July 7, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-5531-IFC
7500 Security Boulevard
Baltimore, MD 21244-1850

Delivered Electronically


Dear Administrator Verma:

The American Medical Rehabilitation Providers Association (AMRPA) appreciates the opportunity to submit comments regarding the interim final rule published in the Federal Register on May 8, 2020 in response to the COVID-19 Public Health Emergency (PHE). AMRPA is the national trade association representing more than 650 freestanding inpatient rehabilitation facilities and rehabilitation units of general hospitals (IRFs), outpatient rehabilitation service providers, long-term care hospitals (LTCHs), and several skilled nursing facilities (SNFs). The vast majority of our members are Medicare participating providers. In 2018, IRFs served 364,000 Medicare beneficiaries with more than 408,000 IRF stays.\(^1\)

AMRPA applauds CMS for all of the flexibilities\(^2\) provided to date, as well as CMS’ responsiveness to our industry. As discussed more below, many actions taken by CMS have given providers the tools and resources to more effectively respond to this PHE. Based on extensive communication with our member hospitals across the country, AMRPA offers several recommendations on how to continue to best support patients and hospitals during these difficult times. This includes ensuring that the PHE stays in effect and its underlying flexibilities remain in place for an extended period of time - particularly due to ongoing challenges facing all hospitals - and providing sufficient notice of any revisions to or rollback of current waivers or regulatory changes. In addition, AMRPA urges CMS to add several new flexibilities, including

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\(^1\) Medicare Payment Advisory Comm., Report to The Congress, Medicare Payment Policy xiii-xxvi (2020).

\(^2\) AMRPA recognizes that CMS responded to this PHE through numerous channels, including 1135 waivers, regulatory changes, and several other authorities. However, for brevity and clarity, AMRPA refers to “waivers” and “flexibilities” throughout this letter to generally mean any changes CMS made through waiver authority, regulatory changes, or other means in response to the COVID-19 PHE.
significantly reforming (or eliminating) prior authorization in the Medicare Advantage program, modifying flexibilities that allow IRFs to provide surge capacity, and withdrawing or delaying upcoming price transparency rules applicable to IRFs. **In summary, our recommendations include:**

1. HHS and CMS should extend the national PHE until a robust set of criteria are met.
2. CMS should keep all current waivers and flexibilities available for the duration of the PHE, and possibly even beyond the PHE for IRFs, given the long-term rehabilitation needs of many COVID-19 survivors and the likelihood their medical rehabilitation needs will extend well-beyond the PHE period.
3. In the future, when HHS and CMS do consider ending the PHE, there should be several months’ notice to hospitals to allow for a non-disruptive transition.
4. CMS should prohibit the use of prior authorization by Medicare Advantage plans for the duration of the PHE.
5. The requirement that freestanding IRFs be located in areas meeting certain re-opening guidance in order to utilize a waiver should be removed, and the flexibility should instead be directly tied to hospital capacity in the area.
6. CMS should withdraw or, at a minimum, delay hospital price transparency requirements applicable to IRFs due to the PHE.
7. AMRPA recommends that the implementation timeline for the IMPACT Act needs to be delayed and the other provisions of the Act should be re-evaluated in light of practical realities and certain intervening developments and events.
8. CMS should make several flexibilities permanent, including removal of the post-admission physician evaluation, permitting the provision of outpatient therapy via telehealth or remote means, and elimination of state licensing restrictions.
9. AMRPA respectfully requests further CMS clarifications on a number of current waivers and flexibilities.
10. AMRPA strongly urges CMS to begin collaborating with providers to issue consistent guidance to Medicare contractors on interpretations of waivers and flexibilities to avoid erroneous denials.

Additional detail on each of these recommendations is provided in the remainder of this letter.

I. **HHS and CMS Should Extend The National Public Health Emergency and Waivers Until Criteria Are Met**

Many flexibilities provided by CMS have given IRFs and other post-acute providers with much-needed bandwidth to meet the demands of their communities during this crisis. Flexibilities such as the waiver of the intensity of therapy requirements, remote physician visits and team meetings, 60 percent rule exclusions, and intermingling of acute and post-acute patients (among numerous others) have allowed IRFs to effectively admit and safely provide hospital level care for patients. These accommodations ensure IRFs can function as frontline hospital providers and help expand critically needed capacity where acute hospitals’ resources and personnel are stretched beyond capacity. As CMS is aware, all of these flexibilities are tied to the PHE declaration, and will no longer be available when the PHE ends.
Given these circumstances, any type of premature termination of the PHE and its underlying waivers are highly concerning to IRFs, since the tail of this pandemic is expected to have a longer-term impact on our field and the patients and beneficiaries we serve. Member hospitals report that, as of the last week of June, they are receiving referrals and subsequently admitting patients that were afflicted and hospitalized with COVID-19 in April or early May. These patients are only now becoming eligible for discharge to post-acute care, indicating that the rehabilitation needs of long-term, complex rehabilitation of COVID-19 survivors will continue for the foreseeable future. In addition, a high number of these patients are encountering serious debilities and other complications that necessitate intensive rehabilitation like those offered in the IRF setting.

The work of all health care providers on the frontlines of this pandemic is far from over – and this is particularly true for IRFs and other post-acute care providers. While the current stress and demand on hospitals varies from state to state and region to region, the situation remains unpredictable and subject to sharp swings in short periods. This is clearly demonstrated by recent data reported in several states. It is therefore essential that IRFs continue to have the flexibilities currently available for the foreseeable future, and at least until certain criteria are met. Specifically, AMRPA agrees with the American Hospital Association (AHA) that the national PHE should continue until the medical supply chain is enhanced and stable, the rate of testing and positivity rates reach acceptable levels, intensive care unit utilization lowers to satisfactory levels, and death rates reach a certain threshold.3

Hospitals across the country, including IRFs, are either still on the front lines of meeting their community’s need for care, remain in a hyper-vigilant state of preparedness to do so, or both. Given the current upward trend of infections and hospitalizations, these hospitals expect to continue these efforts indefinitely, and would be seriously impeded if they no longer had access to the waivers currently available. AMRPA applauded CMS’ repeated assertion during the PHE that its overarching goal was to ensure that every patient in need of a hospital bed would be able to access one, and the waivers that collectively facilitated timely admission to IRFs are a critical part of this effort.

Therefore, given the anticipated long tail of this pandemic, the ongoing fluctuations in case counts across the country, and the defensive measures all hospitals are taking, AMRPA implores CMS and HHS to keep the national PHE declaration in place, along with all currently available flexibilities to hospital providers. For IRFs, these key waivers include, but are not limited to:

- Waiver of the 3-hour rule (specifically 42 C.F.R. § 412.622(a)(3)(ii))
- Waiver of the Post-Admission Physician Evaluation requirement
- Permitting remote rehabilitation physician visits
- Permitting remote therapy services
- Exclusion of admissions from 60% rule calculations

- Allowing acute-care inpatients to be treated in IRF units
- Allowing IRF patients to be treated in acute-care beds
- Waiver of IRF Quality Reporting Program (QRP) requirements
- Suspension of medical reviews and audits
- Waiver allowing freestanding IRFs to admit acute-care “surge” patients and submit claims under the IRF PPS under certain conditions

Finally, when HHS and CMS do consider ending the PHE, providers will need an extensive runway to facilitate their transition. As HHS and CMS appreciate, hospitals have made unprecedented changes to operations and care protocols, and many of those changes were facilitated by these waivers. Therefore, hospitals need and should be granted several-months’ notice prior to the termination of any waiver. This will help with the transition and avoid unnecessary disruptions in care and risks to safety.

**Recommendations:**

1. **HHS and CMS should extend the national PHE until a robust set of criteria are met.**
2. **CMS should keep all current waivers and flexibilities available for the duration of the PHE, and possibly even beyond the PHE for IRFs.**
3. **In the future, when HHS and CMS do consider ending the PHE, there should be several months’ notice to hospitals to allow for a non-disruptive transition.**

**II. CMS Should Add Several Additional Flexibilities to Ensure Patient Care and Safety Can Continue to Be Prioritized**

In addition to keeping the current waivers and PHE intact, AMRPA would like to recommend several additional steps CMS can take to free up valuable hospital resources for patients. While only some of these rules were explicitly included in the interim final rule, all of these suggestions are consistent with the goal of the interim final rule – namely facilitating timely access to care and reducing provider burdens.

**A. Prohibition on Prior Authorization by MA Plans**

The first new waiver CMS should issue is the mandated suspension of prior authorization requirements by Medicare Advantage (MA) plans throughout the PHE. AMRPA has detailed with CMS on several occasions the burden and delays associated with prior authorization. To briefly re-summarize, IRFs routinely encounter significant delays when attempting to admit MA beneficiaries – usually waiting three days but sometimes up to five days to receive a determination from the MA plan. Not only does the beneficiary pay a recovery price tag for this delay, but it also costs acute care hospitals and Medicare unnecessary dollars. MA plans often require secondary reviews that require physicians and/or other hospital personnel to rearrange their schedules to meet the demands of the MA plan’s review requests, just to have the MA plan override the medical judgements of the treating clinicians at a very high frequency.

The end result of current MA practices is that patients spend an unnecessary amount of days in the acute-care hospital, and the IRF devotes unconscionable resources to accomplish admission of a fully appropriate patient. While this is a daily and ongoing problem, it is
particularly egregious and dangerous during the COVID-19 pandemic. In an indirect concession of these facts, many MA plans voluntarily suspended prior authorization for short periods during the PHE. However, most plans have since reinstituted the policies, and in doing so are subjecting beneficiaries, acute hospitals, and the Medicare program once again to unnecessary risk and unjustified expense.

AMRPA appreciates CMS’ guidance that encourages MA plans to waive prior authorization during the PHE. However, AMRPA asks that CMS to go further and use its discretionary authority to fully suspend prior authorization practices for the duration of the PHE. This is especially necessary in light of the outsized number of COVID-19 patients who are in need of intensive rehabilitation services – which is regularly the focus of prior authorization denials. Given the number of plans that have reinstituted their prior authorization policies, it is critical that CMS take timely action in this area. Doing this will ensure patients continue to move to appropriate settings of care as rapidly as possible, maximizing hospital and other provider resources.

B. Additional Flexibility for Freestanding IRFs to Admit Acute-care Patients to Alleviate Acute-care Hospital Capacity

AMRPA hospitals greatly appreciate the flexibility provided in this interim final rule that allows freestanding IRFs to admit acute-care inpatients and submit claims under the IRF PPS if certain conditions are met. IRFs are now permitted to utilize any extra capacity to provide needed services to non-traditional IRF patients. This enables patients that would have otherwise either been without a bed or found themselves at a field hospital to be treated in a safe, hospital-level facility.

Unfortunately, a technicality in this flexibility has inadvertently prevented areas in dire need of relief from using this waiver. Among the conditions that were tied to this flexibility, CMS requires that the state or region where the hospital is located be at the equivalent Phase 1 or below of its reopening plan. In its regulation, CMS includes specific criteria to make an area eligible, including factors like whether the area is requiring vulnerable individuals to shelter in place, the area has restrictions on socializing in groups of more than 10, visitations to hospitals are prohibited, and several others. The connection to Phase 1 is proving problematic and arguably results in unintended consequences given the diversity among state and local approaches.

As just one example, as of the last week of June, the State of Arizona had more than 30,000 new cases of COVID-19 reported in the last 10 days, and hospitalizations have more than tripled in the past month. Despite this, the State had not implemented restrictions that would satisfy Phase 1 or below, such as restricting gatherings to no more than 10 people. However,

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4 See 42 C.F.R. 412.622(c) (Defining “State (or region, as applicable) that is experiencing a surge.”).
6 AZ Exec. Order No. 2020-43 (June 29, 2020) (Restricts gatherings to no more than 50 people).
Freestanding IRFs in Arizona report that their acute-care partners are in urgent need of hospital placements for many patients, as several face capacity issues.

CMS clearly communicated agency intent for this flexibility to be available in any State or area undergoing a surge of COVID-19 patients, and where there is needed acute-care bed capacity. However, by tying the flexibility to such stringent criteria pertaining to reopening plans, hospitals became limited in their ability to utilize this flexibility. While AMRPA understands CMS’ concern that this flexibility could be used improperly in areas where it is not truly needed, the reality is that reopening procedures of States do not necessarily show a nexus to hospital capacity. Therefore, AMRPA recommends it would be more appropriate to tie this flexibility to actual local hospital capacity and need, rather than an indirect indicator.

For these reasons, we ask that CMS take immediate steps to revise the requirement that only hospitals in regions that meet the reopening guidance definition can utilize this flexibility. Instead, CMS should simply require that freestanding IRFs certify they admitted the patient due to a request for help from a local acute-care hospital to alleviate COVID-19 surge capacity. This will accomplish CMS’ goal of ensuring this flexibility is only used when needed, while also not unnecessarily restricting its use based upon factors not relevant to local hospital capacity.

C. CMS Should Withdraw or at a Minimum Postpone Price Transparency Requirements

AMRPA remains steadfastly opposed to CMS’ price transparency rules for hospitals, set to take effect in January 2021. Particularity in the context of IRF services, the requirements of this rule are overly burdensome and will provide little benefit to beneficiaries. This letter will refrain from reiterating AMRPA’s detailed opposition to this rule, but will highlight how the rule is particularly counter-productive as the health care system struggles to respond to COVID-19.

As stated in AMRPA’s response to the proposal, CMS drastically underestimated the burdens associated with this proposal. Hospitals are spending countless hours assembling charge and rate data to conform with CMS’ requirements. IRFs are also investing in creation of a consumer-friendly website for so-called “shoppable-services.” Due to CMS’ mandates, these efforts have been forced to continue despite the PHE. This is particularly detrimental to providers and patients alike, as those resources could be redirected to patient services.

This PHE also illustrates a point AMRPA raised in response to the proposal – namely, that quality of care in health care decisions should not be overshadowed by price considerations. As the COVID-19 pandemic demonstrates clearly, there are drastic differences in quality of care between skilled nursing facilities (SNFs) and hospitals, including IRFs. SNFs across the

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country have found themselves ill prepared and unable to properly manage the needs of their patients and infection control.

A potential IRF patient may consider the option of continuing treatment at either an IRF or a SNF upon discharge from an acute-care hospital. Based solely on gross price (which again has little correlation to the cost borne by the patient), a SNF may appear an appealing alternative. Without also being presented with quality data, a typical consumer may not know the difference between SNF and IRF level care. However, as the PHE has demonstrated, IRFs and SNFs are not comparable, and this has never been so starkly illustrated by the tragic outcomes seen in nursing homes across the country.

Lastly, AMRPA very much supports CMS’ decision to delay the upcoming transition to the IRF Patient Assessment Instrument version 4.0 (IRF PAI v.4.0). In doing so, CMS recognizes the importance of “provid[ing] maximum flexibilities for these providers to respond to the public health threats posed by the COVID-19 PHE, and to reduce the burden in administrative efforts associated with attending training, training their staffs and working with their vendors ….” Given the operational and implementation-based challenges posed by the price transparency requirements, AMRPA asks that CMS to similarly reconsider the timing of this policy.

For these reasons, and all of those articulated in AMRPA’s previous statements, we strongly urge CMS to withdraw its price transparency requirements. If CMS is unable to do so, it is imperative that CMS delay the requirements applicable to IRFs for the foreseeable future. Hospitals are and will continue to be at the forefront of this pandemic indefensibly. It is counterproductive and harmful to patients to continue to require resources to be diverted to meet these requirements.

D. Implementation of the IMPACT Act and a Post-Acute Care PPS Should be Reconsidered

As CMS knows, the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 was the first step in potential development of a unified payment system for post-acute care (PAC PPS). CMS engaged in numerous efforts as part of these efforts, including introduction of standardized patient assessment data elements (SPADEs) in PAC settings and development of a PAC PPS payment model, which is supposed to be delivered in 2022 or later.

AMRPA has fundamental and ongoing concerns about the data (FY and CY 2017 and 2018) currently being used to develop a PAC PPS prototype, given the significant changes in each of the post-acute care setting payment systems since implementation of the IMPACT Act. In October of 2019, CMS introduced new payment structures for both the SNF and IRF PPS. In addition, 2020 is the first year of notable changes in the HHA PPS, and fully implemented site-neutral payments for LTCHs will not go into effect until September. Therefore, the data collection that began in 2018 will likely have serious variances that will make utilizing it for prototype development very difficult. AMRPA has raised numerous concerns with the

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9 Interim Final Rule, 27,596.
proposed use of 2017 and 2018 data and repeatedly advocated for the use of more concurrent data.

Now, however, the COVID-19 PHE raises new and serious concerns about the use of claims and cost data for CY 2020 and likely future years. All providers and patients have faced serious disruption to their typical operations and care delivery, and that disruption will last for quite some time. Therefore, it is neither reasonable nor appropriate for development of a PAC PPS model to continue on the previously prescribed timetables given the separate but serious and compelling issues with both 2017/2018 data and any data generated during the PHE. AMRPA requests CMS work with Congress and other stakeholders to re-evaluate any future work based on these intervening factors, and at a minimum, delay the data collection required under the Act for a minimum of two years following the PHE.

Recommendations:

1. CMS should prohibit the use of prior authorization by Medicare Advantage plans for the duration of the PHE.
2. The requirement that freestanding IRFs be located in areas that meet certain reopening guidance should be removed and instead the flexibility should be directly tied to hospital capacity in the area.
3. CMS should withdraw or, at a minimum, delay the hospital price transparency requirements applicable to IRFs due to the PHE.
4. AMRPA recommends that the implementation timeline for the IMPACT Act needs to be delayed and the other provisions of the Act should be re-evaluated in light of multiple intervening developments and events.

III. CMS Should Consider Permanent Implementation of Certain Waivers and Flexibilities Given their Impact on Patient Outcomes & Provider Burden

AMRPA appreciates the flexibilities granted to date by CMS. Many of these changes are crucial to ensuring hospitals are able to meet the needs of their communities. Certain flexibilities align with prior AMRPA recommendations related to patient-centered care and burden reduction, and the PHE illustrates the practicality and effectiveness of these flexibilities. As a result, AMRPA urges CMS to consider permanent implementation of several waivers given the clear benefit that such flexibilities extend to patients and rehabilitation providers.

First, AMRPA members remain unified in their support for the waiver of the post-admission physician evaluation during the PHE, and AMRPA respectfully asks CMS to permanently implement this policy. AMRPA also appreciates that CMS proposes to permanently remove the post-admission physician evaluation via separate rulemaking. As AMRPA details in response to that rulemaking, AMRPA members report that the PAPE waiver allows them to focus more time to patient care, while practices of collecting critical patient information have not changed. In other words, temporary removal of the PAPE has not resulted in inadequate patient information in the medical record, as much of the same information is included in the PAS and other documentation requirements. We therefore continue to urge CMS to permanently implement this policy following the end of the PHE.
While not IRF-specific, IRFs have also found that IRF patients benefit substantially from access to telehealth and remote therapy services on an outpatient basis. Due to the severity of their illness or injury, IRF patients regularly need ongoing therapy and treatment well after their IRF stay – if not indefinitely. These patients often also remain vulnerable due to conditions such as spinal cord or brain injuries, or other permanent disabilities or co-morbidities. Therefore, traveling to and receiving care can be especially risky for these patients. The ability to connect with and provide treatment to patients while they remain in their homes or communities has proved crucial during this PHE. Relatedly, AMRPA also encourages continued flexibility with the types of technology that can be used to furnish telehealth, as current restrictions do not reflect advancements in technology. AMRPA therefore encourages CMS to retain these flexibilities as long as possible, and furthermore to support any legislative changes needed to make such changes permanent.

AMRPA providers have also found that interstate licensing flexibility serves as a safe and valuable flexibility during this pandemic. Due to the combination of CMS’ waiver and state rule changes, clinicians have been able to expand their capacity and better ensure continuity of care. Since the need to provide care across state lines will continue both during and following the pandemic, AMRPA urges CMS to permanently remove this rule.

Recommendations:
1. CMS should make several flexibilities permanents, including removal of the post-admission physician evaluation, permitting provision of outpatient therapy via telehealth and remote means, and elimination of state licensing restrictions.

IV. Additional Clarifications & Instructions to Medicare Contractors Necessary to Better Effectuate Certain Waivers

Hospitals and providers benefited from the quick and drastic actions CMS took to respond to this emergency. Due to the scale of the changes made, the medical rehabilitation field would benefit from several clarifications and guidance from the agency to further reduce provider burden. For example, the agency indicated through more informal conversations that therapy in an IRF can be provided via remote means through the waiver of the intensity of therapy requirement. However, the agency to date has not included this policy guidance in any official statements or waiver documents. IRFs would appreciate a clarifying statement from CMS confirming this. Some ongoing confusion also exists about the proper modifiers to apply to IRF claims when utilizing certain waivers; AMRPA would appreciate further dialogue with the agency to address these concerns.

Further, IRFs have concerns about the future of medical reviews and audits of Medicare claims for services provided during the PHE. We recognize that CMS has been in constant communication with providers, issued guidance and interpretations via website postings, provider calls, and several other “unofficial” means. However, AMRPA has not noted any ongoing and concurrent instructions to Medicare contractors to mirror all guidance and interpretations. Therefore, AMRPA fears Medicare contractors potentially will follow different interpretations or conclusions regarding the plethora of new rules.
The Association’s concern here is real – one recent illustration is an instance in which a Medicare contractor informed a hospital that the results of its presumptive methodology review indicated it was below the 60% threshold to retain IPPS-excluded status, and requested more than 100 charts to begin an audit. When the hospital explained it should have passed the presumptive methodology review due to its use of the waiver to exclude patients from the 60% rule calculation, the auditor indicated it had not received any instructions from CMS regarding excluding cases from its reviews, and will be proceeding with the audit. This is particularly burdensome and detrimental for the hospital given its location in a current COVID-19 hotspot.

AMRPA therefore strongly urges CMS to promptly collaborate with providers and to issue (or reissue) proper instructions to contractors. This proactive step will ensure that providers, Medicare and contractors are on the same page about the waivers and flexibilities. As we detailed in earlier sections of this comment letter, the demands facing hospitals during the PHE make unnecessary record requests or other inquiries from contractors particularly untenable. Furthermore, improving clarity on waiver compliance will avoid the burden of erroneous denials and appeals, which can lead to years-long backlogs and necessitate mass settlements and other costly resolutions.

Recommendations:
1. AMRPA respectfully requests further CMS clarifications on a number of current waivers and flexibilities.
2. AMRPA strongly urges CMS to begin collaborating with providers to issue consistent guidance to Medicare contractors on interpretations of waivers and flexibilities to avoid erroneous denials.

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AMRPA greatly respects and appreciates the ongoing work of CMS and the waivers and flexibilities granted to date. The Association stands ready to work CMS to help ensure IRFs continue to serve as critical frontline providers during the current and future PHEs. Should you wish to discuss our comments further, please contact Kate Beller (kbeller@amrpa.org; 973-224-4501) or Jonathan Gold (Jgold@amrpa; 314-210-0356).

Sincerely,

Bob Krug, MD
Chair, AMRPA Board of Directors
Medical Director, PM&R Service Line, Mount Sinai Rehabilitation Hospital