FFY 2020 INPATIENT REHABILITATION FACILITY PPS PROPOSED RULE

CHA MEMBER FORUM

May 14, 2019

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Objectives

- Review proposed changes to several key payment and quality provisions in the FFY 2020 IRF proposed rule
  - The full text of the proposed rule and the CHA summary are available on the CHA Regulatory Tracker
- Solicit CHA member feedback on proposed changes for CHA comments
  - All comments due on June 17 at 2:00 pm (PT)
  - Comments submitted online at www.regulations.gov
  - Goal: Draft comments be available approximately one week in advance

Rule Overview

- Context Setting and Key Themes Across PAC PPS Proposed Rules
- IRF PPS Rate Updates and Policy Changes

17244 **Federal Register** / Vol. 84, No. 79 / Wednesday, April 24, 2019 / Proposed Rules

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS–1710–P]

RIN 0938–AT67

Medicare Program; Inpatient Rehabilitation Facility (IRF) Prospective Payment System for Federal Fiscal Year 2020 and Updates to the IRF Quality Reporting Program

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would update the prospective payment rates for inpatient rehabilitation facilities (IRFs) for federal fiscal year (FY) 2020. As required by the Social Security Act (the Act), this proposed rule includes the classification and weighting factors for the IRF prospective payment system's (PPS) case-mix groups (CMGs) and a description of the methodologies and data used in computing the prospective payment rates for FY 2020. We are proposing to rebase and revise the IRF market basket to reflect a 2016 base year rather than the current 2012 base year. Additionally, we are proposing to replace the previously finalized unweighted motor score with a weighted motor score to assign patients to CMGs and remove one item from the score beginning with FY 2020 and to revise the CMGs and update the CMG relative weights and average length of stay values beginning with FY 2020, based on analysis of 2 years of data (FY 2017 and FY 2018). We are proposing to update the IRF wage index to use the concurrent FY inpatient prospective payment system (IPPS) wage index beginning with FY 2020. We are soliciting comments on stakeholder concerns regarding the appropriateness of the wage index used to adjust IRF payments. We are proposing to amend the regulations to clarify that the determination as to whether a physician qualifies as a rehabilitation physician (that is, a licensed physician with specialized training and experience in inpatient rehabilitation) is made by the IRF. For the IRF Quality Reporting Program (QRP), we are proposing to adopt two new measures, modify an existing measure, and adopt new standardized patient assessment data elements. We also propose to expand data collection to all patients, regardless of payer, as well as proposing updates related to the system used for the submission of data and related regulation text.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, not later than 5 p.m. on June 17, 2019.

ADDRESSES: In commenting, please refer to file code CMS–1710–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the "Submit a comment" instructions.
2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1710–P, P.O. Box 8016, Baltimore, MD 21244–8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1710–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT:

Gwendolyn Johnson, (410) 786–6954, for general information.

Catie Kraemer, (410) 786–0179, for information about the IRF payment policies and payment rates.

Kadie Derby, (410) 786–0468, for information about the IRF coverage policies.

Kate Brooks, (410) 786–7877, for information about the IRF quality reporting program.

SUPPLEMENTARY INFORMATION: The IRF PPS Addenda along with other supporting documents and tables referenced in this proposed rule are available through the internet on the CMS website at *http://www.cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/.*

Executive Summary

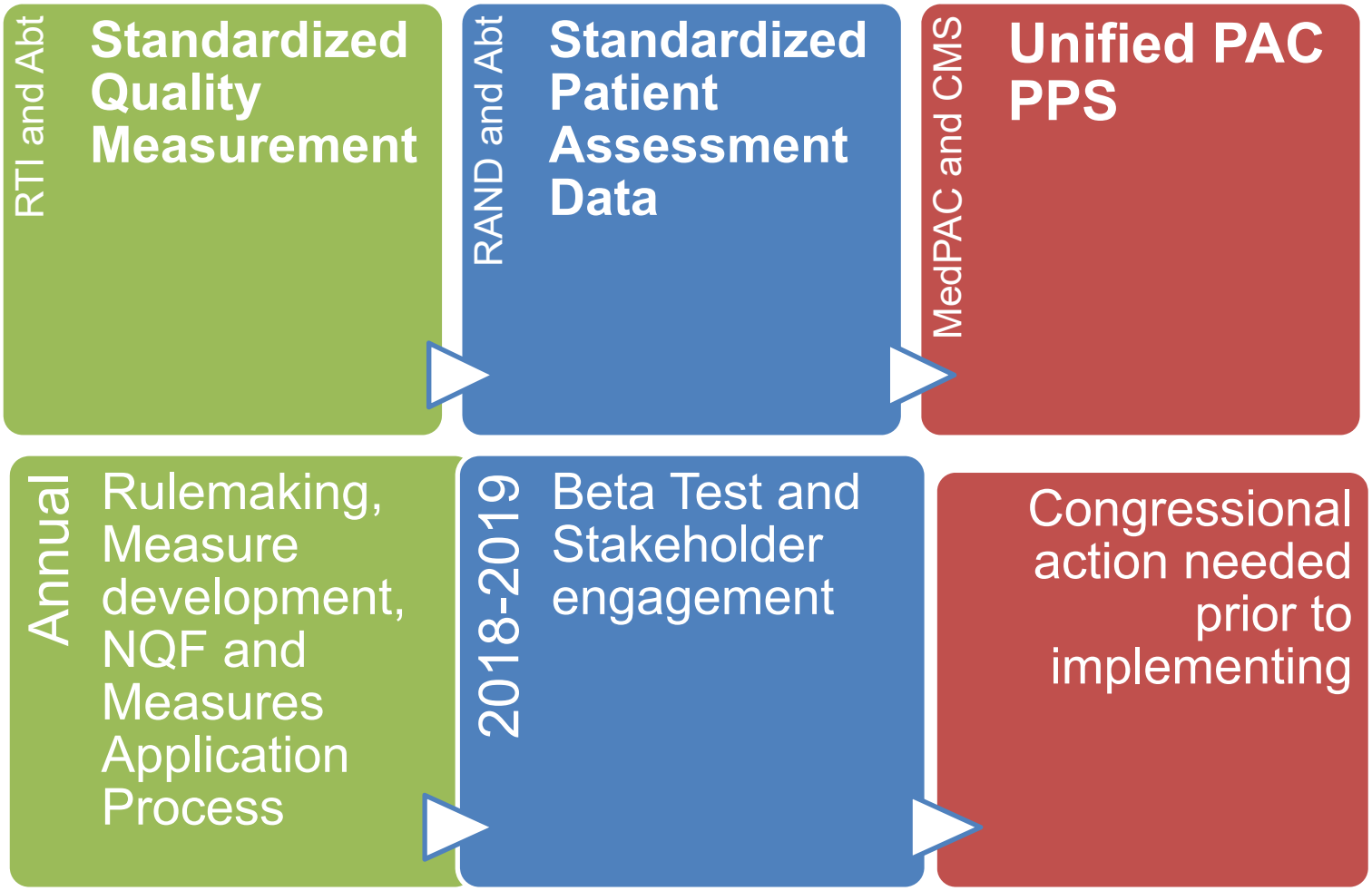
A. Purpose

This proposed rule would update the prospective payment rates for IRFs for FY 2020 (that is, for discharges occurring on or after October 1, 2019, and on or before September 30, 2020) as required under section 1886(j)(3)(C) of the Act. As required by section 1886(j)(5) of the Act, this proposed rule includes the classification and weighting factors for the IRF PPS's case-mix groups and a description of the methodologies and data used in computing the prospective payment rates for FY 2020. This proposed rule would also rebase and revise the IRF market basket to reflect a 2016 base year, rather than the current 2012 base year. Additionally, this proposed rule proposes to replace the previously finalized unweighted motor score with a weighted motor score to assign patients to CMGs and remove one item from the score beginning in FY 2020 and to revise the CMGs and update the CMG relative weights and average length of stay values beginning with FY 2020, based on analysis of 2 years of data (FY 2017 and FY 2018). We are also proposing to update the IRF wage index to use the concurrent IPPS wage index for the IRF PPS beginning with FY 2020. We are also soliciting comments on stakeholder concerns regarding the appropriateness of the wage index used to adjust IRF payments. We are also proposing to amend the regulations at § 412.622 to clarify that the determination as to whether a physician qualifies as a rehabilitation physician (that is, a licensed physician with specialized training and experience in inpatient rehabilitation) is made by the IRF. For the IRF Quality Reporting Program (QRP), we are proposing to adopt two new measures, modify an existing measure, and adopt new standardized patient assessment data elements. We also propose to expand data collection to all patients, regardless of payer, as well as proposing updates related to the system used for the submission of data and related regulation text.

B. Summary of Major Provisions

In this proposed rule, we use the methods described in the FY 2019 IRF PPS final rule (83 FR 38514) to update the prospective payment rates for FY 2020 using updated FY 2018 IRF claims and the most recent available IRF cost report data, which is FY 2017 IRF cost report data. This proposed rule also proposes to rebase and revise the IRF market basket to reflect a 2016 base year rather than the current 2012 base year. Additionally, this proposed rule proposes to replace the previously finalized unweighted motor score with a weighted motor score to assign patients to CMGs and remove one item

IMPACT ACT – A Three Part Series



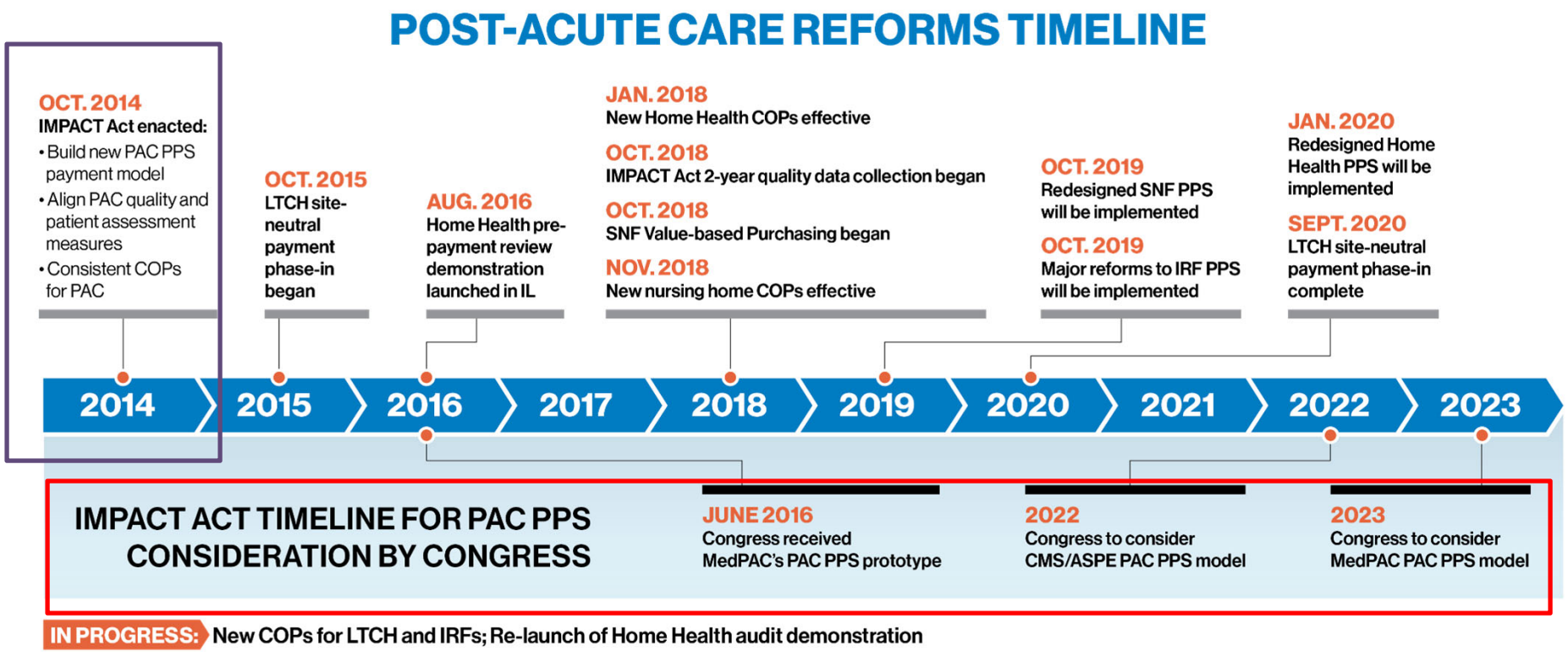
The Trajectory Played Out in 2019 Rulemaking

Payment Setting	Rate Update	Setting-Specific Payment Adjustments	Pay-For-Reporting Programs	Other Notables
SNF (final rule)	+2.4% (+2.8% MB; -0.8 PPT ACA +0.39% BBA MB WI/Labor-Related Share BN 0.9999)	**Significant case mix adjustment change from RUGS-IV to PDPM model effective Oct. 1, 2019 (FY 2020).**	**VBP beg FFY 2019 providing** incentive payments to SNFs w/ > levels of performance and penalties of up to 2% w/ <performance on readmissions; low-volume SNFs be assigned a break-even performance score in SNF VBP; For SNF QRP, increase data from 1 to 2 years for MSPB calculation and D/C to community .	Interrupted stay policy that treats any case that leaves a SNF for 4 or more days and then returns as a new admission, which would be initiated with a new patient assessment. Patients returning within 3 or fewer days would be subject to the prior payer classification with no adjustment to the variable per diem rate.
IRF (final rule)	+1.16% (+2.9% MB; -0.8 PPT ACA *0.999713 WI BN 1.0000 BN Case-Mix Group Relative Weight Revisions BN 0.9981)	Removal of the FIM instrument and associated function modifier from the IRF-PAI beginning Oct 1, 2019 (FFY 2020) CMS will make updates and revise the case-mix for FFY 2020.	Remove 1 measure in FFY 2020 and 1 in FFY 2021. Publically display 4 assessment-based measures.	Post-admission MD evaluation may count as 1 of the 3 face-to-face mtgs, rehab MDs may lead the team mtgs remotely w/o any add'l documentation, and removed requirement to have admission order documentation.

The Trajectory Played Out in 2019 Rulemaking

Payment Setting	Rate Update	Setting-Specific Payment Adjustments	Pay-For-Reporting Programs	Other Notables
LTCH (final rule)	+0.16% [2.7% MB - 1.55 PPT ACA] *0.999713 WI BN *0.990535 BN as a result of elimination of 25% Threshold	Transitional blended PMT rate over after FY2019; Eliminate the 25% PMT threshold, and apply BN adjustment to the LTCH PPS std fed PMT rate. 4.6% reduction to IPPS comparable amount for SN until FFY 2026	Removes 2 measures in FY2020 and 1 measure in FFY 2021.	
HHA (final rule)	2.2% payment update	**New case-mix classification system called the Payment Driven Groupings Model (PDGM) effective FFY 2020** Changes the home health unit of payment from 60 days to 30 days **Includes behavioral adjustment**.	Removes seven measures	Permanent home infusion benefit Implementation of a temporary transitional payment for eligible infusion therapy suppliers .

PAC Payment Reform



Source: Adapted from the AHA PAC Infographic, February 2019

FFY 2020 Payment Provisions

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Payment Provisions

- Net Update - ***+2.5%*** resulting from 3.0% market basket update, offset by ACA-mandated productivity adjustment of 0.5%.
- Proposed standard payment rate - ***$16,573***
  (FFY 2019- $16,021)
- Outlier Threshold - ***$9,935***
  (*FFY 2019 - $9,402)*
- Revision of CMG Relative Weights & ALOS
- Wage Adjustment

Revision of CMG/Case Mix System

Revision of CMG/Case Mix System

- Revises groupings to reflect transition away from use of FIM to use of Section GG items to measure functional status.
- Uses two years of data for revising of CMG categories (FFY 2017 & 2018)
- Proposes use of a weighted motor score
- Revises and updates relative weights and LOS

Provider Impact

IRFs may access provider specific CMG and wage adjustment impact on the CMS website at:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/List-of-IRF-Federal-Regulations-Items/CMS-1710-P.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending

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Current Use of Medicare's Area Wage Index

- The "adjusted"* Area Wage Index is currently used in:
  - Medicare Inpatient prospective payment system
  - Medicare Outpatient prospective payment system
  - Med-cal FFS (APR-DRG) system**
- The "unadjusted" area wage index is used in
  - Medicare skilled nursing facility PPS (70.9% labor share)
  - Medicare inpatient rehabilitation facility PPS (70.9% labor share)***
  - Medicare inpatient psych facility PPS (70.9% labor share)***
- Many hospitals factor the "adjusted" AWI into Medicare Advantage and Medi-cal Managed care contracts.

* The "adjusted" AWI accounts for reclassification and rural floor budget neturality

**Any change to Medi-cal FFS in one year will be adjusted the following year to make the change budget neutral.

*** CMS proposes to update IRF and IPF AWI to FFY 2020 (as opposed to a one year delay.

FFY 2020 CMS Area Wage Index Proposal Overview

Wage Compression for 4 years

CMS proposes to increase wage index values for low-wage hospitals in the bottom 25th percentile and to reduce wage index values for high-wage hospitals in the top 75th percentile to make the policy budget neutral

Recalculation of the Rural Floor

CMS proposes to no longer include wage index data from urban hospitals that reclassify as rural when calculating each state's rural floor and subsequent rural floor budget neutrality adjustment.

1 Year Stop Loss for High Wage Hospitals

CMS proposes to phase in its proposal by capping any decrease in a hospital's wage index to 5 percent in FFY 2020 compared to FFY 2019 (e.g. a one year stop loss).

CMS proposes to fund this one year stop loss by a cut to the standardized amount across all hospitals.

*** Separately, CMS proposes to exclude 81 hospitals from the area wage index for aberrant data. Among the excluded are 7 California hospitals whose data is not accurate, but the AWH is significantly higher than that of other hospitals in the CBSA. CMS notes that it is considering excluding all 38 hospitals in that health system from the data in FFY 2021 and beyond.

Wage Compression

- CMS proposes to increase wage index values for low-wage hospitals in the bottom 25th percentile and to reduce wage index values for high-wage hospitals in the top 75th percentile to make the policy budget neutral. This policy would be effective for at least **four years**, beginning in FFY 2020.

Low-Wage Hospital Increase

- FFY 2020 the 25th percentile across all hospitals is 0.8482
- Proposed increase would be **half of the difference between current wage index and the 25th percentile across all hospitals**

Example:

Alabama Hospital 0.6663

(08482-0.6663)/2 = half the difference 0.0910

0.6663+0.0910 = 0.7573 New AWI for Alabama Hospital

High-Wage Hospital Decrease

- FFY 2020 the 75thpercentile across all hospitals is 1.0351

Example:

Hospital A – AWI 1.7351

(1.7351-1.0351) = 0.700

Hospital B – AWI 1.2351

(1.2351-1.0351) = 0.200

CMS proposes a uniform multiplicative BN factor to reduce the distances (0.7 and 0.2) to offset the payments needed to fund the low wage adjustments. CMS estimates BN factor **at 3.4****

Example: **Hospital A**

Step 1 (0.7*0.034) = 0.0238 **Step 2** (1.7351-0.0238) = 1.7113

OLD AWI 1.7351 ↓ NEW AWI 1.7113

** CMS has confirmed the 3.4 is incorrect, it is 4.3

Regulatory Update

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Clarification of “Rehabilitation Physician”

CMS proposes to revise in regulations the current definition of “rehabilitation physician” to clarify that IRFs are responsible to determine whether a physician has “specialized training and experience in inpatient rehabilitation”, as required.

IRF Quality Reporting Program

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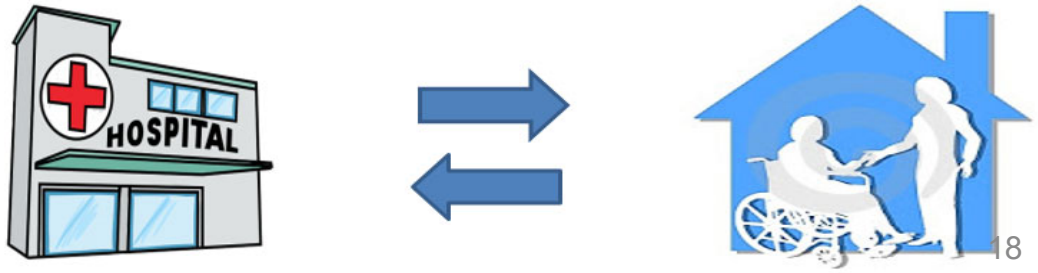
IRF Quality Reporting Program

CMS proposes 2 new measures for FFY 2022 QRP, with data collection beginning in October 2020.

- Transfer of health information to the provider
- Transfer of health information to the patient

These proposed measures are based on the transfer of a current reconciled medication list.



IRF Quality Reporting Program

- CMS proposes to update the Discharge to Community Measure
  - Updated measure will exclude baseline nursing facility residents.
  - Definition: IRF patients who had a long term NF stay in the 180 preceding hospitalization, with no intervening community discharge between the NF stay and hospital admission.
  - CMS reports that this change results in increased discharge to community rates for some IRFs.

IRF Quality Reporting Program

- CMS proposes to require IRFs to report IRF-PAI data on ***all*** patients, regardless of payer type.
  - Effective October 1, 2020

- CMS proposes to add the IRF QRP measure" Drug Regimen Review Conducted with Follow-up for Identified Issues" to the IRF Compare website.
  - Initial data will be based on CY 2019

- CMS proposes to stop publishing list of compliant IRFs.

Standardized Patient Assessment Data Elements (SPADEs)

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SPADE

- CMS previously proposed implementation of many SPADEs in FFY 2018, but deferred most based on provider feedback
- CMS now proposes implementation of previously proposed SPADEs as well as several additional new SPADEs.
- Required reporting would begin with the FFY 2022 IRF QRP.

Newly Proposed SPADEs

- High-Risk Drug Classes: Use and Indications
  - For six identified drug classes
- Pain Interference
  - Effect on Sleep
  - Interference with Therapy Activities
  - Interference with Day-to-Day Activities
- Social Determinants of Health
  - New category
  - 7 items

SPADEs: Cognitive Function and Mental Status

- Brief Interview for Mental Status
  - Currently reported on admission; proposes addition to discharge assessment
- Confusion Assessment Method (CAM) – *New item*
- Patient Health Questionnaire (depression screening) – *New item*

SPADE: Special Services, Treatments and Interventions

- Cancer Treatment: Chemotherapy – *New item*
- Cancer Treatment: Radiation – *New item*

- Respiratory Treatment: oxygen therapy – *New item*
- Respiratory Treatment: suctioning – *New item*
- Respiratory Treatment: tracheostomy –*New item*
- Respiratory Treatment: mechanical ventilation – *New item*
- Respiratory Treatment: mechanical ventilation(invasive) - *New item*

SPADE: Special Services, Treatments and Interventions (continued)

- IV Medications – *New item*
- Transfusions –*New item*
- Dialysis –*New item*
- Other: IV Access –*New item*

- Nutritional Approach: parenteral/IV feeding*
- Nutritional Approach: feeding tube*
- Nutritional Approach: mechanically altered diet*
- Nutritional Approach: therapeutic diet*

- High-Risk Drug Classes - *New item*

*(*Current IRF-PAI items will be replaced by MDS items)*

SPADE: – Medical Condition and Comorbidity Data, Impairment

Medical Condition and Comorbidity

- Pain Interference - *New item*

Impairment

- Hearing, required on admission only - *New item*
- Vision, required on admission only - *New item*

SPADE: Social Determinants of Health

- Race*
- Ethnicity*

(*Current IRF-PAI items will be replaced)

- Preferred Language and Interpreter Services - *New item*
- Health Literacy - *New item*
- Transportation - *New item*
- Social Isolation - *New item*

Proposed Standardized Patient Assessment Data Elements (SPADE) Reporting Beginning in FFY 2022*

Proposed SPADE Categories	Included in National Beta Test	IRF-PAI (IRF)	MDS 3.0 (SNF)	LCDS (LTCH)	Point of Data Collection	Data Collection for FFY 2022
Cognitive Function & Mental Status						Patients admitted and discharged between Oct. 1-Dec. 31, 2020
Brief interview for mental status (BIMS)	x	x	x	x	Admission & Discharge	
Signs and Symptoms of delirium (CAM)	x	x	x	x	Admission & Discharge	
PHQ-2 to 9	x	x	x	x	Admission & Discharge	
Medical Condition & Comorbidity						
Pain Interference	x	x	x	x	Admission & Discharge	
Impairments						
Hearing	x	x	x	x	Admission Only	
Vision	x	x	x	x	Admission Only	
Special Services, Treatments and Interventions (SSTI)						
Nutritional approaches: IV or feeding tube, diet, etc.	x	x	x	x	Admission & Discharge	
Services and Treatments: Cancer, respiratory, other (IV medications, transfusions, dialysis, etc.)	x	x	x	x	Admission & Discharge	
High-Risk Drug Classes (Use and Indication)	x	x	x	x	Admission & Discharge	
Social Determinants of Health (proposed creation of new category)						
Race		x	x	x	Admission Only	
Ethnicity		x	x	x	Admission Only	
Preferred Language		x	x	x	Admission & Discharge	
Interpreter Services		x	x	x	Admission & Discharge	
Health Literacy		x	x	x	Admission & Discharge	
Transportation (PROMISE)		x	x	x	Admission & Discharge	
Social Isolation (PROMISE)		x	x	x	Admission & Discharge	

SPADE

- Data collection via the IRF-PAI would begin for admissions after October 1, 2020.

- A change table for the proposed IRF-PAI is available on the CMS website at:

  https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-Downloads-and-Videos.html

- CMS estimates cost of additional reporting at $ 7,256/year, with 95% ($6,926) of the cost attributable to SPADEs.

Request for Information on Future IRF QRP Measures

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RFI on Future Measures

CMS seeks comment on the importance, relevance appropriateness and applicability of the following:

Assessment-based Quality Measures:

- Opioid Use and Frequency
- Exchange of electronic health information and interoperability

RFI on Future Measures

SPADES:

- Cognitive complexity, (e.g., executive function, memory)
- Dementia
- Bladder and bowel continence, including appliance use and episodes of incontinence
- Care preferences, advance directives, goals of care
- Caregiver status
- Veteran status
- Health disparities and risk factors (e.g., education, sex and gender identity, sexual orientation).

THANK YOU!

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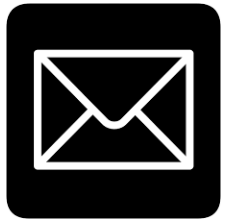

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