

June 30, 2020

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*Submitted Electronically*

**Re: Including Additional Aid to Psychiatrists in a Fourth COVID  
Legislative Package**

Dear Speaker Pelosi and Leaders McConnell, McCarthy, and Schumer:

On behalf of the American Academy of Physical Medicine and Rehabilitation (AAPM&R), I want to thank you and your colleagues in Congress for your swift actions in response to the COVID-19 pandemic to lessen the burden on physician practices and allow them to focus on patient care during this pandemic. AAPM&R has been hearing clinician and patient needs from the frontlines regarding the continuing and urgent needs arising from COVID-19. It is our hope that the following ideas will contribute to Congress' ongoing work to prepare the nation for the progression of COVID-19 such that psychiatrists, hospitals, and communities can handle forthcoming surges, patients will not be overwhelmed with crippling medical bills after recovering from COVID, and psychiatry practices considered "non-essential" can re-open after the crisis has passed. This letter is a follow up from our April 13 letter, which is attached.

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 psychiatrists, treat a wide variety of medical conditions affecting the brain, spinal cord, nerves, bones, joints, ligaments, muscles, and tendons. PM&R physicians evaluate and treat injuries, illnesses, and disability, 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.

**Physiatry’s Unique Position in Treating COVID-19:** Physiatrists, as trained physician experts in rehabilitation, will continue playing a unique role in helping American patients recover from COVID-19. As you know, COVID-19 can be a devastating virus that affects pulmonary, cardiac, and neurological function. On top of recovering from the disease itself, necessary treatments for dire cases of COVID-19, such as intubation, can result in impaired swallowing, difficulty speaking, muscular weakness, and pain after weeks of being sedated. Physiatrists are uniquely able to devise rehabilitation programs aimed at restoring function and maintaining optimal health for these patients to return to their lives and work after their lives were upended by the novel coronavirus. As such, we urge Congress to consider the following recommendations to help physiatrists working in inpatient and outpatient facilities best care for COVID-19 patients, even after the declared public health emergency (PHE) ends.

*I. Protecting Physiatrists*

**Personal Protective Equipment and Adequate Testing:** Though states are re-opening after the initial COVID-19 surges, many hospitals and practices are still having difficulty acquiring Personal Protective Equipment (PPE). We implore Congress to help ensure that PPE is made widely available to all facilities, health care workers, and other health care staff in the United States throughout the PHE and afterwards, if shortages continue. All physicians and health care workers require PPE to work with patients to ensure personal, patient, and community safety from the spread of COVID-19. AAPM&R’s recent position statement on PPE is attached.

Additionally, we encourage Congress to heed the [position](#) of the American Medical Association to take critical steps to protect health care workers by ensuring “manufacturing of PPE is operating at maximum possible capacity” and creating a “tracking system of acquisition and distribution of critical PPE supplies.”<sup>1</sup>

In addition to expanding the supply of PPE, AAPM&R implores Congress to increase access to testing. Many patients who originally required procedures and services that were considered “non-essential” are starting to return to hospitals to catch up on these procedures and services, which may have not been exigent but are truly essential to maintaining health and quality of life. Many hospitals are testing such patients for COVID two days prior to any procedures they have planned as a safety check. Not all

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<sup>1</sup> AMA urges critical steps to protect frontline health care workers. March 28, 2020. <https://www.ama-assn.org/press-center/ama-statements/ama-urges-critical-steps-protect-frontline-health-care-workers>.

hospitals and many independent practices cannot afford this. We ask Congress to do what it can to provide testing to facilities.

**Medical Liability:** As physicians continue providing life-saving care in good faith with a lack of equipment, resources, space, members of the care team, and understanding of this new virus, we ask that greater medical liability protection is provided to physicians working across the country. We urge Congress to include the targeted liability protections in the bipartisan Coronavirus Provider Protection Act (HR 7059) in any upcoming COVID-19 legislative package. Due to the ongoing burden of suspected and confirmed cases of COVID-19, physiatrists, like many medical specialists, continue to heed calls to expand their day-to-day patient care responsibilities and join the frontlines in providing critical care to highly contagious COVID-positive patients, but they should not have to do so at their own legal peril.

We appreciate all the work that has been done to expand liability protections in the CARES Act to provide civil immunity to physicians and clinicians who volunteer to provide care during this public health emergency. However, more needs to be done for physicians, including those who are not providing direct care to COVID-19 patients, but whose medical practice and treatment decisions have shifted due to the pandemic. Such protection should explicitly limit provider liability for harm resulting from government directives to cancel, delay, modify (e.g., treatment via telehealth) or deny care as a result of the COVID-19 pandemic. Physiatrists, like other physicians and clinicians, are currently under tremendous burden as they work to restore the pulmonary function of COVID-19 patients, treat muscular weakness and deconditioning from the illness, and expand care to cover the overflow of patients entering inpatient rehabilitation facilities, where physiatrists traditionally practice. The current state of health care has our members across the country putting themselves at risk every day by working in dramatic and unique situations, such as treating patients without proper PPE, admitting acute care overflow patients to inpatient rehabilitation facility parking lots, and working with fewer staff as frontline workers themselves contract the virus. These circumstances raise concerns regarding the threat of medical liability lawsuits for rehabilitation health care providers, due to circumstances that are beyond their control. As physiatrists and other health care workers put their practices and lives at risk to treat COVID-19 patients without PPE, delay care to patients whose conditions are considered “non-essential,” and potentially take on an overflow of patients they may not normally treat, they should not be concerned by the potential threat of years of costly litigation resulting from these unforeseen circumstances.

**Maintaining the Physiatry Workforce:** As stated earlier in this letter, physiatry’s contribution to COVID-19 recovery is unique and integral to ensuring that the many current and future patients who contract the virus can return to their optimal level of function. It is no secret that the nation has been facing a physician shortage,<sup>2</sup> even

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<sup>2</sup> According to an Article in Human Resources for Health, it is estimated that in 2020 there is a shortage of 91,500 physicians. (Zhang, X; Lin, D; Pforsich, H; Lin, VW. *Physicians workforce*

before COVID-19, which is infecting physicians and clinicians working with COVID-19 patients. As such, it is imperative that the physiatry workforce is enhanced during the COVID-19 crisis by recapturing unused immigrant visas. We urge Congress to include the Healthcare Workforce Resilience Act (S. 3599) and the Conrad State 30 and Physician Access Reauthorization Act (S. 948) in any upcoming COVID-19 legislative package.

AAPM&R has members who would directly benefit from the passage of these bills as they await extraordinarily long lines for their green cards. According to one member, who is an Indian citizen and physiatrist working in West Virginia, the estimated wait time for his green card is over 40 years. This physiatrist is providing care to American patients in a rural area, an already underserved community. Ensuring physiatrists like him and others can continue to provide care will keep us from deepening the American physician shortage during the PHE and as the nation continues to recover from the pandemic.

Additionally, allowing American-trained immigrant physicians who have J-1 nonimmigrant visas to stay in the country after their training, rather than working for two years abroad after training before applying for their visa or green card, would immediately increase the number of physicians and physiatrists working in the country as it heals from the COVID-19 pandemic. These physicians are required to work in underserved and academic medical centers, serving not only patients but the broader public health interest by providing access to health care in areas that lack capacity.

## II. *Financial Security*

**Telemedicine:** We appreciate all that Congress has done to ensure telemedicine flexibility while citizens are social distancing to reduce risk of infection. AAPM&R has found these measures vital to treating patients during this tumultuous time. We encourage Congress to ensure that telemedicine, whether audio-only or audio and visual, are accessible throughout the country and to all patients.

Additionally, AAPM&R asks that telemedicine be expanded to take into account the conditions with which patients present, not just immunocompromised patients, when considering the extension of telemedicine. For example, physiatrists see many patients who have spinal cord injuries and traumatic brain injuries. These patients often need a caregiver to bring them to medical appointments or need help with transportation, creating additional risk for exposure.

As states continue to reopen and patients are returning to physician offices, AAPM&R recognizes that adequate telehealth coverage will continue to be critical. To maintain

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*in the United States of America: forecasting nationwide shortages.* Human Resources for Health. February 2020. Retrieved here: <https://human-resources-health.biomedcentral.com/articles/10.1186/s12960-020-0448-3>

appropriate social distancing and complete need sanitizing of rooms and equipment in reopened practices, telehealth will need to continue to be used for at least a portion of patients. This includes offering telehealth to the immunocompromised patients including those described above, as well as patients in need of routine follow-up that doesn't require in-person care. Telehealth is being used to reduce the number of in-office patients while still ensuring that all patients are able to access the care they need. We urge Congress to maintain existing waivers for telehealth services until physician offices can return to pre-COVID practices in their waiting rooms and patient rooms.

**Student Loans:** As many of our members in the private practice and outpatient setting are closing their doors, being furloughed, and being laid off, we ask that Congress provide student loan relief for physicians and include the Student Loan Forgiveness for Frontline Health Workers Act (HR 6720) in any upcoming COVID legislative package. This bill will directly help physiatrists helping COVID-19 patients recover or those who are taking on overflow acute care patients in their post-acute care inpatient rehabilitation facilities.

As the pandemic has highlighted, physicians play a special part in society by keeping Americans healthy. During the COVID-19 outbreak, many “non-essential” procedures were halted to prevent the spread of the virus. However, “these non-essential” procedures can make all the difference in the quality of life and capabilities of Americans. These “non-essential” procedures are also the livelihoods of many physiatrists who have incurred hundreds of thousands of dollars of debt to become physicians. As such, we ask that a broader student loan bill be introduced such that all physician borrowers can apply for their student loans to be given additional flexibility and relief.

### *III. Patient Access to Necessary Care*

**Access to Outpatient and Post-Acute Care for the Uninsured:** We appreciate Congress' efforts to set aside funds to pay for treatments related to COVID-19 for the uninsured through the Provider Relief Fund. While the effects of COVID-19 are still being discovered, we do know the effects can be devastating and that many Americans infected are being put onto ventilators. The American Hospital Association estimates that 960,000 people will need ventilators to prolong their life and fight the virus during the pandemic in the United States.<sup>3</sup> Patients who require prolonged ventilation, meaning ventilation that is not used following surgery or other routine care, often need post-acute care (PAC) to restore respiratory muscles to optimum function. Additionally, patients who require prolonged ventilation have not moved in weeks and may require rehabilitation to help with muscle weakness and pain. COVID-19 patients at all ages are showing persistent cardiac, pulmonary, and neurological effects. We are

<sup>3</sup> Sullivan, Peter. Severe Ventilator Shortage Sparks Desperate Scramble. March 26, 2020. <https://thehill.com/policy/healthcare/489734-severe-ventilator-shortage-sparks-desperate-scramble>

grateful for the Congressional funding to hospitals for free COVID testing for the uninsured. However, we believe all treatment, should also be waived for the uninsured. This includes including any post-acute care and subsequent outpatient rehabilitation needs to restore respiratory and other muscle function. Outpatient practices can be a vital extension of inpatient care, as they ensure patients who have been discharged maintain their functional gains from the inpatient setting. Such follow up may need to be virtual, so there should be continued incentivization of virtual visit options.

**Social Determinants of Health:** AAPM&R is concerned about the disparate impact of COVID-19 on minority communities. While health disparities in minority populations is not new, COVID-19 has certainly exacerbated and highlighted the ongoing problem of social determinants of health (SDOH) in our nation. AAPM&R has been consistently advocating for a bill collecting data on minority communities, including but not limited to people with disabilities, be included in the upcoming COVID legislative package. The Equitable Data Collection and Disclosure on COVID-19 Act, introduced by Reps. Ayanna Pressley, Robin Keely, and other members of the Congressional Black Caucus, along with Sen. Elizabeth Warren, requires the Department of Health and Human Services (HHS) to collect and report racial, ethnic, and other demographic data on COVID testing, treatment, and fatality rates. AAPM&R strongly supports this bill and its inclusion in the upcoming COVID legislative package. However, we also require edits that 1) integrate the concerns and interests of the disability community throughout the bill to ensure that disability rights are universally considered civil rights, 2) include on the mandated data collection commission agencies with disability, independent living, and rehabilitation research portfolios, and 3) authorize targeted COVID research funding to NIDILRR comparable to the targeted funding provided to other research agencies.

In addition to collecting this data on SDOH during the COVID-19 pandemic, we ask Congress to include language stating that medical researchers who have similar backgrounds to the minority groups be provided equitable funding. For example, any projects researching the disparate effects of COVID-19 on the Black and African American communities should include funding for a Black and/or African American researcher. Studies have found that lower rates of NIH R01 awards go to African American and Black scientists than White scientists.<sup>4</sup> This study controlled for education background, country of origin, training, previous research awards, and employer characteristics. Black and African American researchers deserve equitable funding, particularly when it comes to studying disparate health in similar communities.

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<sup>4</sup> Hoppe et al., Sci. Adv. 2019;5 : eaaw7238. 9 October 2019

#### *IV. Maintaining Inpatient Rehabilitation Facility Waivers*

**Three-Hour Rule:** AAPM&R is grateful to Congress for waiving 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. We ask that the rule be reinstated after the pandemic, but with slight adjustments to expand the types of therapy that count towards the “three-hour rule”. 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 as COVID-positive patients recover from the immediate threat of the virus, but, particularly after weeks on a ventilator, may need 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 Congress to direct 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 Congress to also direct the agency to include other skilled services, as determined by the patient’s rehabilitation physician, such as recreational therapy,<sup>5</sup> 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.

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<sup>5</sup> 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.

**60% Rule:** CMS waived the 60% rule in IRFs early in the PHE. The 60% rule is a mechanism that ensures that only the most appropriate patients are admitted to an IRF level of rehabilitation care.

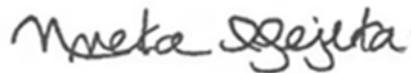
Many recovering COVID-19 patients will need the comprehensive medical and functional care provided in IRFs and by rehabilitation physicians. Many COVID-19 patients, however, do not fall under the 60% rule, as this is a new disease with long-term issues and cardiac/pulmonary diagnoses do not currently count toward the 60% rule.

Additionally, even if Congress does not accept this proposal to expand the three-hour rule as we recommend, we ask that Congress include legislation to except COVID-19 patients in IRFs from the 60% rule even after the PHE ends. COVID-19 patients being discharged from acute care may not be immediately able to participate in three-hours of PT, OT, and SLP when they are first admitted to an IRF. Alternatively, Congress could encourage CMS to take steps to add COVID-19 as a diagnostic group of patients that would count toward the 60% rule.

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Again, we'd like to thank you for your work and leadership during this time of crisis. If you have any questions or if AAPM&R can be of further assistance to you, please contact Reva Singh at 847-737-6030 or by email at [rsingh@aapmr.org](mailto:rsingh@aapmr.org) for further information.

Sincerely,



**Nneka Ifejika, M.D., M.P.H., FAHA**  
**Chair, Health Policy and Legislation Committee**