Medicare Inpatient Rehabilitation Facility Prospective Payment System for FY 2018
[CMS-1671-F]
Summary of Final Rule

On August 3, 2017, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* (82 FR 36238-36305)[1] a final rule on the Medicare inpatient rehabilitation facility prospective payment system (IRF PPS) for federal fiscal year (FY) 2018.

As required by statute, the IRF PPS update factor for FY 2018 is set to be 1.0 percent. Along with other budget neutrality adjustments, this will increase the standard payment conversion factor from $15,708 in FY 2017 to $15,838 for facilities meeting the standards in the IRF Quality Reporting Program (QRP) and $15,524 for facilities not meeting the IRF QRP standards and subject to the 2-percentage point penalty. CMS estimates that under the final rule, Medicare IRF PPS payments in FY 2018 will be about $75 million higher than in FY 2017.

Among other provisions, the rule modifies the ICD-10-CM codes used in the presumptive compliance methodology for determining a facility's eligibility for payment under the IRF PPS, and establishes a subregulatory process for making nonsubstantive updates to the diagnosis code lists; establishes requirements for collection of standardized patient assessment data in keeping with the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT) Act; and modifies the measures required under the IRF QRP. Notably, most of the standardized patient assessment data elements that had been proposed are not finalized. CMS intends to engage in field testing and develop new proposals no later than FY 2020 rulemaking.

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[1] https://www.gpo.gov/fdsys/pkg/FR-2017-08-03/pdf/2017-16291.pdf

I. Introduction and Background

The final rule provides an overview of the IRF PPS, including statutory provisions, a description of the IRF PPS for FYs 2002 through 2017, and an operational overview of the current IRF PPS. Among other things, CMS notes that the FY 2016 final rule changed the market basket index used to update IRF payments to reflect the cost structures of only IRF providers. Also, IRFs are required to complete the appropriate sections of the IRF-Patient Assessment Instrument (IRF-PAI) upon the admission and discharge of each Medicare Part A fee-for-service (FFS) patient and each Medicare Part C (Medicare Advantage) patient. These data are submitted by IRFs through the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) System.

II. Update to the Case-Mix Group (CMG) Relative Weights and Average Length of Stay Values for FY 2018

Updates are finalized for the CMG relative weights and average length of stay values for FY 2018, using the same methodologies that have been used in past years applied to the FY 2016 IRF claims and FY 2015 IRF cost report data. 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. CMS computes a budget neutrality factor of 0.9976 to account for changes to the FY 2018 relative weights. Table 1 of the final rule provides the relative weights and length of stay values by CMG and comorbidity tier.

Table 2 of the final rule (reproduced below) shows the distributional effects (increases and decreases compared to FY 2017) of the changes in the CMG relative weights. CMS says that the largest increase in the final CMG relative weight values that affects a particularly large number of IRF discharges is a 4.0 percent increase for CMG 0603, Neurological, with a motor score greater than 25.85 and less than 37.35 in tier 1. In the 2016 claims data, 1,334 IRF discharges (0.3 percent) were classified in this CMG and tier. The largest decrease that affects the most cases is a 3.6 percent decrease for CMG 0506, Non-traumatic spinal cord injury, with a motor score of less than 23.75 in tier 3. This would have affected 2,421 cases (0.6 percent) in 2016.

CMS Table 2: Distributional Effects of the Changes to the CMG Relative Weights (FY 2017 Values Compared with FY 2018 Values)		
Percentage Change	**# of Cases Affected**	**% of Cases Affected**
Increased by 15% or more	51	0.0
Increased by between 5% and 15%	1,802	0.5
Changed by less than 5%	397,273	99.3
Decreased by between 5% and 15%	999	0.2
Decreased by 15% or more	0	0.0

CMS says that the changes in average length of stay values for FY 2017 are small and do not show any trend in IRF length of stay patterns.

III. Continued Use of FY 2014 Facility-Level Adjustment Factors

CMS will continue to hold the facility-level adjustment factors (that is, the rural, low income percentage (LIP) and teaching status adjustment factors) at the FY 2014 levels as it continues to monitor the most current IRF claims data available and evaluates the effects of the changes that were adopted in the FY 2014 final rule.

IV. FY 2018 IRF PPS Payment Update

A. Background

As noted earlier, CMS in the FY 2016 final rule established a specific 2012-based IRF market basket, using Medicare cost report data for both freestanding and hospital-based IRFs, which replaced the Rehabilitation, Psychiatric, and Long-Term Care market basket that had been used in prior years.

B. FY 2018 Market Basket Update and Productivity Adjustment

As specified by section 411(b) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), CMS proposes that for FY 2018 the update factor for IRF PPS rates be 1.0 percent. The Secretary has no authority to apply a different update. However, consistent with historical practice, CMS reviews the elements of the update factor.

- The FY 2018 market basket increase factor based on IHS Global Insight's (IGI's) most recent forecast, which is for the second quarter of 2017, with historical data through the first quarter of 2017, is 2.6 percent.
- The multifactor productivity (MFP) adjustment called for under section 1886(j)(3)(C)(ii) of the Social Security Act (the Act) is equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multifactor productivity. IGI's second quarter 2017 forecast of the MFP adjustment for FY 2018 is 0.6 percent
- Sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(v) of the Act require a further 0.75 percentage point reduction to the update factor.
- Absent the specified 1.0 percent update factor, these elements would yield an FY 2018 IRF update of 1.25 percent (2.6 percent minus 0.6 percent minus 0.75 percent).

CMS notes that the Medicare Payment Advisory Commission (MedPAC) recommends that for FY 2018 the IRF PPS rates be reduced by 5 percent.

C. Labor-Related Share for FY 2018

CMS finalizes a total labor-related share of 70.7 percent for FY 2018, unchanged from the proposed rule. (The FY 2017 labor share is 70.9 percent.) The 70.7 percent comes from the IGI second quarter 2017 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

(proposed to be 46 percent) of the Capital-Related cost weight from the 2012-based IRF market basket. Table 3 of the final rule provides details on the components of this calculation.

D. Wage Adjustment

CMS continues for FY 2018 the policies and methodologies related to labor market area definitions and calculation of the wage index that were adopted for FY 2017. This includes use of the Core-Based Statistical Area (CBSA) labor market area definitions and the FY 2017 pre-reclassification and pre-floor hospital wage index data (FY 2013 cost report data). CMS also continues to use the same methodology discussed in the FY 2008 IRF PPS final rule to address those geographic areas where there are no hospitals and, thus, no hospital wage index data on which to base the calculation for the FY 2017 IRF PPS wage index.

Updated labor market areas are adopted. CMS adopted in FY 2016 the OMB delineations for Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas described in the February 28, 2013 OMB Bulletin No. 13-01 (available at http://www.whitehouse.gov/sites/default/files/omb/bulletins/2013/b-13-01.pdf). However, on July 15, 2015, OMB issued OMB Bulletin No. 15–01, which provides minor updates to and supersedes Bulletin No.13–01. Bulletin No. 15-10 is available at https://obamawhitehouse.archives.gov/sites/default/files/omb/bulletins/2015/15-01.pdf. The changes made involve Garfield County, OK; the county of Bedford City, VA; and Macon, GA. These updated labor market area definitions were implemented under the acute hospital Inpatient Prospective Payment System (IPPS) beginning on October 1, 2016. CMS will adopt these changes for the IRF PPS beginning October 1, 2017, which it says it consistent with its historical practice of modeling IRF PPS adoption of the labor market area delineations after IPPS adoption. No transition period was proposed because the changes associated with adopting the revised delineations are minor and do not have a substantial effect on a large number of providers.

The previously adopted phase out of the rural adjustment is completed, which means that no adjustment will apply for FY 2018. That is, the budget neutral adjustment that was made for IRFs that were classified as rural in FY 2015 under the old CBSA definitions and classified as rural in FY 2016 under the new definitions was phased down in FYs 2016 and 2017 will no longer apply.

For FY 2018, the budget neutrality wage adjustment factor is 1.0007.

The wage index applicable to FY 2018 can be found in Table A (urban areas) and Table B (rural areas) available on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Data-Files.html.

E. Description of the IRF Standard Payment Conversion Factor and Payment Rates for FY 2018

Table 4 of the final rule (reproduced below) shows the calculations used to determine the FY 2018 IRF standard payment amount. Table 5 of the rule lists the unadjusted FY 2018 payment rates for each CMG, and Table 6 provides a detailed hypothetical example of how the IRF FY 2018 federal prospective payment will be calculated for CMG 0110 (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.

CMS Table 4: Calculations to Determine the Proposed FY 2018 Standard Payment Conversion Factor		
Explanation for Adjustment	**Calculations**	
Standard Payment Conversion Factor for FY 2017		$15,708
Market Basket Increase Factor for FY 2018 (1.0 percent) as required by section 1886(j)(3)(C)(iii) of the Act	x	1.0100
Budget Neutrality Factor for the Wage Index and Labor-Related Share	x	1.0007
Budget Neutrality Factor for the Revisions to the CMG Relative Weights	x	0.9976
FY 2017 Standard Payment Conversion Factor	=	$15,838

V. 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 the final rule will continue this policy. CMS believes this policy 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 2018, CMS will use FY 2016 claims data and the same methodology that have 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 on target at 3.0 percent of total IRF payments in FY 2017. To maintain estimated outlier payments at this level in light of estimated increases in IRF payments and costs, CMS updates the outlier threshold amount to $8,679 for FY 2018 (compared to $7,984 for FY 2017).

CMS further updates the national urban and rural CCRs for IRFs, as well as the national CCR ceiling for FY 2018, based on analysis of the most recent data that are available. 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 2018; and other IRFs for which accurate data to calculate an overall CCR are not available. CMS finalizes its proposal that the national CCR ceiling again be set at 3 standard deviations above the mean CCR for FY 2018. If an individual IRF's CCR exceeds the ceiling, CMS will replace the IRF's CCR with the appropriate national average CCR (either urban or rural).

For FY 2018, CMS estimates a national average CCR of 0.416 for urban IRFs and 0.518 for rural IRFs, and a national CCR ceiling of 1.31. These rural and national figures changed slightly from the proposed rule (0.516 and 1.28 respectively) because more recent data were used.

VI. Removal of the 25 Percent Payment Penalty for IRF-PAI Late Submission

Effective October 1, 2017, CMS eliminates the provision at 42 CFR §412.614(d)(1)(ii) under which an IRF is subject to a 25 percent payment penalty for failure to submit the IRF-PAI on Medicare Part A FFS patients by the required deadline. (Other related changes to the regulatory text at §412.614(d) are made.) CMS says that all 16 comments it received on this matter were supportive. The rationale for this change is that IRFs have other financial incentives to timely submit IRF-PAI data, and that applications for waivers from the penalty are burdensome. Specifically, a change request (CR 7760) effective October 1, 2012 resulted in a new edit to IRF PPS claims under which an error is returned if an IRF attempts to submit a Medicare Part A FFS claim for a patient for which there is no corresponding IRF-PAI for the patient on file. The edit advises the IRF provider that an IRF-PAI needs to be submitted. CMS believes that this incentive is sufficient to encourage providers to comply with IRF-PAI data submission requirements.

Further, CMS notes that under §412.614(e), IRFs may request a waiver of the 25 percent penalty in extraordinary situations such as fires, floods, earthquakes, or similar unusual events that inflect extensive damage to an inpatient facility as well as situations in which data transmission issues beyond the control of the IRF have made it impossible for the IRF to submit IRF-PAIs in the required timeframe. Based on FY 2015 data, CMS has found that the vast majority of the approximately 10,000 fee-for-service IRF-PAIs that it estimates are transmitted late each year, (amounting to a total payment penalty of approximately $37.6 million) qualify for a waiver under §412.614(e). The waiver process results in costs incurred by the IRF requesting a waiver, by CMS reviewing the waiver request, and by CMS reprocessing related claims. Eliminating the penalty also eliminates the need for waivers and eliminates these costs.

CMS modifies the waiver language at §412.614(e) to reflect the elimination of the 25 percent penalty regarding late submission of IRF-PAI data for Medicare Part A patients, and notes that it makes no changes with respect to the requirements on IRFs to collect IRF-PAI data on MA patients. IRFs that fail to timely submit IRF-PAIs on their MA patients forfeit their ability to have any of their MA data used in the calculations for determining their eligibility for exclusion from the IPPS. The waiver at §412.614(e) will continue to apply with respect to reporting data for MA patients.

VII. Revision to the IRF-PAI to Remove the Voluntary Item 27 (Swallowing Status)

CMS finalizes its proposal to remove from the IRF-PAI voluntary item 27: swallowing status effective for discharges beginning on or after October 1, 2017. CMS believes that continuing to collect these data would be duplicative because in the FY 2016 IRF PPS final rule, the IRF-PAI was revised to capture very similar data in new Section K-Swallowing/Nutritional Status, which is used as a risk adjustor for the functional outcome measures. In addition, CMS says that to the extent that such information would be relevant to patient care, it should be captured in either the transfer documentation from the referring physician, or the patient's initial assessment documentation. CMS reports that most commenters supported this removal.

VIII. Refinements to the Presumptive Compliance Methodology ICD-10-CM Diagnosis Codes

CMS finalizes with changes from the proposed rule its modifications to the list of ICD-10-CM codes used in the presumptive compliance methodology, one of two ways that Medicare contractors can evaluate an IRF's compliance with the "60 percent rule". As a condition of payment as an IRF, at least 60 percent of a facility's total inpatient population must require treatment in an IRF for one or more of 13 medical conditions.[2] (The other compliance methodology involves medical record review.) IRFs may be evaluated using the presumptive methodology only if their Medicare fee-for-service and MA populations combined make up more than half of their total patient population, so that the Medicare population can be presumed to be representative of the IRF's total patient population.

In the proposed rule, CMS also invited public comment on the 60 percent rule, including the list of conditions. Most commenters recommended elimination of the 60 percent rule or lowering the compliant percentage to 50 percent, as well as suggesting additional conditions whose diagnoses should be considered sufficient to demonstrate presumptive compliance. CMS neither proposes nor finalizes any modifications to the 60 percent rule or to the list of 13 qualifying conditions for IRF payment, and CMS does not describe a definite timeline for making such modifications.

The changes adopted to the lists of diagnostic codes used in the presumptive compliance methodology are discussed below by clinical topic area.

A. Traumatic brain injury (Impairment Group Codes (IGCs) 0002.21 and 0002.22)

Commenters noted that some codes proposed for exclusion from the presumptive compliance methodology were more specific than their predecessor ICD-9-CM codes that had not been excluded. CMS also noted that a recent ICD-10-CM update had added specificity to some skull fracture codes. CMS finalizes that:

- Skull base fracture codes will now be removed from the exclusion list (S02.101B, S02.102B, S02.101A, and S02.102A).
- Unspecified intracranial injury code S06.9X9A will be retained on the exclusion list as part of an excluded combination diagnosis code.

B. Hip fracture(s) (IGCs 0008.11 and 0008.12)

CMS finalizes as proposed that exclusions will be removed for fractures of "unspecified part of neck of femur" (multiple codes) but that exclusions will be retained for fractures of "unspecified part of neck of unspecified femur" (S72.009A, S72.009B, and S72.009C).

[2] The qualifying medical conditions are: (1) stroke; (2) spinal cord injury; (3) congenital deformity; (4) amputation; (5) major multiple trauma; (6) hip fracture; (7) brain injury; (8) neurological disorders (e.g., multiple sclerosis, Parkinson's disease); (9) burns; (10-12) three arthritis conditions refractory to appropriate, aggressive, and sustained outpatient therapy; and (13) hip or knee replacement when bilateral, when body mass index ≥50, or age 85 or older.

C. Major Multiple Trauma Codes

CMS finalizes counting IRF patients under the presumptive methodology whose IRF-PAIs contain 2 or more ICD-10-CM codes from one or more of three major multiple trauma lists.[3] The codes will need to be combined so that either one lower extremity fracture is combined with an upper extremity fracture or a rib/sternum fracture, or that fractures are present in both lower extremities. A diagnosis of unspecified multiple injuries (T07) will not provide presumptive evidence for IRF payment.

D. Unspecified Codes

CMS agrees with commenters who objected to the placement of multiple "unspecified" diagnostic codes on the presumptive methodology exclusion list, noting that such a descriptor in and of itself should not necessarily mean failure to comply with the 60 percent rule. These codes, proposed as new exclusions, will not be added to the exclusion list. CMS will work with other organizations (including the American Hospital Association and the National Center for Health Statistics) to promote ICD coding to the highest level of specificity and will encourage coding specificity through National Provider Calls. CMS will also continue to monitor use of unspecified codes by IRFs and propose future adjustments based upon code utilization patterns.

E. Arthritis Codes

Only patients with very severe arthritis potentially qualify for IRF treatment. ICD-10-CM arthritis codes do not always indicate disease severity and were, therefore, proposed for addition to the presumptive methodology exclusion list. Commenters voiced concern that the exclusions would impact access to care for beneficiaries belonging to certain populations with high incidences of these conditions. To ensure access to care, CMS finalizes a decision not to exclude the arthritis codes from meeting the presumptive methodology requirement for IRF payment.

F. Other Specified Myopathies (G72.89)

CMS does not finalize its proposal to exclude this code from the presumptive compliance methodology. It had been proposed for exclusion because CMS perceived that this code was being used incorrectly and disproportionately by some facilities to justify IRF treatment for mild-to-moderate generalized weakness not falling within the IRF payment qualifying conditions. Commenters expressed concern that no more specific codes were available for those patients severely debilitated after prolonged hospitalizations. Commenters also suggested that CMS could facilitate proper code utilization through targeted review of facilities. CMS agrees with commenters that focused medical reviews are a better option for addressing the identified coding issue and is not placing G72.89 on the presumptive methodology exclusion list, as it had proposed.

[3] List A: Major Multiple Trauma—Lower Extremity Fracture; List B: Major Multiple Trauma—Upper Extremity Fracture; and List C: Major Multiple Trauma—Ribs and Sternum Fracture; available for download at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Data-Files.html

The changes made as a result of this final rule are presented as Presumptive Compliance Changes (Table 1 IGC Changes), available for download as part of the FY 2018 IRF PPS Final Rule Data Files at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Data-Files.html

IX. Implementation of the Revisions to the Presumptive Methodology

CMS finalizes October 1, 2017 as the effective date for the presumptive methodology revisions, allowing the adoption of multiple codes that satisfy IRF payment requirements. While several commenters expressed concerns that this timeline would not coincide with the start date of the current compliance review period for many IRFs, CMS believes this is not relevant for the finalized changes since no codes that currently satisfy the presumptive methodology criteria are being newly excluded, and that the finalized addition of qualifying codes will actually facilitate IRF compliance with the 60 percent rule. CMS commits to taking compliance review period timelines into account when making future changes that would eliminate codes that support IRF treatment.

X. Subregulatory Process for Certain Updates to Presumptive Methodology Diagnosis Code Lists

CMS finalizes its proposal for a two-part formal process for updating the lists of ICD-10-CM codes used in the presumptive compliance methodology to account for changes to the ICD-10 medical code data set. A subregulatory process will be used for non-substantive updates, and notice and comment rulemaking will be reserved for substantive changes. CMS provides an example in which ICD-10-CM updates that expanded codes providing presumptive evidence for IRF treatment would be added through the subregulatory process, while any restriction of codes would be handled through notice and comment rulemaking. CMS commits to providing lists of which codes are being added and which are being removed during the subregulatory process in conjunction with the IRF final rule or notice for each fiscal year.

XI. Use of IRF-PAI Data to Determine Patient Body Mass Index (BMI) Greater Than 50 for Cases of Lower Extremity Single Joint Replacement

CMS finalizes is proposal to use the information recorded for IRF-PAI items 25A-Height and 26A-Weight to identify lower extremity single joint replacement cases with a BMI greater than 50. Effective for all IRF discharges occurring after October 1, 2017, these cases will be counted toward an IRF's presumptive compliance percentage. Prior to the addition of these items to the IRF-PAI (adopted in the FY 2014 IRF PPS final rule), these patients could only be identified using the medical review methodology.

XII. Revisions and Updates to the IRF Quality Reporting Program (IRF QRP)

A. Background

CMS established the IRF QRP beginning in FY 2014 for IRFs, as required under section 1886(j) of the Act, which was added by the Patient Protection and Affordable Care Act. Further

developed in subsequent rulemaking, the IRF QRP follows many of the policies established for the Hospital IQR Program, including the principles for selecting measures and the procedures for hospital participation in the program. An IRF that does not meet the requirements of participation in the IRF QRP for a rate year is subject to a 2.0 percentage point reduction in the update factor for that year. In the collection of information requirements section of this rule, CMS reports that 80 of the 1137 active Medicare-certified IRFs did not receive the full annual percentage increase for the FY 2017 annual payment update determination.

The IMPACT Act, enacted on October 6, 2014, requires the Secretary to implement quality measures for five specified quality measure domains using standardized data elements to be nested within the assessment instruments currently required for submission by IRFs and other post-acute care (PAC) providers. (LTCHs, SNFs, and home health agencies). Other measures are to address resource use, hospitalization, and discharge to the community. The intent of the Act is to enable interoperability and access to longitudinal information among post-acute providers to facilitate coordinated care, improve outcomes, and provide for quality comparisons across providers. For IRFs, the Secretary was required to specify quality measures by October 1, 2016. The IMPACT Act measure domains are:

- Skin integrity and changes in skin integrity;
- Functional status, cognitive function, and changes in function and cognitive function;
- Medication reconciliation;
- Incidence of major falls;
- Transfer of health information and care preferences when an individual transitions;
- Resource use measures, including total estimated Medicare spending per beneficiary;
- Discharge to community; and
- All-condition risk-adjusted potentially preventable hospital readmissions rates.

Under existing policy, measures adopted to the IRF QRP remain in the program until they are removed, suspended or replaced. A subregulatory process is used to incorporate National Quality Forum (NQF) updates to IRF quality measure specifications that do not substantively change the nature of the measure. Substantive changes are proposed and finalized through rulemaking.

A table at the end of this section (VI.I) displays the measures adopted for the IRF QRP.

CMS responds to general comments related to the IRF QRP addressing program measures, the IMPACT Act, endorsement by the National Quality Forum (NQF) and training needs. Within its responses, CMS discusses the nuances of a “conditional support” recommendation by the Measure Applications Partnership (MAP), under which it says measures are not expected to be resubmitted to the MAP. In addition, CMS says that the data elements currently included in the IMPACT Act measures are standardized and have been mapped to electronic exchange content standardized vocabularies (e.g., LOINC and SNOMED) to enable interoperability. CMS says it is engaging in additional efforts, including populating the Data Element Library data base which includes information to support interoperability.

B. Collection of Standardized Patient Assessment Data under the IRF QRP

The IMPACT Act requires that, beginning in FY 2019, IRFs must report standardized patient assessment data as required for at least the quality measures with respect to certain categories, summarized here as functional status; cognitive function; special services and interventions; medical conditions and comorbidities; impairments; and other categories deemed necessary and appropriate. The standardized patient assessment data must be reported at least with respect to IRF admissions and discharges, but the Secretary may require the data to be reported more frequently.

To implement this requirement, CMS finalizes its proposal that "standardized patient assessment data" be defined as patient assessment questions and response options that are identical in all four PAC assessment instruments, and to which identical standards and definitions apply. IRFs use the IRF Patient Assessment Instrument (IRF-PAI) to collect data on all Medicare Part A fee-for-service patients.

CMS says that the lack of standardization across the different PAC assessment instruments has inhibited comparison, and that standardizing the questions and response options across instruments will also enable the data to be interoperable and shared electronically or otherwise between PAC provider types. CMS intends to use the standardized patient assessment data for several purposes, including facilitating exchange among providers to enable high quality care and care coordination; calculation of quality measures; and identifying comorbidities that increase the medical complexity of an admission.

CMS describes its work with stakeholders and a Technical Expert Panel in identifying appropriate standardized patient assessment data. Data elements in the four existing PAC provider patient assessment instruments were considered, along with a literature search. Public meetings and public comment opportunities were provided. In its search, CMS sought data with the following attributes: (1) being supported by current science; (2) testing well in terms of their reliability and validity, consistent with findings from the Post-Acute Care-Payment Reform Demonstration (PAC PRD); (3) the potential to be shared (for example, through interoperable means) among PAC and other provider types to facilitate efficient care coordination and improved beneficiary outcomes; (4) the potential to inform the development of quality, resource use and other measures, as well as future payment methodologies that could more directly take into account individual beneficiary health characteristics; and (5) the ability to be used by practitioners to inform their clinical decision and care planning activities.

In the proposed rule, CMS also indicated that it considered clinical relevance, ability to support clinical decisions, care planning and interoperable exchange to facilitate coordination during transitions in care; the ability to capture medical complexity and risk factors to inform payment and quality; strong scientific reliability and validity; meaningful to inform longitudinal analysis by providers; general consensus on usability; and the ability for the data to collected once for multiple uses.

CMS finalizes its proposal that the policy for retaining IRF QRP measures until they are removed, suspended or replaced also be applied to the standardized patient assessment data

adopted for the IRF QRP. Similarly, CMS will apply the use of a subregulatory process adopted for IRF QRP measures to incorporate nonsubstantive updates to the standardized patient assessment data.

In the proposed rule, CMS discussed specific data elements it proposed to require that IRFs report as standardized patient assessment data. The elements addressed the five IMPACT Act assessment categories.

Responding to commenter concerns about reporting burden, CMS does not finalize most of the proposed data elements. The elements proposed for two of the five patient assessment categories (functional status and medical conditions and co-morbidities) are finalized. These elements are already required to calculate the pressure ulcer measure (both current and newly finalized) and the measure assessing the percent patients with a functional assessment at admission and discharge and a care plan that addresses function (NQF #2631). All the other proposed elements for the other three patient assessment categories (cognitive function and mental status; special services, treatment and interventions; and impairments) are not finalized at this time. CMS intends to conduct a national field test that allows for stakeholder feedback and that considers how to maximize the time that IRFs have available to prepare for reporting standardized patient assessment data for these categories. It intends to make new proposals for these categories not later than the FY 2020 IRF proposed rule.

Among other comments discussed in the final rule, MedPAC expressed concern that proposed data elements such as oxygen therapy, intravenous medications and nutritional approaches may induce service use. The Commission suggested that these items be tied to medical necessity. A physician attestation could be required to indicate the reported service is reasonable and necessary.

The table below summarizes the proposed and finalized standardized patient assessment data elements. It lists the elements by category, identifies the current PAC patient assessment instruments that include the proposed elements (or similar ones) and indicates whether the new data elements would be added to the IRF-PAI.

Standardized Patient Assessment Data Elements, by Category
Note: Elements for Shaded Categories were Proposed, but NOT finalized

Data Elements	Current Use/Test of Elements*	Change to IRF reporting
Functional Status		
Elements to calculate the measure: Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)	CARE Item Set	Currently reported
Medical Condition and Comorbidity Data		
Elements to calculate the current and newly finalized pressure ulcer measures: Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678) and Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	IRF-PAI	Currently reported

Standardized Patient Assessment Data Elements, by Category Note: Elements for Shaded Categories were Proposed, but NOT finalized		
Data Elements	**Current Use/Test of Elements***	**Change to IRF reporting**
Cognitive Function and Mental Status – NOT finalized		
Brief Interview for Mental Status (BIMS)	MDS 3.0 IRF-PAI PAC PRD	None; currently included in IRF PAI; assess at admission only
Confusion Assessment Method	LCDS MDS 3.0 PAC PRD	Add to IRF PAI
Behavioral Signs and Symptoms	MDS 3.0 OASIS-C2 PAC PRD	Add to IRF PAI (MDS version)
Patient Health Questionnaire-2	MDS 3.0 OASIS-C2 PAC PRD	Add to IRF PAI
Special Services, Treatments, and Interventions – NOT finalized		
Cancer Treatment: Chemotherapy (IV, Oral, Other)	MDS 3.0 PAC PRD	Add to IRF PAI
Cancer Treatment: Radiation	MDS 3.0	Add to IRF PAI
Respiratory Treatment: Oxygen Therapy (Continuous, Intermittent)	MDS 3.0 OASIS-C2 PAC PRD	Add to IRF PAI
Respiratory Treatment: Suctioning (Scheduled, As needed)	MDS 3.0 PAC PRD	Add to IRF PAI
Respiratory Treatment: Tracheostomy Care	MDS 3.0 PAC PRD	Add to IRF PAI
Respiratory Treatment: Non-invasive Mechanical Ventilator (BiPAP, CPAP)	LCDS MDS 3.0 OASIS-C2 PAC PRD	Add to IRF PAI
Respiratory Treatment: Invasive Mechanical Ventilator	LCDS MDS 3.0 PAC PRD	Add to IRF PAI
Other Treatment: Intravenous (IV) Medications (Antibiotics, Anticoagulation, Other)	MDS 3.0 OASIS-C2 PAC PRD	Add to IRF PAI
Other Treatment: Transfusions	MDS 3.0 OASIS-C2 PAC PRD	Add to IRF PAI
Other Treatment: Dialysis (Hemodialysis, Peritoneal dialysis)	LCDS MDS 3.0 PAC PRD	Add to IRF PAI
Other Treatment: Intravenous (IV) Access (Peripheral IV, Midline, Central line, Other)	MDS 3.0 OASIS PAC PRD	Add to IRF PAI
Nutritional Approach: Parenteral/IV Feeding	LCDS MDS 3.0 IRF-PAI OASIS-C2 PAC PRD	Modify the IRF PAI elements

Standardized Patient Assessment Data Elements, by Category Note: Elements for Shaded Categories were Proposed, but NOT finalized		
Data Elements	**Current Use/Test of Elements***	**Change to IRF reporting**
Nutritional Approach: Feeding Tube	MDS 3.0 OASIS-C2 IRF-PAI PAC PRD	Modify the IRF PAI elements
Nutritional Approach: Mechanically Altered Diet	MDS 3.0 OASIS-C2 IRF-PAI PAC PRD	Modify the IRF PAI elements
Nutritional Approach: Therapeutic Diet	MDS 3.0 PAC PRD	Add to IRF PAI
Impairment – NOT finalized		
Hearing	MDS 3.0 OASIS C-2 PAC PRD	Add to IRF PAI (MDS version) assess at admission only
Vision	MDS 3.0 OASIS C-2 PAC PRD	Add to IRF PAI (MDS version) assess at admission
*This column reflects whether the proposed rule indicated that the specific elements proposed or similar or related elements are included in the current PAC assessment instruments or tested in the PAC PRD. The PAC instruments referenced are: Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI); Long-Term Care Hospital Continuity Assessment Record and Evaluation Data Set (LCDS); MDS for Skilled Nursing Facilities; and OASIS C-2 for home health agencies. The Continuity Assessment Record and Evaluation (CARE) Item Set is a standardized patient assessment tool developed as part of the PAC-PRD for use at acute hospital discharge and at PAC admission and discharge.		

In the proposed rule discussion of these standardized patient assessment data elements, CMS provided the following links to further information. First is the report that details the elements, *Proposed Specifications for IRF QRP Quality Measures and Standardized Data Elements*, at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/Proposed-Specifications-for-IRF-QRP-Quality-Measures-and-Standardized-Data-Elements-Effective-10-1-2018.pdf. Second is a CMS web page on IMPACT Act downloads and videos which includes links to reports by the Technical Expert Panels that CMS used in considering which elements to propose and a summary of public comments on the elements: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-Downloads-and-Videos.html.

C. Changes to IRF QRP Measures

CMS finalizes, without change from the proposed rule, the following changes to IRF QRP measures:

- The current pressure ulcer measure -- Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short Stay) (NQF #0678) will be replaced by a modified version with a new name – Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury. Data collection for the new measure will begin October 1, 2018 for the FY

2020 IRF QRP. The modified version includes new or worsened unstageable pressure ulcers, including deep tissue injuries, in the measure numerator. In addition, it contains updated specifications intended to eliminate redundancies in the assessment items needed for its calculation and to reduce the potential for underestimating the frequency of pressure ulcers. The rule discusses the new specifications and the process that CMS used to develop the modified measure. CMS intends to submit the measure for NQF endorsement at the earliest opportunity. The MAP provided conditional support for using the new measure in the IRF QRP, and CMS says it intends to meet the MAP's conditions by offering additional training opportunities and educational materials prior to public reporting and by continuing to monitor and analyze the proposed measure. Specifications are available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/Final-Specifications-for-IRF-QRP-Quality-Measures-and-Standardized-Patient-Assessment-Data-Elements-Effective-October-1-2018.pdf

- The measure, All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from IRFs, will be removed from the IRF QRP beginning with FY 2019. In making this decision, CMS reconsidered comments it received during last year's rulemaking expressing concern about the multiplicity of readmission measures and the overlap between this measure and the All-Cause Readmission and Potentially Preventable Readmission (PPR) 30-Day Post-Discharge measures. CMS believes that removing this measure will prevent duplication.

In responding to comments on the pressure ulcer measure, CMS describes its analyses and comparing the current and new pressure ulcer measures and its testing of the M0300 data element that is used to calculate the new measure. It found the new measure both valid and reliable in the SNF, LTCH and IRF setting. The M0300 data element is found to have a high level of alignment with the M0800 element used in the current measure, and CMS says the M0300 improves accuracy by establishing a standardized calculation method. In a separate response, CMS notes that the M0300 data element is standardized across all PAC settings, enabling interoperability.

Further, CMS clarifies that the definitions of pressure ulcers are adapted from the National Pressure Ulcer Advisory Panel (NPUAP) and are standardized across all PAC settings. CMS notes updates to the NPUPA terminology, and says that for purposes of the measure, a skin condition should be coded on the IRF-PAI as a pressure ulcer if the primary cause of the condition is related to pressure. For example, if the medical record indicates the presence of a Stage 2 pressure *injury*, it should be coded on the assessment as a Stage 2 pressure *ulcer*. To provide greater clarity about the definitions of different types of unstageable pressure ulcers and how to code them on the IRF-PAI, CMS says it is engaging in training events, updates to the manuals and training materials, and responses to Help Desk questions to promote understanding and proper coding of these data elements.

Information and training will also be provided to assist providers and consumers in how to interpret scores on the new measure to avoid any possible confusion with the current measure, as commenters noted that performance scores are likely to differ on the two measures.

D. Measures Under Consideration for Future Years

CMS discusses comments it received on several possible future measures for the IRF QRP. They are:

- Experience of Care. CMS reports that it is developing an experience of care survey for IRFs, involving a public request for measures, focus groups and interviews with patients, family members and caregivers, and a Technical Expert Panel. The areas to be addressed are: beginning stay at the hospital/unit; interactions with staff; experience during the stay; preparing for discharge; and overall hospital/unit rating/
- Application of Percent of Residents Who Self-Report Moderate to Severe Pain (Short Stay) (NQF #0676)
- Advance Care Plan

CMS also indicated in the proposed rule that it is considering modifications to the existing Discharge to Community-PAC IRF QRP measure. In response to previous comments, CMS is considering a modification that would exclude from the measure patients who were nursing facility residents prior to IRF admission. For this rule, CMS says it received supportive comments on this possible change, and clarifies that it is only considering exclusion of long-term nursing facility residents from the measure, not patients admitted to IRF from a SNF setting.

Further, CMS stated in the proposed rule its intent to propose in future rulemaking two IMPACT Act measures to begin with the FY 2021 IRF QRP (2019 data collection) that involve transfer of health information. These are "Transfer of Information at Post-Acute Care Admission, Start or Resumption of Care from other Providers/Settings" and "Transfer of Information at Post-Acute Care Discharge, and End of Care to other Providers/Settings." Data collection for these measures would begin on or about October 1, 2019. CMS says that it will take comments it received into account as the measures are further developed, and that once tested and ready it plans to submit the measures to the MAP PAC/LTC Workgroup and to NQF for endorsement.

E. Accounting for Social Risk Factors in the IRF QRP

CMS describes comments it received in response to its request regarding accounting for social risk factors in the IRF QRP.[4] Specifically, CMS sought public comment on whether to account for social risk factors in the IRF QRP and, if so, what methods would be most appropriate to use. Examples offered included confidential reporting of stratified measure rates to providers; public reporting of stratified measure rates; and potential risk adjustment of a measure as appropriate based on data and evidence. In addition, public comment was sought on which social risk factors are most appropriate for stratifying measure scores and/or potential risk adjustment of a measure, where information on these factors would be available, or whether additional data collection is needed. Examples of social risk factors are dual eligibility/low-income subsidy, race and

[4] The proposed rule reviewed the results of recent reports by the Assistant Secretary for Planning and Evaluation https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicares-value-based-purchasing-programs and the National Academy of Sciences, Engineering and Medicine: http://www.nationalacademies.org/hmd/Reports/2017/accounting-for-social-risk-factors-in-medicare-payment-5.aspx..

ethnicity, and geographic area of residence. Comments on operational considerations were also welcomed.

Commenters generally supported accounting for social risk factors in the IRF QRP through risk adjustment of measures, although CMS reports a few were concerned that approach would result in unintended consequences or mask disparities in quality. MedPAC commented that the stratification approach of peer grouping facilities would be straightforward to implement and would allow for consideration of shared social risk factors in a patient population without dampening these by other individual patient characteristics. CMS received a number of suggestions for additional social risk factors including availability of primary care and therapy; access to food and medication; healthcare literacy; lack of support system; and homelessness and other living conditions.

CMS says it will consider the suggestions as it moves forward. It intends to explore options, including stratification, in a consistent manner across programs.

F. Data Submission for the IRF QRP

New IRFs. CMS finalizes without change its proposal that for new IRFs, the timing for initial reporting of standardized patient assessment data will be the same as the previously adopted schedule for reporting quality data under the IRF QRP. Data will be reported by submitting the IRF-PAI to CMS through the QIES ASAP system.

New Pressure Ulcer Measure. For the FY 2020 IRF QRP, the standardized patient assessment data necessary for the proposed new measure "Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury" will be reported for the last quarter of 2018 (October 1 - December 31). For FY 2021, IRFs will be required to submit data for the full calendar year 2019.

Standardized Patient Assessment Data. CMS finalizes that IRFs must report standardized patient assessment data by completing applicable sections of the IRF-PAI and submitting the IRF-PAI to CMS through the QIES ASAP system. Beginning with the FY 2019 IRF QRP, CMS will extend its current policy regarding the schedule for reporting quality measure data to the reporting of standardized patient assessment data. Under that policy, IRFs report data on quality measures for a full calendar year period except for the first program year of reporting a measure, in which case IRFs are only required to report data for IRF discharges that occur on or after October 1 of the last quarter of the applicable calendar year. Tables 9 and 10 of the final rule illustrate the reporting periods and data submission deadlines under this policy for FYs 2019 and 2020.

Data Completeness Standards. CMS finalizes its proposal that the data completeness standards that currently apply to the IRF QRP be extended to apply to reporting of standardized patient assessment data. Under that policy, IRFs must meet or exceed a threshold set at 95 percent for measures data collected through the IRF-PAI submitted through the QIES ASAP system. A 100 percent threshold applies to data submitted through the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN). CMS notes that some standardized patient assessment data will not invoke a response and, in those circumstances, are not "missing" nor are the data incomplete. These finalized data completeness requirements for

measure and standardized patient assessment data collected from the IRF-PAI are codified in regulations at 42 CFR 412.634(f).

CMS reports that several commenters opposed extending the 95 percent requirement to standardized patient assessment data. These commenters noted that an 80 percent data completion threshold for these data was proposed for SNFs and LTCHs. They further argued that data completion has been historically higher for IRFs than SNFs because the IRF assessment instrument has been shorter, but this has been changing as more requirements are added in rulemaking. CMS appreciates the concerns raised and says it will take them into consideration in future rulemaking. In particular, CMS says that it should take into consideration that reducing the threshold to a level consistent with other programs given the amount of data elements that must be coded and will likely expand over time.

Request for Comment on Collecting Data on All Patients. In the proposed rule, CMS discussed input it has received from the MAP and others suggesting that quality measures be expanded, where feasible, to include data on all patients and not just Medicare beneficiaries. It sought comment on this issue. The benefits of broader data and the potential collection burden for providers were noted, but CMS also understands that it is common practice for IRFs to collect IRF-PAI data on all patients, regardless of payer. CMS reports that MedPAC expressed concern about reporting burden, but many commenters said IRFs commonly complete the IRF-PAI on all patients. CMS will take comments it received into account as it considers expanding the IRF QRP data collection to include all patients regardless of payer.

G. Public Display of IRF QRP Measure Data

CMS previously adopted policies for public display of IRF QRP data on the *IRF Compare* website, and for confidential feedback reports on these measures to IRFs prior to public reporting. No changes were proposed to these policies.

In this rule, pending the availability of data, CMS finalizes its proposal to publicly report data in 2018 on six additional measures. For the replacement of the pressure ulcer measure and removal of the all cause readmissions measure, associated changes will be made with respect to public reporting. A table in the final rule lists the measures previously and newly finalized for public display. These are indicated in the summary table below.

A variety of comments received by CMS regarding public display are discussed. In responding to concerns about the inability of IRFs to review results for the CDC NHSN measures prior to public display on *IRF Compare* due to timing and system issues, CMS says it is working closely with CDC to address this issue. CMS has suppressed public display of the CDC NHSN measures until it can post accurate data. CMS assures providers that they will be given the opportunity to review any corrected data for a full 30 days prior to public posting of the data. Providers will be notified when CMS is ready to add these measure results back to *IRF Compare* through the normal channels of communications. In addition, CMS says that it is considering the potential effect of systems issues that have arisen to date on provider compliance.

H. Method for Applying the Reduction to the FY 2018 IRF Increase Factor for IRFs that Fail to Meet the Quality Reporting Requirements

Table 12 of the final rule (reproduced below) shows the calculation of the adjusted FY 2018 standard payment conversion factor that will be used for any IRF that failed to meet the IRF QRP reporting requirements for the applicable reporting period.

CMS Table 12: Calculations to Determine the Adjusted FY 2018 Standard Payment Conversion Factor for IRFs that Failed to Meet the Quality Reporting Requirement		
Explanation for Adjustment	**Calculations**	
Standard Payment Conversion Factor for FY 2017		$15,708
Increase Factor for FY 2018 (1.0 percent), as required by section 1886(j)(3)(C)(iii) of the Act, and further reduced by 2 percentage points for IRFs that failed to meet the quality reporting requirement	x	0.9900
Budget Neutrality Factor for the Wage Index and Labor-Related Share	x	1.0007
Budget Neutrality Factor for the Revisions to the CMG Relative Weights	x	0.9976
Adjusted FY 2018 Standard Payment Conversion Factor	=	$15,524

I. Summary Table of IRF QRP Measures

Quality Measures Adopted for the IRF QRP

Short Name	**Measure Name & Data Source**	**Change for FY 2020**	**Public Reporting in CY 2018**
IRF-PAI			
Pressure Ulcers	Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678)	Replaced	X Removed by October 2020
	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	Added	Added by October 2020
Patient Influenza Vaccine	Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680)		X
Application of Falls	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)*		Newly added
Application of Functional Assessment	Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)*		Newly added
Change in Self-Care	IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633)**		
Change in Mobility	IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634)**		
Discharge Self-Care Score	IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635)**		
Discharge Mobility Score	IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636)**		

Short Name	Measure Name & Data Source	Change for FY 2020	Public Reporting in CY 2018
DRR	Drug Regimen Review Conducted with Follow-Up for Identified Issues– PAC IRF QRP*		
NHSN			
CAUTI	National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138)		X
MRSA	NHSN Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (NQF #1716)		X
CDI	NHSN Facility-wide Inpatient Hospital-Onset Clostridium difficile Infection (CDI) Outcome Measure (NQF #1717)		X
HCP Influenza Vaccine	Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431)		X
Claims-based			
All-Cause Readmissions	All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from IRFs (NQF #2502)	Removed	Removed
MSPB	Medicare Spending per Beneficiary (MSPB)–PAC IRF QRP*		Newly added
DTC	Discharge to Community–PAC IRF QRP*		Newly added
Potentially Preventable Readmissions (PPR) 30 day	Potentially Preventable 30-Day Post-Discharge Readmission Measure for IRF QRP*		Newly added
PPR Within Stay	Potentially Preventable Within Stay Readmission Measure for IRFs*		Newly added

*Not currently NQF-endorsed for the IRF setting.
**In satisfaction of section 1899B(c)(1) of the Act (i.e., IMPACT Act) quality measure domain: functional status, cognitive function, and changes in function and cognitive function domain.
Note: when a measure is described as "application of" it means the underlying measure was endorsed by the NQF for another setting.

XIII. Miscellaneous Comments

CMS responds to comments unrelated to proposals in the rule. These address: facility-level adjustments; specific codes on the presumptive compliance list; including the 7th character for "subsequent encounters" for diagnosis codes on the presumptive compliance list; treatment of comorbidities in the presumptive compliance list; and inter-rater reliability of the IRF-PAI. Responding to a comment, CMS says that it does not believe that recreational therapy should replace the provision of core skilled therapy services. Recreational therapy is a covered service in an IRF when medical necessity is well documented by the physician in the medical record and ordered by a physician as a part of the patient's plan of care. It may be offered in addition to the core skilled therapy services used to demonstrate the provision of an intensive rehabilitation therapy program.

XIV. Regulatory Impact Analysis

CMS estimates that the final rule will increase Medicare payments to IRFs by $75 million in FY 2018 compared with FY 2017. This falls short of the $100 million threshold defining it as a major rule, and therefore no regulatory impact analysis is provided.

The final rule includes provisions that CMS estimates will reduce costs to IRFs. (The proposed rule also included new patient assessment data elements that would increase reporting burden, but these are not finalized in this rule.) The finalized changes involve removal of the swallowing status item and some pressure ulcer assessment data items from the IRF-PAI. As a result, CMS estimates that reductions in the measure reporting requirements will result in a net 5.5-minute reduction in compliance time spent by LTCHs, with an overall reduction of $2,255 per IRF annually, or $2.6 million for all IRFs annually.