Highlights from the Centers for Medicare and Medicaid Services (CMS) Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) for Federal Fiscal Year 2021 Proposed Rule

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Overview

On April 17, 2020, the Centers for Medicare and Medicaid Services (CMS) released its Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) Proposed Rule for Federal Fiscal Year (FY) 2021, which would update the prospective payment rates for IRFs for federal FY 2021. This proposed rule also includes the classification and weighting factors for the IRF PPS' case-mix groups and a description of the methodologies and data used in computing the prospective payment rates for FY 2021. CMS is also proposing to adopt the most recent Office of Management and Budget (OMB) statistical area delineations and apply a 5 percent cap on any wage index decreases compared to FY 2020 in a budget neutral manner. CMS is also proposing to amend the IRF coverage requirements to remove the post-admission physician evaluation requirement and codify existing documentation instructions and guidance. Additionally, CMS is proposing to amend the IRF coverage requirements to allow non-physician practitioners to perform certain requirements that are currently required to be performed by a rehabilitation physician.

This document provides a summary of this rule. Page numbers refer to the display version of the proposal.

The proposed rule was published in the *Federal Register* on April 21, 2020. Comments will be accepted through June 15, 2020.

Advancing Health Information Exchange (p. 11)

CMS provides a brief overview of activities it has undertaken to further interoperability in post-acute care settings starting on p. 11, including developing systems that use nationally recognized health information technology (IT) standards, establishing a Post-Acute Care Interoperability Workgroup, updating the Data Element Library, and publishing a final rule related to discharge planning requirements that promotes the exchange of health information between health care settings.

Proposed Update to the Case-Mix Group (CMG) Relative Weights and Average Length of Stay Values for FY 2021 (p. 14)

CMS calculates a relative weight for each CMG that is proportional to the resources needed by an average inpatient rehabilitation case in that CMG. Relative weights account for the variance in cost per discharge due to the variance in resource utilization among the payment groups, and their use helps to ensure that IRF PPS payments support beneficiary access to care, as well as provider efficiency.

In this proposed rule, ***CMS proposes to update the CMG relative weights and average length of stay values for FY 2021. For FY 2021, CMS proposes to use the FY 2019 IRF claims and FY 2018 IRF cost report data, which are the most current and complete data available at this time. CMS is also proposing that if more recent data become available after the publication of this proposed rule and before the publication of the final rule, CMS would use such data to determine the FY 2021 CMG relative weights and average length of stay values in the final rule. CMS is proposing to apply these data using the same methodologies that CMS has used to update the CMG relative weights and average length of stay values each FY since CMS implemented an update to the methodology as discussed in the FY 2009 IRF PPS final rule.*** CMS details its methodology starting on p. 15.

Consistent with the methodology that CMS has used to update the IRF classification system in each instance in the past, ***CMS proposes to update the CMG relative weights for FY 2021 in such a way that total estimated aggregate payments to IRFs for FY 2021 are the same with or without the changes (that is, in a budget-neutral***

manner) by applying a budget neutrality factor to the standard payment amount, as discussed starting on p. 16.

CMS presents the CMGs, the comorbidity tiers, the corresponding relative weights, and the average length of stay values for each CMG and tier for FY 2021 in Table 2. The average length of stay for each CMG is used to determine when an IRF discharge meets the definition of a short-stay transfer, which results in a per diem case level adjustment.

Table 3 shows how CMS estimates that the application of the proposed revisions for FY 2021 would affect particular CMG relative weight values, which would affect the overall distribution of payments within CMGs and tiers. CMS notes that, because CMS proposes to implement the CMG relative weight revisions in a budget-neutral manner (as previously described), total estimated aggregate payments to IRFs for FY 2021 would not be affected as a result of the proposed CMG relative weight revisions. However, the proposed revisions would affect the distribution of payments within CMGs and tiers.

CMS invites public comment on its proposed updates to the CMG relative weights and average length of stay values for FY 2021.

Proposed FY 2021 IRF PPS Payment Update (p. 21)

The Social Security Act requires the Secretary to establish an increase factor that reflects changes over time in the prices of an appropriate mix of goods and services for which payment is made under the IRF PPS, reduced by a multifactor productivity adjustment. Beginning with FY 2016, CMS finalized the use of a 2012-based IRF market basket, using Medicare cost report data for both freestanding and hospital-based IRFs. Beginning with FY 2020, CMS finalized a rebased and revised IRF market basket to reflect a 2016 base year.

CMS discusses its proposed FY 2021 market basket update starting on p. 22. CMS notes that the proposed 2016-based IRF market basket increase factor for FY 2021 is 2.9 percent (p. 22) and that the proposed multifactor productivity adjustment is 0.4 percent (p. 23), leading to a FY 2021 IRF update of 2.5 percent (p. 23). CMS proposes that if more recent data become available after the publication of the proposed rule and before publication of the final rule, CMS would use such data to determine the FY 2021 market basket update and MFP adjustment in the final rule. CMS invites public comment on the proposed market basket update and productivity adjustment.

CMS discusses its proposals for an updated labor-related share for FY 2021 starting on p. 24.

CMS discusses its proposed wage adjustment for FY 2021 starting on p. 26. As part of its wage adjustment policies for FY 2021, ***CMS proposes implementation of new labor market area delineations based on OMB Bulletin No. 18-04, issued in September 2018, as discussed starting on p. 27, plus a transition policy that would apply a 5 percent cap on any decrease in an IRF's wage index from the IRF's wage index from the prior year, as discussed starting on p. 38. CMS' methodology for applying proposed wage-adjusted facility payment begins on p. 40.***

CMS discusses the proposed IRF standard payment conversion factor and payment rates for FY 2021 starting on p. 41. The FY 2021 standard payment conversion factor is shown in Table 9 and the unadjusted IRF

prospective payment rates for FY 2021 are shown in Table 10. CMS provides illustrative examples for adjusting the proposed payment rates starting on p. 45.

Proposed Update to Payments for High-Cost Outliers under the IRF PPS for FY 2021 (p. 47)

CMS discusses proposals to update payments for high-cost outliers under the IRF PPS starting on p. 47.

Proposed Removal of the Post-Admission Physician Evaluation Requirement from the IRF Coverage Requirements (p. 51)

CMS discusses its "Patients Over Paperwork" initiative and the Request for Information (RFI) included in the FY 2018 IRF PPS proposed rule soliciting comments on additional flexibilities and efficiencies. CMS notes that Patients Over Paperwork has continued to be a priority, and that CMS is targeting additional ways to reduce paperwork burden, specifically with respect to reducing medical record documentation requirements that it believes are no longer necessary.

CMS notes that IRF care is only considered to be reasonable and necessary if the patient meets all of the IRF coverage requirements outlined in § 412.622(a)(3), (4), and (5). Among the coverage requirements is a requirement that the patient's medical record at the IRF must contain a post-admission physician evaluation that meets several specified requirements, including completion by a rehabilitation physician within 24 hours of admission; documentation of the patient's status on admission and use as the basis for the development of the overall individualized plan of care; and retention in the patient's medical record at the IRF.

CMS discusses policies that have been in place to ensure appropriate IRF admissions starting on p. 52, including a "trial" IRF admission policy that has since been rescinded, and a policy at chapter 1, section 110.1.2 of the Medicare Benefit Policy Manual regarding actions that must be taken if the patient's condition at time of admission does not match the condition on the preadmission screening.

CMS notes that, at this time, CMS believes that "IRFs are more knowledgeable in determining prior to admission, whether a patient meets the coverage criteria for IRF services than they were when the IRF coverage requirements were initially implemented" and that "if IRFs are doing their due diligence while completing the pre-admission screening .. by making sure each prospective IRF patient meets all of the requirements to be admitted to the IRF, then the post-admission physician evaluation is unnecessary." CMS also discusses how it has removed the post-admission physician evaluation requirement during the public health emergency for COVID-19 starting on p. 54. CMS notes its belief that this temporary policy will provide experience to determine whether the requirement can be removed permanently.

Therefore, ***CMS is proposing to remove the post-admission physician evaluation documentation requirement at § 412.622(a)(4)(ii) beginning with FY 2021 on a permanent basis, that is, for all IRF discharges beginning on or after October 1, 2020. Accordingly, CMS is also proposing to amend § 412.622(a)(3)(iv) to remove the reference to § 412.622(a)(4)(ii). CMS also proposes to rescind the above-mentioned policy described in chapter 1, section 110.1.2, of the Medicare Benefit Policy Manual. (p. 54)***

CMS notes that this proposal would not preclude a patient from being evaluated by a rehabilitation physician or (under proposals later in the rule) non-physician practitioners within the first 24 hours of admission if the IRF believes such an evaluation is warranted. The post-admission physician evaluation would simply no longer be an IRF documentation requirement. Additionally, the proposal would not remove one of the required rehabilitation physician visits in the first week of the patient's stay in the IRF.

CMS invites public comment on its proposals identified above.

In the Regulatory Impact Analysis (p. 79), CMS notes that it does not estimate that there will be a cost savings associated with this proposal, since CMS is not proposing to remove any of the required rehabilitation physician face-to-face visits (at least 3 days per week).

CMS notes that it considered not removing the post-admission physician evaluation requirement (p. 88). However, CMS states its belief that IRFs are more than capable of determining whether a patient meets the coverage criteria for IRF services prior to admission. Additionally, CMS believes that if IRFs are doing their due diligence while completing the pre-admission screening, then the post-admission physician evaluation is unnecessary.

Proposed Revisions to Certain IRF Coverage Documentation Requirements (p. 55)

Codification of Existing Preadmission Screening Documentation Instructions and Guidance (p. 55)

CMS notes that it conducted a detailed review of the Medicare Benefit Policy Manual, chapter 1, section 110.1.2, as well as the IRF PPS website to identify policies that would be appropriate to codify through notice and comment rulemaking.

CMS notes that regulations at § 412.622(a)(4)(i)(B) do not specify individual elements required for the pre-admission screening documentation, and that regulations at § 412.622(a)(4)(i)(D) do not specify that the rehabilitation physician must review and concur with the preadmission screening prior to the IRF admission, while such information is provided in the Medicare Benefit Policy Manual, chapter 1, section 110.1.1, as detailed on p. 57 of the rule. CMS notes that the Medicare Benefit Policy Manual guidance has provided CMS' documentation instructions and guidance since the implementation of the IRF coverage requirements on January 1, 2020.

CMS provides a rationale for making proposals to codify requirements (as detailed below), starting on p. 57. ***Specifically, CMS is proposing to make the following regulatory amendments (p. 58):***

- ***At § 412.622(a)(4)(i)(B), to provide that the comprehensive preadmission screening must include a detailed and comprehensive review of each patient's condition and medical history, including the patient's level of function prior to the event or condition that led to the patient's need for intensive rehabilitation therapy, expected level of improvement, and the expected length of time necessary to achieve that level of improvement; an evaluation of the patient's risk for clinical complications; the conditions that caused the need for rehabilitation; the treatments needed (that is, physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics); expected frequency and duration of treatment in the IRF; anticipated discharge destination; and anticipated post-discharge treatments; and***

- ***At § 412.622(a)(4)(i)(D), to provide that the comprehensive preadmission screening must be used to inform a rehabilitation physician who must then review and document his or her concurrence with the findings and results of the preadmission screening prior to the IRF admission.***

CMS refers readers to its proposal to amend the IRF coverage requirements to allow non-physician practitioners to perform certain requirements that are currently required to be performed by a rehabilitation physician.

CMS invites public comment on its proposals. CMS considered not making these changes but believes that it should make the technical changes for the ease of administrative burden and increased ability to locate these requirements (p. 89).

Definition of a "Week" (p. 58)

Section 412.622(a)(3)(ii) states that in certain well-documented cases, the intensive rehabilitation therapy program might instead consist of at least 15 hours of intensive rehabilitation therapy within a 7 consecutive day period, beginning with the date of admission to the IRF. This language is also used many times throughout the IRF Services section of the Medicare Benefit Policy Manual.

However, CMS understands there is some question as to whether the term "week" may be construed as a different period (for example, Monday through Sunday). To provide clarity and reduce administrative burden for stakeholders regarding several of the IRF coverage requirements, ***CMS is proposing to amend § 412.622(c) to clarify its definition of a "week" as a period of "7 consecutive calendar days beginning with the date of admission to the IRF." CMS is also proposing to make conforming amendments to § 412.622(a)(3)(ii) by replacing "7 consecutive day period, beginning with the date of admission to the IRF" with "week". (p. 59)***

CMS invites public comment on these proposals.

Solicitation of Comments Regarding Further Changes to the Preadmission Screening Documentation Requirements (p. 59)

CMS has been reviewing the pre-admission screening documentation requirements under § 412.622(a)(4)(i) and is considering whether CMS could remove some of the requirements, but still maintain an IRF patient's clinical history, as well as documentation of their medical and functional needs in sufficient detail to adequately describe and support the patient's need for IRF services.

CMS is seeking feedback from stakeholders about potentially removing some of the preadmission screening documentation requirements. Specifically, CMS seeks feedback regarding the following:

- ***What aspects of the preadmission screening do stakeholders believe are most or least critical and useful for supporting the appropriateness of an IRF admission, and why? (p. 60)***

Proposal to Allow Non-physician Practitioners to Perform Certain IRF Coverage Requirements that are Currently Required to Be Performed by a Rehabilitation Physician (p. 60)

CMS notes that several of the IRF coverage requirements at § 412.622(a)(3), (4), and (5) expressly state

that a requirement must be completed by a rehabilitation physician, defined at § 412.622(c) as a licensed physician who is determined by the IRF to have specialized training and experience in inpatient rehabilitation. However, in response to the RFI in the FY 2018 proposed rule, CMS received comments suggesting that it consider amending the requirements in § 412.622(a)(3)(iv) and (a)(4)(ii) to allow non-physician practitioners to fulfill some of the requirements that rehabilitation physicians are currently required to complete.

CMS also discusses its comment solicitation in the FY 2019 proposed rule on potentially allowing non-physician practitioners to fulfill some of the requirements on § 412.622(a)(3), (4), and (5) that rehabilitation physicians are currently required to complete, starting on p. 61, and notes that feedback in response to this solicitation was conflicting, as further detailed on p. 62 and p. 63.

After reviewing feedback, as instructed under section 5(c) of the October 3, 2019, Executive Order 13890 on Protecting and Improving Medicare for Our Nation's Seniors, ***CMS is proposing to allow the use of non-physician practitioners to perform the IRF services and documentation requirements currently required to be performed by the rehabilitation physician in § 412.622(a)(3), (4), and (5) (p. 63)***. See Appendix A to this summary for detailed information on the regulations currently found at § 412.622(a)(3), (4), and (5).

CMS states its agreement or belief that:

- Nonphysician practitioners have the training and experience to perform the IRF requirements
- Allowing IRFs to utilize non-physician practitioners practicing to their full scope of practice under applicable state law will increase access to post-acute care services specifically in rural areas, where rehabilitation physicians are often in short supply
- Alleviating access barriers to post-acute care services will improve the quality of care and lead to better patient outcomes in rural areas
- Non-physician practitioners have the appropriate education and are capable of providing hospital level quality of care to complex IRF patients
- It continues to be the IRF's responsibility to exercise their best judgment regarding who has appropriate specialized training and experience, provided that these duties are within the practitioner's scope of practice under applicable state law.

CMS is proposing to add new § 412.622(d) providing that for purposes of § 412.622, a non-physician practitioner who is determined by the IRF to have specialized training and experience in inpatient rehabilitation may perform any of the duties that are required to be performed by a rehabilitation physician, provided that the duties are within the nonphysician practitioner's scope of practice under applicable state law. (p. 64)

If an IRF believes in any given situation a rehabilitation physician should have sole responsibility, or shared responsibility with non-physician practitioners, for overseeing a patient's care, the IRF should make that decision. Furthermore, IRFs are required to meet the hospital Conditions of Participation, which generally require every Medicare patient to be under the care of a physician.

CMS invites public comment on this proposal (p. 65). Specifically, CMS invites comment on its analysis of this issue, and whether they have any other evidence to inform this analysis. CMS encourages commenters to share whether they believe that quality of care in IRFs will be impacted by this proposal, including any specific evidence that may help to inform this issue. CMS also requests information from IRFs regarding whether or not their facilities would allow non-physician practitioners to complete all of the requirements at §

412.622(a)(3), (4), and (5), some of these requirements at § 412.622(a)(3), (4), and (5), or none of the requirements at § 412.622(a)(3), (4), and (5), which CMS states will help to refine its estimates of changes in Medicare payment under this proposal.

CMS discusses its savings estimates starting on p. 80. CMS starts by estimating savings if each activity currently conducted by a rehabilitation physician (i.e. pre-admission screening documentation review and compliance; development of plan of care; and leading the interdisciplinary team meeting) is instead completed by a non-physician practitioner (based on hourly salary, including fringe and overhead costs). CMS estimates $63 million in savings, of which 80 percent, or approximately $51 million, would be savings to the Medicare Trust Funds and the remainder would be savings to beneficiaries. However, CMS notes that it does not expect IRFs will adopt this change for all of the services they provide; rather, CMS expects that IRFs will adopt this change for about 50 percent of the services provided, leading to overall savings to the Medicare Trust Fund of $25.5 million.

CMS also estimates savings based on changes in spending under the Medicare Physician Fee Schedule related to the post-admission physician evaluation and the face-to-face physician visits. Under this approach, CMS estimates that if 100 percent of IRFs allowed non-physician practitioners to complete the requirements, the overall savings to would be $31 million. However, CMS is estimating that IRFs will adopt this proposed change for about 50 percent of the services provided, leading to $15.5 million in savings, of which $12.4 million would accrue to the Medicare program and $3.1 million would be savings to beneficiaries.

To obtain more information to estimate impacts, CMS is soliciting feedback from commenters (p. 86) to determine:

- ***How many IRFs would substitute non-physician practitioners for physicians; and***
- ***Among the IRFs that do substitute non-physician practitioners for physicians, whether it will be for all requirements or only for specific requirements.***

In the absence of this information, the above estimates would apply.

CMS notes that it considered not allowing non-physician practitioners to complete the IRF coverage requirements currently conducted by rehabilitation physicians, but notes its rationale for doing so starting on p. 89, including experience and qualifications of non-physician practitioners and projected positive impacts on the following: the number of available health care providers to work in the PAC setting; physician shortages, especially in rural areas; and rehabilitation physician burn-out.

Method for Applying the Reduction to the FY 2021 IRF Increase Factor for IRFs That Fail to Meet the Quality Reporting Requirements (p. 65)

Table 12 shows the calculation of the proposed adjusted FY 2021 standard payment conversion factor that would be used to compute IRF PPS payment rates for any IRF that failed to meet the quality reporting requirements for the applicable reporting period.

Appendix A – Current IRF Coverage Requirements at § 412.622(a)

§412.622 Basis of payment.

(a) *Method of payment.*

(1) Under the prospective payment system, inpatient rehabilitation facilities receive a predetermined amount per discharge for inpatient services furnished to Medicare Part A fee-for-service beneficiaries.

(2) The amount of payment under the prospective payment system is based on the Federal payment rate, including adjustments described in §412.624 and, if applicable, during a transition period, on a blend of the Federal payment rate and the facility-specific payment rate described in §412.626.

(3) *IRF coverage criteria.* In order for an IRF claim to be considered reasonable and necessary under section 1862(a)(1) of the Act, there must be a reasonable expectation that the patient meets all of the following requirements at the time of the patient's admission to the IRF—

(i) Requires the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy), one of which must be physical or occupational therapy.

(ii) Generally requires and can reasonably be expected to actively participate in, and benefit from, an intensive rehabilitation therapy program. Under current industry standards, this intensive rehabilitation therapy program generally consists of at least 3 hours of therapy (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy) per day at least 5 days per week. In certain well-documented cases, this intensive rehabilitation therapy program might instead consist of at least 15 hours of intensive rehabilitation therapy within a 7 consecutive day period, beginning with the date of admission to the IRF. Benefit from this intensive rehabilitation therapy program is demonstrated by measurable improvement that will be of practical value to the patient in improving the patient's functional capacity or adaptation to impairments. The required therapy treatments must begin within 36 hours from midnight of the day of admission to the IRF.

(iii) Is sufficiently stable at the time of admission to the IRF to be able to actively participate in the intensive rehabilitation therapy program that is described in paragraph (a)(3)(ii) of this section.]

(iv) Requires physician supervision by a rehabilitation physician. The requirement for medical supervision means that the rehabilitation physician must conduct face-to-face visits with the patient at least 3 days per week throughout the patient's stay in the IRF to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process, except that during a Public Health Emergency, as defined in §400.200 of this chapter, such visits may be conducted using telehealth services (as defined in section 1834(m)(4)(F) of the Act). The post-admission physician evaluation described in paragraph (a)(4)(ii) of this section may count as one of the face-to-face visits.

(4) *Documentation.* To document that each patient for whom the IRF seeks payment is reasonably expected to meet all of the requirements in paragraph (a)(3) of this section at the time of admission, the patient's medical record at the IRF must contain the following documentation—

(i) A comprehensive preadmission screening that meets all of the following requirements—

(A) It is conducted by a licensed or certified clinician(s) designated by a rehabilitation physician within the 48 hours immediately preceding the IRF admission. A preadmission screening that includes all of the required elements, but that is conducted more than 48 hours immediately preceding the IRF admission, will be accepted as long as an update is conducted in person or by telephone to update the patient's medical and functional status within the 48 hours immediately preceding the IRF admission and is documented in the patient's medical record.
(B) It includes a detailed and comprehensive review of each patient's condition and medical history.
(C) It serves as the basis for the initial determination of whether or not the patient meets the requirements for an IRF admission to be considered reasonable and necessary in paragraph (a)(3) of this section.
(D) It is used to inform a rehabilitation physician who reviews and documents his or her concurrence with the findings and results of the preadmission screening.
(E) It is retained in the patient's medical record at the IRF.

(ii) A post-admission physician evaluation that meets all of the following requirements, except for the duration of the Public Health Emergency, as defined in §400.200 of this chapter—
(A) It is completed by a rehabilitation physician within 24 hours of the patient's admission to the IRF.
(B) It documents the patient's status on admission to the IRF, includes a comparison with the information noted in the preadmission screening documentation, and serves as the basis for the development of the overall individualized plan of care.
(C) It is retained in the patient's medical record at the IRF.

(iii) An individualized overall plan of care for the patient that meets all of the following requirements—
(A) It is developed by a rehabilitation physician with input from the interdisciplinary team within 4 days of the patient's admission to the IRF.
(B) It is retained in the patient's medical record at the IRF.

(5) *Interdisciplinary team approach to care.* In order for an IRF claim to be considered reasonable and necessary under section 1862(a)(1) of the Act, the patient must require an interdisciplinary team approach to care, as evidenced by documentation in the patient's medical record of weekly interdisciplinary team meetings that meet all of the following requirements—

(i) The team meetings are led by a rehabilitation physician and further consist of a registered nurse with specialized training or experience in rehabilitation; a social worker or case manager (or both); and a licensed or certified therapist from each therapy discipline involved in treating the patient. All team members must have current knowledge of the patient's medical and functional status. The rehabilitation physician may lead the interdisciplinary team meeting remotely via a mode of communication such as video or telephone conferencing.
(ii) The team meetings occur at least once per week throughout the duration of the patient's stay to implement appropriate treatment services; review the patient's progress toward stated rehabilitation goals; identify any problems that could impede progress towards those goals; and, where necessary, reassess previously established goals in light of impediments, revise the treatment plan in light of new goals, and monitor continued progress toward those goals.
(iii) The results and findings of the team meetings, and the concurrence by the rehabilitation physician with those results and findings, are retained in the patient's medical record.

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