American Hospital Association®

Regulatory Advisory

May 15, 2017

INPATIENT REHABILITATION FACILITY PPS: PROPOSED RULE FOR FY 2018

AT A GLANCE

The Issue:

On May 3, the Centers for Medicare & Medicaid Services (CMS) published its fiscal year (FY) 2018 proposed rule for the inpatient rehabilitation facility (IRF) prospective payment system (PPS). Under the proposed rule, IRFs will receive a 1.0 percent market-basket update ($80 million), relative to FY 2017, as mandated by the Medicare Access & CHIP Reauthorization Act. CMS also proposes to increase the high-cost outlier threshold from $7,984 to $8,656 to maintain the 3-percent high-cost outlier pool. In addition, CMS proposes to hold the facility payment adjustments for rural, teaching and low-income IRFs at current levels. The rule also would eliminate the 25-percent penalty for late IRF patient assessment instrument (PAI) submissions and refine the codes used to assess a facility's compliance with the 60% Rule via the presumptive methodology. For the IRF Quality Reporting Program (QRP), CMS proposes to remove one readmission measure, replace a measure regarding pressure ulcers, and require reporting of certain standardized patient assessment data as mandated by the Improving Medicare Post-Acute Care Transformation Act of 2014.

The attached summary provides greater detail on this proposed rule and was prepared by Health Policy Alternatives Inc., for the American Hospital Association.

Our Take:

In general, we are pleased that CMS is proposing to improve the coding guidelines for the 60% Rule presumptive compliance test, which would increase the number of IRF claims that count toward 60% Rule compliance. We also support the removal of the all-cause unplanned readmission measure, as it is duplicative of the other readmissions measures required in the QRP. However, the AHA is concerned that the expanded patient assessment data reporting requirements, which would add more than 15 items to the already lengthy IRF-PAI, would impose a significant burden on providers, particularly since these items have not yet been adequately tested to ensure they collect accurate and useful data in the IRF setting.

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 2018.
- ✓ **Participate in an AHA members-only conference call Thursday, May 18 at 2 p.m. ET to review and discuss this proposed rule.** To register for the call, click here.
- ✓ Submit your comment letter to CMS by Monday, June 26 on this rule, known as CMS-1671-P, at http://www.regulations.gov.

Further Questions:

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

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

On April 27, 2017, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule on the Medicare inpatient rehabilitation facility prospective payment system (IRF PPS) for federal fiscal year (FY) 2018. It will be published in the *Federal Register* on May 3, 2017.

CMS estimates that under the proposed rule, Medicare IRF PPS payments in FY 2018 would be about $80 million higher than in FY 2017.

As required by statute, the IRF PPS update factor for FY 2018 is set to be 1.0 percent. Along with other budget neutrality adjustments, this would increase the standard payment conversion factor from $15,708 in FY 2017 to $15,835 for facilities meeting the standards in the IRF Quality Reporting Program (QRP) and $15,521 for facilities not meeting the IRF QRP standards and subject to the 2-percentage point penalty.

Among other proposals, the rule would modify the ICD-10-CM codes used in the presumptive compliance methodology for determining a facility's eligibility for payment under the IRF PPS, and establish a subregulatory process for making nonsubstantive updates to the diagnosis code lists; establish requirements for collection of standardized patient assessment data in keeping with the Improving Medicare Post-Acute Care Transformation Act (IMPACT) of 2014; and modify the measures required under the IRF QRP.

A general request for information on CMS flexibilities and efficiencies is also included in this proposed rule.

	Table of Contents	

I. Introduction and Background

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

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

Updates are proposed to the CMG relative weights and average length of stay values for FY 2018, using the same methodologies that have been used in past years applied to the FY 2016 IRF claims and FY 2015 IRF cost report data. The average length of stay for each CMG is used to determine when an IRF discharge meets the definition of a short-stay transfer, which results in a per diem case level adjustment. CMS computes a proposed budget neutrality factor of 0.9974 to account for changes to the FY 2018 relative weights. Table 1 of the final rule provides the proposed weights and length of stay values by CMG and comorbidity tier.

Table 2 of the proposed rule (reproduced below) shows the distributional effects (increases and decreases compared to FY 2017) of the proposed changes in CMG relative weights. CMS says that the largest increase in the final CMG relative weight values that would affect a particularly large number of IRF discharges is a 4.1 percent increase for CMG 0603, Neurological, with a motor score greater than 25.85 and less than 37.35 in tier 1. In the 2016 claims data, 1,322 IRF discharges (0.3 percent) were classified in this CMG and tier. The largest decrease that would affect the most cases is a 3.6 percent decrease for CMG 0506, Non-traumatic spinal cord injury, with a motor score of less than 23.75 in tier 3.

CMS Table 2: Distributional Effects of the Changes to the CMG Relative Weights (FY 2017 Values Compared with FY 2018 Values)		
Percentage Change	**# of Cases Affected**	**% of Cases Affected**
Increased by 15% or more	51	0.0
Increased by between 5% and 15%	1,720	0.4
Changed by less than 5%	394,048	99.3
Decreased by between 5% and 15%	850	0.2
Decreased by 15% or more	0	0.0

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

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

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

IV. FY 2018 IRF PPS Payment Update

A. Background

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

B. FY 2018 Market Basket Update and Productivity Adjustment

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

- The FY 2018 market basket increase factor based on IHS Global Insight's (IGI's) most recent forecast, which is for the first quarter of 2017, with historical data through the fourth quarter of 2016, is 2.7 percent.
- The multifactor productivity (MFP) adjustment called for under section 1886(j)(3)(C)(ii) of the Social Security Act (the Act) is equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multifactor productivity. Using IGI's first quarter 2017 forecast, the MFP adjustment for FY 2018 would be 0.4 percent
- Sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(v) of the Act require a further 0.75 percentage point reduction to the update factor.
- Absent the specified 1.0 percent update factor, these elements would yield an FY 2018 IRF update of 1.55 percent (2.7 percent minus 0.4 percent minus 0.75 percent).

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

C. Labor-Related Share for FY 2017

CMS proposes a total labor-related share of 70.7 percent for FY 2018. (The FY 2017 labor share is 70.9 percent.) The 70.7 percent comes from the IGI first quarter 2017 estimate of the sum of the relative importance of Wages and Salaries; Employee Benefits; Professional Fees: Labor-Related; Administrative and Facilities Support Services; Installation, Maintenance and Repair; All Other: Labor-related Services; and a portion (proposed to be 46 percent) of the Capital-

Related cost weight from the 2012-based IRF market basket. Table 3 of the proposed rule provides details on the components of this calculation.

D. Wage Adjustment

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

Use of updated labor market areas is proposed. CMS adopted in FY 2016 the OMB delineations for Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas described in the February 28, 2013 OMB Bulletin No. 13-01 (available at http://www.whitehouse.gov/sites/default/files/omb/bulletins/2013/b-13-01.pdf). However, on July 15, 2015, OMB issued OMB Bulletin No. 15–01, which provides minor updates to and supersedes Bulletin No.13–01. Bulletin No. 15-10 is available at https://obamawhitehouse.archives.gov/sites/default/files/omb/bulletins/2015/15-01.pdf. The changes made involve Garfield County, OK; the county of Bedford City, VA; and Macon, GA. These updated labor market area definitions were implemented under the acute hospital Inpatient Prospective Payment System (IPPS) beginning on October 1, 2016. CMS proposes to adopt these changes for the IRF PPS beginning October 1, 2017, which it says it consistent with its historical practice of modeling IRF PPS adoption of the labor market area delineations after IPPS adoption. CMS says that because the changes associated with adopting the revised delineations are minor and do not have a substantial effect on a large number of providers, no transition period is proposed. It notes that one provider in Oklahoma would be reclassified from rural to urban but the net effect of losing the rural adjustment and gaining a higher wage index would result in a less steep payment reduction than was experienced by the facilities for which the phase out of the rural adjustment was adopted.

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

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

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

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

Table 4 of the proposed rule (reproduced below) shows the calculations used to determine the FY 2018 IRF standard payment amount. Table 5 of the rule lists the unadjusted FY 2018 payment rates for each CMG, and Table 6 provides a detailed hypothetical example of how the IRF FY 2018 federal prospective payment would be calculated for CMG 0110 (without comorbidities) for two different IRF facilities (one urban, teaching and one rural, non-teaching), using the applicable wage index values and facility-level adjustment factors.

CMS Table 4: Calculations to Determine the Proposed FY 2018 Standard Payment Conversion Factor		
Explanation for Adjustment	**Calculations**	
Standard Payment Conversion Factor for FY 2017		$15,708
Market Basket Increase Factor for FY 2018 (1.0 percent) as required by section 1886(j)(3)(C)(iii) of the Act	x	1.0100
Budget Neutrality Factor for the Wage Index and Labor-Related Share	x	1.0007
Budget Neutrality Factor for the Revisions to the CMG Relative Weights	x	0.9974
FY 2017 Standard Payment Conversion Factor	=	$15,835

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

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

To update the IRF outlier threshold amount for FY 2018, CMS proposes to use FY 2016 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 on target at 3.0 percent of total IRF payments in FY 2017. To maintain estimated outlier payments at this level in light of estimated increases in IRF payments and costs, CMS proposes an update of the outlier threshold amount to $8,656 for FY 2018 (compared to $7,984 for FY 2017).

CMS further proposes to update the national urban and rural CCRs for IRFs, as well as the national CCR ceiling for FY 2018, based on analysis of the most recent data that are available. CCRs are used in converting an IRF's Medicare allowable covered charges for a case to costs for purposes of determining appropriate outlier payment amounts. The national urban and rural CCRs are applied in the following situations: new IRFs that have not yet submitted their first Medicare cost report; IRFs with an overall CCR that is more than the national CCR ceiling for FY 2018; and other IRFs for which accurate data to calculate an overall CCR are not available. CMS proposes that the national CCR ceiling again be set at 3 standard deviations above the

mean CCR for FY 2018. If an individual IRF's CCR exceeds the ceiling, CMS would replace the IRF's CCR with the appropriate national average CCR (either urban or rural).

For FY 2018, CMS estimates a national average CCR of 0.416 for urban IRFs and 0.516 for rural IRFs, and a national CCR ceiling of 1.28. These figures may change in the final rule if more recent data are available.

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

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

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

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

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

CMS proposes to remove from the IRF-PAI voluntary item 27: swallowing status effective for discharges beginning on or after October 1, 2017. CMS believes that continuing to collect these data would be duplicative because in the FY 2016 IRF PPS final rule, the IRF-PAI was revised to capture very similar data in new Section K-Swallowing/Nutritional Status, which is used as a

risk adjustor for the functional outcome measures. In addition, CMS says that to the extent that such information would be relevant to patient care, it should be captured in either the transfer documentation from the referring physician, or the patient's initial assessment documentation.

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

CMS proposes to modify the list of ICD-10-CM codes used in the presumptive compliance methodology. This methodology is one of two ways that Medicare contractors can evaluate an IRF's compliance with the "60 percent rule," under which, as a condition of payment as an IRF, at least 60 percent of a facility's total inpatient population must require treatment in an IRF for one or more of 13 medical conditions.[1] (The other compliance methodology involves medical review.) IRFs may be evaluated using the presumptive methodology only if their Medicare fee-for-service and MA populations combined make up more than half of their total patient population, so that the Medicare population can be presumed to be representative of the IRF's total patient population. **CMS specifically seeks public comment on the 60 percent rule, including but not limited to, the list of conditions.**

A list of ICD-10-CM codes for use in the presumptive compliance methodology beginning with discharges on or after October 1, 2015 was adopted in the FY 2015 IRF PPS final rule. (This list was a translation of the previously adopted list of ICD-9-CM codes used for this purpose.) CMS is proposing changes to the ICD-10-CM code list in response to public comments offered during last year's rulemaking. CMS provides the following link to the current list: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Downloads/ICD-10-CM-DataFiles.zip, and the proposed list at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Data-Files.html.

The proposed changes involve the following topics:

- Issues with ICD-10-CM diagnosis codes that were added to the list of Impairment Group Code (IGC) exclusions through the ICD-9-CM to ICD-10-CM conversion process for patients with traumatic brain injury conditions and hip fracture conditions.
    - CMS reports that the code labels for certain etiologic diagnoses for traumatic brain injuries changed during the conversion from ICD-9-CM to ICD-10-CM, and it proposes to remove some of the traumatic brain injury codes listed as exclusions on the relevant IGC Traumatic Brain Dysfunction exclusion lists (IGC 0002.21 Open Injury and 0002.22 Closed Injury). That is, if listed as an Etiologic Diagnosis on the IRF-PAI, these diagnosis codes proposed for removal would count toward the presumptive compliance criteria. CMS does not list in the proposed rule the codes that it proposes to remove. However, CMS specifically

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

proposes to retain the somewhat nonspecific ICD-10-CM code S06.9X9A—"Unspecified intracranial injury with loss of consciousness of unspecified duration, initial encounter," on the IGC 0002.22 exclusion list. as CMS believes other, more specific codes are available on the presumptive compliance list that would be more appropriate for coding conditions for purposes of the presumptive compliance count for a facility.[2]

- Similarly, CMS proposes to remove some of codes that it believes were inadvertently added as exclusions to IGC 0008.11—Orthopedic Disorders-Status Post Unilateral Hip Fracture, and IGC 0008.12—Orthopedic Disorders-Status Post Bilateral Hip Fractures. CMS proposes to remove the diagnosis code exclusions for a fracture of "unspecified part of neck of femur" but to retain the diagnosis code exclusions with the code label, "fracture of unspecified part of neck of femur of unspecified femur." CMS believes that documentation should support which femur (left/right or bilateral) is injured.

- Issues with identification of major multiple trauma codes that did not translate exactly from ICD-9-CM to ICD-10-CM. CMS proposes changes that would allow IRFs, for purposes of the presumptive methodology, to appropriately count patients with multiple fractures that include lower extremity fractures. ICD-9-CM included certain multiple fracture codes (828.0—Closed multiple fractures involving both lower limbs, lower with upper limb, and lower limb(s) with rib(s) and sternum; and 828.1—Open multiple fractures involving both lower limbs, lower with upper limb, and lower limb(s) with rib(s) and sternum) which would count toward meeting the 60 percent rule. Because similar codes do not exist in ICD-10-CM, CMS proposes to count IRF PAIs that contain two or more of the ICD-10-CM codes from three proposed major multiple trauma lists. The codes would need to be combined so that either one lower extremity fracture is combined with an upper extremity fracture or a rib/sternum fracture or that fractures are present in both lower extremities. List A is Major Multiple Trauma—Lower Extremity Fracture; List B is Major Multiple Trauma—Upper Extremity Fracture; and List C Major Multiple Trauma—Ribs and Sternum Fracture. They are available for download in the FY 2018 IRF PPS proposed rule data files located on the CMS website at the link cited above. CMS further proposes to remove ICD-10-CM code T07—Unspecified multiple injuries from the presumptive methodology list because it believes that any patient with multiple trauma who is admitted to an IRF would have had an extensive medical examination in the acute care setting and injuries would be identified and known to the IRF.
- Removal of Unspecified Codes. CMS proposes to remove certain codes from the presumptive compliance methodology list because they lack specificity. It believes that highly descriptive coding is the best way to document the appropriateness of a patient's admission. Further, CMS is concerned that reliance on "unspecified" codes may result in inflated IRF compliance percentages. CMS reviewed the ICD-10-CM codes currently on the presumptive compliance list to determine whether the code is sufficiently specific to identify conditions suitable for inclusion in determining compliance with the 60 percent rule. Where the code was not specific, CMS looked to see whether more specific codes

[2] It is unclear whether CMS intends that S06.9X9A be excluded as a standalone IRF-PAI etiologic code or only when used in combination with other traumatic brain injury codes or both.

were available to identify those patients. The list of codes proposed for removal is said to be available on the CMS website at the link cited above.

- Removal of arthritis codes. CMS proposes to remove from the presumptive compliance list 15 ICD-10-CM codes related to rheumatoid polyneuropathy with rheumatoid arthritis. Similar ICD-9-CM codes were previously removed from the list because information beyond the presence of the code is needed to determine whether the PAI-IRF should be included in the facility's compliance calculation. The codes now proposed for removal were added as a result of the ICD-10-CM conversion process.
- Removal of code G72.89—Other specified myopathies. CMS proposes removal of this code because it has found that some IRFs are using it to include patients with generalized weakness who do not meet the requirements of the 60 percent rule. CMS understood that it would apply only to a narrow set of specified myopathies that are confirmed by the results of specific medical testing.

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

CMS proposes a formal process for updating the lists of ICD-10-CM codes used in the presumptive compliance methodology to account for changes to the ICD-10 medical code data set. Under the proposal, a subregulatory process would be used for non-substantive updates, and notice and comment rulemaking would be reserved for substantive changes. Specifically, nonsubstantive changes made in accordance with annual changes to the medical data codes set made by the ICD-10 Coordination and Maintenance committee would be addressed through a subregulatory process. CMS would apply all relevant changes to the list of codes used in the presumptive compliance methodology so that the codes on that list would be consistent with the most recent ICD-10 medical code set. CMS says that it would apply the changes without regard to any policy judgments about use of the codes for the presumptive compliance methodology. Substantive changes, such as removal of codes from the list, would be proposed through the notice and comment rulemaking process. Under the proposal, each year's updated lists of ICD-10-CM codes for the presumptive compliance methodology would be available on the IRF PPS website prior to the effective date of the changes in the ICD-10 medical code data set.

In explaining the need for a process, CMS discusses a situation in which the Committee made a code invalid (M50.02 – Cervical disc disorder with myelopathy, midcervical region) and replaced it with four new codes, effective October 1, 2016. This is a code that is on the presumptive compliance methodology list, meaning IRFs may count these patients toward meeting the 60 percent rule. Because CMS had no process for updating the list, IRFs were not able to count these patients unless they also happened to be assigned another ICD-10-CM code that is on the list. If the proposed process were in place, CMS says it would have modified the compliance list to remove the invalid code and add the new ones prior to the effective date of the coding change.

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

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

XI. IRF Quality Reporting Program (IRF QRP)

A. Background

CMS established the IRF QRP beginning in FY 2014 for IRFs, as required under section 1886(j) of the Act, which was added by the Patient Protection and Affordable Care Act. Further developed in subsequent rulemaking, the IRF QRP follows many of the policies established for the Hospital IQR Program, including the principles for selecting measures and the procedures for hospital participation in the program. An IRF that does not meet the requirements of participation in the IRF QRP for a rate year is subject to a 2.0 percentage point reduction in the update factor for that year. In the collection of information requirements section of this rule, CMS reports that 80 of the 1137 active Medicare-certified IRFs did not receive the full annual percentage increase for the FY 2017 annual payment update determination.

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

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

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

change the nature of the measure. Substantive changes are proposed and finalized through rulemaking.

A table at the end of this section (VI) displays previously finalized and proposed measures for the IRF QRP.

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

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

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

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

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

Elsewhere in the proposed rule, CMS also indicates that it considered clinical relevance, ability to support clinical decisions, care planning and interoperable exchange to facilitate coordination during transitions in care; the ability to capture medical complexity and risk factors to inform

payment and quality; strong scientific reliability and validity; meaningful to inform longitudinal analysis by providers; general consensus on usability; and the ability for the data to collected once for multiple uses.

CMS proposes that the policy for retaining IRF QRP measures until they are removed, suspended or replaced also be applied to the standardized patient assessment data adopted for the IRF QRP. Similarly, CMS would apply the use of a subregulatory process adopted for IRF QRP measures to incorporate nonsubstantive updates to the standardized patient assessment data.

The specific data elements that CMS proposes to require that IRFs report as standardized patient assessment data are discussed in the proposed rule. The table below summarizes this information. It lists the elements by category, identifies the current PAC patient assessment instruments that include the proposed elements (or similar ones) and indicates whether the data elements would be newly added to the IRF-PAI. For the FY2020 payment determination, IRFs would be required to report all but three of the elements at admission and discharge for patients discharged beginning October 1, 2018 through December 31, 2018. For subsequent payment years, reporting would be for a full calendar year. The three exceptions are the BIMS, hearing, and vision elements, for which collection would only be required for assessments at admission, and not discharge. In addition, CMS proposes that the data elements used to report the current pressure ulcer measure (NQF #0678) would be required standardized patient assessment data elements for the FY 2019 IRF QRP.

Proposed Standardized Patient Assessment Data Elements, by Category		
Data Elements	**Current Use/Test of Elements***	**Change to IRF reporting**
Functional Status		
Elements to calculate the measure: Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)	CARE Item Set	Currently reported.
Cognitive Function and Mental Status		
Brief Interview for Mental Status (BIMS)	MDS 3.0 IRF-PAI PAC PRD	None; currently included in IRF PAI; assess at admission only
Confusion Assessment Method	LCDS MDS 3.0 PAC PRD	Add to IRF PAI
Behavioral Signs and Symptoms	MDS 3.0 OASIS-C2 PAC PRD	Add to IRF PAI (MDS version)
Patient Health Questionnaire-2	MDS 3.0 OASIS-C2 PAC PRD	Add to IRF PAI
Special Services, Treatments, and Interventions		
Cancer Treatment: Chemotherapy (IV, Oral, Other)	MDS 3.0 PAC PRD	Add to IRF PAI
Cancer Treatment: Radiation	MDS 3.0	Add to IRF PAI
Respiratory Treatment: Oxygen Therapy (Continuous, Intermittent)	MDS 3.0 OASIS-C2	Add to IRF PAI

Proposed Standardized Patient Assessment Data Elements, by Category		
Data Elements	**Current Use/Test of Elements***	**Change to IRF reporting**
	PAC PRD	
Respiratory Treatment: Suctioning (Scheduled, As needed)	MDS 3.0 PAC PRD	Add to IRF PAI
Respiratory Treatment: Tracheostomy Care	MDS 3.0 PAC PRD	Add to IRF PAI
Respiratory Treatment: Non-invasive Mechanical Ventilator (BiPAP, CPAP)	LCDS MDS 3.0 OASIS-C2 PAC PRD	Add to IRF PAI
Respiratory Treatment: Invasive Mechanical Ventilator	LCDS MDS 3.0 PAC PRD	Add to IRF PAI
Other Treatment: Intravenous (IV) Medications (Antibiotics, Anticoagulation, Other)	MDS 3.0 OASIS-C2 PAC PRD	Add to IRF PAI
Other Treatment: Transfusions	MDS 3.0 OASIS-C2 PAC PRD	Add to IRF PAI
Other Treatment: Dialysis (Hemodialysis, Peritoneal dialysis)	LCDS MDS 3.0 PAC PRD	Add to IRF PAI
Other Treatment: Intravenous (IV) Access (Peripheral IV, Midline, Central line, Other)	MDS 3.0 OASIS PAC PRD	Add to IRF PAI
Nutritional Approach: Parenteral/IV Feeding	LCDS MDS 3.0 IRF-PAI OASIS-C2 PAC PRD	Modify the IRF PAI elements
Nutritional Approach: Feeding Tube	MDS 3.0 OASIS-C2 IRF-PAI PAC PRD	Modify the IRF PAI elements
Nutritional Approach: Mechanically Altered Diet	MDS 3.0 OASIS-C2 IRF-PAI PAC PRD	Modify the IRF PAI elements
Nutritional Approach: Therapeutic Diet	MDS 3.0 PAC PRD	Add to IRF PAI
Medical Condition and Comorbidity Data		
Elements to calculate the current and proposed pressure ulcer measures: Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678) and Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	IRF-PAI	Currently reported
Impairment		
Hearing	MDS 3.0 OASIS C-2 PAC PRD	Add to IRF PAI (MDS version) assess at admission only

Proposed Standardized Patient Assessment Data Elements, by Category		
Data Elements	**Current Use/Test of Elements***	**Change to IRF reporting**
Vision	MDS 3.0 OASIS C-2 PAC PRD	Add to IRF PAI (MDS version) assess at admission
*This column reflects whether the proposed rule indicates that the specific elements proposed or similar or related elements are included in the current PAC assessment instruments or tested in the PAC PRD. The PAC instruments referenced are: Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI); Long-Term Care Hospital Continuity Assessment Record and Evaluation Data Set (LCDS); MDS for Skilled Nursing Facilities; and OASIS C-2 for home health agencies. The Continuity Assessment Record and Evaluation (CARE) Item Set is a standardized patient assessment tool developed as part of the PAC-PRD for use at acute hospital discharge and at post-acute care admission and discharge.		

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

C. IRF QRP Measures for FY 2020

Beginning with the FY 2020 payment determination, CMS proposes to replace one measure in the IRF QRP and remove another measure:

- The current pressure ulcer measure -- Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short Stay) (NQF #0678) would be replaced by a modified version with a new name – Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury. The modified version includes new or worsened unstageable pressure ulcers, including deep tissue injuries, in the measure numerator. In addition, it contains updated specifications intended to eliminate redundancies in the assessment items need for its calculation and to reduce the potential for underestimating the frequency of pressure ulcers. The proposed rule discusses the new specifications and the process that CMS used to develop the modified measure, including a summary of public comment. CMS intends to submit the measure for National Quality Forum (NQF) endorsement at the earliest opportunity. The Measure Applications Partnership (MAP) provided conditional support for using the new measure in the IRF QRP, and CMS says it intends to meet the MAP's conditions by offering additional training opportunities and educational materials prior to public reporting and by continuing to monitor and analyze the proposed measure. Data collection for the new measure would begin October 1, 2018. Specifications are available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/Proposed-Specifications-for-IRF-QRP-Quality-Measures-and-Standardized-Data-Elements-Effective-10-1-2018.pdf.

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

D. Measures Under Consideration for Future Years

CMS seeks comments on several possible future measures for the IRF QRP. They are:

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

CMS also indicates that it is considering modifications to the existing Discharge to Community-PAC IRF QRP measure. In response to previous comments, CMS is considering a modification that would exclude from the measure patients who were nursing facility residents prior to IRF admission.

Further, CMS intends to propose in future rulemaking two IMPACT Act measures to begin with the FY 2021 IRF QRP (2019 data collection) that involve transfer of health information. These are "Transfer of Information at Post-Acute Care Admission, Start or Resumption of Care from other Providers/Settings" and "Transfer of Information at Post-Acute Care Discharge, and End of Care to other Providers/Settings." Data collection for these measures would begin on or about October 1, 2019.

E. Accounting for Social Risk Factors in the IRF QRP

CMS seeks comment on accounting for social risk factors in the IRF QRP. The proposed rule reviews the results of recent reports on the issue of accounting for social risk factors (also sometimes referred to as socioeconomic status (SES) factors or socio-demographic status (SDS) factors) in its quality reporting and value-based purchasing programs. The Assistant Secretary for Planning and Evaluation (ASPE) issued a report to Congress in December 2016 analyzing the effects of social risk factors on quality and resource use measures in the Medicare value-based purchasing programs: https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicares-value-based-purchasing-programs. A second report, by the National Academy of Sciences, Engineering and Medicine, was issued in January 2017 and addresses accounting for social risk factors in Medicare payment. It is available at:

http://www.nationalacademies.org/hmd/Reports/2017/accounting-for-social-risk-factors-in-medicare-payment-5.aspx. Further, CMS anticipates that the NQF will issue recommendations at the end of the two-year trial period during which social risk factors are being included in the risk adjustment of some measures.

Although CMS continues to be concerned about the potential for risk adjustment for social factors to mask potential disparities or minimize incentives to improve the outcomes for disadvantaged populations, it seeks public comment on whether to account for social risk factors in the IRF QRP and, if so, what methods would be most appropriate to use. Examples offered include confidential reporting of stratified measure rates to providers; public reporting of stratified measure rates; and potential risk adjustment of a particular measure as appropriate based on data and evidence.

In addition, public comment is sought on which social risk factors are most appropriate for stratifying measure scores and/or potential risk adjustment of a particular measure, where information on these factors would be available, or whether additional data collection is needed. Examples of social risk factors are dual eligibility/low-income subsidy, race and ethnicity, and geographic area of residence.

As CMS intends to continue to work with stakeholders on issues regarding accounting for social risk factors in quality reporting and value-based payment, the context for how the IRF QRP and other programs operate will also be considered, such as data submission methods and statistical considerations in data reliability. Comments on operational considerations are also welcomed.

Finally, CMS notes that any changes to account for social risk factors in the IRF QRP would be proposed through future notice and comment rulemaking.

F. Data Submission for the IRF QRP

New IRFs. CMS proposes that for new IRFs, the timing for initial reporting of standardized patient assessment data would be the same as the previously adopted schedule for reporting quality data under the IRF QRP. As under current policy, data would be reported by submitting the IRF-PAI to CMS through the QIES ASAP system.

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

Standardized Patient Assessment Data. As described above, CMS proposes new standardized patient assessment data elements for addition to the IRF-PAI effective with the FY 2020 payment determination. For that initial year, reporting on these elements would be required for discharges beginning October 1, 2018 through December 31, 2018. This is consistent with the general current policy under which IRFs report data on quality measures for a full calendar year period except for the first program year of reporting a measure, in which case IRFs are only required to report data for IRF discharges that occur on or after October 1 of the last quarter of

the applicable calendar year. CMS proposes that this data collection timing policy would also generally apply to standardized patient assessment data. The proposed rule includes tables illustrating the reporting periods and data submission deadlines under this policy for FYs 2019 and 2020.

Data Completeness Standards. CMS proposes that data completeness standards that currently apply to the IRF QRP would be extended to apply to reporting of standardized patient assessment data. Under that policy, IRFs must meet or exceed a threshold set at 95 percent for measures data collected through the IRF-PAI submitted through the QIES ASAP system. (A 100 percent threshold applies to data submitted through the CDC NHSN.) CMS notes that some standardized patient assessment data will not invoke a response and, in those circumstances, are not "missing" nor are the data incomplete. CMS also proposes to codify the data completeness requirements for measure and standardized patient assessment data collected from the IRF-PAI.

Request for Comment on Collecting Data on All Patients. Noting that the Medicare population is 60 percent of the IRF population served, CMS discusses input it has received from the MAP and others suggesting that quality measures be expanded, where feasible, to include data on all patients and not just Medicare beneficiaries. It seeks comment on this issue. The benefits of broader data and the potential collection burden for providers are noted, but CMS also says it understands that it is common practice for IRFs to collect IRF-PAI data on all patients, regardless of payer.

G. Codification of Standardized Patient Assessment Data Proposals

CMS proposes to make various changes in the regulatory text at 42 CFR 412.634 to reflect the changes in the proposed rule regarding required submission of standardized patient assessment data.

H. Public Reporting

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

In this rule, pending the availability of data, CMS proposes to publicly report data in 2018 on six additional measures. For the measures proposed for replacement (pressure ulcers) or removal (all cause readmissions), associated changes would be made with respect to public reporting. A table in the proposed rule lists the 7 previously finalized measures and 7 proposed additional measures. These are indicated in the summary table below.

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

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

CMS Table 12: Calculations to Determine the Adjusted FY 2018 Standard Payment Conversion Factor for IRFs that Failed to Meet the Quality Reporting Requirement		
Explanation for Adjustment	**Calculations**	
Standard Payment Conversion Factor for FY 2017		$15,708
Increase Factor for FY 2018 (1.0 percent), as required by section 1886(j)(3)(C)(iii) of the Act, and further reduced by 2 percentage points for IRFs that failed to meet the quality reporting requirement	x	0.9900
Budget Neutrality Factor for the Wage Index and Labor-Related Share	x	1.0007
Budget Neutrality Factor for the Revisions to the CMG Relative Weights	x	0.9974
Adjusted FY 2018 Standard Payment Conversion Factor	=	$15,521

J. Impact Analysis

CMS provides detailed estimates of impact on IRFs associated with the proposed changes in the IRF QRP, some of which would reduce reporting requirements and others which would increase them. Changes in the measure reporting requirements would result in a net 5.5 minute reduction in compliance time spent by LTCHs, while the new standardized patient assessment data elements would increase the time by 14.4 minutes of burden, with an overall the cost estimated at an additional $2,989 per IRF annually, or $3.4 million for all IRFs annually.

Quality Measures Previously Adopted and Proposed for the IRF QRP

Short Name	**Measure Name & Data Source**	***Proposed change for FY 2020***	**Public Reporting in CY 2018**
IRF-PAI			
Pressure Ulcers	Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678)	*Replace*	X *Remove by October 2020*
	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	*Add*	*Add by October 2020*
Patient Influenza Vaccine	Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680)		X
Application of Falls	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)*		*Proposed*
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)*		*Proposed*
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)**		

Short Name	Measure Name & Data Source	*Proposed change for FY 2020*	Public Reporting in CY 2018
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)		X
MRSA	NHSN Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (NQF #1716)		X
CDI	NHSN Facility-wide Inpatient Hospital-Onset Clostridium difficile Infection (CDI) Outcome Measure (NQF #1717)		X
HCP Influenza Vaccine	Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431)		X
Claims-based			
All-Cause Readmissions	All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from IRFs (NQF #2502)	*Remove*	*Remove*
MSPB	Medicare Spending per Beneficiary (MSPB)–PAC IRF QRP*		*Proposed*
DTC	Discharge to Community–PAC IRF QRP*		*Proposed*
Potentially Preventable Readmissions (PPR) 30 day	Potentially Preventable 30-Day Post-Discharge Readmission Measure for IRF QRP*		*Proposed*
PPR Within Stay	Potentially Preventable Within Stay Readmission Measure for IRFs*		*Proposed*
*Not currently NQF-endorsed for the IRF setting. **In satisfaction of section 1899B(c)(1) of the Act (i.e., IMPACT Act) quality measure domain: functional status, cognitive function, and changes in function and cognitive function domain. Note: when a measure is described as "application of" it means the underlying measure was endorsed by the NQF for another setting.			

XII. Request for Information on CMS Flexibilities and Efficiencies

CMS is requesting ideas for payment system redesign, elimination or streamlining of reporting, monitoring and documentation requirements, aligning Medicare requirements and processes with those from Medicaid and other payers, operational flexibility, feedback mechanisms and data sharing that would enhance patient care, support of the physician-patient relationship in care delivery, and facilitation of individual preferences with the purpose of reducing burdens for hospitals, physicians, and patients. CMS is particularly interested in ideas for incentivizing organizations and the full range of relevant professionals and paraprofessionals to provide screening, assessment and evidence-based treatment for individuals with opioid use disorder and

other substance use disorders, including reimbursement methodologies, care coordination, systems and services integration, use of paraprofessionals including community paramedics and other strategies. CMS notes it does not plan to respond to the comments it receives but will use these ideas as it considers future policies.

Respondents are admonished not to include any information that might be considered proprietary or confidential. Complete but concise responses are encouraged. CMS may publicly post the public comments it receives, or a summary of them.

XIII. Regulatory Impact Analysis

CMS estimates that the final rule will increase Medicare payments to IRFs by $80 million in FY 2018 compared with FY 2017. This falls short of the $100 million threshold defining it as a major rule, and therefore no regulatory impact analysis is provided.