American Hospital Association

IRF PPS
FY 2021 Proposed Rule

Conference Call: May 27, 2020

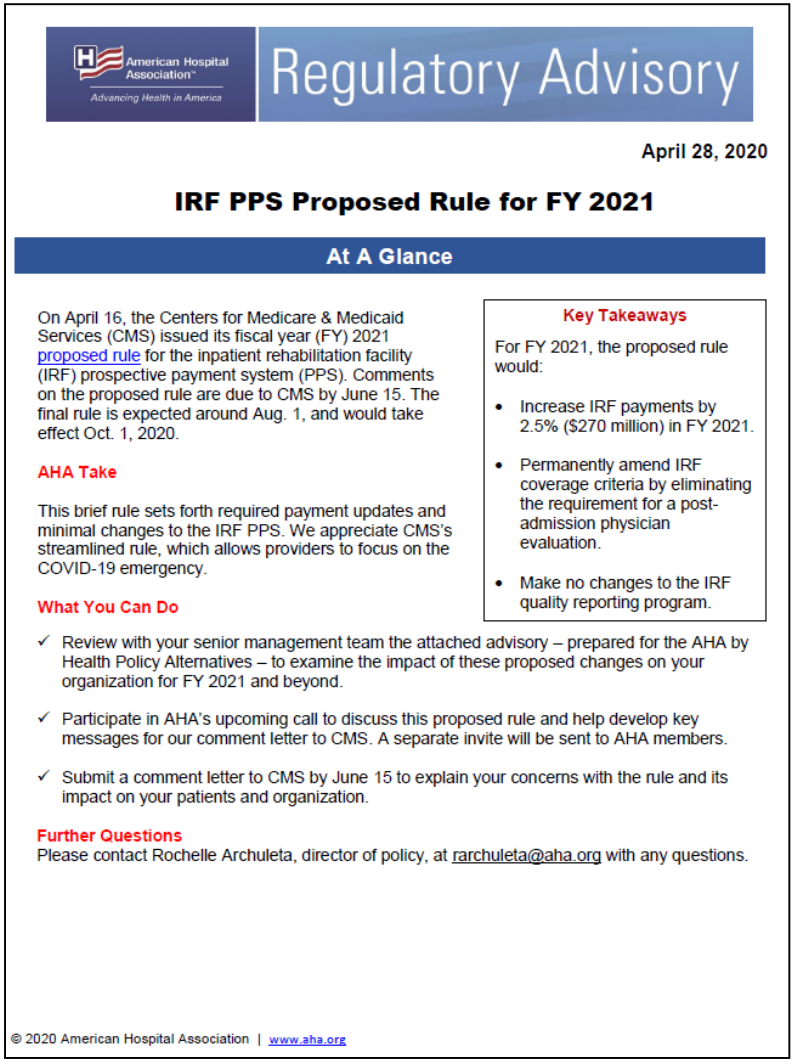
FY 2021 Proposed Rule – PAYMENT

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
    - 2.9% market basket update
    - -0.4% for productivity



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Regulatory Advisory

April 28, 2020

IRF PPS Proposed Rule for FY 2021

At A Glance

On April 16, the Centers for Medicare & Medicaid Services (CMS) issued its fiscal year (FY) 2021 proposed rule for the inpatient rehabilitation facility (IRF) prospective payment system (PPS). Comments on the proposed rule are due to CMS by June 15. The final rule is expected around Aug. 1, and would take effect Oct. 1, 2020.

AHA Take

This brief rule sets forth required payment updates and minimal changes to the IRF PPS. We appreciate CMS's streamlined rule, which allows providers to focus on the COVID-19 emergency.

What You Can Do

- ✓ Review with your senior management team the attached advisory – prepared for the AHA by Health Policy Alternatives – to examine the impact of these proposed changes on your organization for FY 2021 and beyond.
- ✓ Participate in AHA's upcoming call to discuss this proposed rule and help develop key messages for our comment letter to CMS. A separate invite will be sent to AHA members.
- ✓ Submit a comment letter to CMS by June 15 to explain your concerns with the rule and its impact on your patients and organization.

Key Takeaways

For FY 2021, the proposed rule would:

- Increase IRF payments by 2.5% ($270 million) in FY 2021.
- Permanently amend IRF coverage criteria by eliminating the requirement for a post-admission physician evaluation.
- Make no changes to the IRF quality reporting program.

Further Questions

Please contact Rochelle Archuleta, director of policy, at rarchuleta@aha.org with any questions.

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
- *<u>NOTE</u>: 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.*

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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.

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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