

Inpatient Rehabilitation Facilities: CMS Flexibilities to Fight COVID-19

The Trump Administration is issuing an unprecedented array of temporary regulatory waivers and new rules to equip the American healthcare system with maximum flexibility to respond to the 2019 Novel Coronavirus (COVID-19) pandemic. Made possible by President Trump's recent emergency declaration and emergency rule making, these temporary changes will apply immediately across the entire U.S. healthcare system for the duration of the emergency declaration. The goals of these actions are to 1) to ensure that local hospitals and health systems have the capacity to handle a potential surge of COVID-19 patients through temporary expansion sites (also known as CMS Hospital Without Walls); 2) remove barriers for physicians, nurses, and other clinicians to be readily hired from the community or from other states so the healthcare system can rapidly expand its workforce; 3) increase access to telehealth in Medicare to ensure patients have access to physicians and other clinicians while keeping patients safe at home; 4) expand in-place testing to allow for more testing at home or in community based settings; and 5) put Patients Over Paperwork to give temporary relief from many paperwork, reporting and audit requirements so providers, health care facilities, Medicare Advantage and Part D plans, and States can focus on providing needed care to Medicare and Medicaid beneficiaries affected by COVID-19.

Medicare Telehealth

- Telehealth may be used to fulfill the requirement for physicians to conduct the required face-to-face visits at least 3 days a week for the duration of a Medicare patient's stay in an inpatient rehabilitation facility.

Patients Over Paperwork

- *Post Admission Evaluations:* Physicians are no longer required to conduct and document post-admission evaluations for Medicare patients admitted to an IRF. The post-admission evaluation covers much of the same information as continues to be included in the pre-admission screening of the patient and the patient's plan of care. This reduction in burden gives more time for physicians to take care of patients.
- *Flexibility for Inpatient Rehabilitation Facilities Regarding the "60 Percent Rule":* CMS is waiving requirements to allow IRFs to exclude patients from the IRF freestanding hospital's or unit's inpatient population for purposes of calculating the applicable thresholds associated with the requirements to receive payment as an IRF (commonly referred to as the "60 percent rule") if an IRF admits a patient solely to respond to the emergency and the patient's medical record properly identifies the patient as such. In addition, during the applicable waiver time period, we would also apply the exception to facilities not yet classified as IRFs, but that are attempting to obtain classification as an IRF.
- Freestanding IRFs are able to work with acute care hospitals under arrangements to provide surge capacity for the community.
- CMS is also clarifying that an IRF has flexibility when it is having difficulty in conducting the required intensive rehabilitation therapy program because normal staffing shifts may be disrupted as certain staff may have COVID-19 or be self-isolated.

- *Provider Enrollment*: CMS has established toll-free hotlines for all providers as well as the following flexibilities for provider enrollment:
 - o Waive certain screening requirements.
 - o Postpone all revalidation actions.
 - o Expedite any pending or new applications from providers.

Medicare appeals in Fee for Service, Medicare Advantage (MA) and Part D

- CMS is allowing Medicare Administrative Contractors (MACs) and Qualified Independent Contractor (QICs) in the FFS program 42 CFR 405.942 and 42 CFR 405.962 and MA and Part D plans, as well as the Part C and Part D Independent Review Entity (IREs), 42 CFR 562, 42 CFR 423.562, 42 CFR 422.582 and 42 CFR 423.582 to allow extensions to file an appeal;
- CMS is allowing MACs and QICs in the FFS program 42 CFR 405.950 and 42 CFR 405.966 and the Part C and Part D IREs to waive requirements for timeliness for requests for additional information to adjudicate appeals; MA plans may extend the timeframe to adjudicate organization determinations and reconsiderations for medical items and services (but not Part B drugs) by up to 14 calendar days if: the enrollee requests the extension; the extension is justified and in the enrollee's interest due to the need for additional medical evidence from a noncontract provider that may change an MA organization's decision to deny an item or service; or, the extension is justified due to extraordinary, exigent, or other non-routine circumstances and is in the enrollee's interest 42 CFR § 422.568(b)(1)(i), § 422.572(b)(1) and § 422.590(f)(1);
- CMS is allowing MACs and QICs in the FFS program 42 C.F.R 405.910 and MA and Part D plans, as well as the Part C and Part D IREs to process an appeal even with incomplete Appointment of Representation forms 42 CFR § 422.561, 42 CFR § 423.560. However, any communications will only be sent to the beneficiary;
- CMS is allowing MACs and QICs in the FFS program 42 CFR 405.950 and 42 CFR 405.966 and MA and Part D plans, as well as the Part C and Part D IREs to process requests for appeal that don't meet the required elements using information that is available 42 CFR § 422.562, 42 CFR § 423.562.
- CMS is allowing MACs and QICs in the FFS program 42 CFR 405.950 and 42 CFR 405.966 and MA and Part D plans, as well as the Part C and Part D IREs, 42 CFR 422.562, 42 CFR 423.562 to utilize all flexibilities available in the appeal process as if good cause requirements are satisfied.

Cost Reporting

- CMS is delaying the filing deadline of certain cost report due dates due to the COVID-19 outbreak. We are currently authorizing delay for the following fiscal year end (FYE) dates. CMS will delay the filing deadline of FYE 10/31/2019 cost reports due by March 31, 2020 and FYE 11/30/2019 cost reports due by April 30, 2020. The extended cost report due dates for these October and November FYEs will be June 30, 2020. CMS will also delay the filing deadline of the FYE 12/31/2019 cost reports due by May 31, 2020. The extended cost report due date for FYE 12/31/2019 will be July 31, 2020.

- *Accelerated/Advance Payments:* In order to increase cash flow to providers impacted by COVID-19, CMS has expanded our current Accelerated and Advance Payment Program. An accelerated/advance payment is a payment intended to provide necessary funds when there is a disruption in claims submission and/or claims processing. CMS is authorized to provide accelerated or advance payments during the period of the public health emergency to any Medicare provider/supplier who submits a request to the appropriate Medicare Administrative Contractor (MAC) and meets the required qualifications. Each MAC will work to review requests and issue payments within seven calendar days of receiving the request. Traditionally repayment of these advance/accelerated payments begins at 90 days, however for the purposes of the COVID-19 pandemic, CMS has extended the repayment of these accelerated/advance payments to begin 120 days after the date of issuance of the payment. Providers can get more information on this process here: www.cms.gov/files/document/Accelerated-and-Advanced-Payments-Fact-Sheet.pdf

Additional Information

- The Interim Final Rule can be found at: <https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers>.
- CMS has released guidance to providers related to relaxed reporting requirements for quality reporting programs at <https://www.cms.gov/newsroom/press-releases/cms-announces-relief-clinicians-providers-hospitals-and-facilities-participating-quality-reporting>