AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

December 18, 2020

Joseph R. Biden Jr.
President-elect of the United States
1401 Constitution Avenue, NW
Washington, DC 20230

Kamala D. Harris
Vice President-elect of the United States
1401 Constitution Avenue, NW
Washington, DC 20230

Dear President-Elect Biden, Vice President-Elect Harris & the Presidential Transition Team:

On behalf of the American Medical Rehabilitation Providers Association (AMRPA), we are pleased to share with you and your colleagues at the Biden-Harris Presidential Transition Team the medical rehabilitation hospital field's policy priorities. Our recommendations are focused on some of the most critical healthcare issues facing the incoming Administration, including the nation's COVID-19 response, efforts to modernize post-acute care (PAC) policies to promote timely patient-centered care, policies that will bolster our hospitals' future pandemic preparedness, and improving access to care and outcomes for beneficiaries who select the Medicare Advantage program - all with an eye to conserving the Medicare Trust Fund.

AMRPA is the national voluntary trade association representing more than 650 inpatient rehabilitation hospitals and units (IRFs)[1]. AMRPA's mission is to advance the intensive and multi-disciplinary care that is provided by its rehabilitation hospital members for the nation's most complicated patients – including those with traumatic spinal cord injuries, stroke, traumatic brain injury (TBI), and now survivors of critical illness from COVID-19. IRFs play a distinct and critical role in the PAC continuum, with a focus on maximizing the health, functional skills, independence, and participation in society for patients recovering from complex medical conditions for their long-term benefit.

While the distinct value of IRF care and the role of IRFs in the PAC continuum are well documented, the value of inpatient rehabilitation has never been more evident than during the COVID-19 public health emergency (PHE). Since the early stages of the pandemic, IRFs have served as frontline providers in their communities and furnished safe and effective medical rehabilitation care critically needed by many COVID-19 survivors. AMRPA members have continually reported the long-term, positive impact that medical rehabilitation has had for many

[1] Inpatient rehabilitation facilities (IRFs) – both freestanding and units located within acute-care hospitals – are fully licensed hospitals that must meet Medicare Hospital Conditions of Participation (COPs) and provide hospital-level care to high acuity patients. IRFs' physician-led care, staffing, competencies, equipment and infection control protocols are just some of the features that distinguish the hospital-level care provided by IRFs from most other PAC providers. AMRPA prefers the term "inpatient rehabilitation hospitals" and "inpatient rehabilitation hospital units" for these reasons, but use the "IRF" term to reflect the acronym used broadly by CMS and other PAC stakeholders.

Anthony Cuzzola · Chair, AMRPA Board of Directors
Vice President, JFK Johnson Rehabilitation Hospital
529 14th Street NW, Suite 1280, Washington, DC 20045 · Phone: 202-591-2469 · Fax: 202-591-2445

COVID-19 survivors, while they simultaneously continue to facilitate the recovery of non-COVID-19 patients who require medical rehabilitation care.

As our nation faces a confluence of an aging population, the new clinical and care delivery challenges presented by "long-hauler" COVID-19 survivors, and Medicare Trust Fund insolvency projections, protecting patient access to inpatient rehabilitation has never been more important. We therefore look forward to engaging with the Transition Team to ensure the development of the Biden Administration's health-related policies reflect the "new world" of PAC.

To that end, AMRPA appreciates the opportunity to provide two sets of policy recommendations: (1) recommendations focused specifically on the nation's ongoing COVID-19 PHE response and the essential role that IRFs will play in the immediate response efforts and long-term rehabilitation needed by many COVID-19 survivors; and (2) broader coverage and payment recommendations aimed at ensuring that all patients in need of intensive medical rehabilitation have timely and effective access to the hospital-level rehabilitation care they need. These recommendations are briefly summarized below, and discussed in-depth in the following sections of this letter.

Summary of AMRPA's Top Policy Recommendations Related to the COVID-19 Response:

- Continued utilization and expansion of telehealth and remote care services by amending the list of telehealth services to include therapy services; recognition of therapists – including physical therapists, occupational therapists, speech-language pathologists, and respiratory therapists – as eligible telehealth providers; and continued relaxation of distant site guidelines in order to allow more patients to receive care in their home.
- Prohibition on the use of prior authorization practices by Medicare Advantage (MA) and other payers for the duration of the current PHE, and implementation of regulations that would suspend these practices in all PHEs.
- Permanent implementation of interstate licensing flexibilities to provide additional capacity to acute care hospitals.
- Establishment of clear and consistent guidelines for distribution of personal protective equipment (PPE) at the federal level that recognizes the frontline role played by IRFs during the PHE.
- Immediate and automatic availability of certain emergency waivers for hospitals (including IRFs) upon declaration of future PHEs.

Summary of AMRPA Top Post-Acute Care Policy Recommendations:

- Reconsider the Unified Post-Acute Care (PAC) Prospective Payment System (PPS) and IMPACT Act timeline to incorporate more meaningful and timely data.
- Preserve and protect the Medicare Trust Fund by creating advanced placement tools to ensure the proper and efficient use of PAC settings that maximize outcomes for patients.
- Permanently reform Medicare Part C (Medicare Advantage (MA)) prior authorization practices to remedy the harmful delays and denial of care that result from these tactics, and ensure that similar outcomes do not result in the traditional Medicare (fee-for-service (FFS)) program through any new policies or demonstrations.

- Modify hospital price transparency requirements to provide more relevant information to beneficiaries and remove unnecessary administrative burdens for hospitals.
- Invest in and prioritize funding for the post-PHE modernization and construction costs to ensure IRFs continue to be fully equipped for future pandemics.

In closing, AMRPA strongly supports the overarching health policy goals that have been identified by the Biden Administration, such as ensuring patient access to both quality care and care coverage and improving outcomes. For patients with serious functional losses and complex medical conditions, IRFs provide the patient-centered care delivery and facilitate the long-term health outcomes that align with many of these goals. We look forward to close engagement with the Administration in the coming years as your team looks to address a number of critical issues involving post-acute care and broader Medicare policy.

We are most eager to meet with the Transition Team to discuss our ideas further and are available at your earliest convenience. For follow-up with this request and if you have any questions about AMRPA's recommendations in Sections I and II, please contact Kate Beller, J.D., AMRPA Executive Vice President for Government Relations and Policy Development (kbeller@amrpa.org / 202-207-1132).

Sincerely,

Anthony Cuzzola
Chair, AMRPA Board of Directors
Vice President, JFK Johnson Rehabilitation Institute
Hackensack Meridian Health

CC: Chiquita White Brooks-Lasure
Robert Gordon
Jeremy Wertz

I. AMRPA Top Policy Recommendations Related to the COVID-19 Response: Maximizing Patient Access to Safe Care & Equipping IRFs to Continue to Serve as Frontline Providers

IRFs have played a vital role in their communities' PHE response effort, because they are hospitals – specialized to provide intensive complex rehabilitation programs of care, but still hospitals with physicians, nurses other clinical personnel, diagnostic and therapeutic equipment and services, and emergency response/preparedness capabilities that distinguish IRFs from other post-acute care settings. Patients' access to IRFs during the pandemic represents a particularly critical need in light of the unprecedented surge demands faced by acute care hospitals and the infection control/safety issues that restricted patients' PAC options in a number of communities.

AMRPA appreciates your team's stated interest in developing a pandemic preparedness and response strategy that builds off the "lessons learned" from the COVID-19 pandemic, particularly from stakeholders such as hospitals. AMRPA believes that there were a number of key waivers and flexibilities granted to IRFs and other hospital providers by the Federal government that should be extended beyond the technical end-date of the PHE, and some that may warrant permanent implementation. In addition, AMRPA supports a number of new policies that will better position hospitals to respond to future pandemics, such as improving PPE distribution and providing adequate funding for the capital and technological upgrades required by IRFs. Our top policy priorities are detailed immediately below:

Telehealth Expansion

Some of the most important waivers granted during the COVID-19 PHE relate to telehealth expansion, particularly for medical rehabilitation patients. We recognize that policymakers have already identified telehealth as an issue that needs to be assessed in light of the PHE, and we encourage the Biden Administration to modernize telehealth regulations to reflect rapidly evolving medical and communication technology and new types of telehealth utilization during the pandemic. In particular, AMRPA strongly supports permanent implementation of the following temporary PHE waivers: (1) expand the list of telehealth services that can be provided in the Medicare program via telehealth to include therapy services, (2) recognize therapists – including physical therapists, occupational therapists, speech-language pathologists, and respiratory therapists – as eligible telehealth providers, and (3) relax distant site guidelines in order to allow more patients to receive care in their home. Many of our hospital members report that these waivers have allowed patients to continue the outpatient therapy component of their intensive rehabilitation program without undertaking the risk of entering the hospital or outpatient care setting, which will be critical for the duration of this pandemic.

AMRPA further encourages the Biden Administration to consider permanent implementation of these policies following the PHE. Prior to the pandemic, AMRPA has been on record expressing support for efforts to modernize telehealth rules in the Medicare program to better

reflect the state of medicine and technology. Consistent with this position, AMRPA believes that these outpatient therapy-focused waivers will prove beneficial outside of, and long after, a PHE, such as when patients face other obstacles (e.g., weather, protests, or mobility restrictions) that prevent them from traveling to an IRF or outpatient therapy site.

Prohibition of Prior Authorization for Inpatient Rehabilitation for the Duration of the PHE

In the early stages of the pandemic, most MA) plans voluntarily waived their prior authorization/pre-authorization policies in order to ensure that patients were able to access IRF beds in the safest and most timely way possible. These voluntarily waivers enabled patients that were ready for clinical intervention to receive such care expeditiously, rather than incur the 3-5 business day delays that these policies frequently impart. These waivers were especially critical given the surges faced by acute-care hospitals and infection control issues faced by many skilled nursing facilities (SNFs) and nursing homes.

Unfortunately, prior authorization practices have generally been put back in place over the last few months, creating critical problems across the healthcare continuum. For example, our members report that the practices currently being used by MA plans serve to severely delay and restrict clinically-appropriate beneficiaries' access to hospital-level PAC. In addition, a high rate of initial requests are denied, triggering a resource intensive and physician-dependent appeals process, which further delays the patient from moving on to the next appropriate care setting. Even under non-pandemic circumstances, the resources expended by physicians and hospitals with MA plans is draining; in the context of the COVID-19 PHE, the effects of these practices are placing seriously ill patients in jeopardy and forcing unnecessary acute-care bed utilization.

Through the prior authorization waivers - which were specifically encouraged by CMS - patients were able to receive timely and appropriate care in an IRF setting. Included in a document referenced below ("AMRPA Analysis of Medicare FFS and Medicare Advantage Discharges Before and During the COVID-19 Public Health Emergency") AMRPA has analyzed data showing the positive impact of these waivers on patients (e.g., increased access to inpatient rehabilitation and a high discharge-to-home rate). AMRPA therefore urges the Biden Administration to work immediately to prohibit prior authorization for the duration of the current PHE and implement regulations that would suspend these practices in all future national PHEs as well.

Implementing Interstate Licensing Flexibilities

Through the PHE, AMRPA members were able to utilize interstate licensing flexibilities to provide critical capacity to acute care hospitals across state lines and provide both surge and COVID-19 patients with the acute beds they required. This temporary policy change helped ensure that patients received the timely care needed for survival and recovery, without compromising the quality of the care they received. AMRPA requests that this flexibility be made permanent to alleviate patient access issues and address arbitrary restrictions on care options when patients live near state lines. At minimum, AMRPA urges the Biden Administration and the 117th Congress to ensure that interstate licensing flexibilities are

automatically triggered whenever a PHE is declared to ensure that partner hospitals in different states can immediately assist each other in furnishing the capacity and provider access required for their patients.

Additionally, and consistent with our telehealth-related recommendations, AMRPA also recommends that providers be allowed to practice across state lines via telehealth in the same way they would be permitted to do so in-person.

Personal Protective Equipment and Testing Distribution & Development

Many of the most critical issues facing IRFs during the pandemic – like other hospitals throughout the country – involves the coordination, distribution, and maintenance of PPE. With infection and hospitalization rates projected to continue increasing for the months to come, AMRPA urges the Administration to consider a number of commonsense, critical actions in the early weeks of the Administration, such as:

- States should establish distribution plans and procedures to better inform and communicate with health care providers that request supplies, and ensure that IRFs are explicitly covered in the statewide distribution plans.
- The Strategic National Stockpile should provide states, territories, and tribes with guidance on best practices to coordinate and distribute medical supplies, including clear and efficient procedures to request and access resources from the federal stockpile.
- The Administration should require appropriate levels of PPE and ancillary medical supplies to be stockpiled and replenished regularly, both at the Federal and state level.
- In recognition of the frontline role that IRFs assumed during the pandemic, future policies related to vaccine distribution and payment **must treat IRFs like all other hospital providers and provide adequate access to/reimbursement for services provided.**

During the PHE, our members reported a number of issues with PPE distribution to IRFs, as well as coordination issues between the Federal and state governments. Of particular concern, it became clear that distribution plans administered by some states focus primarily on acute-care hospitals, which left other providers – including IRFs- to procure and distribute PPE on their own. AMRPA urges the Biden Administration to establish clear guidelines for distribution at the federal level that recognize the critical role played by IRFs during the PHE, as well as to work with states to ensure local distribution practices promote equitable and efficient PPE access.

In addition to these commonsense measures, AMRPA would also like to call attention to the need for Federal funding and research related to PPE specifically for rehabilitation providers. Compared to other PAC settings, rehabilitation physicians, nurses and therapists often provide face-to-face services for extended periods of time and in very close contact with patients. Given the critical shortages and recognized importance of PPE during the COVID-19 pandemic, AMRPA encourages investment in new types of PPE that are tailored for specific types of PHE frontline providers – such as IRFs.

Lastly, PAC patients and providers, including IRFs, must receive appropriate funding for and adequate access to testing. Given the higher susceptibility of PAC patients to viruses, their medical complexities and co-morbidities, it is critical that IRFs be able to test all patients – including asymptomatic patients – on a frequent basis in order to immediately detect and account for positive patients. While IRFs were able to provide a safer environment for COVID-19 patients than other PAC settings (due to the aforementioned hospital level care, clinical competency, staffing, quality and other features distinguishing IRFs from other settings), improving IRFs' ability to widely test patients and staff would bolster emergency preparedness efforts in the future.

Vaccine Distribution & Reimbursement

In recognition of the frontline role that IRFs assumed during the pandemic, future policies related to vaccine distribution and payment must treat IRFs like all other hospital providers. AMRPA found the guidance issued to date by the Trump Administration to be unclear with whether and how IRFs will receive any add-on payment when furnishing COVID-19 vaccines to their patients once such vaccines are widely available. To avoid issues similar to the PPE access described above, we urge the Biden Administration to promptly make clear that IRFs will both receive vaccines in the quantity and timeframe required for their patient populations, and receive the same reimbursement as other hospitals for these actions.

Providing for Automatic Availability of Certain Hospital Waivers upon Future PHE Declarations

In the early weeks of the COVID-19 pandemic, AMRPA was in near-daily communication with CMS leadership and Federal officials to discuss the flexibilities and waivers required to best position IRFs to effectively serve both surge and COVID-19 patients. To streamline IRFs' (and other hospitals) response efforts in future pandemic response efforts, AMRPA recommends that certain critical waivers and regulatory flexibilities – such as bed commingling, 60% rule waiver, and allowing weekly visits and team conferences to be done virtually/via telehealth, among others – to be available to all IRFs in a city or region subject to a PHE. In the case of a national PHE, all IRFs would be able to utilize these flexibilities if and as required for their patients and community.

Relatedly, AMRPA greatly appreciated the provision in the CARES Act that waived the requirement that a patient admitted to an IRF must require three hours of therapy per day, at least five days a week. This statutory directive allowed IRFs to admit surge patients from hospitals that required medical management (rather than intensive rehabilitation), as well as lower acuity patients who could not safely be admitted to a nursing home or SNF due to safety concerns or other issues. Rather than requiring that this critical flexibility be issued via statute in future pandemics, AMRPA strongly recommends that the "3-hour rule" be included among those waivers that CMS can grant through its Section 1135 waiver authority.

II. AMRPA Top Post-Acute Care Policy Recommendations: Improving Patient Access to Inpatient Rehabilitation & Advancing Patient-Centered Placement & Admission Policies

AMRPA has long enjoyed a constructive and productive working relationship with Agency officials, members of Congress, and career public servants from all political and ideological backgrounds for more than 20 years. Through these collaborations, there have been countless achievements that have benefitted the country's health care system, Medicare beneficiaries[2] and ultimately the American people. Worth noting is the inclusion of rehabilitation and habilitation in the Affordable Care Act's (ACA) 10 protected health benefit categories; the creation and refinements to the Medicare classification requirements for IRFs; and establishment of a separate Medicare PPS for IRFs.

Due to the vital role medical rehabilitation providers play in the nation's health care system, and AMRPA's past success working with previous Administrations and Congress, we are excited to work alongside the Administration of President-elect Biden to improve the lives of Americans, specifically in the realm of Medicare coverage and payment policies. To this end, there are several persistent principles that drive AMRPA's advocacy work on behalf of the medical rehabilitation field.

First among those is that Federal policies should always strive to ensure that all patients in need of intensive medical rehabilitation due to serious functional losses and complex medical conditions should be able to access IRF level of care. Further, AMRPA also wishes to engage with policy makers and other stakeholders in initiatives that drive improvements in the quality of care and build on the successful interdisciplinary approach to rehabilitation provided in the IRF. Through enhanced access and continued efforts to build on the high-quality care delivered by IRFs, AMRPA is confident that the field can continue to deliver meaningful change to the hundreds of thousands of seriously afflicted individuals who rely on IRF care to recover each year.

In order to ensure that Medicare beneficiaries and other patients have access to the high quality rehabilitation services they need, there are a number of actions AMRPA urges the Biden Administration to consider as it further develops its health care plans and agenda. These recommendations are outlined below, with supporting AMRPA comment letters and advocacy materials included in the referenced documents.

Reset the IMPACT Act Implementation Timeline

AMRPA has been engaged with both CMS/RTI and Congress related to the IMPACT Act and implementation efforts over the last several years. While AMRPA had a number of concerns and recommendations with the IMPACT Act policy-related work prior to the COVID-19 pandemic - which are further outlined it the referenced documents - the PHE now fully compels the Administration and Congress to reset the IMPACT Act timeline and reconsider the underlying goals of the statute. For example, the PHE led to a significant delay in the finalization and promulgation of many of the standardized patient assessment data elements

[2] According to MedPAC, in 2018 1,170 IRFs provided 408,000 stays to 364,000 Medicare fee-for-service (FFS) beneficiaries. Medicare FFS beneficiaries accounted for approximately 59 percent of IRF stays.

(SPADEs) on which the prototype is required to be built upon. Several of these SPADEs – such as those related to social determinants of health – are critical to the development of a patient-centered payment system, and warrant a recalibration of the development timeline.

Furthermore, under the numerous waivers that have been granted by CMS since March 2020, IRFs have been better able to respond to the unprecedented clinical and operational challenges presented by the COVID-19 PHE. As a result of these flexibilities, many of our member hospitals are simultaneously providing medical management to surge short-term acute care hospital (STACH) patients, caring for less acute patients who lack access to SNFs or nursing homes, and traditional inpatient rehabilitation patients. As a result, the data derived from the types of patients served by IRFs and the services provided by IRFs over the past 9+ months will differ markedly from pre-PHE claims data. We therefore believe it makes little sense to build a prototype on data that pre-dated the seismic changes to the health system caused by COVID-19, and that resetting the prototype would allow for far more accurate modeling of PAC delivery. To address these issues, AMRPA recommends delaying the collection of all data that would be used to build the prototype until after the PHE ends. This reset would have the added benefit of ensuring that all PAC stakeholders could be fully engaged in the discussion and analysis of the prototype's development.

Reference:

- AMRPA Letter to Congressional Leadership Regarding IMPACT Act's Timeline & Prototype Testing (July 28, 2020).

Reconsider the Broader Goals of the IMPACT Act & Advance Efforts to Improve Post-Acute Care Placements and Achieve Longer-Term Medicare Savings

Beyond requiring a reconsideration of the IMPACT Act's timeline, the COVID-19 emergency also requires policymakers to reconsider the underlying goals of the IMPACT Act. The PHE made clear that hospital-level post-acute care providers – such as IRFs – have been able to play a distinct and critical "frontline" role in their communities due to their clinical competence, staffing, equipment, and patient safety protocols, among other characteristics that fundamentally distinguish IRFs from other post-acute care settings. Even before the pandemic, AMRPA engaged closely with HHS leadership about ways to advance patient-centered post-acute care reform that takes into account the competencies of each setting, the clinical characteristics of patients, and other salient factors (e.g., the patient's home environment). We believe some of these efforts warrant expedited consideration to reflect the lessons learned from the PHE.

AMRPA's top policy priority involves the development of a PAC "sorting tool" that would utilize evidence-based practices and clinical guidelines in conjunction with the incorporation of key patient-specific characteristics to help ensure patients receive the PAC most appropriate for their treatment and recovery needs. AMRPA strongly believes that improving the accuracy of PAC placements and the time in which patients receive medically necessary care will improve care quality and outcomes, which in turn support the Biden Administration's

dedication to preserving the Medicare Trust Fund.

A separate but complementary pathway involves the "Continuing Care Hospital (CCH)" model. AMRPA strongly supported the CCH model's authorization in the Affordable Care Act (ACA), but to date, the model has not been implemented or formally tested. Interestingly, however, many IRFs have at times functioned similar to a CCH due to their community's demands during the PHE. Specifically, acute-care hospital patients have been placed in IRFs due to surge capacity issues, and SNF-level patients have received appropriate care within IRFs when access to SNFs has been limited. AMRPA therefore urges the Biden to consider formal modeling of the CCH by CMMI given the "real-world" testing that it has received during the PHE.

Lastly, AMRPA recognizes that these types of major PAC reforms should reflect the input and perspective of all other PAC stakeholders. We therefore urge the Biden Administration to consider convening a task force or other entity comprised of PAC stakeholders to foster collaborative discussion and identify other potential paths forward to create a patient-centered, cost-effective and high-quality PAC continuum.

References:

- AMRPA Response to RTI/CMS Technical Expert Panel (TEP) on a Unified Post-Acute Care Prospective Payment System (February 15, 2019)
- AMRPA Letter to RTI/CMS Technical Expert Panel (TEP) on a Unified Post-Acute Care Prospective Payment System – Questions for TEP Input (December 17, 2020).

Meaningfully Address Prior Authorization Practices in the Medicare Advantage Program & Other Policies that Could Restrict or Delay Beneficiaries' Access to Timely IRF Care

MA enrollment is rapidly growing, and it is important that the program be administered in a way that protects Medicare beneficiaries' legal rights and guarantees their access to medically necessary care. Unfortunately, AMRPA members report that MA plans routinely deny access to medically necessary PAC services for their enrollees, despite the enrollees being entitled to care that meets Medicare coverage criteria. In particular, prior authorization – which is currently utilized by plans in the MA program – has directly resulted in inappropriate care delays and denials of IRF care. The impact of prior authorization is particularly harmful for IRF patients, given their complex medical and therapy needs and the effect of care delays on their outcomes and recovery. The prior authorization process also deflects valuable hospital resources to administrative red-tape that drives up costs, and arguably undercuts the stringent regulatory requirements that already apply to every Medicare IRF admission.

AMRPA has a number of recommendations to address these issues, which are generally focused on facilitating more timely, better informed, and transparent admission determinations. Collectively, these policy changes will help ensure MA beneficiaries are able to access the PAC services they need going forward. Our key recommendations include:

- MA plan medical reviewers used in making IRF admission determinations must have relevant experience and expertise in medical rehabilitation.

- MA plan medical reviewers must communicate with all clinicians involved in the discharge planning process.
- MA plans must provide determinations and redeterminations within 24 hours, 7 days/week, including holidays.
- MA plans must provide more transparency into the prior authorization process by submitting any proprietary decision tools to HHS for review, and HHS in turn should prohibit the use of any guidelines that do not comport with Medicare coverage requirements.
- MA plans must ensure enrollees are fully informed about Medicare coverage rules, their redetermination and appeal rights, along with information about resources to navigate the process.

While not directly related to prior authorization, AMRPA would also welcome the opportunity to discuss the recently-announced "IRF Review Choice Demonstration," which was proposed in mid-December under the Trump Administration. The demonstration would require IRFs in selected states to be subject to either pre- or post-payment review processes, which we fear could impact timely admissions or result in payment delays. While limited information has been provided about the demonstration to date, AMRPA would appreciate the chance to meet with the Biden Administration in advance of the proposal's mid-February comment deadline to discuss the implementation and policy-related concerns of the field. At minimum, we urge the delay of any policy that would require new reporting requirements from IRFs until an appropriate period of time following the PHE given the clinical and operational demands currently facing the field.

Our full list of recommended measures specific to MA prior authorization are included in the references notated below.

References:

- AMRPA Response to 2021 Medicare Advantage and Part D Advance Notice Part II and Draft Call Letter (March 6, 2020).
- AMRPA Response to Request for Information; Reducing Administrative Burden To Put Patients Over Paperwork (August 12, 2019).
- AMRPA Analysis of Medicare FFS and Medicare Advantage Discharges Before and During the COVID-19 Public Health Emergency (September, 2020).
- AMRPA Statement on Proposed CMS IRF Choice Review Demonstration (December 16, 2020).

Reform Price Transparency Requirements to Provide More Relevant Information to Beneficiaries

While AMRPA strongly supports improving price transparency throughout the healthcare ecosystem, we believe that the current policies of HHS will not achieve its intended goal – improved consumer awareness and decision-making – and may unintentionally result in inappropriate or less clinically effective PAC placements. Beneficiaries are subject to various cost-sharing dependent upon their specific plans of care and payer coverage benefits. Current

price transparency requirements may divert beneficiaries to a facility based purely on assumed cost, while quality is not taken into account.

Further, hospitals – including IRFs – are tasked with responding to the ongoing COVID-19 pandemic which continues to become more widespread. To comply with the price transparency requirements is a significant undertaking, at a time when providers should be focused on addressing the PHE. In the short-term, AMRPA recommends that the requirements must be fully rescinded or delayed until the PHE is over. At minimum and/or in the event of a delay of the requirements, AMRPA recommends such policies be reformed to ensure beneficiaries have transparency, yet meaningful insight, into their true cost of care. These recommendations are further outlined in the references noted below.

References:

- AMRPA Response to Proposed Requirements for Hospitals To Make Public a List of Their Standard Charges & Request for Information (September 27, 2019).
- AMRPA Opposes Recently Finalized Hospital Pricing Regulations Statement (November 27, 2019).

Funding/Appropriations for Hospital Construction/Modernization Efforts

IRFs have and will continue to serve as an essential backbone to the continued recovery of COVID-19 survivors. Furthermore, IRFs clearly demonstrated during the current PHE that our hospitals are particularly well equipped to serve as frontline providers in future pandemics. As such, we urge the Biden Administration and Congress to be mindful of the fact that IRFs along with other key providers will need significant additional support to make the appropriate physical, personnel, technological, and policy changes to best prepare for future pandemic response.

For example, IRFs need the ability to quickly make changes to their infrastructure to cohort patients, ramp up capacity for the unique types of medical rehabilitation COVID-19 patients will need, bolster their telehealth/telemedicine capabilities, and secure an adequate workforce to deliver all this care. These efforts will include the updating disaster staffing plans, constructing negative pressure rooms, creating more private gyms and separated facilities that can be utilized during a PHE/pandemic (for example, rehabilitation gyms), and investing in other infection control protocols that proved useful for other hospitals during the PHE. AMRPA urges the incoming Administration to work with the 117th Congress to ensure these efforts are adequately funded in order to foster safe and effective patient access to IRF care following the PHE.

Appendix

Reference Links

AMRPA Letter to RTI/CMS Technical Expert Panel (TEP) on a Unified Post-Acute Care Prospective Payment System – Questions for TEP Input (December 17, 2020)

AMRPA Statement on Proposed CMS IRF Choice Review Demonstration (December 16, 2020).

AMRPA Analysis of Medicare FFS and Medicare Advantage Discharges Before and During the COVID-19 Public Health Emergency (September, 2020).

AMRPA Letter to Congressional Leadership Regarding IMPACT Act's Timeline & Prototype Testing (July 28, 2020).

AMRPA Response to 2021 Medicare Advantage and Part D Advance Notice Part II and Draft Call Letter (March 6, 2020).

AMRPA Opposes Recently Finalized Hospital Pricing Regulations Statement (November 27, 2019).

AMRPA Response to Proposed Requirements for Hospitals To Make Public a List of Their Standard Charges & Request for Information (September 27, 2019).

AMRPA Response to Request for Information; Reducing Administrative Burden To Put Patients Over Paperwork (August 12, 2019).

AMRPA Response to RTI/CMS Technical Expert Panel (TEP) on a Unified Post-Acute Care Prospective Payment System (February 15, 2019)