American Hospital Association™
Advancing Health in America

Regulatory Advisory

August 20, 2019

Inpatient Rehabilitation Facility PPS: Final Rule for FY 2020

At A Glance

On July 31, the Centers for Medicare & Medicaid Services (CMS) issued its fiscal year (FY) 2020 final rule for the inpatient rehabilitation facility (IRF) prospective payment system (PPS). The final rule will take effect Oct. 1.

AHA Take

The AHA generally supports CMS's reforms to the IRF payment system, which was finalized in last year's rulemaking and is further developed in this rule. However, we remain concerned about the substantial redistribution of cases that occur under the new model. With regard to the finalized motor score methodology, we appreciate CMS's use of the unweighted score, as supported by the AHA. For the IRF Quality Reporting Program (QRP), we maintain that only measures endorsed by the National Quality Forum (NQF) should be adopted for CMS quality programs. In addition, we remain concerned about the burden associated with the number of new patient assessment data elements that CMS added to the IRF patient assessment instrument (PAI).

What You Can Do

- ✓ Share the attached summary with your senior management team to examine the impact these payment changes will have on your organization in FY 2020.
- ✓ **Participate in a members-only conference call Aug. 22, at 2 p.m. ET to review and discuss this rule.** AHA members may register here.

Key Takeaways

In FY 2020, the rule will:

- Increase IRF payments by 2.5% ($210 million).
- Rebase and revise the IRF market basket using more recent data.
- As finalized in last year's rulemaking, refine the IRF payment system by using different patient assessment data and a recalibrated case-mix system.
- Use an unweighted motor score.
- Codify IRFs' ability to interpret the existing definition of a rehabilitation physician.
- Add two new quality measures to the IRF Quality Reporting Program.
- Adopt several new standardized patient assessment data elements.

Further Questions

Please contact Rochelle Archuleta, director of policy, at rarchuleta@aha.org with questions about payment provisions, and Caitlin Gillooley, senior associate director of policy, at cgillooley@aha.org with questions about quality-related provisions.

American Hospital Association™
Advancing Health in America

Regulatory Advisory

August 20, 2019

Inpatient Rehabilitation Facility PPS: Final Rule for FY 2020

Background

On July 31, the Centers for Medicare & Medicaid Services (CMS) released its fiscal year (FY) 2020 final rule for the inpatient rehabilitation facility (IRF) prospective payment system (PPS). In the rule, CMS finalizes a net update of 2.5%, a $210 million increase over FY 2019 levels.

Final FY 2020 Payment Update

Market-basket Update

For FY 2020, CMS finalized an update to the IRF PPS standard rate using the IRF-specific market-basket increase of 2.9%, which, as required by the Affordable Care Act (ACA), will be offset by an adjustment for productivity, -0.4 percentage point. This update also reflects CMS's market-basket rebasing that will use 2016-base year data rather than a 2012-base year, and revising the inputs to more closely reflect current costs. See Table 4 of the rule reproduced below. The rule notes that under the current methodology, the FY 2020 market basket would have been 3%. For IRFs that complete CMS's quality reporting requirements, the IRF standard payment for FY 2020 will be $16,489, an increase from the FY 2019 rate of $16,021.

TABLE 4: Major Cost Categories as Derived from Medicare Cost Reports

Major Cost Categories	Final 2016-Based IRF Market Basket (Percent)	2012-Based IRF Market Basket (Percent)
Wages and Salaries	47.1	47.3
Employee Benefits	11.3	11.2
Contract Labor	1.0	0.8
Professional Liability Insurance (Malpractice)	0.7	0.9
Pharmaceuticals	5.1	5.1
Home Office Contract Labor	3.7	n/a
Capital	9.0	8.6
All Other	22.2	26.1

Note: Total may not sum to 100 due to rounding.

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 final labor-related share for FY 2020 is 72.7%, an increase from 70.5% in FY 2019.

Area Wage Index

CMS finalized the use of a more recent wage index to align the IRF PPS with the methodology of other post-acute care (PAC) settings. Specifically, under this rule, in FY 2020, CMS will use the concurrent FY 2020 pre-floor, pre-reclassification, unadjusted inpatient PPS wage index, which is based on 2016 hospital cost report data. The change will be applied with a budget-neutral adjustment factor of 1.0076.

Historically, CMS has used the most recent *final* inpatient PPS wage index available, which is the pre-reclassification, pre-floor inpatient PPS 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 inpatient PPS wage index. As background, the skilled nursing facility (SNF) and long-term care hospital (LTCH) payment systems use the concurrent year's inpatient PPS wage index (i.e., the FY 2019 inpatient PPS wage index is used for these payment systems in FY 2019). CMS previously argued that the one-year lag does not hinder the ability of IRFs to demonstrate their cost effectiveness relative to other PAC providers for purposes of participating in alternative payment models as suggested by commenters.

Adjustment for High-cost Outliers

CMS allocates 3% of total IRF payments for high-cost outlier payments. For FY 2020, CMS made a modest adjustment to the threshold to account for the FY 2020 market-basket update. Specifically, the agency decreased the high-cost outlier threshold in FY 2020 to $9,300, from the FY 2019 threshold of $9,402. This minor change is expected to result in a slight increase in the IRF cases qualifying for a high-cost outlier payment in FY 2020, relative to FY 2019.

Facility-level Payment Adjustments

As proposed, this rule again extends the current IRF facility-level payment adjustments, which have been in effect since FY 2014. These 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

As previously finalized, beginning with FY 2020, CMS is refining the IRF case-mix classification system by recalibrating the case-mix groupings (CMGs) and altering the clinical data used to assign a patient to a CMG. Specifically, beginning Oct. 1, CMS will incorporate the data items collected on admission and located in the Quality Indicator section of the IRF-Patient Assessment Instrument (PAI) into the 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.

As background, 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 assigned to a CMG that aligns with one of the 21 RICs based on the patient's functional status (using motor and cognitive scores) and sometimes age. Each CMG is further divided into tiers based on the presence of selected comorbidities found to be associated with greater resource needs.

Recalibration of CMG Relative Weights and Average Length of Stay Values. In alignment with the reforms finalized in last year's rulemaking, this rule finalizes a recalibrated set of CMGs, with a modified distribution of IRF cases across the CMGs. Per the FY 2019 final rule, this recalibration was based on two years of data — FYs 2017 and 2018. As rationale for this recalibration, CMS states that the CMGs have not been revised since the initial implementation of the IRF PPS in FY 2002.

Updates to the CMG relative weights and average length of stay values were finalized for FY 2020 using the same, multistep update methodologies used in prior years, applied to FYs 2017 and 2018 IRF claims and FY 2017 IRF cost report data, and a budget neutrality factor 1.0016. The methodology is described further in the March 2019 technical report mentioned above. Table 3 in the rule displays the final relative weights and length of stay values by CMG and comorbidity tier. The effect of the CMG changes on IRF PPS payments to different categories of IRFs is shown in the rule's impact assessment found in Table 20. For provider-specific impact analysis of the CMG changes, CMS refers readers to the FY 2020 proposed rule data files.

In the final rule, CMS notes its disagreement with stakeholder concerns that the CMG revisions will result in higher payments for lower acuity patients and reduced payments for higher acuity patients. Instead, the agency states: "Our analysis has found that higher function is associated with a slight reduction in payment under the revised CMGs and that lower function is associated with a slight increase in payments. The purpose of the revisions to the CMGs is to align payments more appropriately with the costs of caring for all types of patients in IRFs." The agency plans to closely monitor IRF data to ensure that, moving forward, IRF payments are appropriately aligned with the cost of care and preserve appropriate access to IRF services.

Weighted Motor Score. In a departure from the proposed rule, this rule finalized the use of an *unweighted* motor score. While the FY 2019 final rule also had implemented an *unweighted* motor score, in the FY 2020 proposed rule CMS changed its recommendation to a *weighted* motor score. That is, it would have weighted certain items more than others when computing the score. CMS's rationale for the weighted approach was that it "slightly improves" the ability of the IRF PPS to predict patient costs.

However, the final rule notes that nearly all of the comments on this issue, including from the AHA, urged CMS to revert to an unweighted motor score for various reasons. Specifically, the AHA and others argued that the weighted score would result in unexplained and substantial shifts in values for important motor items. In response, CMS reverted to the use of the unweighted score because of its "conceptual simplicity," which the agency believes will help ease providers' transition to the FY 2020 reforms. As such, the 18 items used in the score will have an equal weight of 1. In addition, the rule finalizes as proposed the removal of one motor score item, "roll left to right."

Rehabilitation Physician Protocols

CMS finalized its proposal to amend existing regulations pertaining to the definition of a rehabilitation physician, which currently includes the definition as: *"A licensed physician with specialized training and experience in inpatient rehabilitation."*

Specifically, CMS will codify that each IRF can make its own determination regarding whether a physician qualifies as a rehabilitation physician under this existing definition. To explain its position, CMS states that "… the current definition does not specify the level or type of training and experience required for a licensed physician to be designated as a rehabilitation physician because we believe that the IRFs are in the best position to make this determination." The rule also notes CMS's expectation that IRFs will continue to ensure that the rehabilitation physicians treating patients in their facilities have the necessary training and experience in inpatient rehabilitation. In addition, the rule mentions the high volume of comments and the lack of consensus on this issue, and, in response, the agency plans to continue to assess whether future refinements to this policy may be needed.

IRF Quality Reporting Program (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 (SPADEs). The reporting of this 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 finalized measures.

CMS will adopt two measures to the IRF QRP and modify one for FY 2022. The agency will also adopt several SPADEs in the IRF-PAI.

Table 1: Finalized Measures for the IRF QRP, FY 2019 – FY 2022

Measure	FY 2019	FY 2020	FY 2021	FY 2022
Catheter-associated urinary tract infection (CAUTI)	X	X	X	X
Percent of residents or patients who were assessed and appropriately given the seasonal influenza vaccine	X			
Influenza vaccination coverage among health care personnel	X	X	X	X
Methicillin-resistant Staphylococcus aureus bacteremia	X			
Clostridium difficile infection (CDI)	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 LTCH 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
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
Changes in skin integrity PAC: pressure ulcer/injury		X	X	X
Potentially preventable within stay readmission measure for IRFs	X	X	X	X
Transfer of health information to provider				X
Transfer of health information to patient				X

X = Finalized

FY 2022 Measurement Provisions

CMS will adopt two new process measures to the FY 2022 IRF QRP and modify one existing measure. Detailed specifications for the measures are available on CMS's IRF QRP website.

Transfer of Health Information to the Provider — PAC: CMS will adopt this process measure that assesses the proportion of patient stays with a discharge assessment indicating that a current reconciled medication list was given to the subsequent provider at the time of discharge or transfer from the patient's current PAC setting.

The IMPACT Act requires CMS to develop standardized and interoperable quality measures and implement them across all four PAC settings. These measures must meet certain domains, one of which is the transfer of health information and patient care preferences. A detailed summary of the IMPACT Act's requirements can be found in the AHA's Oct. 16, 2014, Legislative Advisory. In the FY 2019 IRF PPS final rule, CMS

stated that the agency intended to specify and proposed two measures that would satisfy this domain for the FY 2022 IRF QRP. The measures, which have undergone pilot testing, public comment periods and review by several technical expert panels, were proposed to the National Quality Forum (NQF)'s Measure Applications Partnership (MAP) in December 2019. The MAP conditionally supported the measures pending NQF endorsement. Measures are not required to be endorsed in order to be included in CMS quality programs, but the AHA strongly recommends that CMS adopt only measures that have gone through the rigorous NQF review and endorsement process. In response to AHA's and other stakeholder's comments regarding endorsement, CMS stated that it "plan[s] to submit the measure[s] to the NQF for consideration of endorsement as soon as feasible."

Performance on the measure is expressed as a proportion. The denominator for the Transfer of Health Information to the Provider measure is the total number of IRF patient stays ending in discharge to a subsequent provider. "Subsequent provider" is defined as a short-term general acute care hospital, intermediate care (i.e., intellectual and developmental disabilities providers), home under the care of a home health agency or hospice, institutional hospice, a SNF, another IRF, an inpatient psychiatric facility (IPF), swing bed, LTCH, Medicaid nursing facility, or a critical access hospital (CAH).

The numerator for this measure is the number of IRF patient stays with an IRF-PAI discharge assessment indicating that a current reconciled medication list was provided to the subsequent provider at the time of discharge. For patients with multiple stays, each stay is eligible for inclusion in the measure.

Measure performance will be calculated using a new item in the IRF-PAI and will ask whether the assessor's facility provided the medication list to the subsequent provider. CMS notes in the final rule that "defining the completeness of that medication list is left to the discretion of the providers and patient who are coordinating this care," and that the agency does not have a data validation program in place "at this time."

Providers will be asked to complete an additional data element to indicate the route through which the list was transmitted, e.g., via an electronic health record, verbally, on paper, through a health information exchange organization, or another method. This measure is not risk-adjusted or stratified.

IRFs will be required to submit data on the Transfer of Health Information to the Provider measure beginning with Oct. 1, 2020, admissions and discharges.

Transfer of Health Information to the Patient — PAC: CMS also will add this process measure that assesses the proportion of patient stays with a discharge assessment indicating that a current reconciled medication list was provided to the patient, family or caregiver at the time of discharge to the home. This measure was developed in conjunction with the Transfer of Health Information to the Provider measure, and also lacks NQF endorsement.

This measure is specified identically to the previous measure and will employ similar IRF-PAI items, except that the denominator is the total number of IRF patient stays ending in discharge to a private home/apartment, a board and care home, assisted living, a group home, transitional living or home under the care of a home health agency or hospice.

IRFs will be required to submit data on the Transfer of Health Information to the Patient measure beginning with Oct. 1, 2020, admissions and discharges.

Update to Discharge to Community Measure: CMS will exclude baseline nursing facility residents, defined as patients who had a long nursing facility stay in the 180 days preceding their hospitalization and IRF stay with no intervening community discharge between the nursing facility stay and hospitalization, from the Discharge to Community measure beginning with the FY 2020 IRF QRP. The measure, originally adopted in the FY 2017 IRF PPS final rule, reports an IRF's risk-standardized rate of Medicare FFS patients who are discharged to the community (e.g., private home/apartment, assisted living, or group home) following an IRF stay and do not have an unplanned readmission to an acute care hospital or LTCH and remain alive in the 31 days following discharge. CMS makes this change because IRF patients who lived in a nursing facility prior to their IRF stay are less likely to return to the community following their IRF stay and, as CMS has demonstrated through analysis of performance, skew measure performance unfairly.

Public Reporting of Measure Data. CMS will begin publicly displaying data for the Drug Regimen Review Conducted with Follow-Up for Identified Issues measure beginning calendar year (CY) 2020 "or as soon as technically feasible." Data collection on this measure began with patients discharged on or after Oct. 1, 2018.

CMS will display four rolling quarters of data on *IRF Compare*, initially using discharges from Jan.1, 2019, through Dec. 31, 2019. IRFs with fewer than 20 cases during any four consecutive rolling quarters of data for any of these measures will not have a rate displayed; instead, the site will display a note stating that the number of cases/patient stays is too small to publicly report.

Standardized Patient Assessment Data Elements

In addition to requiring the adoption of standardized and interoperable quality measures, the IMPACT Act also requires that, for FY 2019 and each subsequent year, PAC providers must report SPADEs. The reporting of this data is required in the PAC quality reporting programs, and as a result, failure to comply with the requirements results in a payment reduction. The standardized patient assessment data elements must satisfy five domains as specified by the IMPACT Act, including functional status, cognitive function, special services, medical conditions and comorbidities, and impairments.

In the FY 2018 IRF PPS proposed rule, CMS proposed to adopt SPADEs that would satisfy all five categories. However, the agency did not finalize most of these proposals in response to the concerns raised by AHA and other commenters regarding the speed and magnitude of the additions to already lengthy patient assessment instruments. Stakeholders also were concerned that the data elements had not been tested for use in

each specific PAC setting. That is, CMS proposed to adopt for all four settings data elements that were tested in only one PAC setting without determining whether those elements provided reliable and valid data in other settings. Instead, CMS finalized the adoption of SPADEs in just two categories (functional status and medical conditions and comorbidities) based on data elements already finalized for adoption in the various instruments. Please see AHA's Regulatory Advisory of the FY 2018 IRF PPS final rule for more details.

In this year's proposed rule, CMS asserted that IRFs have had enough time to familiarize themselves with other new reporting requirements adopted under the IMPACT Act. In addition, CMS cited the results of a recent National Beta Test of the data elements conducted by its contractor to suggest that the SPADEs are now tested adequately. Please see the research report from the National Beta Test for details and results from the analysis, as well as AHA's Regulatory Advisory on this year's proposed rule for our take on these results.

Despite continued opposition from commenters, CMS finalized the adoption of all SPADEs as proposed. The agency will require IRFs to report many of the same SPADEs it proposed for FY 2018 and a few new elements beginning with the FY 2022 IRF QRP. IRFs will be required to collect and report this data with respect to admission and discharge for patients discharged between Oct. 1, 2020, and Dec. 31, 2020. For each subsequent year, CMS will require IRFs to collect and report the data for admissions and discharges that occur during the subsequent calendar year (e.g., data for patients discharged between Jan. 1, 2021, through Dec. 31, 2021, will inform the FY 2023 IRF QRP).

Table 2 summarizes the adopted SPADEs, whether adoption will result in a new item added to the IRF-PAI, the number of elements associated with each item (i.e., the number of check boxes assessors will have to consider when completing the item) and the time to complete the item according to the National Beta Test.

Table 2. AHA Analysis of Adopted SPADEs

Domain	Element	New IRF-PAI Item	Number of Elements	Time to Complete (minutes)
Cognitive Function & Mental Status	Brief Interview for Mental Status (BIMS)	No	7	2.2
	Confusion Assessment Method (CAM)	Yes	6	1.4
	Patient Health Questionnaire – 2 to 9	Yes	2-9	1.7 for PHQ-2 2 only, 4 for PHQ-9

Special Services, Treatments and Interventions	Cancer Treatment: Chemotherapy (IV, Oral, Other)	Yes	1-4 (1 principal; 3 sub)	0.25
	Cancer Treatment: Radiation	Yes	1	0.25
	Respiratory Treatment: Oxygen Therapy (Intermittent, Continuous, High-concentration)	Yes	1-2 (1 principal; 3 sub either/or)	0.25
	Respiratory Treatment: Suctioning (Scheduled, As needed)	Yes	1-2 (1 principal; 2 sub either/or)	0.25
	Respiratory Treatment: Tracheostomy Care	Yes	1	0.25
	Respiratory Treatment: Non-invasive Mechanical Ventilator (BiPAP, CPAP)	Yes	1-3 (1 principal; 2 sub)	0.25
	Respiratory Treatment: Invasive Mechanical Ventilator	Yes	1	0.25
	Intravenous (IV) Medications (Antibiotics, Anticoagulation, Vasoactive Medications, Other)	Yes	1-5 (1 principal; 4 sub)	0.25
	Transfusions	Yes	1	0.25
	Dialysis (Hemodialysis, Peritoneal dialysis)	Yes	1-2 (1 principal; 2 sub either/or)	0.25
	Intravenous (IV) Access (Peripheral IV, Midline, Central line)	Yes	1-4 (1 principal; 3 sub)	0.25
	Nutritional Approach: Parenteral/IV Feeding	No	1	0.25
	Nutritional Approach: Feeding Tube	No (will rename current IRF item)	1	0.25
	Nutritional Approach: Mechanically Altered Diet	Yes (will replace current IRF item)	1	0.25
	Nutritional Approach: Therapeutic Diet	Yes	1	0.25
	High-risk Drug Classes: Use and Indication	Yes	0-12 (indicate whether patient is taking any medication within each of six drug classes, for each that patient is	1.1

			noted as taking indicate whether patient has indication for drug in class)	
Medical Condition & Comorbidity	Pain Interference	Yes	3 (sleep, therapy activities, day-to-day activities)	2.6
Impairment	Hearing*	Yes	1	0.3
	Vision*	Yes	1	0.3

*IRFs will only need to submit data on these elements with respect to admission and will not need to collect and report the data again at discharge, as it is unlikely that patient status for these elements will change.

Social Determinants of Health (SDOH). In addition to the five domains that SPADEs must meet according to the IMPACT Act, CMS finalized its proposal to add a sixth domain. This domain will collect and assess data about SDOH, also known as social risk factors. Each of the data elements that will be adopted is identified in the 2016 National Academies of Sciences, Engineering, and Medicine (NASEM) report "Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors," which was commissioned by the Department of Health and Human Services (HHS) Assistant Secretary for Planning and Evaluation (ASPE). In this report, NASEM identified these factors as having impact on care use, cost and outcomes for Medicare beneficiaries.

Despite many comments stating concern for the lack of detail on how CMS plans to use these data elements (i.e., in "future adjustments" to quality measures and payments, as stated in the proposed rule), CMS finalized nearly all the SDOH SPADEs as proposed. The agency made a technical change to the Ethnicity element — by adding the word "of," as seen bolded in the table below — and only will require the collection of the Preferred Language and Interpreter Services items upon admission (rather than both admission and discharge), as the agency agrees with comments that suggested these SPADEs are unlikely to change over time. All of the other elements will be required for collection at both admission and discharge, as CMS disagreed with comments suggesting these, too, would be unlikely to change over time; for each, the agency responded that "a patient could lose a family member or caregiver between admission and discharge, which could impact" the answer to the element.

Table 3 summarizes the adopted SPADEs that will inform the new SDOH domain, whether adoption will result in a new item added to the IRF-PAI, the number of discrete elements associated with each item, and a description of the item.

Table 3. AHA Analysis of Adopted SPADEs to Inform New SDOH Domain

Item	New IRF-PAI Item	Number of Elements	Description
Race*	No	1-15 (15 sub options, check all that apply)	Asks, "What is your race?" Replaces current item on Race & Ethnicity with two items

Ethnicity*	No	1-6 (6 sub options, check all that apply)	Asks, “Are you **of** Hispanic, Latino/a, or Spanish origin?” Replaces current item on Race & Ethnicity with two items
Preferred Language*	Yes	1	Open-ended (What is your preferred language?) to allow for indication of American Sign Language (ASL)
Interpreter Services*	Yes	1	1 with 3 sub options (Do you need or want an interpreter to communicate with a doctor or health care staff?)
Health Literacy	Yes	1	Uses Single Item Literacy Screener (SILS) question, “How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?”, with six options of Never to Always and patient unable to respond
Transportation	Yes	1-4 (4 sub options, check all that apply)	Uses single transportation data element from the Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences (PREPARE) tool that is part of the Accountable Health Communities (AHC) Screening tool. Asks, “Has lack of transportation kept you from medical appointments, meetings or work, or from getting things needed for daily living?”, and answers differentiate between medical and non-medical appointments/activities
Social Isolation	Yes	1	Uses single social isolation data element that is part of the AHC Screening Tool. Asks, “How often do you feel lonely or isolated from those around you?”, with six options of Never to Always and patient unable to respond

*IRFs will only need to submit data on these elements with respect to admission and will not need to collect and report the data again at discharge, as it is unlikely that patient status for these elements will change.

Overall, CMS will add 24 new items to the IRF-PAI, which are associated with more than 60 new data elements that could be necessary to complete depending on the patient.

The AHA is disappointed that CMS finalized these proposals; we also are disappointed in CMS’s response to our and other commenters’ concerns on the burden associated with these low-value data elements. According to the research report regarding the findings from the National Beta Test and acknowledged by CMS in the final rule, very few patients actually received the services/treatments IRFs will be required to report. Multiple items had 0% of patients noting use of the service/treatment,

and several others showed less than 3% of patients receiving the service. In response to these concerns, the agency merely states that these elements are "check all that apply," and if the treatments do not apply, "the assessor need only check one row for 'None of the Above.'" In addition, AHA and other commenters noted that some of the data elements demonstrated moderate, low or even poor reliability; CMS simply responded that only four elements had moderate to poor reliability, and that these elements would be adopted anyway.

The AHA stated in our comments that we believe that this information is already considered by care teams and for other purposes and can be gleaned from administrative sources rather than painstaking assessment that requires gathering information from multiple sources. In response, CMS noted that it "will take under consideration the commenters' recommendation to explore the feasibility of collecting [this information] through claims-based data."

Other Quality Reporting Program Updates

Reporting IRF-PAI Data on All Patients Regardless of Payer: CMS did not finalize its proposal to require IRFs to collect and report minimum data set (MDS) data for the purposes of the IRF QRP on all patients, regardless of payer.

CMS initially made the proposal to expand reporting as the agency believed that the most accurate representation of the quality provided in IRFs would be best calculated using data on all residents; in addition, comments on past proposals suggested that this expansion would not be overly burdensome (as "most of their organizations' members currently complete the IRF-PAI on all patients, regardless of payer"). However, comments on this year's proposed rule raised several questions in regards to which residents the required data collection pertained to, the intended use of the data from payers other than Medicare, and how the proposal would affect penalties for non-compliance in the IRF QRP. Commenters also disagreed that the expansion would not be overly burdensome, and that the implementation timeline would be challenging considering the addition of several SPADEs to the IRF-PAI (CMS proposed that expanded data collection would begin FY 2022).

CMS agreed that further details are needed before the agency requires expanded data reporting. While the proposal was not finalized in this rule, the agency states that it plans to propose the expansion again in future rulemaking.

Removal of the List of Compliant IRFs. In the FY 2016 IRF PPS final rule, CMS stated that it would publish and annually update a list of IRFs that successfully met the reporting requirements for the applicable payment determination year on the IRF QRP website. In response to feedback that this list offers minimal benefit, as it does not provide new information to providers, CMS will no longer publish this list beginning with the FY 2020 payment determination.

Next Steps

AHA Member Call to Discuss Final Rule. **The AHA will host a member call on Aug. 22, at 2 p.m. ET to discuss this rule.** AHA members may register here. Related materials and a recording of this call will be available at: www.aha.org/postacute in the IRF section.

Further Questions

Please contact Rochelle Archuleta, director of policy, at rarchuleta@aha.org with any questions about the payment provisions, and Caitlin Gillooley, senior associate director of policy, at cgillooley@aha.org, with any quality-related questions.