The official publication of the American Medical Rehabilitation Providers Association (AMRPA)

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AMRPA and IRFs Responding to COVID-19 Pandemic

I was recently asked to provide a quote for a health care periodical detailing how our industry has been challenged by COVID-19 and how long I anticipate these challenges will last. As I drafted my response, I recalled a point that AMRPA Vice Chairman Anthony Cuzzola raised during a recent meeting. He asserted that it will be absolutely critical to educate policymakers on the “post-ICU” side of this pandemic, which will uniquely impact our rehabilitation hospitals well after the public health emergency is technically declared over.

As I’ve started to hear more frequently on our industry-wide calls, many COVID-19 survivors are requiring prolonged ventilator support, often with residual lung and cardiac issues, along with profound deconditioning and co-morbidities. To Anthony’s point, our hospitals are equipped – more than any other post-acute care provider – to deliver the intensive, long-term rehabilitation required for these patients to regain their prior levels of function. This in turn makes robust IRF access all the more critical in future post-acute care payment policies.

To this end, AMRPA is working to ensure that policymakers understand both the current needs of IRFs in COVID-19 hotspots, as well as the industry-wide relief that will be required to meet the long-term rehabilitation needs of COVID-19 patients. For example, our Association has highlighted the significant operational expenses that some frontline IRFs are incurring as part of their COVID-19 response, such as creating negative pressure rooms, adding bed capacity and additional respiratory therapy services, and acquiring the necessary personal protective equipment to ensure staff safety in caring for these patients.

In addition to our efforts focused on fiscal relief, AMRPA leadership and staff have held weekly (at a minimum) meetings with CMS leaders and Members of Congress to discuss the emerging clinical and operational issues facing our members and importance of certain types of regulatory relief. AMRPA has successfully advocated for certain types of waivers and flexibilities – including audit relief, a waiver of the three-hour rule, and 60% rule relaxation. I urge members to continue to reach out to leadership and staff and inform us if and how other regulations are impeding your COVID-19 response efforts so that our advocacy is aligned with the issues facing our industry in real-time.

In closing, our members are to be applauded for putting patients first and doing what is needed for their communities to address the crisis. While this will undoubtedly be a challenging time for our members, I also believe that IRFs have and will continue to distinguish their critical role in the post-acute care sector through our response efforts. Rest assured that AMRPA is working on behalf of all of our members to ensure that Congress and CMS will address these extraordinary efforts – both now and in the future – through effective regulatory and legislative change.

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Overview of COVID-19 Response Legislation

In response to the outbreak of the novel coronavirus (COVID-19) in the United States, Congress has passed three major pieces of legislation to provide support to the health care system and relief to individuals and businesses affected by the crisis. Further legislation is expected in the coming weeks as the virus continues to strain hospitals and the economy.

Phase 1
Congress provided $8.3 billion in emergency supplemental appropriations in early March as part of its "Phase 1" package, the Coronavirus Preparedness and Response Supplemental Appropriations Act (Pub. L. No. 116-123). The funding package provided more than $3 billion for research and development related to potential therapeutics, diagnostics, and vaccines. The measure also loosened Medicare restrictions on telehealth services during the public health emergency and directed $950 million to the Centers for Disease Control and Prevention (CDC) to distribute to states, localities, territories, and tribes for COVID-19 preparedness and response efforts.

Phase 2
Following negotiations between House Speaker Nancy Pelosi (D-CA) and Treasury Secretary Steven Mnuchin, Congress quickly took up and passed a second COVID-19 package, the Families First Coronavirus Response Act (Pub. Law No. 116-127). The Families First Act, signed into law on March 18, required employers to provide 14 days of emergency paid sick leave to workers affected by COVID-19. The package also expands family medical leave and unemployment benefits and provides additional funding for the Supplemental Nutrition Assistance Program (SNAP) and other food assistance programs.

The health care provisions of the Families First Act required public and private payers to cover COVID-19 diagnostic testing at no cost to patients, including a provider visit to receive the testing. The package also appropriated $1 billion to reimburse providers for the costs of testing services provided to uninsured individuals. The law permitted states to extend Medicaid eligibility to uninsured populations for the purposes of such testing and increased the Medicaid Federal Medical Assistance Percentage (FMAP) by 6.2 percentage points during the public health emergency. In order to receive the increase, states and territories must not restrict their eligibility standards beyond what they were at the date of enactment. The Families First Act provided for the treatment of personal respiratory protective devices, such as N95 respirators, as covered countermeasures under the Public Readiness and Emergency Preparedness (PREP) Act. The PREP Act
allows the Department of Health and Human Services (HHS) to provide protection from tort liability for claims of loss caused by countermeasures. Finally, the bill made a technical change to the Phase 1 measure to clarify that new Medicare beneficiaries are able to access telehealth services under the emergency authority granted to the HHS Secretary.

**Phase 3**

Soon after passage of the Phase 2 package, work began on a broader stimulus bill to provide relief to individuals, small businesses, and health care providers. Following a week of intense bipartisan negotiations, Congress passed the Coronavirus Aid, Relief, and Economic Security (CARES) Act (Pub. L. No.116-136), which President Trump signed into law on March 27. The $2.2 trillion measure – considered the largest relief package in U.S. history – includes direct payments to individuals; loans, tax credits, and other aid for small businesses; enhanced unemployment insurance; economic relief for local and state governments; and federal assistance for hard-hit industries such as airlines.

The health care provisions of the CARES Act span the jurisdiction of several Senate Committees and are primarily designed to offer financial support and flexibilities to providers as they care for patients during the public health emergency. The CARES Act suspends sequestration-mandated cuts on Medicare claims from May 1, 2020 through December 31, 2020. In addition, the Act creates a new 20% add-on payment under the Medicare inpatient prospective payment system (IPPS) for care provided to patients with COVID-19 and expands a program to provide hospitals with advance Medicare payments during the public health emergency, among other new resources and flexibilities for providers. The Centers for Medicare and Medicaid Services (CMS) subsequently expanded the Accelerated and Advance Payment Program to all Part A providers and Part B suppliers.

The CARES Act also includes an expansion of telehealth under Medicare, eliminating a provision from the Phase 1 package that required providers to have treated a patient within the last three years in order to furnish telehealth services to that person during the emergency period. Federally qualified health centers and rural health clinics will be allowed to provide telehealth services and high-deductible health plans are permitted to cover telehealth before an enrollee reaches their deductible.

Of particular interest to AMRPA members, the Act aims to increase access to post-acute care during the emergency period through additional flexibilities for post-acute care providers. Specifically, the Act includes a waiver of 42 C.F.R. § 412.622(a)(3)(ii) pertaining to the requirement that IRF patients receive at least 15 hours of therapy per week. The CARES Act also includes a waiver to allow long-term care hospitals (LTCHs) to maintain their designation even if more than 50% of cases qualify for the site-neutral payment rate. It would also temporarily pause the current LTCH site-neutral payment methodology. The legislation allows nurse practitioners and physician assistants to order home health services during the six months following enactment. Another provision would permit state Medicaid programs to pay for direct support professionals to assist hospitalized individuals in transitioning to home care and community-based care, thereby reducing length of stay and freeing up hospital beds.

With respect to testing, the CARES Act clarifies that diagnostics covered under the Phase 2 bill include all cleared and approved tests for COVID-19, including those authorized by the Food and Drug Administration (FDA) under an emergency use authorization and those authorized by a state. The Act includes several provisions to address potential shortages of medical supplies, prescription drugs, and medical devices, including new mandatory reporting for manufacturers, as well as measures to alleviate health professional workforce shortages during the public health emergency. The Act sets aside an additional $1.32 billion for supplemental awards for the treatment, detection and diagnosis of COVID-19 in community health centers. The Act reauthorizes the Rural Health Care Services Outreach, Rural Health Network Development and Small Health Care Provider Quality Improvement grant programs administered by the Health Resources and Services Administration (HRSA), as well as the Telehealth Network and Telehealth Resource Center grant programs.

The CARES Act extends a number of health care programs and provisions that were set to expire on May 22, 2020, providing funding through November 30, 2020 for community health centers, the National Health Service Corps, the Teaching Health Center Graduate Medical Education program, the Special Diabetes Program, and the Special Diabetes Program for Indians. The Act extends several expiring Medicaid programs through November 30, including the Money Follows the Person demonstration and Medicaid spousal impoverishment protections, and expands the Community Mental Health Services demonstration to two additional states, as selected by the HHS Secretary. The Act delays scheduled Medicaid disproportionate share hospital (DSH) payment reductions until December 1, 2020.

Division B of the CARES Act includes supplemental appropriations for a number of health-related programs and activities under HHS. The measure provides $127 billion for medical response efforts under the Assistant Secretary for Preparedness and Response (ASPR). This funding includes $100 billion for the Public Health and Social Services Emergency Fund to reimburse, through grants or other mechanisms, providers for coronavirus-related expenses or lost revenues attributable to the outbreak. Eligible providers include public entities, Medicare or Medicaid enrolled providers and suppliers, and other for-profit and not-for-profit entities as determined by the Secretary that provide diagnoses, testing or care for individuals with COVID-19. HHS began distributing a first tranche of an estimated $30 billion in payments to provider and suppliers in mid-April using a formula based on 2019 Medicare fee-for-service payments.

The Act also includes $3.5 billion for the development and purchasing of vaccines and therapeutics for COVID-19, and $16 billion for the Strategic National Stockpile to procure personal protective equipment (PPE) and other supplies. $250 million is provided for grantees of the Hospital Preparedness Program. The measure also adds $4.3 billion in funding for the Centers for Disease Control and Prevention (CDC), including $1.5...
increase for the PPP, the Democrats’ counterproposal includes Small Business Administration funding for Paycheck Protection Program (PPP) loans and technical corrections. In addition to this interim COVID-19 relief funding, informally dubbed “Phase 3.5.” On April 9, the Senate failed a procedural vote to get consent on the Affordable Care Act (ACA) Exchanges for uninsured individuals. The Senators also stated their commitment to have the necessary resources to respond to the pandemic, and clinics, critical access hospitals, among other providers, are expected to be included in an additional round of funding. It is still unclear whether these targeted funds will flow to hospitals or providers more broadly.

Meanwhile, Senate Minority Leader Chuck Schumer (D-NY), Health, Education, Labor and Pensions (HELP) Committee Ranking Member Patty Murray (D-WA), and Finance Committee Ranking Member Ron Wyden (D-OR) sent a letter to HHS Secretary Alex Azar on April 13, urging the Department to distribute the funds to COVID-19 hotspots in a targeted manner that does not “discriminate against providers in need based on payer mix.” The Senators also stated their commitment to provide an additional $100 billion in funding to ensure providers have the necessary resources to respond to the pandemic, and called for the administration to open a special enrollment period on the Affordable Care Act (ACA) Exchanges for uninsured individuals.

Further Legislation
On April 9, the Senate failed a procedural vote to get consent to consider either Republican or Democratic proposals for interim COVID-19 relief funding, informally dubbed “Phase 3.5.” The Republican proposal is limited to $250 billion in additional Small Business Administration funding for Paycheck Protection Program (PPP) loans and technical corrections. In addition to this increase for the PPP, the Democrats’ counterproposal includes an additional $100 billion for health care providers via the Public Health and Social Services Emergency fund and an additional $150 billion to states and localities. Senate Minority Leader Chuck Schumer (D-NY) and House Speaker Nancy Pelosi (D-CA) are also calling for additional funding for testing capacity, personal protective equipment (PPE), and SNAP. Funding for PPP was fully expended by mid-April, which will be an impetus for obtaining a compromise for additional funding. Serious negotiations are expected to continue, and there is significant and growing pressure to include an additional $100 billion in health care funding in addition to small business loans.

Meanwhile, many health care providers and other businesses are already looking ahead to a “Phase 4” package that could include a broad array of federal aid and relief measures. Speaker Pelosi and Senate Minority Leader Schumer initially proposed that the package would include Democratic agenda items such as infrastructure funding and rural broadband access, but Republicans balked at these ideas. More recently, Speaker Pelosi has called for a targeted Phase 4 bill that builds on the CARES Act, extending enhanced unemployment insurance and adding funds for small business relief. On the health care side, items under discussion for a Phase 4 package potentially include statutory drafting corrections to the CARES Act; additional funding for health care providers; further telehealth expansion; enhanced liability protections for manufacturers and distributors; delay of the Medicaid Fiscal Accountability Regulation (MFAR); competitive bidding reform; and financial relief for associations.

The House and Senate are unlikely to reconvene before May 4 unless an urgent vote demands it (and that timing could slip), although staff are already at work on the next stimulus package. A reluctance to bring Members back to Washington for votes could encourage leadership to devise a Phase 4 package that can pass by unanimous consent as well as examine alternative voting procedures.

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Members of Congress and federal agencies continue to face this unprecedented pandemic health crisis and economic emergency and take action to respond to the COVID-19 national and international crisis. At the same time, we salute how AMRPA members are doing their part to help in the face of ever-increasing demands on and dislocations in their hospitals and our health care system. We all keenly recognize already that when the pandemic is formally declared over, in reality rehabilitation hospitals will face many new and longer term challenges in serving new medically complex patients in the COVID-19 aftermath. AMRPA continues to work with Congress and the administration on critically important issues to further improve patient and IRF access during the pandemic. Thank you for all of your tireless efforts to help patients during this most challenging of times. ★
AMRPA Schedule of Events

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 Conference
October 4-7, 2020
Renaissance Dallas Hotel
Dallas, Texas
CALL FOR ABSTRACTS NOW OPEN!

MEMBERS-ONLY CALLS

Wednesday, June 17, 2020, Noon - 1:00 p.m. ET
Wednesday, September 13, 2020, Noon - 1:00 p.m. ET
Wednesday, November 10, 2020, Noon - 1:00 p.m. ET

WEBINARS

Processes to Drive Change
Wednesday, May 13, Noon - 1:00 p.m. ET
Presented By: Ellen G. Wilson, MSPT - UCLA Healthcare System, Susan Rodman, MSPT, GCS, CPC - California Rehabilitation Institute, and David Alexander, MD - California Rehabilitation Institute

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On March 27, President Trump signed the third COVID-19 response legislation, the Coronavirus Aid, Relief, and Economic Security (CARES) Act, into law. Among more than $2.2 trillion in emergency spending to address the ongoing crisis, this legislation includes several programs that can provide financial relief to health care providers across the country, including rehabilitation hospitals and units. The CARES Act provided nearly $350 billion in funds for the Small Business Administration (SBA) to issue potentially forgivable loans for which some hospitals may be eligible, as described below, and authorized a $100 billion provider relief fund, which the Department of Health and Human Services has already begun to distribute to Medicare providers. Taken together, these programs provide several avenues for AMRPA members to bolster their finances as they face the unprecedented circumstances of the COVID-19 pandemic.

**Provider Relief Fund**

In addition to (and wholly separate from) the AAPP, the CARES Act appropriated $100 billion to the Public Health and Social Services Emergency Fund, specifically designated to provide relief to hospitals and other health care providers responding to the COVID pandemic. The legislation left the HHS Secretary broad discretion on how to distribute these funds. Beginning April 10, HHS began distributing the first round of funding from this appropriation, delivering $30 billion to health care providers via direct deposit. HHS has made it clear that these are payments, not loans, and will not need to be repaid. Any provider’s existing or future application for advance Medicare payments or loans from the SBA (as detailed below) have no bearing on their eligibility for or ability to accept these direct payments from the Provider Relief Fund.

According to HHS, all facilities and providers that received Medicare fee-for-serve (FFS) reimbursements in 2019 are eligible for the initial distribution. Many rehabilitation hospitals received this direct deposit the first day the initial $30 billion was distributed. These payments were formulaic, determined by an individual providers’ share of total 2019 Medicare FFS reimbursements. Most providers received these funds via direct deposit into their accounts, paid through CMS and its distribution partner, UnitedHealth Group. For providers that normally receive a paper check for CMS reimbursement, payment will come automatically within the next few weeks. Payments will be distributed to each billing Taxpayer Identification Number associated with a large provider organization, health system, or solo practitioner, while employed physicians and physicians in group practice should not receive payments directly but will see payments distributed to their billing organization.
The payments come with an attached set of terms and conditions, which can be viewed here, and recipients are required to sign an attestation, which was not available at the time of this writing. However, the terms and conditions are quite broad and providers should generally feel secure in accepting the payments, as the intent of the program is to inject needed capital into providers’ accounts to ensure a functional health care system during the pandemic. For example, the terms and conditions state that recipients must certify they provide diagnoses, testing, or care for individuals with possible or actual cases of COVID-19. However, CMS has clarified that they view any American as a potential COVID case. They have also clarified that even providers that shut their doors to avoid infection of staff and patients satisfy this language. Additionally, recipients who want to keep their payments must abstain from “balance” or surprise billing for any COVID-related treatment.

At the time of this writing, the Administration is developing a process for the distribution of the remaining $70 billion in the Provider Relief Fund, and AMRPA has conveyed its recommended priorities for this additional funding. President Trump has already announced that some portion of the funds will be used to reimburse health care providers for COVID-related treatment of the uninsured at Medicare rates; however, the process for such reimbursement has not yet been detailed. Additionally, HHS expects to prioritize distribution of additional funds to providers in rural areas and areas particularly impacted by the COVID outbreak (e.g., “COVID hot spots”), as well as providers who predominantly serve the Medicaid population or who have lower shares of Medicare fee-for-service reimbursement.

Small Business Administration Loan Opportunities

Finally, the CARES Act created a Paycheck Protection Program (PPP), administered by the SBA, to enable small businesses, nonprofits, and other entities to obtain loans to cover costs incurred during the COVID-19 pandemic. The $349 billion program is designed to provide incentives for loan applicants to keep their employees on the payroll. Loans provided by the PPP will be forgiven by the SBA if employees are kept on the payroll for eight weeks, with the money used for payroll, rent, mortgage interest, and utilities. The program is first-come, first-serve and is scheduled to expire on June 30, 2020 or whenever funds are exhausted. Congress is currently considering passing additional legislation to expand the funds available for the program since demand for the initial $350 billion in funding is so high.

Any small business with fewer than 500 employees, private 501(c) (3) nonprofits, or 501(c)(19) veterans organizations affected by COVID-19 are eligible to apply for the loans. Some rehabilitation hospitals may be eligible if they meet the SBA’s size standards for certain industries, which are calculated based on average annual revenue. An entity applying for a PPP loan must have been in operation on February 15, 2020, and had employees for whom it paid salaries and payroll taxes or paid independent contractors. Applicants should apply for loans through an SBA-approved lender for sums up to $10 million, based on a formula tied to their payroll costs. The loans carry an interest rate of 1.0% for a maximum term of two years. No personal guarantee or collateral is required, and the borrower pays no fees. Loans do not have to begin to be repaid for six months, but interest does accrue during that time.

Any payroll costs to which the loan amount may be applied must be incurred between February 15 and June 30, 2020. Amounts spent on the employer’s payroll costs, mortgage interest, rent, and utility costs may be forgiven, so long as the borrower continues to pay employees for eight weeks after the loan origination date. Applicable payroll costs include: employee compensation (not over $100,000 per worker) in the form of salary, wages, commissions, and cash tips; payments for vacation, parental, family, medical, or sick leave; allowance for separation or dismissal; and benefits. Additional employee benefits included in the payroll costs can include group health care coverage, insurance premiums and retirement, payment of state and local (but not federal) taxes assessed on employee compensation, and any net earnings from self-employment for independent contractors or sole proprietors. At least 75% of the forgiven amount of such loans must be used for payroll costs – if this condition is met, loans used to pay payroll costs, mortgage interest payments, rent, and utility payments may be entirely forgiven.

SBA is also offering economic injury disaster loans (EIDL) of up to $2 million to cover economic losses suffered by small businesses, nonprofits, and others impacted by COVID-19. Unlike the PPP loan applications, EIDL applications are completed and submitted directly to the SBA through its website. These expanded EIDL loans were authorized as part of the first COVID emergency bill, the Coronavirus Preparedness and Response Supplemental Appropriations Act, signed into law on March 6, 2020. EIDL loans may be used to pay fixed debts, payroll, accounts payable, and other bills that cannot otherwise be paid as a result of the disaster. The interest rate is 3.75% for small businesses and 2.75% for nonprofits. The term of the loan can be up to 30 years, determined on a case-by-case basis depending on each borrower’s ability to pay.

If a borrower received an EIDL loan from January 31, 2020 through April 3, 2020, they may also apply for a PPP loan. If the borrower’s EIDL loan was not used for payroll costs, it does not affect their eligibility to apply for a PPP loan. However, if the EIDL loan was used for payroll costs, the PPP loan must be used to refinance the EIDL loan. The EIDL has the benefit of establishing an emergency grant that allows an eligible entity to request an advance of up to $10,000, and the borrower will not be required to repay the advance even if the applicant is denied the EIDL. SBA has been directed to provide this advance within three days, however, at the time of this writing, SBA reported weeks-long delays of these emergency payments. The proceeds from any advance up to $10,000 on the EIDL loan will be deducted from the loan forgiveness amount available under the borrower’s PPP loan.

Due to the quick rollout of the PPP program, some lenders and borrowers have reported that the SBA has struggled to fully administer the loan program. This is not necessarily a surprise, because the SBA has been a chronically underfunded and
understaffed federal agency for years. Though the details above still apply, some may find that loans take longer to process or that funds may not be fully available at the present time.

**Conclusion**

The challenges of these unprecedented times are manifold, but the programs described above offer health care providers meaningful fiscal relief in the face of the COVID-19 pandemic. Additional relief is under serious consideration by Congress and the Administration that may be enacted in the coming weeks and perhaps months. ★

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The COVID-19 public health emergency (PHE) has placed unprecedented strains upon America’s hospitals, including inpatient rehabilitation hospitals and rehabilitation units of acute care hospitals (IRH/Us). The Centers for Medicare & Medicaid Services (CMS) has waived a number of audit and appeal requirements during the PHE, suspending audits and granting limited flexibility during the first two levels of administrative appeal. More needs to be done, however, to ease these burdens so that IRH/Us can focus on the important work of furnishing health care, often to COVID-19 patients and medical/surgical patients displaced from acute care hospitals during this crisis. The Fund for Access to Inpatient Rehabilitation (FAIR Fund), a sister organization of AMRPA, recently brought these concerns to the Secretary of Health and Human Services (HHS) and requested increased audit and appeal relief, including at the Administrative Law Judge (ALJ) level of appeal.

Medicare audits place extraordinary burdens on IRH/U staff, who are required to organize and submit voluminous patient records. If a contractor denies a claim, the hospital must then navigate a four-level administrative appeals process. Preparing these appeals often requires physicians and nurses to review the medical records and write detailed explanations of the care provided, which takes their focus away from patient care.

CMS has suspended most audits by Medicare Administrative Contractors (MACs), Recovery Audit Contractors (RACs), and the Supplemental Medical Review Contractor (SMRC). CMS states, however, that it “may conduct medical reviews during or after the PHE if there is an indication of potential fraud.” Cost report filing deadlines have been extended and CMS has granted exceptions from quality reporting requirements. However, CMS has not suspended audits by the Comprehensive Error Rate Testing Contractor (CERT) and Unified Program Integrity Contractors (UPICs). Audits by the Office of Inspector General (OIG) have also not been suspended.

CMS has granted MACs and Qualified Independent Contractors (QICs) flexibility in the appeals process. Specifically, MACs and QICs are authorized to grant extensions of

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2 Id.
time to file appeals on a claim-by-claim basis. MACs and QICs can process appeals even if the appointment of representative form is incomplete, which may allow attorneys and consultants to meet filing deadlines if they are unable to obtain all necessary information for an appointment. MACs and QICs can process requests for appeal that do not meet the required elements using information that is available. MACs and QICs can “utilize all flexibilities available in the appeal process as if good cause requirements are satisfied.” The “good cause” regulation requires a provider to show the circumstances that kept them from making the request on time and whether the contractor’s actions misled the provider. Presumably, increased burdens due to the PHE would satisfy the good cause requirement.

Critical gaps, however, remain in these waivers. The CERT, UPIICs, and the OIG, entities that typically audit a significant number of claims from one provider at a single point in time, may still conduct audits. Although MACs and QICs have the discretion to waive certain appeal requirements, they are not required to do so. At the ALJ level of appeal, the Office of Medicare Hearings and Appeals states, “The Chief Administrative Law Judge supports the Administrative Law Judges exercising flexibility with regard to reasonable requests to reschedule hearings and reasonable requests for extension of time to file a request for hearing.” However, HHS has issued no formal waivers for the ALJ or the Medicare Appeals Council levels of appeal.

To remedy these gaps, the FAIR Fund, which is comprised of leaders in the IRH/U field, wrote to the HHS Secretary on April 3 requesting additional regulatory relief for the duration of the PHE via the following steps:

- Order all UPIICs and the CERT to cease auditing claims for payment. These contractors should not request medical records (known as Additional Documentation Requests) or finalize audits.
- Order the HHS OIG to cease auditing claims for payment when the OIG lacks evidence of fraud or abuse.
- Order MACs to cease audits for compliance with the “60% Rule” applicable to IRH/Us.
- Toll all appeal deadlines for the duration of the PHE, including the deadlines for redetermination, reconsideration, ALJ hearing, Medicare Appeals Council review, and judicial review.
- Order all audit contractors not to deny payment retroactively for patients that hospitals are currently admitting and caring for as a result of the crisis. CMS should recognize that hospitals are furnishing altered levels of services and suffering from staffing shortages associated with the pandemic. Services that are provided during this unprecedented period should not be subject to the same level of scrutiny as claims furnished before or after the public health crisis.

These steps are fully consistent with actions that CMS and HHS have already taken to ease administrative burdens upon hospitals during the pandemic. As of the writing of this article, HHS has not yet responded to the FAIR Fund’s requests. Individual IRH/Us that are burdened by continued audit and appeal efforts should consider making similar requests of CMS and HHS through the Sec. 1135 waiver process. IRH/Us need all the relief they can get so they can care for patients and help their communities through this pandemic.★

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6 42 C.F.R. § 405.942(b)(2).
7 See id. § 412.29. This regulation requires that 60 percent of IRH/U patients have one of 13 conditions. If an IRH/U falls below this threshold, it loses its status as an Inpatient Prospective Payment System (IPPS)-excluded hospital or unit. This is commonly referred to as the “60 percent rule.”
8 See id. §§ 405.942 (redetermination), 405.962 (reconsideration), 405.1002(a)(1) (ALJ), 405.1102(a)(1) (Medicare Appeals Council), 405.1136(c) (judicial review).
In early March – a time that now seems like it was years ago – I was busy preparing for the AMRPA in-person spring conference and focusing on issues ranging from post-acute care (PAC) payment reforms to Medicare Advantage prior authorization practices. At the time, I was unsure how the COVID-19 public health emergency would impact our communities, our hospitals, and our Association at large. In the intervening weeks, we’ve seen our members serve on the front lines of their community response efforts and respond to the clinical and operational challenges that have ensued.

As an Association, we are working every day to ensure that policymakers are responsive to the regulatory flexibility, capital/operational costs, and long-term fiscal relief required by our hospitals as we engage in the pandemic response. AMRPA has been successful in getting several of our requests, including three-hour rule requirements and waiver of the post-admission physician evaluation, enacted for the duration of the public health emergency. Staff also has engaged with CMS leaders on a weekly basis to get clarity on other waivers that have been granted to date, and has received timely guidance on issues such as the scope of the intensity of therapy waiver. Other examples of our efforts include:

**Industry Calls to Share Best Practices & Respond to Emerging Issues**
AMRPA has assumed leadership of industry-wide calls focused on issues tied to COVID-19 preparedness and response for the inpatient rehabilitation industry. These calls have spotlighted a number of our hospital leaders and given our members the opportunity to discuss the current and emerging challenges they are facing, as well as share best practices. AMRPA staff and counsel also provide the most up-to-date information on regulatory and legislative developments tied to COVID-19, equipping attendees to respond to the rapidly changing policy environment.

**A Dedicated COVID-19 Resource Page**
AMRPA staff has created a dedicated COVID-19 resource page that is updated almost daily and tracks CMS calls, policy updates, CDC recommendations, and other key reference materials for providers in their COVID-19 response.

**Assistance with Individual Waiver Applications/AMRPA Waiver Toolkit**
While AMRPA has successfully advocated for a number of blanket waivers for our hospitals, individual members must still apply for certain flexibilities on an individual basis. AMRPA staff have been fielding numerous member questions about the relief that has been granted to date and on what issues providers must apply for their own...
1135 waiver. To provide further assistance to our members and expedite the waiver request process given the demands facing every hospital right now, AMRPA has created a “Waiver Toolkit” with background information on CMS’ waiver protocols and template language.

Ongoing Engagement with CMS/HHS Leadership
AMRPA leaders held a meeting in early April with CMS leadership to convey the issues facing inpatient rehabilitation hospitals on the front lines of the COVID-19 response and advocate for regulatory and fiscal relief for the industry. AMRPA staff continues to engage in outreach with various branches at CMS regarding questions we receive from our members, such as requesting a potential delay in the effective date of the IRF PAI v. 4.0 and seeking clarity on the application of some of the waivers issued by CMS to date.

Grassroots Efforts Tailored to Individual Hospital Needs
AMRPA has launched a grassroots effort designed to help facilitate timely and effective engagement between our member hospitals and their representatives to obtain specific forms of relief that may be required for individual hospitals and/or their communities. Please reach out to AMRPA staff and counsel if you have questions or assistance about your hospital's outreach efforts.

Financial Relief Resource for Members
In conjunction with counsel, AMRPA provides our members with information on various fiscal relief programs, such as the small business and paycheck relief programs.

Undoubtedly, the questions and issues we receive from our members help shape our advocacy efforts and ensure that we are seeking the relief most-needed by our industry. AMRPA is incredibly grateful for the response received to date, and the Association will continue to champion our members’ needs in this constantly-evolving policy environment.

AMRPA: Working Together To Preserve Access To Medical Rehabilitation

Maggie Ramirez · VP of Membership Services · 347-573-3732 · mramirez@amrpa.org

JOIN TODAY!

AMRPA: Working Together to Preserve Access to Medical Rehabilitation

Elizabeth Katsion, AMRPA Member Services Coordinator, ekatsion@amrpa.org, 202-207-1102.
AMRPA Submits Response to CMS on Proposed MA Program for 2021

Editor’s Note: On April 6, 2020, AMRPA submitted a formal response to the Centers for Medicare and Medicaid Services’ (CMS) proposed rule for the Medicare Advantage program for plan year 2021. AMRPA's comments are reprinted here in abbreviated form and edited for clarity. You can find AMRPA's entire comment letter at www.amrpa.org.

I. Background on MA Plans Tactics for Post-Acute Care Admissions

Despite the life-changing (and cost-saving) benefits offered by Inpatient Rehabilitation Hospitals and Units (IRH/Us), Medicare Advantage (MA) plans routinely and inappropriately deny and delay access to IRH/Us for patients in need of these services, usually through utilization of a prior authorization process. AMRPA hospitals report a high rate of initial denials from MA plans. Many providers report that they are able to secure admission for MA beneficiaries only after a long and resource intensive appeal, if at all. Hospitals also experience extensive delays in receiving responses from MA plans on prior authorization determinations, particularly when such determinations are needed over a weekend or holiday. These delays can have catastrophic effects on the outcomes and recovery for patients needing inpatient rehabilitation, and are inconsistent with the 24/7 operation of hospitals and the needs of these patients.

Most typically, a patient seeking admission to an IRH/U is awaiting discharge at an acute-care hospital. When clinicians screen acute-care Medicare patients for post-acute placement, they must follow very specific Medicare guidelines to determine whether the patient is appropriate for an IRH/U. When screening indicates the patient is appropriate for IRH/U care, at least one physician with specialized training and experience in rehabilitation must concur, but in actuality there are usually multiple physicians involved and in agreement about the referral. This mandated Medicare pre-admission process already amounts to a self-administered prior authorization process which – in contrast to the process used by MA plans – is administered by clinicians who are appropriately trained in rehabilitation medicine and have actually evaluated the patient in question.

The first flaw in the MA prior authorization process is that plans take up to 72 hours – which does not include weekends – to make an initial organization determination. This is wholly unacceptable and, practically speaking, means that a patient ready for discharge on Thursday may be required to remain in the acute-care hospital five additional days before a determination is made on Tuesday, without running afoul of Medicare rules. Not only does this delay subject the patient to additional risks, such as hospital-acquired infections, and force them to incur additional costs while waiting in the acute-care hospital, the delay in receiving therapeutic intervention at the IRH/U often has meaningful negative and lasting impacts on the patient's recovery and overall outcomes.

Once an initial determination has been reached, the frustrations for patients and providers usually continue because a very high rate of requests for IRH/U admission are initially denied. Denials are largely due to the fact that MA plans utilize proprietary decision tools such as Milliman and InterQual – guidelines that reportedly conflict with Medicare IRH/U coverage criteria in spite of the aforementioned requirements that MA enrollees receive the same benefits as those in the traditional program. Plans’ use of these decision tools seem to drive admissions to lower-acuity settings, such as skilled nursing facilities and homecare, regardless of a patient’s appropriateness for inpatient rehabilitation. Most importantly, these proprietary guidelines do not follow Medicare coverage guidelines, representing a violation of the MA enrollees’ right to the same benefits covered under traditional Medicare.

Further, MA plans will often offer a “peer-to-peer” physician discussion before issuing the final organization determination. Providers are constantly disappointed by the lack of relevant experience offered by the MA plan physician reviewer, as well as the burden with participating in these calls. Providers report that normally the Medical Director or other MA physician representative discussing the case with the provider has no experience with post-acute care (PAC) or rehabilitation. This is in stark contrast to the Medicare requirements imposed on IRFs, which require a specially trained rehabilitation physician or medical director to approve admissions.
Beyond the lack of specialized training, MA physician reviewers often have little understanding of the Medicare coverage criteria for PAC, and sometimes cite erroneous standards for IRH/U admissions. Further, the MA plans usually offer limited windows for the peer-to-peer, with little advance notice, requiring physicians to rearrange their care for patients at the last minute to participate in a call that is rarely fruitful due to the aforementioned defects. Despite the 24/7 operation and treatment of patients in hospitals, the peer-to-peers are offered only during typical business hours Monday through Friday.

As CMS knows, beneficiaries are also entitled to an appeal of the initial organization determination. However, providers and enrollees are equally stymied by these appeals because they contain most of the same shortcomings as the initial determinations. It is important to contextualize that once the initial determination has been made, the patient in question has been waiting in an acute-care hospital ready for discharge for three to five days. The MA plan then usually takes up to another 72 hours to render a reconsideration decision. This means the patient and hospitals are faced with the choice of accepting the MA plan’s lower level of care against physician advice, or unnecessarily holding the patient for another three days in the acute-care hospital. This is simply an untenable position that puts the MA organization’s interests before that of the patient. Similarly, hospitals report that just like the initial determination, the MA representatives conducting the reconsideration requests often lack training or experience in PAC, and render affirmations of the initial decision based on faulty coverage and medical premises.

Technically speaking, MA enrollees are entitled to additional levels of review beyond the reconsideration stage. However, due to the unacceptable delays in receiving earlier decisions from MA plans, it is practically impossible for a patient who has been waiting for discharge for a week or more to remain in the acute-care hospital to pursue further levels of appeal. The interests all parties dictate that the patient will at least initially need to move to a lower level of care, where they may or may not have the resources to continue to appeal their case. This is especially unfortunate since CMS’ current review of appeals via the MA Star Ratings program only examines appeal outcomes at the third level of appeal, when it is already too late, and which leads to an inaccurate picture of access to care.

Unfortunately, this life-threatening issue for beneficiaries has amounted to what could be called an “invisible problem.” Throughout the prolonged process of seeking admission to an IRH/U, the beneficiaries themselves often have little understanding of the distinctions between the different levels of PAC, let alone a grasp of their rights as an MA enrollee. Patients who are denied entry to an IRH/U may never be informed or understand that they had a right to appeal and that a higher level of care is a covered benefit under Medicare.

II. Dismissal and Withdrawal of Medicare Part C Organization Determination and Reconsideration, p. 9,069

For the reasons outlined above, AMRPA has serious concerns about how Part C Organization Determinations and Reconsiderations are handled. In addition to addressing CMS’ specific proposals, AMRPA will also provide additional recommendations consistent with CMS’ request for comment in the proposed rule on whether “additional beneficiary protections need to be addressed.”

A. Proposed Regulations for Dismissal of a Part C Organization Determination and Reconsideration, 9,069

CMS proposes to codify its rules for when an MA plan can dismiss an expedited organizational determination (EOD). CMS proposes that an MA plan may properly dismiss an MA EOD if “the individual or entity making the request is not permitted to request an organization determination under §422.566(c).” The referenced regulation, 42 C.F.R. §422.566(c) states that the enrollee (including his or her representative), or a physician (regardless of whether the physician is affiliated with the MA organization), can request an EOD.

AMRPA finds that this proposed regulatory language is insufficiently vague and should be amended to avoid beneficiaries being denied a fair EOD. As previously noted, hospitals often are told by MA plans that a rehabilitation physician seeking to admit a patient to an IRH/U cannot participate in EOD discussions with MA plans. Instead, MA plans say, only the attending physician of record can participate in the EOD. However, these rehabilitation physicians that are precluded from participating are the same rehabilitation physicians required to perform the de facto prior authorization process required by Medicare.

Denying the rehabilitation physician the ability to participate in the EOD is harmful for several reasons. First, the attending physician often relies on the rehabilitation physician’s advice to determine the patient’s proper PAC placement. Second, the rehabilitation physician is most familiar with the service that will be provided at the IRH/U, and how the patient’s medical and functional needs do or do not align with IRH/U service. Therefore, CMS should clarify in its regulatory text that any physician familiar with the patient’s care needs, like a rehabilitation physician from an IRH/U, is considered a proper party to request a EOD under §422.566(c). In addition, CMS should specify that these physicians are fully entitled to participate in any peer-to-peer discussions or other aspects of the EOD.

Finally, these proposed regulations have highlighted the confusing differences in terminology between the initial levels of appeal for Fee-for-service and MA organization appeals. AMRPA recommends CMS align the two appeal terminologies to avoid provider confusion and burden. For example, the initial level of appeal should have the same name for both programs, rather than redetermination for Fee-for-service and reconsideration for MA appeals.
B. Additional Beneficiary Protections That Need to be Addressed, p. 9,071-9,072

CMS concluded this section of the proposed rule by requesting information on additional beneficiary protections that need to be addressed by the agency. As AMRPA expressed in the introduction to this letter, MA plans currently engage in harmful practices via a vis prior authorization that results in adverse outcomes for patients and wasteful spending for the Medicare program. To address this, CMS should substantially amend its current regulations and enhance its oversight to address these practices.

As an overarching matter, in instances when a physician (or multiple physicians, which is often the case for a referral to an IRH/U) have deemed an admission to a hospital or facility medically necessary, and that admission is a Medicare covered benefit, MA plans should not be permitted to override this decision. Even if an MA plan deploys the requisite medical expertise in a timely fashion for these decisions, the MA plan physicians cannot be deemed to be in any better position than the treating physician or physicians with an IRH/U who have actually evaluated the patient, to make this decision. The only additional perspective an MA plan reviewer brings to this decision is a financial incentive to choose the less costly course of treatment. Therefore, prior authorization should be eliminated for hospital admissions ordered by an appropriate physician.

If CMS chooses to continue to permit MA plans to utilize prior authorization, the practices of MA plans need to be drastically altered through amended regulations and enhanced oversight. First, when MA plans are choosing to interject in the practice of medicine, their operations should match that of the providers. In the case of hospitals, this means operating 24/7, and available to address needs of patients in minutes, not days. Therefore, when a patient is currently admitted to a hospital, and/or is seeking admission to a hospital, MA plans requiring prior authorization should be required to respond to a prior authorization request in no more than 6 hours.

Requiring decisions within this timeframe will ensure patients can continue their course of treatment without undue delay, which will provide for both better outcomes and prevent any wasted resources. CMS should amend regulations requiring EODs to be made within this 6 hour timeframe, and if no response is received, the EOD is deemed favorable to the patient. If MA plans offer “peer-to-peer” discussions before rendering an EOD, the MA plan must ensure this discussion can take place within this timeframe.

CMS should require an even more expedited timeline for reconsiderations of an EOD. Given the fragile nature of patients seeking admission to a facility, it would be inappropriate to allow for another 6 hours for each level of appeal. Therefore, MA plans should be required to issue its reconsideration determination within 3 hours of notification of a request for a reconsideration, and IREs should likewise be required to issue a decision within 3 hours of notification of a request for a reconsideration of the MA plan’s reconsideration determination. It is both medically appropriate and consistent with hospital level of care ensure that in no instance should it take more than 12 hours for a MA beneficiary in need of admission to a facility to have an appropriate placement.

In addition to ensuring the timeliness of decisions, CMS needs to amend its regulations and oversight to ensure that the decisions rendered on prior authorization requests are sound. The prior authorization decisions of MA plans should be based upon two things: 1) the medical judgement of physician with specialized training and experience in treating patients similarly situated to the beneficiary in question; and 2) application of this medical expertise to the applicable Medicare coverage criteria. Unfortunately, many plans either utilize decision tools that do not align with Medicare coverage guidelines to make placement decisions. To ensure MA plans base decisions upon these two factors, CMS needs to amend regulations to curtail the use of proprietary guidelines that are not tailored to strictly match Medicare coverage guidelines. CMS can accomplish this by revising its regulations to require MA plans to make public its tools as well as to submit them to CMS before they are utilized.

Further, CMS should require that only physicians with appropriate expertise make decisions on prior authorizations pertaining to admissions. This is particularly needed in instances when an unfavorable decision would be overriding a practicing physician’s judgement who has seen and evaluated the beneficiary in question. For IRH/U admissions, this should be a physician that meets Medicare’s definition of a rehabilitation physician, which is CMS’ requirement for overseeing admission decisions to IRH/Us. Likewise, the same level of expertise must be required of MA plans for each level of appeal, as well as for peer-to-peer discussions.

CMS should additionally amend regulations to hold MA plans accountable to the accuracy of its decisions. As previously stated, many MA plans reverse themselves on reconsideration at a very high rate. Even though a favorable decision is ultimately reached, this still means acute-care patient has spent extra days in the hospital, and the provider has spent time and resources on appeals. Further, when a favorable decision is not reached on initial reconsideration, it is difficult for a hospital or beneficiary to continue appeals to additional levels, given the acute nature of the patient. Therefore, CMS should enhance its regulations to require MA plans maintain a sufficiently high level of accuracy at all levels of determination, not just the third level of appeal.

AMRPA further recommends CMS engage in several oversight activities and enact penalties to ensure the accuracy of MA plan determinations. First, CMS should audit plans to ensure all decisions are made within the 6 or 3 hour timeframe. Next, the agency should audit plan decisions using independent physicians who are actively
practicing in their field to review MA plan determinations at all levels. When plans have accuracy rates below 95%, the plans should be subject to financial penalties, and plans with lasting deficiencies should no longer be permitted to participate in the MA program. Further, it should be telling to CMS if practicing physicians are regularly disagreeing with MA plan decisions, and find these decisions harmful enough to their patients to take up valuable time and resources to contest those findings. Therefore, simply having high rates of appeal by physicians should subject MA plans to penalties.

In addition to accuracy, there should be accountability for long-term cost for MA plans. MA plans may have a financial incentive to deny admission to an IRH/U when the alternative PAC placement is less expensive in the short-term. However, when patients receive more intensive rehabilitation in an IRH/U, their improved functional status can lead to less resource use in the long-term. While it might seem as though the per-capita relationship between the CMS and MA plan already incentivizes cost control, that line of thinking misses several nuances, particularly when looking at the longer-term picture. Data suggests that high-cost patients leave MA plans and enroll in traditional Medicare at a substantial rate. In addition, studies show IRH/Us actually extend life expectancy relative to lower intensity settings.

Armed with this information, an MA plan can save money in the short-term by denying more intensive post-acute care, and not be on the hook for the higher-long term cost for many of those patients in light of the rate in which these patients leave their plans as well as their shorter life expectancy. Accordingly, CMS should track and rate MA plans on cost-measures such as Medicare Spending Per Beneficiary, and that tracking should extend well beyond the plan year to incorporate rolling updates of beneficiaries who were once or are still are enrolled in the MA plan. Holding MA plans accountable for long-term costs will incentivize plans taking the best action for the patient in the long-term and focus less on short-term financial implications.

III. Proposed Network Adequacy Requirements, p. 9,092

CMS is proposing to codify several network adequacy requirements for MA plans. These proposed requirements include the types of providers that will be evaluated, and the minimum time and distance requirements for these provider types. CMS proposes several types of facility types that must be available in an MA plan network. This includes acute inpatient hospitals, cardiac surgery programs, intensive care units, and skilled nursing facilities (SNFs). However, CMS does not include IRH/Us on the list. This is a critical omission that needs to be corrected.

As previously stated, IRH/Us play a critical role in the PAC continuum. IRH/Us are the only hospital-level PAC setting required to provide close medical supervision and an intensive rehabilitation therapy program. For the nearly 400,000 Medicare beneficiaries that receive care in an IRH/U each year, having access to these services meant the ability to maximize their functional recovery following a serious injury or illness. For many patients, the high level of PAC services, both in terms of intensity and expertise, cannot be matched at a SNF or in a home-based course of treatment. If CMS fails to include IRH/Us in their list of required facilities, it will not only deny MA beneficiaries their rights to all Medicare covered benefits, but also preclude many from making a full recovery.

AMRPA insists that CMS include IRH/Us in its list of facilities subject to network adequacy reviews. This is consistent with CMS’ own regulations pertaining to guaranteed access to all covered Medicare services. In addition, and as CMS knows, acute care hospitals are under no obligation to have an IRU, and many do not have one. Therefore, CMS cannot consider IRH/Us to be part of its acute inpatient hospital network adequacy requirements.

IV. Proposed MA Call Center Requirements, p. 9,115

CMS proposes to codify its requirements for MA plan requirements to have a call center available for beneficiaries. Currently, CMS only requires the call center be available during regular business hours. CMS proposes that the new regulations will require a call center be available from 8:00am-8:00pm local time. AMRPA recommends CMS enhance these requirements and add additional specificity.

As AMRPA has repeated, medical care, particularly in hospitals, does not stop on the weekends. Therefore, CMS should specify that these call centers need to be operated 7 days per week, every day of the year. Some of the most vulnerable MA beneficiaries, such as those admitted or seeking admission to a facility, often times are doing so on a weekend. These beneficiaries should have full access to real time information from their plan while this is happening. Therefore, these call centers must be operated every day of the year. In addition, these call centers need to be available 24 hours per day, at least for certain inquiries, such as coverage of hospital admissions.

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AMRPA is committed to continuing to work with CMS to enhance oversight of MA plans and ensure access to critical services for Medicare beneficiaries. If you have any questions about AMRPA’s recommendations, please contact AMRPA’s Director of Government Relations and Regulatory Counsel, Jonathan Gold, JD, at jgold@amrpa.org or 202-860-1004.

Sincerely,

Dr. Robert Krug, M.D.
Chair, AMRPA Board of Directors
President and Medical Director, Mount Sinai Rehabilitation Hospital

R. Krug

AMRPA Magazine / May 2020

COVID-19 Special Issue
L300 Go is a functional electrical stimulation [FES] system that provides low-level electrical stimulation which activates the nerves and muscles that lift the foot. Featuring 3D motion detection, the foot sensor is now optional providing the added flexibility of either wearing shoes of your choice or even walking barefoot.

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Individual results may vary. Patients are advised to consult with a qualified physician to determine if this product is right for them.

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The COVID-19 pandemic continues to be a rapidly evolving public health emergency and looks different in various parts of the country. In order to create a forum for the inpatient rehabilitation industry to facilitate the exchange of information, AMRPA began hosting regular informational calls in March that are open to both association members and potential new members. The calls have garnered record attendance for AMRPA webinars and include opportunities for speakers to discuss the COVID-19 response in their regions and facilities and share best practices from their experiences. The calls also allow attendees to hear regulatory and legislative updates impacting IRFs and include Q&A sessions with panelists on the COVID-19 impact on IRFs from both a clinical and policy standpoint.

Informational Call 1 – COVID 19 & the Rehabilitation Hospital Impact: Views from the Field
AMRPA’s first informational call, held on March 20, included the following panelists:

- Bruce Gans, MD, Kessler Institute for Rehabilitation and Select Medical
- Karl Sandin, MD, MPH, Immanuel Rehabilitation Institute
- Kayleen Degener, BSN, CRRN, Immanuel Rehabilitation Institute
- David Storto, Partners Continuing Care and Spaulding Rehabilitation Network
- Kate Beller, JD, AMRPA staff
- Jonathan Gold, JD, AMRPA staff
- Martie Kendrick, JD, Akin Gump

While most hospitals and providers had been preparing for a potential COVID-19 emergency for many weeks, by March 20 many hospitals were beginning to see that COVID-19 presented a tangible threat to their communities and patients. AMRPA’s first informational call provided attendees with insight into what some hospitals were beginning to experience and how others were preparing. In addition, AMRPA staff and counsel provided information on what IRFs could potentially expect in terms of regulatory relief. The call concluded with a question and answer session.

Informational Call 2 – COVID-19 & the Rehabilitation Hospital Impact: Emerging Issues
The second informational call focused on emerging issues for rehabilitation hospitals and best practices to address them and included the following speakers:

- Suzanne Snyder Kauserud, FACHE, MBA, PT, Carolinas Rehabilitation
- Ronella Eaddy, MHA, BSN, NEA-BC, CRRN, Carolinas Rehabilitation

As Carolinas Rehabilitation prepared for a potential surge related to the COVID-19 pandemic, several policies were put in place to protect patients and staff and most

Visit the AMRPA COVID-19 Resource webpage for a list of frequently asked questions (FAQs) received during our informational calls and from AMRPA member alerts!
efficiently use resources. During the call, Kauserud and Eaddy highlighted the importance of utilizing the Emergency Incident Command Structure and providing staff refresher courses related to the structure in advance of any potential surge. In addition, Kauserud and Eaddy discussed how visitor restrictions were implemented, methods being utilized to maintain appropriate supplies of personal protective equipment (PPE), and the importance of ensuring rehabilitation clinicians and staff were up to date on competencies necessary to care for medical-surgical patients who may potentially be admitted to an IRF during a surge.

The presentation was followed by a comprehensive legislative and regulatory update provided by AMRPA staff and counsel. At the time of the call, the CARES Act was near final passage, and highlights of the legislation were shared with attendees, including language waiving the “three-hour rule and $100 billion in funding for healthcare providers to receive financial relief during the emergency.

Informational Call 3 – COVID-19 & the Rehabilitation Hospital Impact: Perspectives from the Front Lines in New York and Detroit

At the time of AMRPA’s third informational call, many Northeastern and Midwestern states were experiencing high rates of COVID-19 infection and surge capacity at many hospitals. The third informational call focused on first-hand experiences from:

- Janet Herbold, PT, MPH, PhD, Burke Rehabilitation Hospital in New York
- Patty Jobbitt, MSA, PT, DMC Rehabilitation Institute of Michigan in Detroit

The presentations highlighted strategies that were successful for their hospitals and those that were continuing to evolve while still maintaining the rehabilitation hospital’s mission. Of particular interest among attendees were strategies for optimizing the use of PPE and managing caregiver training for rehabilitation patients in a time of restricted visitor access.

Much like the first two calls, this session proceeded with a regulatory and legislative update related to newly released IRF flexibilities. At the time, CMS had recently released an interim final rule waiving several IRF regulatory requirements including the post-admission physician evaluation (PAPE), three-hour rule, and allowing rehabilitation physicians to conduct the three weekly visits by telehealth. Additionally, CMS had recently announced the “Hospital without Walls” program to provide hospitals more flexibility during the emergency. Despite the flexibilities granted at that time, AMRPA staff announced ongoing advocacy efforts that the Association would continue to engage in to ensure IRFs were able to provide the care patients need.

Informational Call 4 – COVID-19 & the Rehabilitation Hospital Impact: Emerging Clinical and Policy Perspectives with Extended Q&A

In light of the constantly changing COVID-19 landscape, the fourth AMRPA informational call provided attendees an extended question and answer opportunity with the following speakers:

- Justin Riutta, MD, Beaumont Health in Michigan
- Joyal Pavey, MBA, OTR, Mary Free Bed Advisory Group in Michigan
- Bruce Gans, MD, Kessler Institute for Rehabilitation and Select Medical in New Jersey

The speakers provided both an operational and clinical perspective from their hospitals’ experience and, along with AMRPA staff and counsel, served as panelists to answer the numerous questions submitted by attendees. A detailed list of questions and answers from this call, as well as all others, can be found on the AMRPA COVID-19 Resource webpage.

As of press time, AMRPA had hosted four informational calls and has two others in the works. Given the ever-evolving COVID-19 emergency, AMRPA expects to continue hosting informational calls on a regular basis, as well as maintaining an up-to-date resource webpage, providing member alert emails and responding to member inquiries as they are submitted. Recordings of each call are available on the AMRPA website and are free to access. Should you or your hospital have any questions related to the COVID-19 emergency, including operational or policy issues, please do not hesitate to contact AMRPA staff.
Patient Success Story: Julie Guthrie and Kim Steele
From Tragedy to Triumph

By Adam Robertson, AMRPA Marketing Communications Manager

Faced with unexpected tragedies, both Julie Guthrie and Kim Steele suffered from sepsis and multi-organ failures that led to quadruple amputation. Lovers of life by nature and fighters by circumstance, these women confronted their grim situations head on.

Things may look a little different for them now, but with optimism, strength, unwavering hope and hard work at Roosevelt Warm Springs Rehabilitation Hospital, they have reclaimed their lives and their independence.

These are the stories of their inspirational and emotional journeys to recovery.

Julie Guthrie

"Float, float on. Float on, float on . . ."

For most, these are just lyrics that some recognize from the song “Float On” by The Floaters.

For Julie Guthrie, they will forever remind her of one of her most positive memories of the time she spent at Roosevelt Warm Springs Rehabilitation Hospital.

Julie Guthrie

In August of 2019, Julie suffered septic shock and multi-organ failure after a kidney stone unexpectedly became stuck and caused a massive blood infection.

AMRPA Seeking Member Submissions of Patient Success Stories and Testimonials

In 2020, AMRPA Magazine wants to feature you! We are currently soliciting patient success stories and testimonials from AMRPA member hospitals, to better showcase the outstanding work of our industry and membership. If you are interested in submitting a success story or testimonial, please visit https://amrpa.org/For-Patients/Patient-Success-Stories
“I had an extremely poor prognosis. Most people do not survive severe sepsis with multi-organ failure, and the ICU doctors told my daughters I had about a 30% chance of surviving.”

In just the first 48 hours of sepsis, she experienced kidney failure, liver failure and a heart attack.

But the complications did not stop there.

Julie also had disseminated intravascular coagulation (DIC), which prevented circulation to her extremities.

After spending a week in ICU on a ventilator and five full days on dialysis, she was faced with the most difficult decision of her life: undergo a quadruple amputation or be sent to hospice.

Told she may not even survive the surgery, it was at that very moment that she, along with the support of her daughters, decided to fight.

Two days later, surgeons amputated both of her legs above the knee, her right hand and all of her fingers and top of her thumb on her left hand.

“I truly do not think any of us thought I would make a full recovery, but once I survived through my amputation surgery, I think it became clear that I am not giving up and I will survive!”

When she arrived at Roosevelt, her dedicated team worked diligently to teach her how to successfully live a whole new lifestyle. What seemed impossible at first, like eating and bathing, soon become easy, and now Julie is able to independently water her flowers at home, put on makeup and even hold her “new grandson and love on him.”

And she will never forget when she put on her prosthetic legs for the first time and stood up. “I felt so tall,” she said, expressing her gratitude to her rehab team for helping her regain her strength and dexterity to even be ready to use her prosthetics.

“Rehab might sound scary to some after having such a major surgery such as amputation, but it was truly a life-changing experience for me. They ensured that I left there with all the necessary tools to live a successful life as an amputee.”

Julie’s life is not what it was before, but her experience has taught her a number of lessons that she wishes to pass on to others who may face a similar situation.

As The Floaters sing in their hit song, “Now, I like a woman who loves her freedom,” and Julie’s love for her ability to live a free, independent life even after a quadruple amputation is in no short supply.

She says, “I may look a little different now, but every day I am reminded that I am still me. And I am here because my story is not over, and neither is yours!”
And sometimes a little concert, even if you are not the world’s best singer, is all you need to remind yourself of what you have been through, where you will go and how much life has to offer.

Kim Steele

Not many of us are brave enough to take part in adrenaline-inducing activities like snorkeling, zip lining and skydiving.

53-year-old Kim Steele is, however, and she does so as a quadruple amputee.

“You never know what you can do until you are faced with a tragedy.”

And that includes extreme sports, all part of a new bucket list that Kim has just gotten started on as a sepsis survivor.

In May of 2016, after four days of taking a new medication, she had a severe toxic reaction. She was rushed to the ER, and within 30 minutes, she coded three times.

She was then intubated and placed in coma, at which time she suffered multi-organ failure. She developed sepsis, which lead to septic shock. In order to save her vital organs, including her heart, brain and kidneys, doctors used medication that increases blood pressure by constricting peripheral vessels. Unfortunately, that led to a lack of blood supply and oxygen in her limbs, causing necrosis and gangrene of her limbs.

“My family was told that I had less than a 9% chance of surviving.”

But despite the odds, she did survive, fighting for her life at every point.

“I never thought I would recover until I realized that I had to fight if I wanted my life back.”

Shortly after, she underwent a quadruple amputation but made a full recovery from sepsis.

In November, she arrived at Roosevelt Warm Springs Rehabilitation Hospital, where she was started on a robust plan to restore her mobility and independence.

Kim first learned how to use her prosthetic hands, picking up blocks and beads, then hanging up clothes, cooking and taking care of her farm animals. Once she mastered use of her upper body, it was time to focus on walking.

It was the night before she was to take her first steps. She said, “I couldn’t sleep that night because of the anticipation of what this day was going to mean.”

Surrounded by the nurses, doctors and other patients all with tears of joy in their eyes, she took her first step on December 28, 2016, filming the dramatic moment, so she could send it as a video to surprise to her family.

Looking back to her first days of rehab, she said, “I thought I was literally going to die. I had never worked out so hard . . . but you find that inner strength and fight through it. And that is what I did!”
“I'm happier than I have ever been and it flows through me. I feel this is the life I was meant to live and will continue sharing my experiences and knowledge with the world.”

Now, more than three years later, Kim continues to share her optimism with others and express a love for life.

“I’m happier than I have ever been and it flows through me. I feel this is the life I was meant to live and will continue sharing my experiences and knowledge with the world.”

She regularly holds motivational speaking events and has published a book, advocating for sepsis awareness and communicating to not only those that have gone through a similar situation but to everyone that “we don’t always get to choose the circumstances that happen to us, but we do get to choose what comes next!”

Most importantly, Kim focuses on sharing this message that highlights sepsis awareness and life lessons that she has learned:

“Educate yourself of the signs and symptoms of sepsis, and don’t wait until it is too late. We have to fight to save lives and limbs. The challenge is to make sure that everyone in the health care system understands how to recognize the key symptoms and responds.

The human spirit is one of perseverance and courage that no one can take away. There are things that we can’t change, but, in the end, they end up changing us. We are all in this together! Be bold to live the life the way you want and never apologize for it. You can always take the road less traveled instead of a well-beaten path. If I can help individuals to overcome those obstacles and fears of intimidation, and concentrate on the things that they can do and give them back the life they should be living, my purpose in this second chance at this thing called life will be complete!

We all have the strength and resilience to appreciate what we have and who we are. Each one of us has the strength and determination to succeed. I am not what happened to me but what I have become.”

For more information on the life-changing services provided by Roosevelt Warm Springs Rehabilitation Hospital, visit their website.

Learn more about the #powerofmedicalrehab by visiting this page on AMRPA’s website and reading our other patient success stories, Challenging the Prognosis and Fighting for Mobility and An Impossible Embrace.
CMS Releases Proposed FY 2021 IRF PPS Rule Provides 2.9% Payment Update; Proposes New Forms of Regulatory Relief for IRFs

Editor’s Note: Below is AMRPA’s preliminary summary of the recently released FY 2021 IRF PPS Proposed Rule sent out to members in the form of a special edition Off the Record newsletter. In the coming weeks AMRPA will continue with a deep dive into the rule. A more in-depth summary of the rule and AMRPA’s comment letter to CMS will be included in an edition of AMRPA Magazine later this summer. Should you or your hospital have any questions related to the rule, please contact AMRPA policy staff.

On April 16, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FY) 2021 Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) Proposed Rule and accompanying fact sheet. The rule will be published in the April 21, 2020 edition of the Federal Register.

This Off the Record: Special Edition provides section-by-section highlights of the proposed rule. A more in-depth analysis will be included in an upcoming issue of the AMRPA Magazine, as well as other forms of member communication. Comments are due to CMS on June 15, 2020.

CMS acknowledges the impact of the COVID-19 public health emergency and the demands facing the IRF industry, and for that reason, CMS states that it has “limited annual IRF rulemaking required by statute to essential policies including Medicare payment to IRFs, as well as proposals that reduce provider burden and may help providers in the COVID-19 response.”

With respect to payment, CMS proposes to implement its annual updates to the weights and average lengths of stays for the IRF PPS Case Mix Groups (CMGs), update the standard payment conversion factor due to growth in the IRF market basket, and increase the labor-related share. CMS is also proposing to use updated delineations to determine hospitals’ wage index, which may result in notable changes for some providers (described more below). Overall, CMS estimates payments to IRFs will increase by 2.9 percent, or approximately $270 million nationwide in FY 2021. For reference, CMS finalized a 2.5 percent update in its final FY 2020 IRF PPS rule.

CMS also proposes several policy changes, including:

- Amending the IRF coverage requirements to remove the post-admission physician evaluation (PAPE) requirement;
- Modifying the IRF coverage requirements to allow non-physician practitioners to perform certain services that are currently required to be performed by a rehabilitation physician, such as completing the pre-admission screening, developing the individual overall plan of care (IPOC), performing three face-to-face visits per week; and leading interdisciplinary team meetings. CMS is also proposing to allow non-physician practitioners to complete the review and concurrence of the preadmission screening;
- Codifying existing documentation instructions and guidance to ensure uniformity between the Medicare Benefit Policy Manual and applicable regulations;
- Clarifying that, for the purposes of the intensity of therapy requirement, a “week” would be defined as a period of 7 consecutive calendar days beginning with the date of admission to the IRF.

For IRFs that fail to comply with quality data submission requirements for the purposes of the IRF quality reporting program (QRP), CMS proposes to apply a 2 percent reduction to the applicable FY 2021 market basket increase factor used to calculate an adjusted FY 2021 standard payment conversion factor. Such reductions to the market basket increase factor are not cumulative and will only apply to a particular FY. This is the only provision impacting the QRP in the FY 2021 rule.

CMS notes that some of these proposed regulatory relief measures have been waived as part of the COVID-19 public health emergency, and that CMS will “use this experience to determine whether” several of these requirements “can be removed permanently to reduce paperwork burden for hospitals and clinicians while improving quality of care for patients.”
A high-level section-by-section summary follows:

**Highlights**

**A. FY 2021 Case Mix Revisions and Payment Changes**
CMS proposes several of its typical yearly updates to the IRF PPS CMGs, the standard payment conversion factor, and the labor-related share. Less typical, CMS is proposing some notable shifts in wage index assignments for certain regions. In conjunction with this, CMS is also proposing to implement a blended wage index adjustment that would cap any wage index decreases for providers at 5 percent. CMS does not propose any changes to the low income pool adjustment, teaching adjustment, or rural adjustment.

**1. Proposed FY 2021 Case Mix Groups and Average Lengths of Stay**
Consistent with previous annual updates, CMS proposes to use FY 2019 IRF claims and FY 2018 IRF cost report data to update the CMG relative weights and average lengths of stay (ALOS) for FY 2021. Table 2 on page 16 of the display version of the proposed rule presents the proposed relative weights for all CMGs and tiers, as well as the new proposed ALOS.

CMS’ analysis shows that 99.3 percent of all IRF cases are in CMGs and tiers that would experience less than a 5 percent change (either increase or decrease) in the CMG relative weight under this proposal. Further, the agency states 0.4 percent of all cases are in a CMG and tier that would experience an increase between 5 and 15 percent, and 0.2 percent are in CMGs and tiers that would experience a decrease of between 5 and 15 percent.

As it usually does, CMS proposes to implement the CMG relative weights in a budget-neutral manner so CMS does not estimate an overall change because of the new weights. In addition, CMS states that the proposed changes in the ALOS for FY 2021 are small and do not show any particular trends.

**2. Standard Payment Conversion Factor**
The standard payment conversion factor is the dollar figure by which the CMG weight is multiplied to calculate payment (which is then further adjusted by other facility-specific factors). As it does every year, CMS updates the standard payment conversion rate based on a number of factors. The first of those factors is the market basket. A CMS contractor is hired to forecast the growth in the items and services that make up the IRF market basket. CMS states its forecaster projects a growth rate of 2.9 percent based on a number of factors. The first of those factors is the market basket. A CMS contractor is hired to forecast the growth in the items and services that make up the IRF market basket. CMS states its forecaster projects a growth rate of 2.9 percent based on a number of factors. The first of those factors is the market basket. A CMS contractor is hired to forecast the growth in the items and services that make up the IRF market basket. CMS states its forecaster projects a growth rate of 2.9 percent based on a number of factors. The first of those factors is the market basket. A CMS contractor is hired to forecast the growth in the items and services that make up the IRF market basket. CMS states its forecaster projects a growth rate of 2.9 percent based on a number of factors. The first of those factors is the market basket. A CMS contractor is hired to forecast the growth in the items and services that make up the IRF market basket. CMS states its forecaster projects a growth rate of 2.9 percent based on a number of factors. The first of those factors is the market basket. A CMS contractor is hired to forecast the growth in the items and services that make up the IRF market basket. CMS states its forecaster projects a growth rate of 2.9 percent based on a number of factors. The first of those factors is the market basket. A CMS contractor is hired to forecast the growth in the items and services that make up the IRF market basket. CMS states its forecaster projects a growth rate of 2.9 percent based on a number of factors. The first of those factors is the market basket. A CMS contractor is hired to forecast the growth in the items and services that make up the IRF market basket. CMS states its forecaster projects a growth rate of 2.9 percent based on a number of factors. The first of those factors is the market basket. A CMS contractor is hired to forecast the growth in the items and services that make up the IRF market basket. CMS states its forecaster projects a growth rate of 2.9 percent based on a number of factors. The first of those factors is the market basket. A CMS contractor is hired to forecast the growth in the items and services that make up the IRF market basket. CMS states its forecaster projects a growth rate of 2.9 percent based on a number of factors. The first of those factors is the market basket. A CMS contractor is hired to forecast the growth in the items and services that make up the IRF market basket. CMS states its forecaster projects a growth rate of 2.9 percent based on a number of factors. The first of those factors is the market basket. A CMS contractor is hired to forecast the growth in the items and services that make up the IRF market basket. CMS states its forecaster projects a growth rate of 2.9 percent based on a number of factors. The first of those factors is the market basket. A CMS contractor is hired to forecast the growth in the items and services that make up the IRF market basket. CMS states its forecaster projects a growth rate of 2.9 percent based on a number of factors. The first of those factors is the market basket. A CMS contractor is hired to forecast the growth in the items and services that make up the IRF market basket. CMS states its forecaster projects a growth rate of 2.9 percent based on a number of factors. The first of those factors is the market basket.

CMS is also required to apply a budget neutrality factor due to any changes in CMGs and any changes to the labor-related share and wage index. Those proposed changes are discussed below. After it applies those budget neutrality factors, CMS estimates the FY 2021 standard payment conversion factor to be $16,847. This is compared to $16,489 for FY 2020. CMS usually slightly adjusts the final conversion factor in the final rule after receiving updated data via claims and cost reports.

**3. Proposed Wage Index and Labor Related Share Changes**
For IRF payment purposes, a wage index is applied to the labor-related share of IRF payment to determine a facility-specific payment. Based on its updated market basket estimates, CMS is proposing a labor-related share for FY 2021 of 72.9 percent. This is a slight increase from the current labor-related share of 72.7 percent. This will correspondingly lead to a slight increase in variations in payments across regions.

More significantly, CMS is proposing to change its wage index designations for providers in certain areas. These new designations will be based upon an updated delineation called Core-Based Statistical Area (CBSA) market definitions from the White House Office of Management and Budget (OMB). Changes to CBSAs mean a hospital can be grouped into a different region, potentially with a different rural, urban or other designation, and/or with a different wage index figure. Under these new OMB delineations, there are newly created CBSAs, urban counties that would become rural, rural counties that would become urban, and existing CBSAs that would be split apart.

CMS analysis shows that a total of 34 urban counties would now be considered part of a rural area under these new OMB delineations. Table 5 on page 32 of the display version of the proposed rule lists the 34 urban counties that would become rural. Further, CMS says that 47 counties currently considered rural areas would be designated urban under these delineations. Table 6 on page 34 of the proposed rule lists the 47 rural counties that would become urban.

Beyond the changes with urban and rural designations, the proposed rule also details how some hospitals would be placed in notably different CBSAs. Table 7 lists these changes on page 36 of the proposed rule. Ultimately, due to these changes, CMS estimates approximately 5 percent of IRFs would see a decrease in their wage index value. Therefore, CMS is proposing to transition to the new wage indexes over a two year period. CMS proposed to cap any decrease in the wage index at 5 percent for FY 2021. Any remaining change would then be realized in FY 2022. CMS has included a supplemental file with the proposed rule that provides the current and proposed CBSA for every IRF as well as their proposed wage index adjustment for FY 2021. That file is available for download here.

**4. Outlier Threshold**
The outlier threshold is used to determine when an IRF is entitled to an outlier payment. CMS attempts to set the outlier threshold each year so that 3 percent of total payments are outliers. Based on current data, it estimates only 2.6 percent of payments in FY 2020 will be outliers. Therefore, CMS proposes to update the outlier threshold amount from $9,300 for FY 2020 to $8,102 for FY 2021. CMS also adjusts the standard payment rate based on a statutorily required productivity factor, which its contractor estimates to be -0.4 percent based on Bureau of Labor Statistics data.

CMS is also required to apply a budget neutrality factor due to any changes in CMGs and any changes to the labor-related share and wage index. Those proposed changes are discussed below. After it applies those budget neutrality factors, CMS estimates the FY 2021 standard payment conversion factor to be $16,847. This is compared to $16,489 for FY 2020. CMS usually slightly adjusts the final conversion factor in the final rule after receiving updated data via claims and cost reports.

**5. Total Estimated Payment Changes**
After accounting for all of the aforementioned proposed changes, CMS provides estimates of the payment impact across different types of IRFs. Overall, CMS estimates an increase of $270 million in aggregate payments to all IRF providers over FY 2020 payments, or about 2.9 percent. $230 million in aggregate payments to all IRF providers over FY 2020 will be outliers. Therefore, CMS proposes to update the outlier threshold amount from $9,300 for FY 2020 to $8,102 for FY 2021. CMS also adjusts the standard payment rate based on a statutorily required productivity factor, which its contractor estimates to be -0.4 percent based on Bureau of Labor Statistics data.

CMS is also required to apply a budget neutrality factor due to any changes in CMGs and any changes to the labor-related share and wage index. Those proposed changes are discussed below. After it applies those budget neutrality factors, CMS estimates the FY 2021 standard payment conversion factor to be $16,847. This is compared to $16,489 for FY 2020. CMS usually slightly adjusts the final conversion factor in the final rule after receiving updated data via claims and cost reports.
is attributable to the market basket increase (including the productivity factor adjustment). In addition, CMS also estimates urban IRFs would see a 2.9 percent increase overall and rural IRFs would see a 3.2 percent increase overall.

B. Proposed Removal of the PAPE Requirement from the IRF Coverage Requirements

Under current coverage regulations, IRF services are only considered reasonable and necessary if a patient meets all regulatory requirements, including that a patient’s record contains a PAPE that: (1) is completed by the rehabilitation physician within 24 hours of the patient’s admission to the IRF; (2) documents the patient’s status on admission to the IRF, includes a comparison with the information noted in the preadmission screening documentation, and serves as the basis for the development of the overall individualized plan of care (IPOC) and (3) is retained at the IRF. As part of its Patients over Paperwork initiative, CMS now proposes to remove the PAPE documentation requirement. CMS provides several grounds for this proposed 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.”

This proposal follows the temporary relaxation of the requirement as part of the April 6, 2020 interim final rule in response to the COVID-19 emergency, and CMS asserts that it intends to use this temporary waiver to determine the impact of this proposal as permanent policy. CMS clarifies that an IRF patient can still be evaluated by a rehabilitation physician (or potentially non-physician practitioners, if the relevant section of the proposed rule is finalized) within the first 24 hours of admission if the IRF believes this is warranted by the patient’s condition. Furthermore, proposal would not remove one of the required rehabilitation physician visits (or non-physician practitioner visits, if the relevant section of the proposed rule is finalized) required in the first week of the IRF stay.

CMS says that this proposal would not result in direct Medicare Part A or B savings, but would reduce administrative burden on IRFs and MACs. CMS invites comments on this proposal, noting that IRFs’ experience with waiving this policy during the COVID-19 can help inform future policy.

C. Proposed Revisions to Certain IRF Coverage Documentation Requirements

1. Pre-admission Screening Documentation Instructions & Guidance

CMS notes that it is undertaking a broad effort to “review subregulatory guidance to identify any longstanding policies, instructions, or guidance that would be appropriate to codify through notice and comment rulemaking.” To that end, CMS states that there are differences between the regulatory text describing preadmission screening requirements (at 42 C.F.R. § 412.622) and the Medicare Benefit Policy Manual (Ch. 1, Section 110.1.2). For example, while regulations require that a pre-admission screening includes a “detailed and comprehensive review” of the patient’s condition and medical history, the specific elements that must be included as part of this screening are found in the Manual (for example, the patient’s prior level of function and expected level of improvement, among others). The Manual also provides that a rehabilitation physician must document that he/she has reviewed and concurs with the preadmission screening.

CMS states that it proposes to codify the guidance included in the Benefit Policy Manual for a number of reasons, including that codification “would improve clarity and reduce administrative burden on both IRF providers and MACs,” and that “IRF providers and MACs will appreciate all preadmission screening documentation requirements being located in the same place for ease of reference.” Specifically, CMS proposes to update its regulatory text in the following ways:

- At § 412.622(a)(4)(ii)(B), the regulatory text would now provide that the comprehensive preadmission screening must include a detailed and comprehensive review of each patient’s condition and medical history, including the patient’s level of function prior to the event or condition that led to the patient’s need for intensive rehabilitation therapy, expected level of improvement, and the expected length of time necessary to achieve that level of improvement; an evaluation of the patient’s risk for clinical complications; the conditions that caused the need for rehabilitation; the treatments needed (that is, physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics); expected frequency and duration of treatment in the IRF; anticipated discharge destination; and anticipated post-discharge treatments (consistent with the current Manual language); and

- At § 412.622(a)(4)(ii)(D), the regulatory text would now provide that the comprehensive preadmission screening must be used to inform a rehabilitation physician (or, if separately finalized, a non-physician practitioner at the IRF’s discretion) who must then review and document his or her concurrence with the findings and results of the preadmission screening prior to the IRF admission (consistent with the current Manual language).

2. Definition of a “Week”

CMS proposes to clarify that, for the purposes of the IRF intensity of therapy requirement, 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 proposes to use the “a 7 consecutive calendar day period” language for clarity.

3. Solicitation of Comments on Further Changes to the Preadmission Screening Documentation Requirements

CMS asserts that it is considering whether it could remove “some of the requirements” related to the preadmission screening while retaining the patient’s clinical history, as well as documentation of their medical and functional needs in sufficient detail to adequately describe and support the patient’s need for IRF services. To this end, CMS specifically asks for comments as to “what aspects of the preadmission screening do stakeholders believe are most or least critical and useful for supporting the appropriateness of an IRF admission,” and the rationale for such assessment.
D. Proposals Impacting Non-physician Practitioners & IRF Coverage Requirements

In the proposed rule, CMS notes that it has previously solicited comments as to whether it should allow non-physician practitioners to perform some of the IRF services and documentation requirements that are currently required to be performed by a rehabilitation physician (these requirements are included at 42 C.F.R. § 412.622(a)(3), (4), and (5)). These requirements include:

- The rehabilitation physician must conduct face-to-face visits with the patient at least 3 days per week throughout the patient’s stay in the IRF.
- The rehabilitation physician must designate the clinician to conduct the preadmission screening, as well as review and concur with the findings of the preadmission screening.
- The rehabilitation physician must develop the IPOC.
- The rehabilitation physician must lead the interdisciplinary team meeting.
- The rehabilitation physician must complete the PAPE within 24 hours of the patient’s admission to the IRF (note: CMS proposes to eliminate the PAPE in this rule).

CMS asserts that the comments it received on this issue in past solicitations were “conflicting,” with some commenters in support of expanding the use of non-physician practitioners (noting, for example, that this could help address physician supply issues and burnout), and others voicing strong concern (noting, for example, the lack of specialized training by non-physician practitioners and the complex needs of IRF patients). In today’s proposed rule, CMS asserts that it currently “agree[s] with commenters that non-physician practitioners have the training and experience to perform the IRF requirements, and believes that allowing IRFs to utilize non-physician practitioners practicing to their full scope of practice under applicable state law will increase access to post-acute care services …”

With respect to the definition of a “non-physician practitioner,” CMS proposes to “mirror” its current definition of a rehabilitation physician and provides that a “non-physician practitioner who is determined by the IRF to have specialized training and experience in inpatient rehabilitation may perform any of the duties that are required to be performed by a rehabilitation physician, provided that the duties are within the non-physician practitioner’s scope of practice under applicable state law.” IRFs would retain full discretion as to whether to have certain responsibilities continue to be furnished solely by a rehabilitation physician. CMS adds that this proposal would not alter the Condition of Participation requirement that every Medicare patient is generally required to be under the care of a physician.

Section XIII(C)(9) of the proposed rule provides an estimate of the total cost savings for all IRFs annually if IRFs employed “maximum use” of these regulatory provisions. Examples of CMS’ estimated savings include:

- $6 million across all IRFs for the use of non-physician practitioners to complete the pre-admission screening;
- $38 million across all IRFs for the use of non-physician practitioners to develop each patient’s IPOC;
- $19 million across all IRFs for the use of non-physician practitioners to lead the interdisciplinary team meeting.

CMS states that these cost savings would reflect both savings to the Medicare Trust fund and reductions to Medicare Part B savings. CMS also notes it does not expect IRFs would implement “maximum use” of non-physician practitioners, and instead estimates that IRFs would adopt the proposed changes “for about 50% of the services provided” (with the savings estimate modified to reflect this). A separate analysis of the potential savings/utilization tied to allowing non-physician practitioners to conduct face-to-face visits with the patient at least three days a week is included later in this section, as this is a separately payable service.

CMS asks comments to focus their comments on whether they believe the quality of care will be impacted by the proposal and any specific supporting evidence, as well as whether individual IRFs would or would not allow their facilities to allow non-physician practitioners to complete all, some, or none of the current rehabilitation physician-specific requirements.

E. Quality Reporting Program Provisions

1. Clarification on the Application of the QRP Reporting Penalty

For IRFs that fail to comply with quality data submission requirements, CMS proposes to apply a 2% reduction to the applicable FY 2021 market basket increase factor used to calculate an adjusted FY 2021 standard payment conversion factor. Such reductions to the market basket increase factor are not cumulative and will only apply to a particular FY.

2. No Further Information on CMS’ Prior All-Payer Data Collection Proposal

In the FY 2020 proposed rule, CMS proposed to expand the reporting of the IRF-PAI data to include data on all patients, regardless of their payer, beginning with patients discharged on or after October 1, 2020. CMS did not finalize this proposal, however, based on comments raising concern about the additional burden such policy would present for IRFs, but noted that it would continue to develop an all-payer policy in the future. This proposal is not included in this year’s proposed rule, nor does CMS provide any information about a potential future timeframe.

FY 2021 IRF PPS Proposed Rule Resources

- FY 2021 IRF PPS Proposed Rule (display version) and Fact Sheet
- Other files related to the rule are available here for download. See “FY 2021 Data Files – Proposed [ZIP]” at the bottom.
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