Medicare Inpatient Rehabilitation Facility Prospective Payment System for FY 2020
[CMS-1710-F]
Summary of Final Rule

On August 8, 2019, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* (84 FR 39054) a final rule on the Medicare inpatient rehabilitation facility prospective payment system (IRF PPS) for federal fiscal year (FY) 2020.

The IRF PPS update factor for FY 2020 is 2.5 percent, reflecting a market basket increase (+2.9 percent) and the required multifactor productivity adjustment (-0.4 percent). Including budget neutrality adjustments, the standard payment conversion factor will increase from $16,021 in FY 2019 to $16,489 for facilities meeting the standards in the IRF Quality Reporting Program (QRP), and $16,167 for facilities not meeting the IRF QRP standards and subject to the 2-percentage point penalty. CMS estimates that Medicare IRF PPS payments in FY 2020 will be about $210 million higher than in FY 2019.

In addition to provisions to update the IRF PPS payment rates and outlier threshold for FY 2020, the rule rebases the IRF PPS market basket, modifies the wage index, adds two new measures to the IRF QRP and requires IRFs to report on a set of standardized patient assessment data elements (SPADEs) beginning with the FY 2022 IRF QRP.

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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 2019, and an operational overview. Among other things, CMS notes that the FY 2019 final rule removed the Functional Independence Measure (FIM™) instrument and associated Function Modifiers from the IRF patient assessment instrument (IRF-PAI) beginning in FY 2020.

II. Refinements to the Case-Mix Classification System

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.

As previously finalized, beginning with FY 2020, CMS will incorporate the data items collected on admission and located in the Quality Indicator section of the IRF-PAI into the CMG classification system. This was necessitated by finalizing the removal of the FIM™ instrument from the IRF-PAI beginning with FY 2020.

In this rule, CMS does not finalize its proposal to vary weights in calculating the motor score used to assign patients to a CMG. However, does revise the CMGs and update the relative weights and average length of stay values for FY 2020 as proposed.

A. Use of a Weighted Motor Score Beginning with FY 2020

In the 2019 IRF PPS final rule, CMS adopted (for FY 2020 and later years) an unweighted additive motor score for use in assigning patients to CMGs. The score is derived from 19 data items located in the Quality Indicator section of the IRF-PAI: eating, oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear, bladder continence, bowel continence, roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, walk 10 feet, walk 50 feet with two turns, walk 150 feet, and 1 step (curb). In finalizing this policy, CMS stated that this unweighted score was preferable to a weighted score because it is less complex and more easily understood. Beginning in 2020, the unweighted additive motor score replaces the current weighted score, which is based on FIM™ instrument data elements.

CMS had proposed to instead use a weighted motor score to assign patients to CMGs beginning with FY 2020, but this policy is not finalized. Removal of the data item "roll left to right," is finalized, however. The final motor score index for 2020 is shown in Table 2, reproduced below. As previously finalized, the motor score will be the sum of the scores for these items, each effectively given a weight of 1.0.

The decision not to move forward with the proposed weighted motor score is made in response to the overwhelming number of commenters opposing or requesting delay in this change. Reviewing the comments, CMS concluded that the weighted score is only slightly more accurate while the unweighted score is less complex. It believes that use of the unweighted score will ease providers' transition to the use of the Quality Indicators section of the IRF-PAI.

TABLE 2: Final Motor Score Weight Index for FY 2020

Item	Weight
GG0130A1 - Eating	1
GG0130B1 - Oral hygiene	1
GG0130C1 - Toileting hygiene	1
GG0130E1 - Shower bathe self	1
GG0130F1 - Upper-body dressing	1
GG0130G1 - Lower-body dressing	1

Item	Weight
GG0130H1 - Putting on/taking off footwear	1
GG0170B1 - Sit to lying	1
GG0170C1 - Lying to sitting on side of bed	1
GG0170D1 - Sit to stand	1
GG0170E1 - Chair/bed-to-chair transfer	1
GG0170F1 - Toilet transfer	1
GG0170I1 - Walk 10 feet	1
GG0170J1 - Walk 50 feet with two turns	1
GG0170K1 - Walk 150 feet	1
GG0170M1 - One-step curb	1
H0350 - Bladder Continence	1
H0400 - Bowel Continence	1

B. Revisions to CMGs and Updates to CMS Relative Weights and Average Length of Stay Values

Updates to the CMG relative weights and average length of stay values are made for FY 2020, using the same methodologies that have been used in past years, now applied to FYs 2017 and 2018 IRF claims and FY 2017 IRF cost report data. The methodology is described in a March 2019 technical report available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Downloads/IRFPPSAnalysis2019RTI032219.pdf. The final budget neutrality factor is 1.0010.

Table 3 in the final rule displays the final relative weights and length of stay values by CMG and comorbidity tier. Table 20 in the impact section of the final rule (section VIII below) shows the distributional effects of the changes in the CMGs by type of facility. For provider-specific impact analysis of the CMG changes, CMS refers readers to the FY 2020 final rule data files available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/List-of-IRF-Federal-Regulations-Items/CMS-1710-F.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending

CMS responds to a number of comments it received on the revisions to the CMGs. It disagrees with commenters that the revisions will result in payment rate compression or could compromise access to care for particular patients, and refers readers to the technical report cited above. CMS acknowledges that payments to providers may be redistributed as a result of revised CMGs, and will consider monitoring the impact of the use of the Quality Indicators "section GG" items on the distribution of patients among the CMGs for future updates. It will continue to provide educational opportunities for the IRF community regarding training and guidance on proper coding of the Quality Indicator data items.

III. Facility-Level Adjustment Factors

For FY 2020, the facility-level adjustment factors (that is, the rural, low income percentage (LIP) and teaching status adjustment factors) will continue to be held at the FY 2014 levels. CMS continues monitor the most current IRF claims data available and evaluate the effects of the changes that were adopted in the FY 2014 final rule.

IV. FY 2020 IRF PPS Payment Update

For FY 2020 payment, CMS rebases the IRF PPS market basket; applies the annual market basket update and productivity adjustment; updates the labor-related share of payment; and aligns the market basket used for the IRF PPS with that used in other PAC payment systems.

A. Rebasing and Revising of the IRF PPS Market Basket

The IRF PPS market basket is rebased from a 2012-based index to a 2016-based index beginning with the FY 2020 payment update. CMS believes that 2016 represents the most recent and complete set of Medicare cost report data available. The cost reports included are those for providers with cost reporting periods beginning on or after October 1, 2015 and prior to September 30, 2016.

The final rule details the methodology used to rebase the market basket, which is generally the same methodology CMS used in creating the current 2012-based IRF market basket. That involves using Medicare cost report data to calculate weights for seven cost categories: Wages and Salaries; Employee Benefits; Contract Labor; Pharmaceuticals; Professional Liability Insurance; Home Office Contract Labor; and Capital. A residual category captures all remaining costs, and detailed weights are calculated for 17 categories within this residual by using 2012 Benchmark Input-Output data for hospitals as published by the Bureau of Economic Analysis (BEA). http://www.bea.gov/industry/input-output-accounts-data.[1]

The major difference from the 2012-based market basket is that CMS derives the Home Office Contract Labor cost weight from Medicare cost report data instead of including it among the residual categories. The price proxies are the same as used for the 2012-based market basket although in some cases where blended proxies are used (e.g., chemicals; fuel, oil, and gasoline; medical instruments) the weights given to the proxies are different to reflect the updated BEA data. Similarly, the vintage weights developed for capital-related price proxies for the 2016-based market basket use the same methodology as was used for the 2012-based market basket, but the values are different to reflect updated information.

CMS received a number of comments opposing the change in the method for calculating the Home Office Contract Labor cost weight. It is finalizing the proposed methods, but invites commenters to submit additional data regarding treatment of home office expenses for IRF units for future rulemaking.

[1] Specifically, CMS applies data from the "Use Tables/Before Redefinitions/Purchaser Value" for NAICS 622000, Hospitals.

Final rule Table 7, reproduced below, compares the final 2016-based market basket cost weights with those from the 2012-based market basket. (Table 10, not included in this summary, shows the 2016-based market basket weights and price proxies.)

TABLE 7: Final 2016-based IRF Market Basket Cost Weights Compared to 2012-based IRF Market Basket Cost Weights

Cost Category	2016- based IRF Market Basket Cost Weight	2012-based IRF Market Basket Cost Weight
Total	**100.0**	**100.0**
Compensation	**59.4**	**59.2**
Wages and Salaries	47.9	47.9
Employee Benefits	11.4	11.3
Utilities	**1.4**	**2.1**
Electricity	1.0	1.0
Fuel, Oil, and Gasoline	0.4	1.1
Water & Sewerage	n/a	0.1
Professional Liability Insurance	**0.7**	**0.9**
All Other Products and Services	**29.5**	**29.1**
All Other Products	**12.5**	**13.3**
Pharmaceuticals	5.1	5.1
Food: Direct Purchases	1.1	1.7
Food: Contract Services	1.2	1.0
Chemicals	0.4	0.7
Medical Instruments	2.9	2.3
Rubber & Plastics	0.4	0.6
Paper and Printing Products	0.6	1.1
Miscellaneous Products	0.8	0.8
All Other Services	**17.0**	**15.8**
Labor-Related Services	**9.2**	**8.0**
Professional Fees: Labor-related	5.0	3.5
Administrative and Facilities Support Services	0.7	0.8
Installation, Maintenance, and Repair	1.6	1.9
All Other: Labor-related Services	1.8	1.8
Nonlabor-Related Services	**7.9**	**7.8**
Professional Fees: Nonlabor-related	5.4	3.1
Financial Services	0.9	2.7
Telephone Services	0.3	0.7
All Other: Nonlabor-related Services	1.3	1.3
Capital-Related Costs	**9.0**	**8.6**
Depreciation	**6.5**	**6.4**
Fixed Assets	4.1	4.1
Movable Equipment	2.5	2.3
Interest Costs	**1.5**	**1.4**
Government/Nonprofit	0.9	0.9
For Profit	0.6	0.5
Other Capital-Related Costs	**1.0**	**0.8**

Note: Detail may not add to total due to rounding.

Finally, Table 11 from the final rule, reproduced below, compares the percent change in the 2012-based and 2016-based IRF market baskets for FYs 2015 through FY 2022 (forecasts). It is updated from the proposed rule to reflect more recent forecasts. There are small differences in a few years and a 0.1 percentage point difference on average between the two IRF PPS market baskets over the entire period.

TABLE 11: Final 2016-Based IRF Market Basket and 2012-Based IRF Market Basket Percent Changes, FY 2015 through FY 2022

	Fiscal Year (FY)	Final 2016-Based IRF Market Basket Index Percent Change	2012-Based IRF Market Basket Index Percent Change
Historical data	FY 2015	1.7	1.6
	FY 2016	1.8	1.8
	FY 2017	2.4	2.5
	FY 2018	2.3	2.4
	Average 2015-2018	**2.1**	**2.1**
Forecast	FY 2019	2.5	2.6
	FY 2020	2.9	2.9
	FY 2021	3.1	3.2
	FY 2022	3.1	3.1
	Average 2019-2022	**2.9**	**3.0**

Note that these market basket percent changes do not include any further adjustments as may be statutorily required.
Source: IHS Global Inc. 2nd quarter 2019 forecast.

Responding to commenters concerned about transparency, CMS says that detailed forecasts of the IRF market basket are available upon request by sending an email to CMSDNHS@cms.hhs.gov. The data provided can be used to replicate historical and forecasted IRF market basket updates.

B. Market Basket Update and Productivity Adjustment

An update factor of 2.5 percent is finalized for the IRF PPS payment rates for FY 2020, composed of the following elements.

Final FY 2020 IRF PPS Update Factor	
Market basket	2.9%
Multifactor productivity (MFP)	-0.4%
Total	2.5%

The 2.9 percent FY 2020 market basket increase factor is based on IHS Global Insight's (IGI's) most recent forecast, which is from the second quarter of 2019. Similarly, the statutorily required MFP adjustment is based on IGI's second quarter 2019 forecast of the 10-year moving average (ending in 2020) of changes in annual economy-wide private nonfarm business multifactor productivity. (No further statutory reduction is required for FY 2020.) The update factor for IRFs that fail to meet requirements for the IRF QRP is discussed in section VII.H below and totals 0.5 percent.

CMS notes that the Medicare Payment Advisory Commission (MedPAC) recommends that for FY 2020 the Congress should reduce the IRF PPS rates by 5 percent, citing margins that have been above 11 percent since 2012.

C. Labor-Related Share for FY 2020

CMS adopts a total labor-related share of 72.7 percent for FY 2020, reflecting the category weights associated with the use of the 2016-based market basket. (The FY 2019 labor share is 70.5 percent.) The 72.7 percent comes from the IGI second 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.

Table 12 of the final rule compares the components of the 2019 and 2020 labor shares. The largest change (+1.6 percentage points) is for Professional Fees: Labor-Related. In the rule, CMS details how expenses are attributed to this category.

D. Wage Adjustment

CMS adopts a change to the wage index used for the IRF PPS. Historically CMS has used the most recent final IPPS wage index available, which is the pre-reclassification, pre-floor IPPS wage index values with a one-year lag. For example, for the FY 2019 IRF PPS CMS used the FY 2018 pre-reclassification, pre-floor IPPS wage index. In response to a request for information, CMS has previously received comments recommending that it modify its methodology to use the same wage index data across post-acute care settings. For the skilled nursing facility and long-term care hospital payment systems, CMS uses the concurrent year's IPPS wage index (i.e., the FY 2019 IPPS wage index is used for these payment systems in FY 2019). CMS has previously argued that the one-year lag does not hinder the ability of IRFs to demonstrate their cost effectiveness relative to other post-acute providers for purposes of participating in alternative payment models as suggested by commenters.

In this rule, CMS reverses its past position and aligns the IRF wage index methodology with other post-acute care settings. Specifically, the pre-floor, pre-reclassification IPPS wage index for the current fiscal year will be used. For FY 2020, therefore, CMS will use the FY 2020 pre-floor, pre-reclassification IPPS wage index. (This is based on 2016 hospital cost report data.) The change will be made in a budget neutral manner; the final budget neutral wage adjustment factor is 1.0076. Labor market delineations are updated, including addition of a new Twin Falls, Idaho urban CBSA.

E. Description of the IRF Standard Payment Conversion Factor and Payment Rates for FY 2020

Table 13 of the final rule (reproduced below) shows the calculations used to determine the FY 2020 IRF standard payment amount. In addition, Table 14 of the rule lists the FY 2020 payment rates for each CMG, and Table 15 provides a detailed hypothetical example of how the IRF FY

2020 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 final rule.

Table 13: Calculations to Determine the FY 2020 Standard Payment Conversion Factor		
Explanation for Adjustment	**Calculations**	
Standard Payment Conversion Factor for FY 2019		$16,021
Market Basket Increase Factor for FY 2020 (2.9 percent), reduced by 0.4 percentage point for the statutory productivity adjustment	x	1.025
Budget Neutrality Factor for the Wage Index and Labor-Related Share	x	1.0031
Budget Neutrality Factor for the Revisions to the CMGs and CMG Relative Weights	x	1.0010
FY 2020 Standard Payment Conversion Factor	=	$16,489

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 this policy is continued for FY 2020. 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 2020, CMS used FY 2018 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 3.0 percent of total IRF payments in FY 2019. To maintain estimated outlier payments at the 3 percent level, CMS updates the outlier threshold amount from $9,402 for FY 2019 to $9,300 for FY 2020.

Updates are made to the national urban and rural CCRs for IRFs, as well as the national CCR ceiling for FY 2020, based on analysis of the most recent data that are available (FY 2017). 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 will again be set at 3 standard deviations above the mean CCR for FY 2020. 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 national average CCRs for FY 2020 are 0.405 for urban IRFs and 0.500 for rural IRFs, and the national CCR ceiling is 1.31.

VI. Clarification of the Definition of a Rehabilitation Physician

In 42 CFR 412.622(a)(3)(iv) a rehabilitation physician is defined as "a licensed physician with specialized training and experience in inpatient rehabilitation." CMS notes that the level of training and experience is not specified because it believes that IRFs are in the best position to make this determination. A change in the regulatory text is made to clarify this. The new definition reads as follows: "*Rehabilitation physician* means licensed physician who is determined by the IRF to have specialized training and experience in inpatient rehabilitation." The revised definition is moved to a new paragraph at §412.622(c), and other conforming changes are made to regulatory text.

Many commenters supported the change, and CMS responds to others concerned that some IRFs may hire or contract with unqualified or underqualified physicians. CMS emphasizes that it has not changed the requirement that a rehabilitation physician is licensed with specialized training and experience in inpatient rehabilitation. It is clarifying that the IRF makes the determination as to whether a physician meets this qualification. CMS expects that IRFs will continue to ensure that rehabilitation physicians have the necessary training and experience and, based on stakeholder feedback, will continue to assess whether future refinements may be needed.

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

A. Background

CMS established the IRF QRP beginning in FY 2014 as required under section 1886(j)(7) 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. Under the statute, 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.

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 adopted through notice and comment rulemaking.

Section VII.I below provides a table that displays the measures adopted for the IRF QRP for FY 2020. This rule does not change the 2020 measures.

B. New Measures for FY 2022

CMS finalizes the addition of two new process measures for the IRF QRP beginning with FY 2022 for a new quality measure domain entitled "Transfer of Health Information." In addition, CMS updates the specifications for the Discharge to Community - PAC IRF QRP measure in order to exclude baseline nursing facility (NF) residents. Specifications for these measures 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-SPADEs.pdf

Data submission requirements for the two new measures are discussed in VII.E.2 below.

- Transfer of Health Information to the Provider -- PAC Measure. This measure assesses whether a current reconciled medication list is given to the subsequent provider when an individual transitions from a post-acute care (PAC) setting to another setting. Specifically, it is calculated as the proportion of patient stays with a discharge assessment indicating that a current reconciled medication list was provided to the subsequent provider at discharge. The denominator is the total number of IRF patient stays ending in discharge to a subsequent provider (an acute care hospital, intermediate care, home under the care of a home health service organization or hospice, institutional hospice, skilled nursing facility (SNF), another IRF, a long-term care hospital (LTCH), inpatient psychiatric facility, or a Critical Access Hospital). The numerator is the number of IRF patient stays with an IRF-PAI discharge assessment indicating a current reconciled medication list was provided to the subsequent provider at discharge.
- Transfer of Health Information to the Patient -- PAC Measure. This related new measure assesses whether a current reconciled medication list was provided to the patient, family, or caregiver when a patient was discharged from a PAC setting to a private home/apartment, board or care home, assisted living, group home, transitional living, or home under care of a home health service organization or hospice. The measure denominator is the total number of IRF patient stays ending in discharge to the locations listed above, and the numerator is the number of IRF patient stays with an IRF-PAI discharge assessment indicating that a current reconciled medication list was provided to the patient, family, or caregiver at discharge.
- Update to the Discharge to Community PAC Measure. The specifications for this measure are updated to remove baseline nursing facility residents beginning with the FY 2020 IRF QRP. The measure reports an IRF's risk-standardized rate of Medicare fee-for-service patients who are discharged to the community following an IRF stay, who within the following 31 days remain alive and do not have an unplanned readmission to an acute care hospital or LTCH. Baseline NF residents are defined as IRF patients who had a long-term NF stay in the 180 days preceding their hospitalization and IRF stay, with no intervening community discharge between the NF stay and qualifying hospitalization.

CMS responds to a number of comments regarding the transfer of information measures. It states that it plans to submit them for NQF endorsement as soon as feasible. CMS believes these measures will not substantially increase burden on IRFs because many hospitals already generate medication lists as a best practice for discharge planning. Further, CMS rejects a suggestion that the "not applicable" answer choice available in the home health version of this measure be applied to all PAC settings, including IRFs. It says that this option is available because, unlike facility settings, a home health agency may not be immediately aware of a patient's status, for example, when a patient is taken to the emergency room.

Regarding exclusion of baseline nursing facility residents from the discharge to community measure, CMS reports that MedPAC does not support this change. MedPAC suggests instead expanding the definition of "return to the community" to include baseline nursing home residents returning to the nursing home where they live. CMS disagrees with MedPAC and says that community is generally understood by policy makers, providers and other stakeholders to mean non-institutional settings, and that baseline nursing facility residents are an inherently different patient population.

C. Request for Information on IRF QRP Quality Measures, Measure Concepts and SPADEs under Consideration for Future Years

In the proposed rule CMS sought comment on the importance, relevance, appropriateness and applicability of the following measures, SPADEs and concepts under consideration for future years. (From Table 17 in the final rule.) CMS describes the comments it received, which will be considered in future policy making.

- Measures and Measure Concepts
  - Opioid use and frequency
  - Exchange of Electronic Health Information and Interoperability
- Standardized Patient Assessment Data Elements
  - Cognitive complexity, such as executive function and memory
  - Dementia
  - Bladder and bowel continence including appliance use and episodes of incontinence
  - Care preferences, advance care directives, and goals of care
  - Caregiver Status
  - Veteran Status
  - Health disparities and risk factors, including education, sex and gender identity, and sexual orientation

D. Standardized Patient Assessment Data Reporting Beginning with FY 2022

The IMPACT Act requires that, beginning in FY 2019, IRFs must report SPADEs 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 by the Secretary. The standardized patient assessment data must be reported under the IRF QRP at least with respect to IRF admissions and discharges, but the Secretary may require the data to be reported more frequently.

In this rule, CMS finalizes requirements that IRFs report a new series of SPADEs. The list of newly adopted SPADEs, along with information on their current use in PAC patient assessment instruments and whether changes apply to the IRF PAI are summarized in a table at the end of this section. Detailed specifications for the SPADEs 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-SPADEs.pdf.

A final change table and mockup of IRF QRP items are available at 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. These latter two documents also include the data elements associated with the new transfer of health information measures discussed above.

The required reporting will begin with the FY 2022 IRF QRP. For FY 2022 the data will be reported with respect to both admissions and discharges for Medicare Part A and Medicare Advantage patients discharged between October 1, 2020 and December 31, 2020. For FY 2023 and later years, the data will be required for admissions and discharges that occur during a calendar year – 2021 for the FY 2023 IRF QRP, 2022 for the FY 2024 IRF QRP, etc.

For each SPADE, the final rule discusses the rationale, whether the element is currently used in any PAC patient assessment instruments, describes past comments from stakeholders and pilot testing and responds to comments on the proposed rule. Most of the newly adopted SPADEs were proposed but not finalized as part of FY 2018 rulemaking. Those that were new in this year's rulemaking involve functional status (six mobility-related data elements already adopted for the other three PAC settings); high risk drug classes; pain interference; and social determinants of health, which is a newly added category of SPADEs. These address race, ethnicity, preferred language and interpreter services, health literacy, transportation, and social isolation.

With a change from the proposed rule, CMS finalizes that if certain SPADEs are submitted with respect to admission only, they will be deemed to have been submitted for both admission and discharge as generally required. This policy is finalized because assessment of certain elements is unlikely to change between admission and discharge. As proposed, this policy is finalized for the Hearing, Vision, and Race and Ethnicity SPADEs. In addition, based on comments received from stakeholders, CMS will also apply this policy to the new SPADEs regarding preferred language and interpreter services. CMS disagrees with comments suggesting the policy also apply to other SPADEs, including transportation, social isolation and health literacy.

In responding to several comments, CMS notes that the SPADEs in no way preclude providers from conducting further patient evaluation or assessment in their settings that they believe to be needed and useful. CMS intends to engage with stakeholders about how the SPADEs will be used in the IRF QRP as those plans are developed. Numerous comments on individual SPADEs are discussed.

In the collection of information requirements section of the final rule, CMS estimates that the burden of additional reporting of these SPADEs would increase costs to IRFs by $6,902 per IRF annually, and $7.7 million across all IRFs.

Standardized Patient Assessment Data Elements, by Category		
Data Elements	**Current Use/Test of Elements***	**Change to IRF-PAI**
Cognitive Function and Mental Status		
Brief Interview for Mental Status (BIMS)	MDS IRF-PAI	Add to discharge assessment (currently admission only)
Confusion Assessment Method	LCDS (6 items) MDS (4 items)	New item Add to IRF PAI (4 questions)
Patient Health Questionnaire-2 to 9 (depression screening)	MDS (PHQ-9) OASIS (PHQ-2)	New item
Special Services, Treatments, and Interventions		
Cancer Treatment: Chemotherapy (IV, Oral, Other)	MDS (single)	New item
Cancer Treatment: Radiation	MDS	New item
Respiratory Treatment: Oxygen Therapy (Intermittent, Continuous, High-concentration Oxygen Delivery)	MDS OASIS PAC PRD	New item
Respiratory Treatment: Suctioning (Scheduled, As needed)	MDS PAC PRD	New item
Respiratory Treatment: Tracheostomy Care	MDS	New item
Respiratory Treatment: Non-invasive Mechanical Ventilator (BiPAP, CPAP)	LCDS MDS	New item
Respiratory Treatment: Invasive Mechanical Ventilator	LCDS MDS	New item
Intravenous (IV) Medications (Antibiotics, Anticoagulation, Vasoactive Medications, Other)	MDS OASIS	New item
Transfusions	MDS PAC PRD	New item
Dialysis (Hemodialysis, Peritoneal dialysis)	LCDS MDS	New item
Other Treatment: Intravenous (IV) Access (Peripheral IV, Midline, Central line, Other)	None	New item
Nutritional Approach: Parenteral/IV Feeding	LCDS MDS IRF-PAI OASIS	Replace current IRF PAI nutrition elements with MDS nutrition elements
Nutritional Approach: Feeding Tube	MDS OASIS IRF-PAI PAC PRD	
Nutritional Approach: Mechanically Altered Diet	MDS OASIS IRF-PAI	
Nutritional Approach: Therapeutic Diet	MDS	
High-Risk Drug Classes: Use and Indications		New item
Medical Condition and Comorbidity Data		
Pain Interference (Pain Effect on Sleep, Pain Interference with Therapy Activities, and Pain Interference with Day-to-Day Activities)	OASIS MDS	New item

Standardized Patient Assessment Data Elements, by Category		
Data Elements	**Current Use/Test of Elements***	**Change to IRF-PAI**
Impairment		
Hearing	MDS	New item **
Vision	MDS OASIS	New item ** (MDS version)
Social Determinants of Health		
Race	MDS LCDS IRF-PAI OASIS	Replace current IRF-PAI elements**
Ethnicity		
Preferred Language and Interpreter Services	MDS LCDS	New item**
Health Literacy		New item
Transportation	PREPARE/AHC screening tool	New item
Social Isolation	PROMISE/AHC screening tool	New item
*This column reflects whether the final rule indicates that the specific elements, or similar or related elements, are included in the current PAC assessment instruments or tested in the Post-Acute Care Payment Reform Demonstration (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 for home health agencies. ** IRFs submitting these SPADEs with respect to admission only will be deemed to have submitted them for both admission and discharge, because it is unlikely that assessment of these SPADEs would change during the IRF stay.		

E. Form, Manner, and Timing of Data Submission

1. Reporting System Update

CMS reports that it is upgrading the Quality Improvement and Evaluation System (QIES) Assessment and Submission Processing (ASAP) system used by IRFs to report the IRF-PAI data. The new system will be called the internet QIES (iQIES) and CMS proposes changes to the regulatory text consistent with this change, effective October 1, 2019. A general reference to use of a "CMS-designated data submission system" will replace the existing references to the QIES ASAP.

2. Schedule for Reporting Transfer of Health Information Quality Measures

As summarized in section VII.B above, two new measures are adopted for the IRF QRP beginning with FY 2022 payment. IRFs are required to collect data for these measures beginning with patients discharged on or after October 1, 2020.

3. Schedule for Reporting SPADEs

Similarly, with respect to reporting on the new SPADEs as summarized in section VII.D above, IRFs are required to collect data for all patients discharged after October 1, 2020 at both

admission and discharge. As noted above, for some SPADEs collection by an IRF at admission only will be deemed to meet this requirement. These are the SPADES on Race and Ethnicity, Preferred Language and Interpreter Services, Hearing and Vision.

4. All-Patient Data Reporting for IRF-PAI

CMS does not finalize its proposal to require IRFs to report IRF-PAI data on all patients, regardless of payer, beginning October 1, 2020. It acknowledges the concerns raised by some commenters regarding administrative challenges, the need to account for the reporting burden on IRFs, and the need to provide further detail and training to IRFs. It intends to use the comments received to help inform a future all-payer data reporting proposal.

F. Policies Regarding Public Display of Measure Data for the IRF QRP

The measure "Drug Regimen Review Conducted with Follow-Up for Identified Issues" is added to the *IRF Compare* website (https://www.medicare.gov/inpatientrehabilitationfacilitycompare/). Display will be for a rolling four quarters of data, initially using data for discharges occurring during calendar year 2019. Data for IRFs with fewer than 20 eligible cases in any four consecutive rolling quarters will not be publicly displayed. The website will indicate when the number of cases is too small to publicly report.

G. Removal of the List of Compliant IRFs

CMS will stop publishing a list of compliant IRFs, (i.e., those meeting the IRF QRP reporting requirements) on the IRF QRP website, effective beginning with the FY 2020 payment determination. CMS agrees with feedback it has received from stakeholders that this listing does not provide new information to providers regarding their annual payment update status.

H. Method for Applying the Reduction to the FY 2020 IRF Increase Factor for IRFs That Fail to Meet the Quality Reporting 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 18 of the final rule (reproduced below) shows the calculation of the adjusted FY 2020 standard payment conversion factor that would be used for any IRF that failed to meet the IRF QRP reporting requirements for the applicable reporting period.

Table 18: Calculations to Determine the Adjusted FY 2020 Standard Payment Conversion Factor for IRFs that Failed to Meet the Quality Reporting Requirement

Explanation for Adjustment	Calculations	
Standard Payment Conversion Factor for FY 2019		$16,021
Market Basket Increase Factor for FY 2020 (2.9 percent), reduced by 0.4 percentage point for the statutory productivity adjustment and reduced by 2.0 percentage points for IRFs failing to meet the quality reporting requirement	x	1.005
Budget Neutrality Factor for the Wage Index and Labor-Related Share	x	1.0031
Budget Neutrality Factor for the Revisions to the CMG Relative Weights	x	1.0010
Adjusted FY 2020 Standard Payment Conversion Factor	=	$16,167

I. Summary Table of IRF QRP Measures

Quality Measures for the 2020 IRF QRP (Previously Adopted)

Short Name	Measure Name & Data Source
IRF-PAI	
Pressure Ulcer/Injury	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury
Application of Falls	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)
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)
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)
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)
CDI	NHSN Facility-wide Inpatient Hospital-Onset Clostridium difficile Infection (CDI) Outcome Measure (NQF #1717)
HCP Influenza Vaccine	Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431)
Claims-based	
MSPB IRF	Medicare Spending per Beneficiary (MSPB)–PAC IRF QRP
DTC	Discharge to Community–PAC IRF QRP
PPR 30 day	Potentially Preventable 30-Day Post-Discharge Readmission Measure for IRF QRP
PPR Within Stay	Potentially Preventable Within Stay Readmission Measure for IRFs

VIII. Regulatory Impact Analysis

CMS estimates that the final rule will increase Medicare payments to IRFs by $210 million in FY 2020 compared with FY 2019. This represents an aggregate increase of 2.5 percent resulting from the update factor. Table 20 of the final rule, reproduced below, breaks down components of the increase and shows distributional effects by category of IRF. Note that there is no aggregate effect of the changes in outlier thresholds, changes to the CMGs, and the CMG relative weights and average length of stay values. In the latter two cases these policies are designed to be budget neutral and there is no estimated change in aggregated payments to IRFs. In the case of the outlier thresholds, CMS estimates that FY 2019 outlier payments will represent 3.0 percent of

total payments, which is the target for FY 2020 and therefore no differences are shown between the two years.

As noted above, CMS estimates that combined effects of the changes to the IRF QRP (the addition of two new measures and a set of SPADES), will increase the annual burden on IRFs by $7,339 per IRF and $8.2 million across all IRFs. Almost all this estimate is associated with the expansion of SPADEs ($6,902 per facility and $7.7 million across all IRFs).

TABLE 20: IRF Impact Table for FY 2020 (Columns 4 through 7 in percentage)

Facility Classification	Number of IRFs	Number of Cases	Outlier	FY 2020 CBSA wage index and labor-share	CMG Weights	Total Percent Change [1]
(1)	(2)	(3)	(4)	(5)	(6)	(7)
Total	1,122	411,622	0.0	0.0	0.0	2.5
Urban unit	697	167,770	0.0	0.1	2.3	5.0
Rural unit	136	21,883	0.0	0.3	2.8	5.7
Urban hospital	278	217,445	0.0	-0.1	-2.1	0.2
Rural hospital	11	4,524	0.0	-0.9	-3.7	-2.1
Urban For-Profit	357	211,142	0.0	-0.2	-1.7	0.6
Rural For-Profit	36	8,217	0.0	-0.3	0.2	2.4
Urban Non-Profit	526	151,927	0.0	0.2	1.4	4.1
Rural Non-Profit	90	15,018	0.0	0.4	2.0	5.0
Urban Government	92	22,146	0.0	0.1	2.7	5.4
Rural Government	21	3,172	0.0	0.3	3.9	6.8
Urban	975	385,215	0.0	0.0	-0.1	2.4
Rural	147	26,407	0.0	0.1	1.7	4.4
Urban by region						
Urban New England	29	16,298	0.0	-0.1	-2.2	0.1
Urban Middle Atlantic	135	51,771	0.0	0.0	-1.4	1.1
Urban South Atlantic	147	77,544	0.0	-0.4	-0.5	1.6
Urban East North Central	167	50,728	0.0	-0.3	2.2	4.4
Urban East South Central	56	28,030	0.0	-0.7	-0.8	1.0
Urban West North Central	74	20,958	0.0	0.1	0.6	3.2
Urban West South Central	184	84,286	0.0	0.3	-0.4	2.3
Urban Mountain	84	30,427	0.0	-0.8	-0.9	0.8
Urban Pacific	99	25,173	0.0	2.0	2.0	6.6
Rural by region						
Rural New England	5	1,321	0.0	-2.4	-3.1	-3.1
Rural Middle Atlantic	12	1,294	0.0	0.0	1.0	3.6
Rural South Atlantic	16	3,647	0.0	0.4	-2.2	0.7
Rural East North Central	23	4,094	0.0	0.2	1.8	4.6
Rural East South Central	21	4,547	0.0	-0.1	3.4	5.8
Rural West North Central	22	3,223	0.0	0.3	2.1	5.0
Rural West South Central	40	7,361	0.0	0.5	3.6	6.8
Rural Mountain	5	627	0.0	0.8	2.2	5.6
Rural Pacific	3	293	0.0	0.2	2.8	5.6

Facility Classification	Number of IRFs	Number of Cases	Outlier	FY 2020 CBSA wage index and labor-share	CMG Weights	Total Percent Change [1]
Teaching status						
Non-teaching	1,015	363,012	0.0	0.0	-0.2	2.3
Resident to ADC less than 10%	61	34,980	0.0	0.1	0.6	3.3
Resident to ADC 10%-19%	33	12,061	0.0	0.0	2.3	4.9
Resident to ADC greater than 19%	13	1,569	0.0	-0.3	3.4	5.7
Disproportionate share patient percentage (DSH PP)						
DSH PP = 0%	29	5,153	0.0	-0.6	-1.5	0.3
DSH PP <5%	134	58,240	0.0	-0.1	-1.8	0.6
DSH PP 5%-10%	303	131,572	0.0	-0.2	-0.4	1.9
DSH PP 10%-20%	381	139,294	0.0	-0.1	0.1	2.5
DSH PP greater than 20%	275	77,363	0.0	0.4	1.7	4.7

[1]This column includes the impact of the updates in columns (4), (5), and (6) above, and of the IRF market basket increase factor for FY 2020 (2.9 percent), reduced by 0.4 percentage point for the productivity adjustment.