American Hospital Association

IRF PPS
FY 2021 Final Rule

Conference Call: Sept. 8, 2020

FY 2021 Final Rule – PAYMENT

FY 2021

- Very brief rule; allows the field and policymakers to focus on COVID-19 pandemic.
- No PPS structural changes
- No changes to the IRF QRP

Proposed Payment Update

- 2.4% market basket update; 0.0% productivity update
  - $260 million increase over FY 2020 payments
  - Market basket update lower than the 2.9% update in the proposed rule, primarily due to slower growth in compensation, as labor markets have been impacted by the recession that began in February 2020.
  - Productivity update reflects the economic uncertainty associated with the COVID-19 pandemic.

Wage Index Change

- **Finalized as proposed**
- OMB announced new wage area boundaries in Sept. 2018
- Final change for FY 2021
  - 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
- Further OMB boundary updates issued in Mar 2020; if needed, adjustments would be proposed for FY 2022

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Removal of Post-admission Physician Evaluation Requirement

- **Finalized as Proposed**
- 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.
  - 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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Reference: 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 Final Rule:

- FINALIZED AS PROPOSED. CMS proposed to remove the post-admission physician evaluation.
- SCALED BACK IN FINAL RULE. CMS proposed to allow non-physician practitioners to perform services and documentation currently required by a rehabilitation physician.

Reference: 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);
- 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.

Limited Expansion of Non-physician Practitioner Role

- **Proposed Rule** would have allowed NPPS to substitute for a rehabilitation physician.
  - Strong objections from AHA and other stakeholders.
- **Final Rule**
  - Notes that NPPs play an important role in treating IRF patients, a view the AHA wholeheartedly shares.
  - Allows NPPs to conduct one of the three required, weekly rehabilitation physician visits; if permitted under state law,
  - However, for the **first week of care**, a rehabilitation physicians will still be required to visit patients a minimum of three times to oversee their care and oversee the establishment of the plan of care.

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AHA POLICY:

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MATERIALS

www.aha.org/postacute