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December 21, 2020

Secretary Alex Azar
200 Independence Avenue S.W.
Washington, D.C.
20201

Delivered Electronically

Re: Regulatory Relief to Support Economic Recovery; Request for Information (RFI)

Dear Secretary Azar,

The American Academy of Physical Medicine and Rehabilitation (AAPM&R) appreciates the opportunity to comment on the Health and Human Services (HHS) RFI, *Regulatory Relief to Support Economic Recovery*. AAPM&R has supported a number of waivers made during the public health emergency (PHE) and believes several should be made permanent or otherwise extended.

AAPM&R is the national medical specialty organization representing more than 9,000 physicians who are specialists in physical medicine and rehabilitation (PM&R). PM&R physicians, also known as physiatrists, treat are medical experts on a wide variety of conditions affecting the brain, spinal cord, nerves, bones, joints, ligaments, muscles, and tendons. PM&R physicians evaluate and treat injuries, illnesses, and disabilities, and are experts in designing comprehensive, patient-centered treatment plans. Physiatrists utilize cutting-edge as well as time-tested treatments to maximize function and quality of life.

AAPM&R is grateful for HHS' work during the PHE to ensure health care providers have flexibility to provide safe care to the overwhelming number of patients. Several waivers that should be continued, to varying extents, are:

- allowing the use and payment of audio-only telehealth,
- the Inpatient Rehabilitation Facility (IRF) intensity of therapy requirement, or the "three-hour rule,"
- elimination or flexibility of the IRF 60% rule, and
- the SNF three-day rule.

Audio-Only Telehealth

AAPM&R is grateful for the critical telehealth flexibilities advanced in the PHE. One of the most immediately meaningful flexibilities has been the coverage of audio-only telehealth encounters at a rate comparable to in-person or real-time audiovisual telehealth evaluation and management services. It is our



understanding that HHS intends for this flexibility to end with the PHE. AAPM&R asserts this flexibility should be maintained permanently.

Our members have reported using telephone-only visits in place of real-time audiovisual telehealth for a variety of different types of patient encounters. For example, it has been a way to conduct comprehensive follow-up visits with their spinal cord injury patients they typically would have seen in the outpatient hospital setting. These patients can verbally report on their function, improved or worsening spasticity, and bowel issues even though a physical exam is not completed. A historical account of these conditions can result in a process of medical decision making similar if not identical to when a service is provided face-to-face.

A large portion of our members practice in the musculoskeletal and/or pain management space. Due to the non-urgent nature of many of the procedures these physicians perform, many of these practices are either closed to in-office visits or are seeing only the most urgent cases. For these members, the telephone has become their primary tool with patients who do not have access to or agility with real-time audiovisual technology. As with the spinal cord injury patients previously described, these patients can be assessed verbally with respect to their function in a way that approximates a physical exam such that our members can confidently consider changes to their plan of care including medication management.

We understand our members are using the telephone to remove barriers to care for their patients during this challenging time. Further, we recognize there are many other appropriate uses for audio-only telehealth services which will remain applicable at the conclusion of the PHE. Therefore, ***AAPM&R urges HHS to permanently allow audio-only telehealth visits and to appropriately reimburse physicians for this work.***

“Three-Hour Rule” Waiver

AAPM&R is grateful that Congress waived the inpatient rehabilitation facility (IRF) three-hour rule in the CARES Act. When the PHE is lifted, the three-hour rule will go back into effect. ***AAPM&R asserts that the rule be reinstated after the pandemic, but with adjustments to expand the types of therapy that count towards the “three-hour rule” such that therapy can be tailored to individual patient needs.*** The world after the PHE will not be the same world as before the COVID-19 outbreak. AAPM&R recognizes the overwhelming need for rehabilitation for COVID-19 patients as they recover from the immediate threat of the virus, especially after weeks on a ventilator, or deal with the effects of post-COVID syndrome. Such patients may need inpatient rehabilitation to restore muscle function and avoid chronic muscle pain; optimize cardiopulmonary function; recover from multiorgan failure, anoxic brain injury,

and strokes; and help patients return to basic functions such as speaking and swallowing. AAPM&R asks HHS to work with the Centers for Medicare and Medicaid Services (CMS) to expand the types of skilled therapy rehabilitation physicians may prescribe that count towards the “three-hour rule” in addition to physical therapy (PT), occupational therapy (OT), speech-language pathology (SLP), and orthotics and prosthetic services (O/P). AAPM&R asks HHS to encourage CMS to include other skilled services, as determined by the patient’s rehabilitation physician, such as recreational therapy,¹ psychological and neuropsychological services, and respiratory therapy. Respiratory therapy may have increased demand for those recovering COVID patients. AAPM&R members know that all these therapies are part of the comprehensive treatment IRF patients receive. If these therapies count towards the “three-hour rule,” IRFs will be more apt to provide these services.

AAPM&R does not believe that expanding the “three-hour rule” will come with an associated cost. The current intensity of therapy requirement outlined in the “three-hour rule,” allowing the current four therapies (PT, OT, SLP, O/P) to count towards the 15 hours of therapy a week furnished to IRF patients, was instituted in 2010. Prior to 2010, before the intensity of therapy requirement was limited to the current four therapies, IRF admissions were at the same level as they were after the 2010 intensity of therapy requirement was limited and remained at nearly the same level through 2017.

AAPM&R has long advocated for rehabilitation physicians to be able to prescribe this expanded list of skilled therapies and apply them to the “three-hour rule.” We believe, now more than ever, that IRF patients, including those that are recovering from COVID-19, will require these other skilled therapy modalities to optimize their function and get the most out of inpatient rehabilitation. Rehabilitation physicians, through their years of higher education and experience, are equipped to determine what combination of therapies patients need.

60% Rule Waiver

AAPM&R is grateful CMS waived the 60% rule in IRFs early in the PHE. The 60% rule is a mechanism that attempts to ensure that only the most appropriate patients are admitted to an IRF level of rehabilitation care. The rule requires that 60% of an IRF’s patient population have a diagnosis that is included in a list of 13 diagnosis codes to be eligible to receive Medicare/Medicaid funding.

¹ Recreational therapy is a vital therapy used to re-integrate people with disabling conditions and chronic illnesses back into society and function independently. Recreational therapy includes teaching patients to do things like ride the bus or get groceries.

Many recovering COVID-19 patients will continue to need the comprehensive medical and functional care provided in IRFs and by rehabilitation physicians. Many COVID-19 patients, however, do not fall under the 60% rule, as this is a new disease with long-term issues and cardiac/pulmonary diagnoses do not currently count toward the 60% rule. ***As such, we request either the 60% rule be permanently waived or that the diagnosis codes be revised to include cardiac and pulmonary diagnoses and/or COVID-19 and resulting conditions.***

IRFs who are currently treating patients with post-COVID syndrome will likely need to turn away similar patients after the PHE if the 60% rule is not waived or altered. This will also apply to recent survivors of critical COVID-19 cases who are being discharged from acute care will continue to require care after several weeks on a ventilator.

Skilled Nursing Facility Three-Day Rule Waiver

AAPM&R members are grateful for this waiver during the PHE and ***recommends that this waiver be made permanent and replaced with updated admission criteria that focus on the medical and rehabilitative needs of the patient and address concerns with related regulations.*** Our report numerous benefits from this waiver. For instance, without the waiver, if an otherwise qualified patient does not meet the three-day requirement for a Skilled Nursing Facility (SNF), they might be transferred for a short duration in an IRF, then transferred to a SNF. The waiver would allow that patient to transfer directly to the SNF. Fewer transfers help reduce both patient and caregiver exposure to COVID-19 and drastically reduce costs. Additionally, the ability to move patients more quickly out of the acute care setting has allowed hospitals to free up vitally needed hospital beds during the pandemic.

There is evidence that the three-day rule is problematic irrespective of the pandemic. An article², *The Cost of Unnecessary Hospital Days for Medicare Joint Arthroplasty Patients Discharging to Skilled Nursing Facilities* from Sibia et al, to demonstrate that, for the study population, an acute stay that is shorter by one day can result in substantially lower costs of care.

Another study from Grebla et al³, *Waiving the Three-Day Rule: Admissions and Length-of-Stay at Hospitals and Skilled Nursing Facilities did not Increase,*

² Sibia US, Turcotte JJ, MacDonald JH, King PJ. The Cost of Unnecessary Hospital Days for Medicare Joint Arthroplasty Patients Discharging to Skilled Nursing Facilities. *J Arthroplasty*. 2017 Sep;32(9):2655-2657. doi: 10.1016/j.arth.2017.03.058. Epub 2017 Apr 5. PMID: 28455180.

³ Grebla RC, Keohane L, Lee Y, Lipsitz LA, Rahman M, Trivedi AN. Waiving the threeday rule: admissions and length-of-stay at hospitals and skilled nursing facilities did not

found declines in average hospital length of stay for patients transferred to SNF care for Medicare Advantage plans that eliminated the three-day hospital stay requirement, suggesting that the three-day stay requirement might be inappropriately lengthening hospital stays for patients.

AAPM&R is grateful that expansion of telehealth services and other waivers granted during the PHE, such as the waivers impacting the Inpatient Rehabilitation Facility (IRF) setting (e.g., waiver of the 60% rule), have complemented the SNF three-day waiver and allowed patients to continue to access care while limiting exposure to COVID-19. However, the unique circumstances of the pandemic and the resulting waivers have led to an increased awareness of certain outdated regulations and are sparking hope that the regulatory environment can be reimagined to further expand access and improve quality of care beyond the PHE. For instance, our members have identified numerous frustrations and confusion on behalf of patients getting observation services in the hospital who do not understand when they are told they have not met the three-day stay requirement. At the same time, the onerous and clinically insignificant requirements that must be met to qualify for IRF admission can inappropriately restrict access to some rehabilitation patients. A comprehensive reevaluation of these interrelated regulations is needed.

As it stands, the three-day stay requirement has many unintended consequences including increasing acute length of stay and perversely requiring patients to be sick enough for a hospital admission before they can be admitted to a SNF. At the same time, the three-day rule can serve a critical role in preventing hasty patient discharge to the wrong level of care. For instance, absent the three-day requirement, patients might be discharged to a SNF before they can be properly evaluated for IRF admission, putting certain patients at risk for inadequate rehabilitation treatment. As such, we recognize the need for standard admission criteria to ensure appropriate transitions of care and avoid fraud and abuse. Such criteria should account for the distinct needs of patients and be based on science and research, not on arbitrary calendar or time-based requirements or on proprietary algorithms.

The selection of the appropriate PAC setting for an individual patient largely depends on the diagnosis, functional status, expected gains in function and ability to participate in rehabilitative therapies, but there are several important non-clinical factors to consider. Some of these factors include geographic availability of various types of PAC settings, patient preference for a PAC setting close to home, and conditions in patients' homes (e.g., home accessibility and level of caregiver assistance available at the time of discharge).

As such, a replacement for the three-day rule should offer flexibility for the attending physician and interdisciplinary care team to assess the patient's specific characteristics to discern the right setting and level of care needed. As previously stated, physiatrists are well-equipped to make the proper determination regarding an appropriate destination for the patient and should be recognized as vital specialists in informing development of any admission criteria or policies that address minimum stay requirements for PAC settings ranging from IRF to outpatient care. AAPM&R welcomes the opportunity to work with CMS on developing new admission criteria.

AAPM&R respectfully requests that HHS encourage CMS to continue collecting data, including stakeholder feedback, to further inform its analysis and recommendations regarding the SNF three-day requirement and related regulatory issues.

Thank you for your consideration of these comments. Please consider AAPM&R a resource in these efforts. For more information, please contact Reva Singh, Director of Advocacy and Government Affairs at AAPM&R at rsingh@aapmr.org or 847.737.6030.

Sincerely,

A handwritten signature in black ink, appearing to read "Thiru Annaswamy". The signature is fluid and cursive, with a large, stylized flourish at the end.

Thiru Annaswamy, MD, MA
Chair, Quality, Practice, Policy and Research Committee