Medicare Inpatient Rehabilitation Facility Prospective Payment System for FY 2021 [CMS-1729-P]

Summary of Proposed Rule

On April 21, 2021, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* (85 FR 22065) a proposed rule on the Medicare inpatient rehabilitation facility prospective payment system (IRF PPS) for federal fiscal year (FY) 2021. In the Fact Sheet accompanying this proposed rule CMS notes that because of the limited capacity of health care providers to review and comment on extensive proposals during the COVID-19 public health emergency, it has limited the provisions of the proposed rule to essential policies including Medicare payment to IRFs, as well as proposals that reduce provider burden.

In addition to provisions that would update the IRF PPS payment rates and outlier threshold for FY 2021, the proposed rule would adopt revised wage index areas with a transition year for IRFs that would experience a lower wage index; permanently remove the post-admission evaluation requirement; make revisions to certain IRF coverage requirements; and allow non-physician practitioners to perform certain coverage requirements in place of a rehabilitation physician. No changes are proposed to the IRF Quality Reporting Program (IRF QRP) or to the IRF PPS facility-level adjustment factors (i.e., for rural, low income percentage and teaching status).

The deadline for comments on the proposed rule is June 15, 2020.

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I. Introduction and Background

The proposed rule provides an overview of the IRF PPS, including statutory provisions, a description of the IRF PPS for FYs 2002 through 2020, and an operational overview. In addition, CMS highlights efforts at promoting adoption of interoperable health information technology and health information exchange in post-acute settings. It cites the hospital discharge planning final rule (84 FR 51836) provisions promoting the exchange of patient information between health care settings.

II. Update to the CMG Relative Weights and Average Length of Stay Values

Under the IRF case-mix classification system, a patient's principal diagnosis or impairment is used to classify the patient into a Rehabilitation Impairment Category (RIC). The patient is then placed into a case mix group (CMG) within the RIC based on the patient's functional status (motor and cognitive scores) and sometimes age. Other special circumstances (e.g., very short stay or patient death) are also considered in determining the appropriate CMG. CMGs are further divided into tiers based on the presence of certain comorbidities; the tiers reflect the differential cost of care compared with the average beneficiary in the CMG.

Updates to the CMG relative weights and average length of stay values are proposed for FY 2021, continuing the same methodologies used in past years, and now applied to FY 2019 IRF claims and FY 2018 IRF cost report data. (More recent data from these sources will be used for the final rule, if available.) Changes to the CMG weights are made in a budget neutral manner; the proposed budget neutrality factor is 0.9969.

Table 2 in the proposed rule displays the proposed relative weights and length of stay values by CMG and comorbidity tier. Table 3 shows displays distributional effect of changes in CMS weights across cases. It shows that 99.3 percent of IRF cases are in CMGs for which the proposed FY 2021 weight differs from the FY 2020 weight by less than 5 percent (either increase or decrease).

CMS says that the proposed changes in the average length of stay values from FY 2020 to FY 2021 are small and do not show any particular trends in IRF length of stay patterns.

Column 7 of Table 13 in the impact section of the proposed rule (section IX below) shows the distributional effects of the changes in the CMGs by type of facility. Note that for this proposed rule, CMS has not posted the usual accompanying provider-specific files on the IRF PPS web page.

III. FY 2021 IRF PPS Payment Update

For FY 2021 payment, CMS applies the annual market basket update and productivity adjustment; updates the labor-related share of payment; adopts revised wage index areas and provides a transition for resulting changes to the wage index.

A. Market Basket Update and Productivity Adjustment

An update factor of 2.5 percent is proposed for the IRF PPS payment rates for FY 2021, composed of the following elements.

Proposed FY 2021 IRF PPS Update Factor	
Market basket	2.9%
Multifactor productivity (MFP)	-0.4%
Total	2.5%

The 2.9 percent FY 2021 market basket increase factor is based on IHS Global Insight's (IGI's) forecast from the fourth quarter of 2019, based on actual data through the third quarter. Similarly, the statutorily required MFP adjustment is based on IGI's fourth quarter 2019 forecast of the 10-year moving average (ending in 2021) of changes in annual economy-wide private nonfarm business multifactor productivity. The update factor for IRFs that fail to meet requirements for the IRF QRP is discussed in section VIII below and totals 0.5 percent. CMS will use more recent data, if available, for the final rule.

B. Labor-Related Share

CMS proposes a total labor-related share of 72.9 percent for FY 2021, a minor change from the FY 2020 labor share of 72.7 percent. The 72.9 percent comes from the IGI fourth quarter 2019 estimate of the sum of the relative importance of Wages and Salaries; Employee Benefits; Professional Fees: Labor-Related; Administrative and Facilities Support Services; Installation, Maintenance and Repair; All Other: Labor-related Services; and a portion (46 percent) of the Capital-Related cost weight from the IRF market basket. The relative importance reflects the different rates of price change for these cost categories between the base year (2016) and FY 2021. Table 4 of the proposed rule compares the components of the FY 2020 and proposed FY 2021 labor shares.

C. Wage Adjustment

Under previously adopted policy, for the IRF PPS wage index CMS uses the Core Based Statistical Areas (CBSA) labor market area definitions and the pre-floor, pre-reclassification Inpatient Prospective Payment System (IPPS) hospital wage index for the current fiscal year. For FY 2021, therefore, CMS would use the FY 2021 pre-floor, pre-reclassification IPPS wage index. The FY 2021 pre-reclassification and pre-floor hospital wage index is based on FY 2017 cost report data. Any changes made to the IRF PPS wage index from the previous fiscal year are made in a budget neutral manner.

The CBSAs are established by the Office of Management and Budget (OMB). They are generally subject to major revisions every 10 years to reflect information from the decennial census, but OMB also issues minor revisions in the intervening years through OMB Bulletins. CMS has previously OMB changes to CBSA delineations for purposes of the IRF PPS labor market areas. The history of these changes to the IRF wage index is discussed in the proposed

rule. For purposes of the IRF wage index, OMB-designated Micropolitan Statistical Areas[1] are considered to be rural areas. The OMB Bulletins are available at https://www.whitehouse.gov/omb/information-for-agencies/bulletins/.

For FY 2021, CMS proposes to modify the IRF wage index to reflect changes included in OMB Bulletin No. 18-04, issued on September 14, 2018, and to provide for a transition policy as detailed further below. CMS notes that on March 6, 2020, OMB issued OMB Bulletin 20-01, but it was not issued in time for development of this proposed rule. CMS does not believe that the minor updates included in that Bulletin would impact its proposed updates to the labor market area delineations. If needed, CMS will propose any updates from that bulletin in the FY 2022 IRF PPS proposed rule.

Adopting the revised delineations included in OMB Bulletin No 18-04 would change 34 urban counties from urban to rural; another 47 counties from rural to urban, and would shift some urban counties between existing and new CBSAs. Tables 5, 6 and 8 in the proposed rule detail the areas affected by these substantive changes. Table 7 identifies areas where only the CBSA name or number would change, without affecting assignment of a wage index.

The proposed transition policy would cap the decrease in any IRF's wage index from FY 2020 to FY 2021 to 5 percent. No such cap would be applied in FY 2022. CMS believes this proposal improves the accuracy of the IRF PPS wage index while giving negatively affected IRFs time to adapt. **Comments are invited on the proposed implementation of the new OMB delineations and proposed transition methodology**

Changes to the IRF PPS wage index are made in a budget neutral manner; CMS estimates the budget neutrality adjustment for FY 2021 under the proposed rule to be 0.9999. To make this calculation, CMS estimates aggregate IRF PPS payments using the FY 2020 labor-related share and wage index values and then estimates aggregate payments using the proposed FY 2021 labor share and wage index values. The ratio of the amount based on the FY 2020 index to the amount estimated using the proposed 2021 index is the budget neutrality adjustment to be applied to the federal per diem base rate for FY 2021.

D. Description of the IRF Standard Payment Conversion Factor and Payment Rates for FY 2021

Table 9 of the proposed rule (reproduced below) shows the calculations used to determine the proposed FY 2021 IRF standard payment amount. In addition, Table 10 of the proposed rule lists the FY 2021 payment rates for each CMG, and Table 11 provides a detailed hypothetical example of how the IRF FY 2021 federal prospective payment would be calculated for CMG 0104 (without comorbidities) for two different IRF facilities (one urban, teaching and one rural, non-teaching), using the applicable wage index values and facility-level adjustment factors under the proposed rule.

[1] OMB defines a Micropolitan Statistical Area as an area 'associated with at least one urban cluster that has a population of at least 10,000, but less than 50,000.

Table 9: Calculations to Determine the Proposed FY 2021 Standard Payment Conversion Factor	
Explanation for Adjustment	**Calculations**
Standard Payment Conversion Factor for FY 2020	$16,489
Market Basket Increase Factor for FY 2021 (2.9 percent), reduced by 0.4 percentage point for the productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act	x 1.025
Budget Neutrality Factor for the Updates to the Wage Index and Labor-Related Share	x 0.9999
Budget Neutrality Factor for the Revisions to the CMGs and CMG Relative Weights	x 0.9969
Proposed FY 2021 Standard Payment Conversion Factor	= $16,847

IV. Update to Payments for High-Cost Outliers under the IRF PPS

Under the IRF PPS, if the estimated cost of a case (based on application of an IRF's overall cost-to-charge ratio (CCR) to Medicare allowable covered charges) is higher than the adjusted outlier threshold, CMS makes an outlier payment for the case equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold. From the beginning of the IRF PPS, CMS' intent has been to set the outlier threshold so that the estimated outlier payments would equal 3 percent of total estimated payments, and this policy is continued for FY 2021. CMS believes this level reduces financial risk to IRFs of caring for high-cost patients while still providing adequate payments for all other cases.

To update the IRF outlier threshold amount for FY 2021, CMS proposes to use FY 2019 claims data and the same methodology that has been used to set and update the outlier threshold since the FY 2002 IRF PPS final rule. CMS currently estimates that IRF outlier payments as a percentage of total estimated payments will be 2.6 percent of total IRF payments in FY 2020. To maintain estimated outlier payments at the 3 percent level, CMS updates the outlier threshold amount from $9,300 for FY 2020 to $8,102 for FY 2021.

Updates are proposed to the national urban and rural CCRs for IRFs, as well as the national CCR ceiling for FY 2021, based on analysis of the most recent cost report data that are available (FY 2018). CCRs are used in converting an IRF's Medicare allowable covered charges for a case to costs for purposes of determining appropriate outlier payment amounts. The national urban and rural CCRs are applied in the following situations: new IRFs that have not yet submitted their first Medicare cost report; IRFs with an overall CCR that is more than the national CCR ceiling for FY 2019; and other IRFs for which accurate data to calculate an overall CCR are not available. The national CCR ceiling for FY 2021 would continue to be set at 3 standard deviations above the mean CCR. If an individual IRF's CCR exceeds the ceiling, CMS replaces the IRF's CCR with the appropriate national average CCR (either urban or rural).

The proposed national average CCRs for FY 2021 are 0.400 for urban IRFs and 0.490 for rural IRFs, and the national CCR ceiling is 1.33. That is, if an individual IRF's CCR were to exceed this ceiling of 1.33 for FY 2021, we would replace the IRF's CCR with the appropriate proposed national average CCR (either rural or urban, depending on the geographic location of the IRF).

V. Removal of the Post-Admission Physician Evaluation Requirement

CMS proposes to permanently remove the post-admission physician evaluation requirement at §412.622(a)(4)(ii) that it has removed for the duration of the COVID-19 public health emergency.[2] This requirement provides that the patient's medical record at the IRF must contain a post-admission physician evaluation that meets all of the following requirements:

- It is completed by the rehabilitation physician within 24 hours of the patient's admission to the IRF.
- 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.
- It is retained in the patient's medical record at the IRF.

Under this proposed rule the requirement would be permanently removed for all IRF discharges beginning on or after October 1, 2020. Conforming changes would be made to regulatory text at §412.622(a)(3)(iv), and CMS would also rescind the associated policy described in Chapter 1, Section 110.1.2, of the Medicare Benefit Policy Manual. Among other things the policy manual provides for up to three days of IRF payment in cases where the post-admission evaluation determines that the patient is not an appropriate candidate for IRF care in disagreement with the preadmission screening.

The rationale offered for permanent removal of this requirement is that CMS believes 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. It believes that IRFs are doing due diligence while completing the pre-admission screening, and offers that over time, the number of cases for which the post admission evaluation determines the patient was not an appropriate candidate for IRF care has decreased to a total of 4 times across all IRFs in FY 2019.

CMS notes that this proposal would not preclude an IRF patient from being evaluated by a rehabilitation physician or by a non-physician practitioner (see proposal in section VII below) within the first 24 hours of admission if the IRF believes that the patient's condition warrants it. Further CMS reminds readers that the requirements for rehabilitation physician visits within the first week of the patient's stay are retained. It believes that removing the post-admission physician evaluation would reduce administrative and paperwork burden for both IRF providers and Medicare Administrative Contractors (MACs), and states that the temporary removal of this policy during the public health emergency will provide experience for CMS to determine whether permanent removal would reduce paperwork burden for hospitals and clinicians while improving quality of care for patients.

[2] See the interim final rule with comment "Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency", published on April 6, 2020 (85 FR 19230).

VI. Revisions to Certain IRF Coverage Documentation Requirements

Citing its Patients over Paperwork initiative, CMS proposes to modify existing regulations regarding preadmission screening. Comments are sought on the specific proposals and in a comment solicitation as summarized here.

A. Codification of Existing Preadmission Screening Documentation Instructions and Guidance

CMS proposes to codify existing requirements for preadmission screening, some of which currently appear in regulatory text at §412.622(a)(4)(i), and further details which are set forth in the Medicare Benefit Policy Manual Chapter 1, Section 110.1.1. Because the latter represent longstanding guidance and instructions in place since the IRF coverage requirements were implemented in 2010, CMS believes codification would (1) improve clarity and reduce administrative burden on both IRF providers and MACs; (2) mitigate tasks that take away from time spent directly with the patient, and (3) locate all preadmission screening documentation requirements in the same place for ease of reference by providers and MACs.

Specifically, the following modifications are proposed to the regulatory text:

- 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 notes that elsewhere in this proposed rule (section VII below) it proposes to allow non-physician practitioners to perform certain requirements that are currently required to be performed by a rehabilitation physician.

B. Definition of a "Week"

The regulation at §412.622(a)(3)(ii) states that current industry standards for an intensive rehabilitation therapy program generally consist of at least 3 hours of 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.

In this rule CMS proposes to clarify for purposes of the IRF coverage requirements that the "week" is defined as "7 consecutive calendar days beginning with the date of admission to the IRF." This proposal is made out of concern that the term might otherwise be construed to mean something different, such as Monday through Sunday. Specifically, the proposal would add the

definition at 412.622(c) and modify the text at 412.622(a)(3)(ii) to replace "7 consecutive day period, beginning with the date of admission to the IRF" with "week."

C. Solicitation of Comments Regarding Further Changes to the Preadmission Screening Documentation Requirements

CMS seeks comments on whether it could remove some of the preadmission screening requirements under §412.622(a)(4)(i) and 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. **Feedback is specifically sought regarding which aspects of the preadmission screening stakeholders believe are most or least critical and useful for supporting the appropriateness of an IRF admission, and why.**

VII. Allowing Non-physician Practitioners to Perform Certain IRF Coverage Requirements Currently Required of a Rehabilitation Physician

Currently, several of the IRF coverage requirements (§412.622(a)(3), (4), and (5)) must be performed 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. For example, a 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 and to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process. More information and guidance are available in the Medicare Benefit Policy Manual, Chapter 1, Section 110.2.4. For reference, the text of §412.622(a)(3), (4), and (5) is provided in an Appendix to this summary.

In this rule CMS proposes to allow non-physician practitioners to perform certain IRF coverage requirements. It has previously sought and received comments on this issue from stakeholders and reports that these comments were divided. Some commenters questioned whether non-physician practitioners have the training necessary to adequately assess the interaction between patients' medical and functional care needs in an IRF and to ensure that patients receive the hospital level and quality of care that is necessary to treat complex conditions in an IRF. On the other hand, industry commenters stated that non-physician practitioners (1) have the necessary education and are qualified to provide the same level of care currently being provided to IRF patients by rehabilitation physicians; (2) can perform the same tasks that rehabilitation physicians currently must perform in IRFs; (3) have a history of treating complex patients across all settings, and are already doing so in IRFs; (4) are currently authorized to provide similar patient assessments in other settings, such as inpatient hospitals, skilled nursing facilities, hospice, and outpatient rehabilitation centers; and (5) in many cases have gained experience by practicing with rehabilitation physicians in IRFs. Further, these commenters stated that non-physician practitioner educational programs prepare graduates for advanced clinical practice and that current accreditation requirements and competency-based standards ensure that non-physician practitioners are equipped to provide safe, high level quality care. Finally, some commenters argued that providing this flexibility would increase the number of providers able to work in the post-acute setting and offset shortages in physician supply, especially in rural areas, as well as physician burnout.

After review, CMS agrees with industry comments that non-physician practitioners have the training and experience to perform the IRF requirements, and it believes that 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. CMS notes that it continues to be the IRF's responsibility to exercise judgment regarding who has appropriate training and experience.

Specifically, the proposed rule would provide (at a new §412.622(d)) 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 non-physician practitioner's scope of practice under applicable state law. CMS notes that this proposal does not preclude IRFs from making decisions regarding the role of rehabilitation physicians or non-physician practitioners, and 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. Hospital Conditions of Participation continue to require that every Medicare patient generally be under the care of a physician. (See section 1861(e)(4) of the Social Security Act and §482.12(c)).

CMS invites comment on this proposal, specially on its analysis of this issue and whether there is other evidence to inform the analysis. Commenters are encouraged to share with CMS 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. Further, CMS requests information from IRFs regarding whether or not their facilities would allow non-physician practitioners to complete all, some, or none of the requirements at §412.622(a)(3), (4), and (5). This information will assist CMS in refining its estimates of the changes in Medicare payment that may result from this proposal. (This aspect is discussed further in the impact analysis section of the proposed rule, summarized in section IX below.)

VIII. Update Factor Reduction for IRFs That Fail to Meet IRF QRP Requirements

An IRF that fails to meet the requirements of the IRF QRP for a year is subject to a 2-percentage point reduction in the applicable update factor for that year. Table 12 of the proposed rule (reproduced below) shows the calculation of the proposed adjusted FY 2021 standard payment conversion factor for any IRF that failed to meet the IRF QRP reporting requirements.

TABLE 12: Calculations to Determine the Proposed Adjusted FY 2021 Standard Payment Conversion Factor for IRFs That Failed to Meet the Quality Reporting Requirement

Explanation for Adjustment	Calculations
Standard Payment Conversion Factor for FY 2020	$ 16,489
Market Basket Increase Factor for FY 2021 (2.9 percent), reduced by 0.4 percentage point for the productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act, and further reduced by 2 percentage points for IRFs that failed to meet the quality reporting requirement	X 1.005
Budget Neutrality Factor for the Updates to the Wage Index and Labor-Related Share	X 0.9999
Budget Neutrality Factor for the Revisions to the CMGs and CMG Relative Weights	X 0.9969
Adjusted FY 2021 Standard Payment Conversion Factor	= $ 16,518

IX. Regulatory Impact Analysis

CMS estimates that the proposed rule will increase Medicare payments to IRFs by $270 million in FY 2021 compared with FY 2020. This reflects the 2.5 percent increase from the update factor and the change in the outlier threshold, which will increase aggregate payments to IRFs by an estimated 0.4 percent. Table 13 in the proposed rule, reproduced below, shows the effects of these and other policy changes by type of IRF. The other policy changes shown in Table 13 involving the wage index and labor market areas and changes to the CMG weights are all designed to be budget neutral and therefore have no effect on aggregate payments to IRFs. The $270 million figure excludes the effects of payment reductions to IRFs that fail to meet the IRF QRP requirements.

Further, CMS estimates total annual cost savings from its proposals to allow non-physician practitioners to fulfill the requirements of the rehabilitation physician, where possible within the practitioner's scope of practice under state law. (See section VII above.) CMS believes this proposal would significantly reduce burden for rehabilitation physicians and providers.

If all IRFs took full advantage of the flexibility to substitute non-physician practitioners for these requirements as proposed, CMS estimates $31 million in Medicare Part B savings based on Medicare Physician Fee Schedule (PFS) payment and billing policies.[3] However, it assumes that IRFs would adopt this proposed change for about half of the services provided for a total of $15.5 million in Part B savings. Of this total, $12.4 million would accrue to the Medicare program and $3.1 million to beneficiaries in reduced cost sharing. Medicare savings accrue from this proposal because non-physician practitioners are able to bill 80 percent of what physicians bill.

To obtain more information on which to base its estimates, CMS seeks feedback from commenters on:

- **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.**

[3] The proposed rule Accounting Statement displays the $15.5 million estimate developed using the Medicare PFS. CMS also provides an estimate of the burden reduction on IRFs resulting from this proposal using hourly wage rates for physicians and non-physician practitioners. That estimate totals $63 million if all IRFs took full advantage of the substitution and $25.5 million in savings assuming use of non-physician practitioners for only half of services. However, CMS notes that physician services provided in an IRF are billed directly to Part B, and IRFs do not pay physicians for their services.

TABLE 13: IRF Impact Table for FY 2021 (Columns 4 through 8 in percentage)

Facility Classification	Number of IRFs	Number of Cases	Outlier	FY 21 Wage Index and Labor Share	FY 21 Wage Index New CBSA and 5% Cap	CMG Weights	Total Percent Change [1]
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Total	1,117	409,232	0.4	0.0	0.0	0.0	2.9
Urban unit	683	160,590	0.7	0.0	0.0	0.0	3.3
Rural unit	132	20,608	0.7	0.1	0.0	0.0	3.4
Urban hospital	291	222,986	0.2	0.0	0.0	0.0	2.6
Rural hospital	11	5,048	0.0	0.2	-0.1	-0.1	2.5
Urban For-Profit	361	218,830	0.2	0.0	0.0	0.0	2.6
Rural For-Profit	33	8,454	0.3	0.2	0.0	0.0	2.9
Urban Non-Profit	521	143,397	0.7	0.0	0.0	0.0	3.2
Rural Non-Profit	89	14,078	0.7	0.1	0.0	0.0	3.4
Urban Government	92	21,349	0.7	-0.1	0.2	0.0	3.4
Rural Government	21	3,124	0.4	0.2	0.0	0.1	3.3
Urban	974	383,576	0.4	0.0	0.0	0.0	2.9
Rural	143	25,656	0.6	0.1	0.0	0.0	3.2
Urban by region							
Urban New England	29	16,062	0.4	-0.8	0.0	-0.1	2.0
Urban Middle Atlantic	132	48,621	0.5	0.2	-0.2	0.1	3.1
Urban South Atlantic	152	78,107	0.3	0.2	0.0	0.0	3.0
Urban East North Central	159	49,969	0.5	0.0	0.0	0.0	3.0
Urban East South Central	56	28,340	0.2	0.1	0.0	0.0	2.8
Urban West North Central	73	21,045	0.5	-0.5	0.0	0.0	2.3
Urban West South Central	188	85,097	0.3	0.2	0.1	0.1	3.1
Urban Mountain	87	30,531	0.4	-0.3	0.0	-0.1	2.5
Urban Pacific	98	25,804	0.8	-0.3	0.3	-0.1	3.3
Rural by region							
Rural New England	5	1,345	0.5	-0.4	0.0	-0.2	2.3
Rural Middle Atlantic	11	1,185	1.2	0.5	0.0	0.0	4.3
Rural South Atlantic	16	3,778	0.3	0.3	-0.2	0.0	2.9
Rural East North Central	23	4,034	0.6	0.5	0.1	0.0	3.6
Rural East South Central	21	4,404	0.4	0.0	0.0	-0.1	2.8
Rural West North Central	20	3,024	0.7	0.0	0.2	-0.1	3.3
Rural West South Central	39	6,965	0.4	0.0	0.1	0.1	3.2
Rural Mountain	5	559	1.2	-0.2	0.0	0.1	3.7
Rural Pacific	3	362	1.5	0.8	0.0	0.0	4.8
Teaching status							
Non-teaching	1,014	363,349	0.4	0.0	0.0	0.0	2.9
Resident to ADC less than 10%	59	32,695	0.5	-0.1	0.2	0.0	3.1
Resident to ADC 10%-19%	31	11,643	0.8	0.2	-0.1	0.1	3.6
Resident to ADC greater than 19%	13	1,545	0.4	0.0	0.2	0.1	3.3
Disproportionate share patient percentage (DSH PP)							
DSH PP = 0%	35	7,558	0.5	0.5	-0.1	0.0	3.4
DSH PP <5%	144	58,952	0.4	0.3	-0.3	0.0	2.8
DSH PP 5%-10%	294	129,346	0.4	0.1	-0.1	0.0	2.9
DSH PP 10%-20%	395	144,151	0.4	-0.1	0.1	0.0	2.8
DSH PP greater than 20%	249	69,225	0.6	-0.1	0.1	0.0	3.2

[1]This column includes the impact of the updates in columns (4), (5), (6), and (7) above, and of the IRF market basket increase factor for FY 2021 (2.9 percent), reduced by 0.4 percentage point for the productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act

Appendix: Existing IRF Coverage Regulations Requiring Specific Actions by a Rehabilitation Physician

As discussed in section VII of this summary, the proposed rule would add a new §412.622(d)) stating 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 non-physician practitioner's scope of practice under applicable state law.

The affected regulatory text is provided below for reference.

From 42 CFR 412.622(a):

……..

(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.