included in a thorough history and physical. The proposal followed the temporary relaxation of the PAPE requirement as part of the April 6, 2020 interim final rule in response to the COVID-19 PHE. At the time of issuing that interim final rule, CMS asserted that it intended to use the temporary waiver to determine the impact of eliminating the PAPE requirement as permanent policy.

C. Revisions to Certain IRF Coverage Documentation Requirements
1. Pre-admission Screening Documentation Instructions and Guidance
In an effort to reduce burdens on MACs, CMS proposed to codify the pre-admission screening elements included in the Medicare Benefit Policy Manual in full. CMS’ proposal was likely a response to the Supreme Court’s Allina decision, which held that Medicare interpretive guidance is not binding unless issued through notice-and-comment rulemaking. However, due to stakeholder concerns about the duplication of some of the elements, CMS finalized the following narrower set of pre-admission screening elements:

- Prior level of function
- Expected level of improvement
- Expected length of time to achieve that level of improvement
- Risk for clinical complications
- Conditions that caused the need for rehabilitation
- Combinations of treatments needed
- Anticipated discharge destination.

As a result of the finalized rule, three of the elements currently included in the MBPM will no longer be part of the pre-admission screening requirements: (1) the expected frequency and duration of treatment in the IRF; (2) any anticipated post-discharge treatments; and (3) other information relevant to the patient’s care needs. CMS states that these elements are duplicative requirements that will be captured in other medical documentation, such as the history and physical or the individualized overall plan of care. Furthermore, these elements require the rehabilitation physician to predict what will happen during and after the IRF admission, which often changes during the IRF stay. As such, CMS will be removing these elements from the MBPM.

2. Definition of a “Week”
In the proposed rule, CMS proposed to clarify that, for the purposes of the IRF intensity of therapy requirement (i.e., the so-called “3 hour rule”), a “week” is defined as “a 7 consecutive calendar day period.” CMS notes that stakeholders asserted that a “week” may be construed in different ways (for example, Sunday-Monday), and for that reason, CMS proposed to use “a seven consecutive calendar day period” language for clarity. CMS is finalizing this proposal without change.

D. Provisions Impacting Non-Physician Practitioners & IRF Coverage Requirements
With respect to the non-physician practitioner issue in the FY 2021 IRF PPS proposed rule, CMS referenced the October 2019 Executive Order that requires federal agencies to assess whether any current regulatory requirements restrict “professionals from practicing within their full scope of practice.” Pursuant to this Executive Order, CMS initiated a review of the current requirements specific to rehabilitation physicians to determine whether some of these requirements could be fulfilled by NPPs. The proposed rule did not specifically define the term, “non-physician practitioner.” Based on this review, CMS proposed that an NPP could perform the following services that are currently required to be performed by a rehabilitation physician:

- Conduct face-to-face visits with the patient at least 3 days per week throughout the patient’s stay in the IRF;
- Conduct or appoint the clinician to conduct the preadmission screening, as well as review and concur with the findings of the preadmission screening;
- Develop the Individualized Plan of Care (IPOC)
- Lead the interdisciplinary team meeting
- Complete the PAPE within 24 hours of the patient’s admission to the IRF (Note: CMS proposed and subsequently finalized the removal of the PAPE, rendering this NPP proposal moot).

AMRPA joined the majority of other commenters in opposing this proposal on numerous grounds (full comments available here). Citing many of the points raised by AMRPA in our comment letter, CMS only finalized a portion of the proposed policy, allowing NPPs to conduct one of the three required rehabilitation physician visits in every week of the IRF stay after the first week (and only if permitted within the NPP’s scope of practice under state law). CMS asserts that it “believe[s] it is prudent at this time to take a more measured approach to expanding the role of non-physician practitioners in the IRF setting to ensure that the
vulnerable IRF populations will continue to receive the highest quality of care for their post-acute rehabilitation needs.” CMS also notes that it will require the rehabilitation physician to visit patients a minimum of three times in the first week to “ensure that the patient’s plan of care is fully established and optimized to the patient’s care needs in the IRF.” Significantly, the final rule does not permit NPPs to perform any of the other rehabilitation physician-focused coverage requirements included in the proposed rule. Finally, the final rule specifically defines NPPs as physician assistants, nurse practitioners, and licensed practical nurses.

AMRPA strongly supports CMS’ decision with respect to the NPP policies. As AMRPA emphasized in our comment letter, the role and judgment of rehabilitation physicians in IRFs is central to the successful outcomes of complex IRF patients, and this component is one of several that distinguish IRFs from other less intensive post-acute care settings – particularly during the public health emergency. AMRPA is gratified that CMS recognized the value of IRFs and rehabilitation physician direction of the rehabilitation team in the final rule.

CMS asserts that its decision to finalize a portion of the proposed policy “mitigates many of the concerns expressed by commenters,” as it “preserves the existing benefit structure of the IRF setting, ensures the quality of care for IRF patients by continuing the rehabilitation physician’s close involvement in the establishment of the patient’s plan of care and the initial implementation of the plan of care, and allows non-physician practitioners to assist in implementing the plan of care once it has been fully established.” CMS adds that it believes its approach takes “full advantage” of the training and experience that rehabilitation physicians bring to the care of IRF patients, while also allowing patients to benefit from the training of NPPs in certain circumstances. We look forward to receiving member feedback on this provision.

CMS estimates that any savings from this provision will not be significant (less than $3 million while anticipating that IRFs will adopt this new flexibility about 50% of the time), but it also does not anticipate that this approach will increase costs to the Medicare program.

E. Quality Reporting Program
For IRFs that fail to comply with quality data submission requirements, CMS proposed and finalized application of a 2% reduction (i.e., payment penalty) to the applicable FY 2021 market basket increase factor used to calculate an adjusted FY 2021 standard payment conversion factor. CMS says such reductions to the market basket increase factor are not cumulative and will only apply to a particular fiscal year as a penalty for failing to comply with quality reporting requirements. Accordingly, IRFs that do not meet the quality reporting requirements will receive an adjusted standard payment conversion factor of $16,527, a significant financial penalty when the vast majority of infractions involve good faith errors in electronic submission of data. No other QRP provisions were included in the final rule.

Resources
- FY 2021 IRF PPS Final Rule (display version) and Fact Sheet
- FY 2021 IRF PPS Data Files (when available)
- AMRPA Comments on the FY 2021 IRF PPS Proposed Rule
AMRPA Continues to Work to Secure Needed Relief for IRFs

Jonathan Gold, JD, AMRPA Director of Government Relations and Regulatory Affairs

As COVID-19 continues to impact communities across the country, AMRPA has pursued relief for rehabilitation providers to ensure they have the flexibility and resources to address the challenges of their communities. This work involved direct engagement through formal and informal means with officials from the Department of Health and Human Services (HHS) and Centers for Medicare and Medicaid Services (CMS) to convey the broad-range of needs of Inpatient Rehabilitation Facility (IRF) and other post-acute care providers. AMRPA is appreciative that HHS and CMS has been responsive to AMRPA's requests on several fronts.

Flexibilities Secured
On April 30, 2020, CMS released a second interim final rule that provided additional flexibilities to IRFs and was responsive to several of AMRPA's requests following CMS' initial round of waivers and an earlier interim final rule. Among the more notable changes, CMS indefinitely delayed implementation of the IRF PAI v. 4.0, so that hospitals could divert resources being used to implement the new assessment towards needed patient care. The agency also provided flexibilities for freestanding IRFs to admit non-rehabilitation patients in areas that were experiencing a surge of patients. Additionally, CMS used recently delegated legislative authority to make outpatient therapy eligible for telehealth or remote delivery, and also froze teaching status and graduate medical education payment levels so hospitals could avoid payment cuts.

As the PHE has evolved and CMS has issued additional changes, providers have had ongoing questions and requests for technical guidance on the various waivers and flexibilities. AMRPA brought these questions to CMS' attention, and CMS issued several clarifications as a result, including issuing a statement permitting IRF weekly team conferences to be conducted remotely. In addition, CMS was responsive to industry concerns that many skilled nursing facilities had stopped taking new patients, and began permitting IRFs to utilize a waiver to create “swing-beds” within their facilities to provide sub-acute care when necessary.

AMRPA also pursued further information on a number of other waivers on behalf of member hospitals. Through this work, CMS clarified the options for providing outpatient, hospital-based therapy on a remote basis, as well as how to properly submit claims for these services. CMS additionally issued a clarification on the application of claim modifier codes, including which modifiers need to be applied when utilizing specific IRF waivers.
HHS has also been disbursing provider relief funds to hospitals across the country, including IRFs, to assist with the cost of delivering care in the COVID-19 environment, and with other hardships hospitals have faced. Several rounds of funding through the Provider Relief Fund, were distributed nationally, while others focused solely on areas hit hardest by COVID-19. Most recently, on July 17, HHS distributed an additional $10 billion in funds to “high-impact” COVID-19 areas of the country.

Looking Ahead
AMRPA is acutely aware that the tail of this pandemic will be particularly long for IRFs and other post-acute care providers. For this reason, AMRPA is persistent in pushing for retention of all current flexibilities available to IRFs, and several additional changes. In July, AMRPA submitted formal comments in response to CMS’ COVID-19 interim final rule. In its comments, AMRPA emphasized the need to renew the PHE indefinitely and to keep all current flexibilities in place for IRFs. Fortunately, HHS was responsive to this request, and on July 23 HHS Secretary Alex Azar renewed the PHE for an additional 90 days.

In its formal comments, AMPRA also asked CMS suspend use of prior authorization by Medicare Advantage plans for the duration of the Public Health Emergency (PHE). The letter also brought numerous other issues to CMS’ attention, including the need to make technical modifications to current waivers, and to reconsider longer-term reforms in light of COVID-19, including development of a unified post-acute care payment system.

Additionally, AMRPA reiterated its strong concerns about the hospital price transparency rule, set to go into effect in January, and again asked CMS to withdraw the rule.

In May and June, AMRPA also analyzed and provided a comprehensive response to CMS’ proposed rule for the IRF Prospective Payment System (PPS), which includes numerous notable proposals. Its letter emphasized the importance of the physician-led care in IRFs and how important rehabilitation physicians are in providing intensive rehabilitation services. AMRPA’s response also pushed for permanent removal of burdensome documentation requirements, and encouraged CMS to continue its work to calibrate IRF PPS case-mix groups to properly account for IRF resource use.

To assist member hospitals with navigating the rapidly evolving environment, AMRPA continues to hold informational calls with featured hospitals, providing insights into their approach to tackling COVID-19, and making staff and counsel available to discuss technical questions. The association’s COVID-19 Resource Center website also provides numerous resources to members, including waiver trackers, frequently asked questions, and several others.

AMRPA will continue working to ensure hospitals have all the information they need to overcome the current challenges they face. If any assistance is needed, reach out to myself or AMRPA staff or counsel. ★
AMRPA leaders continue to monitor the unfolding COVID-19 pandemic and will keep you notified if any of the dates of in-person events change.

CONFERENCE DATES

AMRPA 2020 Fall Educational Virtual Conference & Expo
October 4-8, 2020
Register today

MEMBERS-ONLY CALLS

Wednesday, September 13, 2020, Noon - 1:00 p.m. ET
Wednesday, November 10, 2020, Noon - 1:00 p.m. ET

Visit www.amrpa.org to register.
Over the past several months, AMRPA and its member hospitals have received national print and broadcast news media attention for their responses to the COVID-19 pandemic. As scientists and health care providers learned more about the novel coronavirus, the importance of inpatient rehabilitation hospitals and units (IRH/Us) was dramatically highlighted. Many survivors of COVID-19 will require ongoing rehabilitation following the acute-phase of the illness, and this increased press coverage helps to ensure federal officials and policymakers recognize the need to support IRH/Us throughout the duration of the public health emergency (PHE) and beyond. Furthermore, the coverage helps bring awareness to the general public about the availability and role of inpatient rehabilitation for COVID-19 recovery and other illnesses and injuries. We’ve highlighted below just a sample of major trade press coverage received by our Association and members:

AMRPA in MedPage Today
In July, AMRPA hosted a joint Congressional briefing with the American Academy of Physical Medicine & Rehabilitation (AAPM&R). AMRPA Board members Patty Jobbitt MSA, PT, and David Storto, JD, along with AAPM&R members Steven R. Flanagan, MD, and Keith Foster, MD, MBA, provided insight into the long-term rehabilitation needs facing COVID-19 survivors and their innovative approaches to providing necessary care – including new outpatient centers dedicated to COVID-19 recovery. Panelists urged members of Congress to ensure rehabilitation hospitals and units have the necessary flexibilities, resources (e.g. personal protective equipment) and funding to treat current patients and respond to future pandemics.

AMRPA received coverage of the briefing in MedPage Today, which underscored the value of post-acute care for patients recovering from COVID-19 in hard-hit areas such as Florida. The coverage also highlighted the importance of the many temporary flexibilities and waivers advocated for by AMRPA and ultimately granted by the Centers for Medicare and Medicaid Services (CMS), such as the 3-hour rule and 60% rule waivers.

Immanuel Rehabilitation Institute
In May, Immanuel Rehabilitation Institute was one of the first AMRPA member hospitals to receive press coverage. In its story, Live Well Nebraska magazine detailed the 25-day stay (15 of which were on a ventilator) of Ruby Jones, a 73-year old patient in the acute-care hospital’s intensive care unit. Following the prolonged period on a ventilator, Jones, like many COVID survivors, faced complications. She was then admitted to Immanuel Rehabilitation Institute for comprehensive rehabilitation aimed at addressing the complex issues that arose from her time in the ICU. Jones experienced significant functional gains and after 14 days was able to return home, where she continues her recovery.

“Long ICU stays can lead to other problems: muscle weakness, fatigue, depression, anxiety, a form of disorientation called “ICU delirium” and cognitive problems with memory and problem-solving.”
– Live Well Nebraska Magazine
MossRehab
MossRehab in Philadelphia also received coverage in May for the innovative care they provide to COVID-19 patients. Like Ruby Jones in Nebraska, Dee Messina was placed on a ventilator for more than two weeks and faced many complications, such as debility and trouble eating. Philadelphia magazine detailed his recovery treatment experience at MossRehab’s specialized COVID-19 unit. In the article, AMRPA Board Member and Chief Medical Officer at MossRehab, Alberto Esquenazi, MD, was quoted on the wide-range of complications COVID-19 survivors face. The article also included coverage of the CORE+ unit, which provides rehabilitation to COVID-19 patients who are seven days past their diagnosis and fever free for 72 hours. At capacity since it opened, the unit is a model for other inpatient rehabilitation hospitals and units across the country.

Spaulding Rehabilitation Network
Spaulding Rehabilitation Network also received press and broadcast media coverage in recent months for their COVID-19 care. Like many other AMRPA members, Spaulding Hospital Cambridge created a dedicated COVID-19 unit. Boston’s NBC-affiliate interviewed AMRPA Board Member David Storto, JD, regarding the need for the unit, which included coverage of Jose Rios, a patient who was placed on a ventilator at Massachusetts General Hospital and later discharged to Spaulding’s COVID unit. Despite co-occurring risk factors, Rios survived COVID-19 and continues in his recovery. The dedicated unit at Spaulding Hospital Cambridge is able to provide a unique level of care that is addressing many of the concerns facing coronavirus patients, and is helping to ensure successful outcomes for survivors. Spaulding also received coverage in the Boston Globe, which detailed a patient’s treatment at Spaulding Rehabilitation Hospital in Boston. AMRPA Board Chair, Bob Krug, MD, was interviewed for the piece and emphasized that survivors often face months of recovery following acute-care hospital stays.

Burke Rehabilitation Hospital
While the general public is well aware of how hard New York and New Jersey were hit by COVID-19, far fewer know the role inpatient rehabilitation hospitals and units played in the response effort. In a June story, the Washington Post featured New York AMPRA member Burke Rehabilitation Hospital. At the time, Burke was housing 39 COVID-19 patients, but at its peak Burke housed 90 coronavirus patients, including Hugo Sosa. Sosa, a first responder, was in an intensive care unit for 44 days – 19 of which were on a ventilator – followed by a stay at Burke. There, Sosa, like many other COVID survivors, engaged in a complex rehabilitation program to help build back his strength and re-learn to walk. Like the aforementioned AMRPA member rehabilitation hospitals across the country, Burke continues to respond to the public health emergency to ensure COVID-19 survivors receive the rehabilitative care they need.

TIRR Memorial Hermann
In July, TIRR Memorial Hermann in Houston received national coverage by ABC News for the care they provided to Dr. Grant Lashley, an emergency room physician, who spent 39 days on a ventilator, followed by 96 days at Memorial Hermann. Following diagnosis with COVID-19, Lashley suffered a stroke. In his time at Memorial Hermann he completed a rehabilitation program to help improve his strength. He has now been discharged and will return to his home in Louisiana as he continues on his road to independence.

“Together these survivors form an undercurrent of struggle and disability that will challenge the health care system and the economy – even before a possible second wave of COVID-19 crashes in.” — Boston Globe

“AMRPA would like to highlight media coverage your rehabilitation hospital may have received during the pandemic. Please contact Adam Robertson, AMRPA Marketing Communications Manager, if your hospital received any coverage for its response efforts. The Association applauds the efforts our members are making across the country to ensure patients receive high-level rehabilitation care as the public health emergency continues.”
Thirty years ago, a major victory was achieved in the ongoing civil rights movement for legal rights and protections for people with disabilities. On July 26, 1990, the Americans with Disabilities Act (ADA) was passed and signed into law, prohibiting discrimination on the basis of disability and helping ensure equal access to opportunities.

This groundbreaking legislation is recognized today as the most comprehensive disability law in the United States, mirroring and supplementing the Civil Rights Act of 1964 and the Rehabilitation Act of 1973.

In commemoration of this important anniversary, AMRPA spoke with Lex Frieden, who is widely considered the chief architect behind the ADA, about the meeting that sparked his advocacy journey, the years of work that led up to the ADA, what still needs to be done to ensure equality and promote equity for people like him, how to become an advocate for change and the power of medical rehabilitation.

A Chance Meeting

Throughout life, there are key moments that end up defining who we are and encouraging us to take the first step on a future path that we couldn’t have possibly imagined for ourselves before. For Lex Frieden, as a freshman in college, one of those moments occurred in November 1967 when he was involved in a car accident and sustained a life-threatening spinal cord injury.

“I went to an acute care hospital in a really bad situation. I couldn’t move. I couldn’t feel anything.”

After his health stabilized in January 1968, his doctors gave him two options: go home and be in a local hospital for the rest of his life or go to a rehabilitation hospital, a new post-acute care offering at the time, to attempt to regain some level of independence.

Faced with this decision, he enlisted the help of his father to visit some rehabilitation hospitals. After touring the very few choices around the country, one stuck out as the clear choice: TIRR (known today as TIRR Memorial Hermann) in Houston. With medical rehabilitation being a relatively new science in the late 1970s, there wasn’t much information on how best to choose care, but Lex recalled his father’s personal welcome from TIRR’s founder, Dr. William A. Spencer, as well as assistance from employees who had actually been patients at the facility and the overall relaxed, patient-centered environment.

“My life was changed at the point the decision was made by myself and my family to engage in a comprehensive medical rehabilitation program rather than just stop the world and go home and live in a hospital,” Frieden said.

In addition to his daily rehab with his specialized team, Frieden noted the positive influence that sharing a room with six other patients, a standard at the time, had: “After the lights went off at night, I would say as much occurred just by having the peer support and conversation in that room.”

After two and a half months of intensive and successful rehabilitation, Lex went home and reapplied to college.

Then came another defining moment in his life.
“I was shocked then to discover that I could not even be readmitted to the college because I had indicated on my application that I used a wheelchair for mobility, and that had a profound impact on my life. At that point, I would say I became a disability rights advocate,” Frieden said.

An expected encounter occurred after he was eventually accepted into graduate school at another institution when Dr. Spencer, who become one of Lex’s mentors, invited him to a meeting at TIRR with Congressman Olin Teague.

“The meeting with Teague led me to believe that in fact our representatives in the Congress could relate to some of the issues we had as people with disabilities.”

The Journey
Meeting Congressman Teague quickly led to Lex’s recently-undertaken journey in advocacy being realized, when he was invited to be part of a panel of experts commissioned by a congressional committee that dealt with science and technology.

Lex traveled around the country discussing how those with disabilities could benefit from the latest technology that was being developed for use in the then booming space program, giving his unique perspective in the process.

“That also kind of conditioned and reinforced the notion that people with disabilities must be involved in programs that affect their lives, in making decisions about those programs and leading those programs.”

This panel eventually became the National Institute on Handicapped Research in 1978 and later in 1986 the National Institute on Disability and Rehabilitation Research.

Shortly after, the first step in legislation ensuring equal access for those living with disabilities was taken with the Rehabilitation Act of 1973. However, Title V of the Act, which would have delegated federal funds to be used for public space accessibility, was not implemented.

“Apparently, nobody understood how you could apply non-discrimination laws to people with disabilities. It just was not intuitive,” Frieden said.

In 1976 in protest of the non-inclusion of Title V, people with disabilities blocked the Golden Gate Bridge and organized a sit-in in federal office buildings in San Francisco, shutting some down for weeks. The following year, Lex helped found the Independent Living Research Utilization Program (ILRU) at TIRR Memorial Hermann, of which he currently serves as director.

As part of the same protest, a candlelight vigil was held in Washington, D.C., to urge then Secretary of Health, Education and Welfare Joseph A. Califano Jr. to officially sign Section 504 of the Rehabilitation Act. The protest worked, and the section was signed into law.

Looking now to ensuring equal rights under non-discrimination protections, Frieden took the next step.
In 1983, he gave a testimony before Congress about independent living programs recommended in amendments made in 1978 to the Rehabilitation Act of 1973, which was due soon for reauthorization. A year later, he was appointed director of the National Council on the Handicapped (now the National Council on Disability) by President Ronald Reagan.

Under his leadership, the council produced two special reports, “Toward Independence” in 1986 and “On the Threshold of Independence” in 1988, which produced information on the legislative needs of people with disabilities in the United States. Congress chose not to move forward with the former, and thus the latter was produced with sample legislation called the “Americans with Disabilities Act” (ADA).

Two weeks after Frieden met with members of the Senate and participated in a televised interview in public support of the ADA, George H.W. Bush was made president, and it was at that moment that Lex was certain his vision was going to made reality.

But in 1990, the year that the ADA was passed, a number of small business owners with financial concerns lobbied against the bill. In response, a historic protest was held in Washington, where people with mobility disabilities abandoned their wheelchairs and dragged themselves up the steps of the Capitol building.

“I thought there aren’t going to be anymore barriers. Members of Congress came out of the Capitol to encourage us and basically said, ‘You all have done what’s needed to prove to the nation we need this bill.’”

The ADA was signed into law on July 26, 1990.

What Comes Next

While the 30th anniversary of the ADA is cause for celebration to commemorate the strides that have been made in securing equal rights for people with disabilities, it is also a time for reflection and review of areas that still need attention.

One such area is employment, where Frieden mentions rates are almost the same as they were 30 years ago.

“It’s very clear to me that employment remains one of the biggest challenges for inclusion of people with disabilities. … While we have changed the physical environment and while we have changed … the attitudinal and social environment, we have not effectively changed the workplace.”

Another central issue that has yet to be resolved is access to affordable housing, about which Frieden said, “People are stuck in places where they don’t belong, simply because there’s no other place to live.”

Over the years, disability rights advocates made major progress in health care, especially with the Affordable Care Act, but with the change in administrations, this progress has been reversed.

“People’s access to health care has improved until now, and recent action by Congress and by the administration to take away access that was provided under the Affordable Care Act has had a profound impact on many people.”
Frieden says that since employer-paid insurance can now factor preexisting conditions into their insurance assessments, many are worried that they will lose their coverage and/or compromise their Medicare and Medicaid benefits.

He also advocates for and is proposing a better community-based infrastructure, where a team can provide services to people with disabilities in their home. In this new model, caregivers and assistants would be on-call and provide support for daily tasks, such as preparing meals and putting on clothes.

Finally, he sees opportunities brought on by the public health emergency for those with disabilities in that remote work has become a viable option for many industries and their employees, in addition to the growth of telehealth offerings.

“I think COVID … may improve opportunities for people with disabilities, as we’ve proved that remote work can effectively be done. … This may be a silver lining somewhere in this cloud. … I think there are huge opportunities in adapting our clinical approaches to a telemedical modality, and we really need to exert some effort there … and build programs people can use to seek good medical care from rehabilitation programs in telemedicine and remotely.”

**Becoming an Advocate**

So how can someone like Frieden take the first step on a journey of advocacy?

“People should take initiative, and they should be assertive, and they should expect to be treated equally and not simply resign themselves to a lifestyle that they may have perceived living … but instead be aggressive and attack those barriers.”

Frieden gave numerous recommendations for how to get started, including being in touch with the local mayor's office, working in campaigns for candidates who have solid platforms on disability issues and participating in centers for independent living.

Organizations like the United Spinal Association for those with spinal cord injuries and the American Association of People with Disabilities, which Lex helped found, also provide platforms for advocates and offer peer support.

**The Power of Medical Rehab**

In January of this year, Frieden was again a patient at TIRR Memorial Hermann for rehabilitative care for 10 days after he was intubated and treated in the ICU for pneumonia.

“If I had been discharged from the ICU to my home, it’s very likely that I would not be mobile in the wheelchair right now; I’d still be recovering from the results of the intubation, from the ventilator and from the treatment that I received to get over the pneumonia.”

Frieden went on to explain the power of medical rehabilitation, saying, “When I left there, I felt like I was actually more fit than I was before I had the pneumonia and probably more fit than I had been for three years.”

Given the variety of post-acute care options, making a decision about where to be treated can be difficult, but for Lex, as it was back in 1968, the choice was clear.

“My advice to people who have the option is to choose the elite care that one would get in a comprehensive medical rehabilitation facility.”

Two years ago, Frieden formally accepted the AMRPA National Leadership Excellence Award, he recalled that one of his doctors told him, “You can anything you want to do, as long as you can figure out how to do it on four wheels.”

It goes without saying that Frieden did figure it out, and while his advocacy journey still continues, his life-defining moment back in 1967 came to fruition with the passage of the ADA 30 years ago.

To connect with Lex Frieden and follow along on his ongoing journey, follow him on Twitter and LinkedIn.

For more information on the Americans with Disabilities Act, visit its website.

To learn more about the life-changing care provided by TIRR Memorial Hermann Hospital and talk with someone from their team, go to their website.

Explore the #powerofmedicalrehab by visiting this page on AMRPA's website and reading our other patient success stories, Challenging the Prognosis and Fighting for Mobility, An Impossible Embrace and From Tragedy to Triumph. ★

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