American Hospital Association

IRF PPS
FY 2021 Proposed Rule
Conference Call: May 27, 2020
FY 2021 Proposed Rule – PAYMENT

FY 2021
- Comments due by June 15
- Very brief rule
- No PPS structural changes

Proposed Payment Update
- 2.5% net payment increase
  - $270 million increase over FY 2020 payments
    o 2.9% market basket update
    o -0.4% for productivity
Proposed Wage Index Change

• OMB announced new wage area boundaries in Sept. 2018;
  • Further boundary updates issued in Mar 2020; if needed, adjustments would be proposed for FY 2022;
• Proposed FY 2021 changes
  • Budget neutral overall
  • 5% cap on any decrease (no cap in FY 2022)
  • 34 urban counties change to rural
  • 47 rural counties change to urban
Proposed Removal of Post-admission Physician Evaluation Requirement

• CMS Rationale:
  • IRFs are more knowledgeable, relative to when this requirement was initially implemented, in determining whether a patient meets IRF coverage criteria prior to admission.
  • In FY 2019, only on four occasions did the post-admission evaluation alter the determination that an IRF admission was warranted.
  • CMS: IRFs are conducting appropriate due diligence while completing the required pre-admission screening.

• MedPAC
  • Beneficiaries whose conditions do not require close physician oversight can be appropriately cared for in other, less-intensive settings at a lower cost to Medicare.
  • Relaxing conditions of coverage and payment that have been established, in part, to ensure that Medicare’s higher payments are warranted, calls into question whether such payments may be too high.
    • It also underscores the need to move away from payments based on setting and toward a unified PAC payment system

• NOTE: CMS’s March 31 interim final rule implemented a temporary waiver of this particular patient evaluation for the duration of the COVID-19 emergency period.
CMS’s Actions on New IRF Flexibilities

FY 2018 Proposed Rule:
• Request for information (RFI) from stakeholders re ways to reduce the burden for IRFs and physicians, improve quality of care, and decrease costs.

FY 2019 Proposed Rule:
• CMS solicited comments on potentially allowing non-physician practitioners to fulfill some of the requirements that rehabilitation physicians are currently required to complete.

FY 2019 IRF Final Rule:
• CMS allowed the post-admission evaluation to count as one of the three face-to-face visits required weekly by a rehabilitation physician.
• CMS allowed rehabilitation physicians to lead weekly interdisciplinary meetings remotely (by video or telephone conferencing) without additional documentation requirements.

FY 2020 Final Rule:
• CMS clarified that each IRF may define whether a physician qualifies as a rehabilitation physician.

FY 2021 Proposed Rule:
• CMS states that non-physician practitioners have the training and experience to perform certain IRF requirements and that utilizing non-physician practitioners would increase access to post-acute care services in areas with physician shortages.
• CMS proposes to remove the post-admission physician evaluation and to allow non-physician practitioners to perform services and documentation currently required by a rehabilitation physician.
Current Rehabilitation Physician Requirements

IRF patients must need physician supervision, including:

• at least 3 face-to-face visits per week throughout the patient's stay in the IRF to assess the patient both medically and functionally;

• a comprehensive preadmission screening within the 48 hours immediately preceding the IRF admission;

• a post-admission physician evaluation conducted within 24 hours of admission (which, as noted above, can be counted as one of the required physician face-to-face visits during the first week of care);3

• an individualized overall plan of care for the patient that is developed by a rehabilitation physician with input from the interdisciplinary team within 4 days of the patient's admission to the IRF; and

• an interdisciplinary team approach, including weekly team meetings led by a rehabilitation physician.
Policy Questions

• Given the trend of recent IRF flexibilities, how far is too far?
  • AHA members:
    • Don’t dilute the IRF role.
    • Don’t make changes that could be interpreted as equating IRFs and SNF.
    • COVID has highlighted the sizeable gap between SNFs/nursing clinical capacity and that of PAC hospitals.

• AHA comment letter: seeking input on physician evaluation and other issues of concern.
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MATERIALS:
www.aha.org/postacute