

April 29, 2021

INPATIENT REHABILITATION FACILITY PPS: PROPOSED RULE FOR FY 2022

At A Glance

On April 7, the Centers for Medicare & Medicaid Services (CMS) issued its [fiscal year \(FY\) 2022 proposed rule](#) for the inpatient rehabilitation facility (IRF) prospective payment system (PPS). Comments on the rule are due to CMS by June 7. The final rule is expected around Aug. 1 and will take effect Oct. 1.

AHA Take

We appreciate that this relatively brief proposed rule allows the field to concentrate on their local COVID-19 responses – especially as many communities continue to experience surges of the virus. The proposed rule sets forth required payment updates and a few COVID-19-related changes to the IRF Quality Reporting Program (QRP).

What You Can Do

- ✓ Share the attached summary with your senior management team to examine the impact these payment changes would have on your organization in FY 2020.
- ✓ Participate in an upcoming members-only conference call to review and discuss this rule. **AHA members will receive a separate invitation to this call.**
- ✓ Submit a comment letter on the proposed rule to CMS not later than June 7 explaining this proposed rule's impact on your patients, local continuum of care, staff and facility.

Further Questions

For questions about payment provisions, contact Rochelle Archuleta, AHA's director of policy, at rarchuleta@aha.org; for quality-related questions, contact Caitlin Gillooley, AHA's senior associate director of policy, at cgillooley@aha.org.

Key Takeaways

The proposed rule:

- Would increase IRF payments by 1.8% (\$160 million) in FY 2022
- Would add a new measure to the IRF QRP and change policy regarding publicly reported data affected by COVID-19 reporting exemptions
- Requests information on possibly collecting data on digital quality and health equity

Background

On April 7, the Centers for Medicare & Medicaid Services (CMS) released its [fiscal year \(FY\) 2022 proposed rule](#) for the inpatient rehabilitation facility (IRF) prospective payment system (PPS). In the rule, CMS proposes a net update of 1.8%, a \$160 million increase over FY 2021 levels.

Proposed FY 2022 Payment Update

Market-basket Update

For FY 2022, CMS proposes to update the IRF PPS standard rate using the IRF-specific market basket of 2.4%. As required by the Affordable Care Act (ACA), this update would be offset by a 0.2 percentage-point cut for productivity and 0.3 percentage-point to adjust outlier payments, as mentioned below. For IRFs that complete CMS's quality reporting requirements, the IRF standard payment for FY 2022 would be \$17,273, an increase from the FY 2021 rate of \$16,856.

Labor-related Share

The labor-related share is the national average proportion of total costs that are related to, influenced by or vary with the local labor market, such as wages, salaries and benefits. The proposed labor-related share for FY 2022 is 73.0%, a slight increase from 72.9% in FY 2021.

Area Wage Index

CMS proposes to use a more recent wage index for the IRF PPS, a move that would align with the methodology of other post-acute care settings. Under this rule, in FY 2022, CMS would use the concurrent FY 2022 pre-floor, pre-reclassification, unadjusted inpatient PPS wage index, which is based on FY 2018 hospital cost report data. The change would be applied with a budget-neutral adjustment factor of 1.0027.

Adjustment for High-cost Outliers

CMS allocates 3% of total IRF payments for high-cost outlier payments. However, for FY 2022, CMS used FY 2020 claims and the same methodology in effect since FY 2002 to estimate that outlier payments would be 3.3% of total payments if the high-cost outlier threshold were not adjusted. Therefore, to maintain estimated outlier payments at the 3% level, the agency proposes to increase the threshold from \$9,402 in FY 2021 to \$9,935 in FY 2022. This change would result in fewer IRF cases qualifying for a high-cost outlier payment, compared to the current fiscal year.

Facility-level Payment Adjustments

CMS again proposes to extend the current IRF facility-level payment adjustments, which have been in effect since FY 2014. The following adjustments would remain:

- Rural adjustment: 14.9%
- Low-income patient adjustment factor: 0.3177
- Teaching adjustment factor: 1.0163

Refinements to the Case-mix Classification System

CMS proposes to update the IRF case-mix group relative weights and average-length-of-stay values for FY 2022, continuing the same methodologies used in past years, and now applied to FY 2020 IRF claims and FY 2019 IRF cost report data. These proposed updated weights were calculated in a budget neutral manner.

Table 2 in the proposed rule displays the proposed relative weights and length of stay values per CMG and comorbidity tier. Table 3 displays the redistributive effect of changes in CMS weights across cases. It shows that 97.3% of IRF cases are in CMGs for which the proposed FY 2022 weight differs from the FY 2021 weight by less than 5% (either increase or decrease).

As background, in FY 2020, CMS began incorporating the data items collected on admission and located in the Quality Indicator section of the IRF-Patient Assessment Instrument (PAI) into the case-mix group (CMG) classification system, as required by the agency's concurrent removal of the FIM™ instrument from the IRF-PAI.

Details on several case-mix refinements, including the CMG recalibration, are included in a March 2019 technical report available [online](#).

AHA has [asked](#) CMS to provide additional information beyond that in this technical report with regard to the data and analytics used by the CMS contractor to establish the new CMGs and weights.

[IRF Quality Reporting Program \(IRF QRP\)](#)

The ACA mandated that reporting of quality measures for IRFs begin no later than FY 2014. Failure to comply with IRF QRP requirements will result in a 2-percentage point reduction to the IRF's annual market-basket update. The Improving Medicare Post-Acute Care Transformation (IMPACT) Act requires that, for FY 2019 and each subsequent year, providers must report standardized patient assessment data elements (SPADE) The reporting of these data is required in the IRF QRP, and as a result, failure to comply with the requirements results in a payment reduction. See Table 1 for proposed and finalized measures.

Table 1: Proposed and Finalized Measures for the IRF QRP, FY 2020 – FY 2023

Measure	FY 2020	FY 2021	FY 2022	FY 2023
Catheter-associated urinary tract infection (CAUTI)	X	X	X	X
Influenza vaccination coverage among health care personnel	X	X	X	X
<i>Clostridium difficile (CDI) infection</i>	X	X	X	X
Percent of residents experiencing one or more falls with major injury (Long stay)	X	X	X	X
Functional Status: Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function	X	X	X	X
Change in Self-Care Score for Medical Rehabilitation Patients	X	X	X	X
Change in Mobility Score for Medical Rehabilitation Patients	X	X	X	X
Discharge Self-Care Score for Medical Rehabilitation Patients	X	X	X	X

Measure	FY 2020	FY 2021	FY 2022	FY 2023
Discharge Mobility Score for Medical Rehabilitation Patients	X	X	X	X
Medicare spending per beneficiary for post-acute care IRF QRP (MSPB – IRF)	X	X	X	X
Discharge to community – PAC IRF	X	X	X	X
Potentially preventable 30-day post-discharge readmission measure for IRF QRP	X	X	X	X
Drug regimen review conducted with follow-up for identified issues	X	X	X	X
Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	X	X	X	X
Potentially Preventable Within Stay Readmission Measure for IRFs	X	X	X	X
Transfer of Health Information to Provider			X	X
Transfer of Health Information to Patient			X	X*
COVID-19 Vaccination Coverage among Healthcare Personnel				Y

X = Finalized

Y = Proposed

* = Proposed Modification

FY 2022 Measurement Provisions

CMS proposes to adopt one new quality measure and adjust the denominator of one measure beginning with the FY 2023 IRF QRP. Detailed specifications for the measures are available on CMS’s IRF QRP [website](#). The agency also offers proposals regarding publicly reported data affected by the COVID-19 pandemic and related reporting exemptions; CMS also solicits input on several cross-cutting quality topics.

Proposed Adoption of COVID-19 Vaccination among Health Care Personnel (HCP) Measure.

CMS proposes to adopt this measure that calculates the cumulative number of HCP eligible to work in the IRF for at least one day during the reporting period who received a complete vaccination course. If finalized, IRFs would be required to submit data beginning Oct. 1, 2021.

The measure would exclude persons with contraindications to the COVID-19 vaccination as described by the Centers for Disease Control and Prevention (CDC). For the purposes of this measure, “health care personnel” is defined — regardless of clinical responsibility or patient contact — as:

- employees (all persons receiving a direct paycheck from the reporting facility);
- licensed independent practitioners affiliated with, but not directly employed by, the reporting facility (including post-residency fellows); or
- adult students/trainees and volunteers.

Facilities may include other contract personnel, but are not required to. Detailed specifications for this measure can be found of CDC’s [website](#).

To report this data, IRFs would use the CDC’s National Healthcare Safety Network (NHSN) Healthcare Personnel Safety Component submission framework, which facilities currently use to report data for other measures; HCP and resident COVID-19 vaccination data reporting modules are currently available

for voluntary reporting through NHSN. IRFs would submit data through NHSN for at least one week each month, and the CDC would calculate a summary measure of the data each quarter; if IRFs submit more than one week of data in a month, CDC would use the most recent week's data to calculate the rate.

This quarterly rate would be publicly reported on the IRF *Care Compare* website.

The measure, which is also proposed for adoption in the QRPs for all other post-acute and acute care settings, is not endorsed by the NQF. In its preliminary recommendations, the NQF's Measure Applications Partnerships PAC-Long-term Care Workgroup did not support this measure for rulemaking, subject to potential for mitigation; the mitigating factors included well-documented evidence, finalized specifications, testing, and NQF endorsement.

CMS and CDC contend that because the measure is aligned with the Influenza Vaccination Coverage among HCP (NQF #0431), which is currently endorsed by NQF and used in several QRPs, and underwent some validity testing using NHSN data, it is sufficiently specified for inclusion in the QRP.

Proposed Modification of Transfer of Health Information to the Patient (TOH-Patient) Measure. CMS proposes to exclude residents discharged to home under the care of a home health agency or to a hospice from the denominator of this measure, which was adopted in the FY 2020 SNF PPS final rule for use beginning with the FY 2022 IRF QRP. The measure evaluates whether a medication list is transferred to a patient upon discharge from a post-acute care facility to a non-PAC setting. A similar measure, Transfer of Health Information to the Provider, assesses whether the medication list is transferred to a subsequent provider if the patient is discharged to another PAC setting. Patients discharged home under the care of a home health agency or to a hospice are included in both measures; to avoid double-counting these patients, CMS would exclude them from the TOH-Patient measure beginning with the FY 2023 IRF QRP.

Publicly Reported Data Affected by the COVID-19 Pandemic. IRF quality measures are publicly reported on the *Care Compare* website, which uses four quarters of data for IRF-PAI assessment-based measures and eight quarters for claims-based measures. However, due to the COVID-19 pandemic, CMS granted exceptions to reporting requirements for the fourth quarter of 2019 and the first two quarters of 2020; the agency also stated that it would not publicly report any IRF QRP data that might be greatly impacted by these exceptions.

CMS determined that freezing the data displayed on the *Care Compare* website with the December 2020 refresh values—that is, holding the data constant without subsequent update—would be the best approach. However, these data are becoming increasingly out-of-date and thus less useful for consumers. Therefore, CMS proposes to calculate IRF QRP measures for the December 2021 refresh using three quarters of data for assessment-based measures and six quarters for claims-based measures for the December 2021 through June 2023 refreshes.

Requests for Information (RFIs)

In addition to the various proposals regarding the IRF QRP, CMS uses the proposed rule to solicit feedback on various topics. The agency will not respond to comments on these RFIs in the final rule, and states that it might release additional RFIs to collect more information on these topics at a later date.

Future Measures for the IRF QRP. CMS seeks input on the importance, relevance, appropriateness and applicability of the following measures and concepts for future years in the SNF QRP:

- Frailty
- Opioid use and frequency
- Patient-reported outcomes
- Shared decision-making process
- Appropriate pain assessment and pain management processes
- Health Equity

Fast Healthcare Interoperability Resource (FHIR). CMS is considering adopting the following standardized definition of digital quality measures (dQMs) in alignment across quality programs:

“Digital Quality Measures (dQMs) are quality measures that use one or more sources of health information that are captured and can be transmitted electronically via interoperable systems. A dQM includes a calculation that processes digital data to produce a measure score or measure scores. Data sources for dQMs may include administrative systems, electronically submitted clinical assessment data, case management systems, EHRs, instruments (for example, medical devices and wearable devices), patient portals or applications (for example, for collection of patient-generated health data), health information exchanges (HIEs) or registries, and other sources.”

CMS also seeks feedback on the potential use of FHIR for dQMs within the IRF QRP aligning with other quality programs. FHIR is a free and open source standards framework that establishes a common language and process for all health information technology. CMS believes that using FHIR-based standards to exchange clinical information through application programming interfaces (APIs) would allow clinicians to digitally submit quality information one time that can then be used in many ways. The agency relates that it is currently evaluating the use of FHIR-based APIs to access patient assessment data collected and maintained through the Quality Improvement and Evaluation System (QIES) systems.

CMS states that it is considering the future development and staged implementation of a cohesive portfolio of dQMs across quality programs, agencies, and private payers. This would require standardization of measures and data elements. In this RFI, CMS seeks feedback on the steps that would enable transformation of CMS’ quality measurement enterprise to be fully digital.

Health Equity. CMS requests information on revising several CMS programs to make the reporting of health disparities based on social risk factors, along with race and ethnicity, more comprehensive and actionable for providers and patients.

The agency is specifically seeking recommendations for quality measures or measurement domains that address health equity as well as the collection of other SPADEs that address gaps in health equity in the IRF QRP. In addition, CMS requests feedback on how the agency can promote health equity in outcomes among IRF residents by stratifying quality measure results by social risk factors and what challenges exist for effective capture, use, and exchange of health information including data on race, ethnicity and other social determinants of health.

[Next Steps](#)

[AHA Member Call to Discuss Proposed Rule](#). AHA members will receive an upcoming invitation to a member call to discuss this rule and gather input for our comment letter to CMS. Related materials and a recording of this call will be available at aha.org/postacute in the IRF section.

[Submitting Comments](#). The AHA urges all IRFs to submit comments to CMS by June 7. Comments may be submitted electronically at: www.regulations.gov.

You also may mail written comments to CMS:

[Via regular mail:](#)

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1748-P
P.O. Box 8016
Baltimore, MD 21244-8016

[Via overnight or express mail:](#)

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1748-P
Mailstop: C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

[Further Questions](#)

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