MEMORANDUM

To: **Association of Rehabilitation Nurses**

From: **Jeremy Scott, Peter Thomas, and Joe Nahra**

Date: **April 23, 2020**

Re: **Proposed Rule on Inpatient Rehabilitation Facility Prospective Payment System for Fiscal Year 2021**

On April 16, 2020, the Centers for Medicare & Medicaid Services (CMS) issued the proposed rule updating the prospective payment rates for inpatient rehabilitation hospitals and units (IRFs) for federal fiscal year (FY) 2021, along with an accompanying fact sheet. Due to the ongoing COVID-19 public health emergency, CMS states that it has limited annual IRF rulemaking required by statute to essential policies including Medicare payment to IRFs, as well as proposals that CMS expects will reduce provider burden and may help providers in the COVID-19 response. CMS is not proposing any changes to the IRF Quality Reporting Program (QRP) for FY 2021. **Comments on the proposed rule are due June 15, 2020.**

I. Overview of IRF Proposed Rule

CMS proposes to increase payments to IRFs by 2.9% in FY 2021, reflecting an additional estimated $270 million in aggregate payments for the coming fiscal year. The rule also provides updates to a variety of payment adjustments included in the IRF PPS, detailed below. However, in addition to the statutorily required payment updates, the rule includes several significant proposals to revise the IRF coverage requirements. Most notably, CMS proposes a significant amendment to IRF regulations to allow non-physician practitioners to perform a wide range of duties within the IRF that are currently required to be performed by a rehabilitation physician. Because this change is the most notable of this year's proposal IRF rule, it is described immediately below.

This proposal could have a dramatic impact on a rehabilitation physician's role in an IRF, though this flexibility would be optional for IRFs, and only permissible if state law allows non-physician practitioners to provide such services within the scope of their practice. Additionally, CMS proposes to permanently extend the removal of the IRF requirement to conduct a post-admission physician evaluation (PAPE)—which has been waived under the COVID-19 public health emergency—and codify in regulation existing documentation instructions that are currently defined in sub-regulatory guidance only.

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II. Proposed Expansion of the Role of Non-Physician Practitioners in IRFs

The FY 2021 proposed rule includes a significant proposal to expand the scope of the IRF coverage requirements to allow non-physician practitioners to perform many duties which are currently required to be performed by a rehabilitation physician. CMS believes that this proposal will increase access to post-acute care (PAC) services, especially in rural and underserved areas where rehabilitation physicians may be in short supply. However, this proposal may also have a significant impact on the role of a rehabilitation physician in an IRF, and we expect that there may be serious controversy among stakeholders in the provider community regarding this proposal.

Background for the Proposal
In the FY 2018 IRF payment proposed rule (three years ago), CMS included a Request for Information (RFI) broadly seeking stakeholder feedback on flexibilities and efficiencies CMS could provide to reduce provider burden. In response, CMS states that they received suggestions to expand the ability of non-physician practitioners (NPPs) to fulfill some duties in an IRF that are currently required to be completed by rehabilitation physicians. In the following year's (FY 2019) proposed rule, CMS included a targeted solicitation of comments regarding changes to the use of NPPs in meeting IRF coverage requirements. Specifically, CMS requested feedback on four questions:

- Do non-physician practitioners have the specialized training in rehabilitation that they need to have to assess IRF patients both medically and functionally?
- How would the non-physician practitioner's credentials be documented and monitored to ensure that IRF patients are receiving high quality care?
- Are non-physician practitioners required to do rotations in inpatient rehabilitation facilities as part of their training, or could this be added to their training programs in the future?
- Do stakeholders believe that utilizing non-physician practitioners to fulfill some of the requirements that are currently required to be completed by a rehabilitation physician would have an impact on the quality of care for IRF patients?

CMS did not detail any of the responses to this RFI in the FY 2019 final rule, and did not elaborate on their considerations of this proposal. In this year's proposed rule, CMS notes that the agency received "conflicting" feedback from stakeholders regarding the solicitation in the FY 2019 proposed rule, stating that opposing commenters raised two major concerns: 1) that IRF patients would not continue receiving the hospital level and quality of care necessary for the treatment of complex conditions in an IRF if treated only by an NPP; and 2) that NPPs have no specialized training in inpatient rehabilitation that would allow them to adequately assess the necessary education and qualification to provide the same level of care that IRF patients receive under the current requirements.

However, CMS also states that some commenters agreed with their proposal, who stated that NPPs do, in fact, have the necessary education and qualification to provide adequate care for patients' medical and functional needs. Additionally, some supporters of the proposal noted that allowing NPPs to practice to the full extent of their education, training, and scope of practice would increase

the number of available health care providers for PAC settings in underserved areas and would decrease physician burnout.

CMS Proposal for FY 2021

In response to these comments, CMS is currently proposing to allow NPPs to perform the IRF services and documentation requirements currently required to be performed by the rehabilitation physician at §412.622(a)(3), (4), and (5). This is at least partially in response to President Trump's October 2019 Executive Order[1], which directed the Department of Health and Human Services (HHS) to propose regulations that allow health care professionals to practice at the top of their profession.

Specifically, CMS proposes an addition to the IRF regulations that states an NPP (which is not explicitly defined in the proposed rule) 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 those duties are within the NPP's scope of practice under state law.

This proposal directly cites several requirements currently outlined in the IRF regulations. Under the CMS proposal, NPPs would be able to conduct or designate another certified clinician to conduct the preadmission screening, review and concur with the findings of the preadmission screening, conduct the post-admission physician evaluation (which, as detailed below, CMS is also proposing to eliminate), lead the required weekly interdisciplinary team meetings, conduct required face-to-face visits with the patient, and develop and modify the patient's plan of care. In sum, CMS is deferring to the IRF to determine whether an NPP has sufficient specialized training and experience in inpatient rehabilitation to essentially fulfill the role of the rehabilitation physician in material respects. However, CMS does note that under the Medicare Conditions of Participation, every Medicare patient is generally required to be under the care of a physician and the proposed rule does not seek to eliminate the requirement for an IRF to have a medical director.

CMS estimates the cost savings for this provision by replacing the estimated hourly salary and time spent by a rehabilitation physician in conducting each of these duties with the comparatively lower salary of the average non-physician practitioner. CMS assumes that IRFs would be able and would choose to take maximum use of this regulatory provision and estimates annual savings across all IRFs of $63 million.

CMS specifically requests feedback from commenters that would help CMS determine how many states would allow for this flexibility if the proposal is finalized in order to analyze the impact of this provision for the final rule. Additionally, CMS requests feedback on how many IRFs would substitute NPPs for physicians and for what requirements they would be expected to do so.

[1] Exec. Order No. 13890, *Protecting and Improving Medicare for Our Nation's Seniors.* 84 Fed. Reg. 195 (October 8, 2019)

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III. Proposed Revisions to IRF Coverage and Documentation Requirements

As part of their "Patients Over Paperwork" initiative, CMS is proposing additional revisions to the IRF coverage and documentation requirements to reduce hospital and clinician burden. These revisions should reduce the amount of time practitioners in IRFs must spend on duplicative documentation requirements.

Post-Admission Physician Evaluation
The most notable of these proposals is to eliminate the post-admission physician evaluation (PAPE), which is required as a condition to meet the "reasonable and necessary" coverage criteria for IRF care. Currently, the PAPE must be completed by the rehabilitation physician within 24 hours of the patient's admission to the IRF and must include information on the patient's status upon admission as well as a comparison with the information noted in the preadmission screening documentation. However, CMS notes that the information contained in the PAPE is duplicative of the data recorded in the pre-admission screening and may be unnecessary if the pre-admission screening is performed as required.

CMS has already waived the requirement for a PAPE during the COVID-19 public health emergency. Therefore, for all IRF discharges beginning on or after October 1, 2020, CMS is proposing to permanently rescind the requirement to complete a PAPE. CMS also notes that if finalized, this proposal would not preclude the completion of a PAPE if the treating physician determines it is necessary. The proposed rule also would not remove one of the required rehabilitation physician visits in the first week of the patient's stay in the IRF, which is a requirement under current regulation.

Codification of Preadmission Screening Guidance
Current IRF regulations require a comprehensive preadmission screening to be conducted within 48 hours immediately preceding the IRF admission, which must include a detailed review of the patient's condition and medical history. The regulations do not specify elements for the preadmission screening, but the Medicare Benefit Policy Manual (MBPM) does.[2] CMS now proposes to codify these elements in the IRF regulations at § 412.622(a)(4)(i)(B). These proposed requirements reflect longstanding guidance and documentation instructions and are not expected to change the practice of practitioners in IRFs. [Note: CMS is likely proposing to codify into regulation this guidance that appears in the MPBM because the MBPM was not promulgated through notice and comment rulemaking, which the U.S. Supreme Court held was required in order to be enforceable in the *Azar v. Allina* case.]

[2] Medicare Benefit Policy Manual, Ch.1, § 110.1.1, states, "The preadmission screening documentation must indicate the patient's prior 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. It must also include 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, any anticipated post-discharge treatments, and other information relevant to the care needs of the patient."

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Definition of a "Week"
CMS currently uses an intensity of therapy requirement, in part, to determine eligibility for IRF admission. This is defined as at least three hours per day, five days per week, of intensive rehabilitation therapy, or at least 15 hours within a consecutive 7-day period. CMS notes some potential confusion about the definition of a "week" in the current requirement, and therefore proposes to amend the regulatory text to replace instances of the term "week" with the term "7 consecutive day period."

Request for Comment on Preadmission Screening Requirements
CMS includes a specific request for comment from stakeholders about potentially removing some of the preadmission screening documentation requirements. Specifically, CMS requests that stakeholders provide feedback on "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?" [Note: This is actually a fundamental question of IRF care that goes to the heart of the rationale for an IRF admission. Stakeholders should pay significant attention to this question in responding to the proposed rule.]

IV. Update of the IRF Federal Prospective Payment Rates (FY 2021 IRF PPS)

This section of the proposed rule is highly technical and most relevant for IRF administrators.

- Market Basket Rebasing and Resulting Payment Updates for FY 2021. As required by statute, CMS proposes to update the market basket reflecting the goods and services purchased by IRFs to remain in operation for the FY 2021 year. The revised formula results in a market basket update of 2.5%. With applicable adjustments, the total payment update for IRFs in FY 2021 is proposed to be 2.9%. CMS rejected the recommendation made by the Medicare Payment Advisory Commission (MedPAC) for a 5.0 percent decrease (rebasing) for FY 2021 but this, in part, is due to the statutory formula for annual updates to the IRF payment rates.

- Updates to the Case-Mix Group Relative Weights and Average Length of Stay Values. CMS proposes to update the relative weights for the case-mix groups (CMGs) for FY 2021 using FY 2019 IRF claims data and FY 2018 IRF cost report data (as most of the FY 2019 cost report data are as yet unavailable). As in past years, CMS' methodology for updating the relative weights will ensure budget neutrality for the total estimated aggregate payments to IRFs in FY 2021. The proposed relative weights and average length of stay values for FY 2021 can be found here. CMS' analysis shows that the vast majority (99.3%) of IRF cases are in CMGs and tiers that would experience less than a 5 percent change in the CMG relative weight with the proposed revisions.

- Calculation of the labor-related share. CMS proposes to include the sum of the FY 2021 relative importance of Wages and Salaries, Employee Benefits, Professional Fees: Labor-Related, Administrative and Facilities Support Services, Installation, Maintenance, and Repair Services, All Other: Labor-Related Services, and a portion of the Capital-Related

cost weight from the 2016-based IRF market basket. This results in a proposed total labor-related share for FY 2021 of 72.9%.

- Wage index change. CMS proposes to maintain the policies related to the labor market area definitions and wage index methodology from the 2020 IRF PPS final rule. Beginning with the FY 2021 IRF PPS wage index, CMS proposes to adopt new delineations for Core-Based Statistical Areas (CBSAs) set forth in Office of Management and Budget (OMB) Bulletin No. 18-03, which would create some new CBSAs, split apart some existing CBSAs, and switch certain county designations from urban to rural and vice versa. CMS acknowledges that this proposed adoption may significantly impact wage index values for certain geographic areas, and thus proposes to phase in the changes over a two-year period by capping any decrease on an IRF's wage index for 2021 at a maximum of 5 percent. For a full list of areas that would change their designation or CBSA code under the new proposal, please see Table 5, Table 6, Table 7, and Table 8 in the proposed rule. CMS expects that approximately 5 percent of IRFs would experience a decrease in their area wage index values as a result of this proposal, but there would clearly be winners and losers under this proposal.

- Proposed FY 2021 standard payment conversion factor. The base payment rate for use in calculating reimbursement for IRFs is proposed as $16,847 for FY 2021.

- Updated outlier payments. CMS proposes to decrease the outlier threshold amount from $9,300 in FY 2020 to $8,102 for FY 2021 to maintain estimated outlier payments at approximately 3% of total aggregate IRF payments for FY 2021.

- Update to the cost-to-charge (CCR) ratio ceiling and urban/rural average CCRs. Using the most recent available cost report data (from FY 2018), CMS proposes to update the national average CCR to 0.490 for rural IRFs and 0.400 for urban IRFs. Accordingly, CMS proposes to set the national CCR ceiling at 1.33 for FY 2021.

V. Conclusion

Comments on the proposed rule are due to CMS by June 15, 2020 and can be submitted directly to www.regulations.gov at this link, or by searching for file code CMS-1729-P. We expect that many in the rehabilitation community will seek to comment on the proposal to expand the role of non-physician practitioners in the IRF and that there is likely to be some controversy between stakeholders. The other key proposals involve the elimination of the PAPE and questions involving the key elements of the pre-admission screening for purposes of IRF admission. The proposed changes provide stakeholders with a meaningful opportunity to underscore the importance of inpatient rehabilitation for appropriate patients.

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