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Medicare Inpatient Rehabilitation Facility Prospective Payment System for FY 2022 and Updates to the IRF Quality Reporting Program Proposed Rule Summary

On April 12, 2021, the Centers for Medicare & Medicaid Services (CMS) published in the Federal Register (86 FR 19086) a proposed rule on the Medicare inpatient rehabilitation facility prospective payment system (IRF PPS) for federal fiscal year (FY) 2022.

In addition to provisions that would update the IRF PPS payment rates and outlier threshold for FY 2022, the rule proposes to add one new measure to the IRF Quality Reporting Program (QRP) and modify the denominator for another measure currently under the IRF QRP beginning with the FY 2023 IRF QRP. In addition, this rule proposes to modify the number of quarters used for publicly reporting certain IRF QRP measures due to the COVID-19 public health emergency (PHE). CMS also seeks comment on the use of Health Level Seven International (HL7®) Fast Healthcare Interoperability Resources® (FHIR)-based standards in post-acute care, specifically the IRF QRP, and on its continued efforts to close the health equity gap.

CMS estimates that the Medicare IRF PPS payments in FY 2022 will be about $160 million higher than in FY 2021.

The deadline for comments on the proposed rule is June 7, 2021.

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I. Introduction and Background

The proposed rule provides an overview of the IRF PPS, including statutory provisions, a description of the IRF PPS for FYs 2002 through 2021, and an operational overview. It also notes IRF specific changes to IRF payment and conditions for participation adopted based on two interim final rules with comment period made in response to the COVID-19 Public Health Emergency (PHE).[1] This included certain changes to the IRF PPS medical supervision requirements as well as modifying certain IRF coverage and classification requirements for freestanding IRF hospitals to relieve acute care hospital capacity concerns in certain states that are experiencing a surge during the PHE for COVID-19. In addition, CMS highlights efforts at promoting adoption of interoperable health information technology and health information exchange in post-acute settings. It cites the hospital discharge planning final rule (84 FR 51836) provisions promoting the exchange of patient information between health care settings, and the May 2020 rules from CMS and the HHS Office of the National Coordinator for Health Information Technology pertaining to patient access, interoperability and information blocking (85 FR 25642 and 85 FR 25510).

II. Update to the CMG Relative Weights and Average Length of Stay Values

Under the IRF case-mix classification system, a patient's principal diagnosis or impairment is used to classify the patient into a Rehabilitation Impairment Category (RIC). The patient is then placed into a case mix group (CMG) within the RIC based on the patient's functional status (motor and cognitive scores) and sometimes age. Other special circumstances (e.g., very short stay or patient death) are also considered in determining the appropriate CMG. CMGs are further divided into tiers based on the presence of certain comorbidities; the tiers reflect the differential cost of care compared with the average beneficiary in the CMG.

Updates to the CMG relative weights and average length of stay values are proposed for FY 2022, continuing the same methodologies used in past years, and now applied to FY 2020 IRF claims and FY 2019 IRF cost report data. (More recent data from these sources will be used for the final rule, if available.) Changes to the CMG weights are made in a budget neutral manner; the proposed budget neutrality factor is 1.0000.

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

CMS says that the proposed changes in the average length of stay values from FY 2021 to FY 2022 are small and do not show any trends in IRF length of stay patterns.

[1]These are referred to as the April 6, 2020 IFC (85 FR 19230) and the May 8, 2020 IFC (85 FR 27550).

Column 7 of Table 17 in the impact section of the proposed rule (section VII below) shows the distributional effects of the changes in the CMGs by type of facility. Note that for this proposed rule, CMS has not posted the accompanying provider-specific files on the IRF PPS web page.

III. FY 2022 IRF PPS Payment Update

For FY 2022 payment, CMS proposes to apply the annual market basket update and productivity adjustment; updates the labor-related share of payment; and updates the wage index based on the most recent IPPS hospital wage index data.

A. Market Basket Update and Productivity Adjustment

An update factor of 2.2 percent is proposed for the IRF PPS payment rates for FY 2022, composed of the following elements.

Proposed FY 2022 IRF PPS Update Factor	
Market basket	2.4%
Multifactor productivity (MFP)	-0.2%
Total	2.2%

The 2.4 percent FY 2022 market basket increase factor is based on IHS Global Insight's (IGI's) forecast from the fourth quarter of 2020, based on actual data through the third quarter. Similarly, the statutorily required MFP adjustment is based on IGI's fourth quarter 2020 forecast of the 10-year moving average (ending in 2022) of changes in annual economy-wide private nonfarm business multifactor productivity. The update factor for IRFs that fail to meet requirements for the IRF QRP is discussed in section VIII below and totals 0.2 percent. CMS will use more recent data, if available, for the final rule.

CMS proposes one technical modification to the 2016-based IRF market basket. Specifically, for the price proxy for the For-profit Interest cost category of the 2016-based IRF market basket, CMS proposes to use the iBoxx AAA Corporate Bond Yield index instead of the Moody's AAA Corporate Bond Yield index. IGI no longer has a license to use the Moody's series and thus constructed its own index that closely replicates the Moody's corporate bond yield. CMS found that over the historical period of FY 2001 to FY 2020, the 4-quarter percent change moving average growth in the iBoxx series was approximately 0.1 percentage point higher, on average, than the Moody's series. Given the relatively small change and its small weight for this cost category, CMS notes that the replacement of the index does not impact the historical top-line market basket increases when rounded to the nearest tenth of a percentage point over the past ten fiscal years (FY 2011 to FY 2020).

B. Labor-Related Share

CMS proposes a total labor-related share of 72.9 percent for FY 2022, a very minor change from the FY 2021 labor share of 73.0 percent. The 72.9 percent comes from the IGI fourth quarter

2020 estimate of the sum of the relative importance of Wages and Salaries; Employee Benefits; Professional Fees: Labor-Related; Administrative and Facilities Support Services; Installation, Maintenance and Repair; All Other: Labor-related Services; and a portion (46 percent) of the Capital-Related cost weight from the IRF market basket. The relative importance reflects the different rates of price change for these cost categories between the base year (2016) and FY 2022. Table 4 of the proposed rule compares the components of the FY 2021 and proposed FY 2022 labor shares.

C. Wage Adjustment

Under previously adopted policy, for the IRF PPS wage index CMS uses the Core Based Statistical Areas (CBSA) labor market area definitions and the pre-floor, pre-reclassification Inpatient Prospective Payment System (IPPS) hospital wage index for the current fiscal year. Thus, for FY 2022 CMS would use the FY 2022 pre-floor, pre-reclassification IPPS wage index. The FY 2022 pre-reclassification and pre-floor hospital wage index is based on FY 2018 cost report data. Any changes made to the IRF PPS wage index from the previous fiscal year are made in a budget neutral manner.

The CBSAs are established by the Office of Management and Budget (OMB). They are generally subject to major revisions every 10 years to reflect information from the decennial census, but OMB also issues minor revisions in the intervening years through OMB Bulletins. CMS has previously adopted OMB changes to CBSA delineations for purposes of the IRF PPS labor market areas. The history of these changes to the IRF wage index is discussed in the proposed rule. For purposes of the IRF wage index, OMB-designated Micropolitan Statistical Areas[2] are considered to be rural areas. The OMB Bulletins are available at https://www.whitehouse.gov/omb/information-for-agencies/bulletins/.

In the FY 2021 IRF PPS final rule (85 FR 48434 through 48440), CMS adopted the changes included in OMB Bulletin No. 18-04, issued on September 14, 2018. CMS also adopted a1-year transition for FY 2021 under which CMS applied a 5 percent cap on any decrease in a hospital's wage index compared to its wage index in the prior fiscal year. CMS noted in the 2021 proposed rule that OMB issued OMB Bulletin No. 20-01 on March 6, 2020, but it was not issued in time for development of that proposed rule. CMS has determined that the changes in OMB Bulletin No. 20-01 do not impact the CBSA-based labor market delineations adopted in FY 2021. Thus, CMS is not proposing to adopt the revised OMB delineations identified in OMB Bulletin No. 20-01 for FY 2022.

Changes to the IRF PPS wage index are made in a budget neutral manner; CMS estimates the budget neutrality adjustment for FY 2022 under the proposed rule to be 1.0027. To make this calculation, CMS estimates aggregate IRF PPS payments using the FY 2021 labor-related share and wage index values and then estimates aggregate payments using the proposed FY 2022 labor share and wage index values. The ratio of the amount based on the FY 2021 index to the amount

[2] OMB defines a Micropolitan Statistical Area as an area 'associated with at least one urban cluster that has a population of at least 10,000, but less than 50,000.

estimated using the proposed 2022 index is the budget neutrality adjustment to be applied to the proposed federal per diem base rate for FY 2022.

D. Description of the IRF Standard Payment Conversion Factor and Payment Rates for FY 2022

Table 5 of the proposed rule (reproduced below) shows the calculations used to determine the proposed FY 2022 IRF standard payment amount. In addition, Table 6 of the proposed rule lists the FY 2022 payment rates for each CMG, and Table 7 provides a detailed hypothetical example of how the IRF FY 2022 federal prospective payment would be calculated for CMG 0104 (without comorbidities) for two different IRF facilities (one urban, teaching and one rural, non-teaching), using the applicable wage index values and facility-level adjustment factors under the proposed rule.

Table 9: Calculations to Determine the Proposed FY 2022 Standard Payment Conversion Factor	
Explanation for Adjustment	**Calculations**
Standard Payment Conversion Factor for FY 2021	$16,856
Market Basket Increase Factor for FY 2022 (2.4 percent), reduced by 0.2 percentage point for the productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act	x 1.022
Budget Neutrality Factor for the Updates to the Wage Index and Labor-Related Share	x 1.0027
Budget Neutrality Factor for the Revisions to the CMGs and CMG Relative Weights	x 1.0000
Proposed FY 2022 Standard Payment Conversion Factor	= $17,273

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

Under the IRF PPS, if the estimated cost of a case (based on application of an IRF's overall cost-to-charge ratio (CCR) to Medicare allowable covered charges) is higher than the adjusted outlier threshold, CMS makes an outlier payment for the case equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold. From the beginning of the IRF PPS, CMS' intent has been to set the outlier threshold so that the estimated outlier payments would equal 3 percent of total estimated payments, and this policy is continued for FY 2022. CMS believes this level reduces financial risk to IRFs of caring for high-cost patients while still providing adequate payments for all other cases.

To update the IRF outlier threshold amount for FY 2022, CMS proposes to use FY 2020 claims data and the same methodology that has been used to set and update the outlier threshold since the FY 2002 IRF PPS final rule. CMS currently estimates that IRF outlier payments as a percentage of total estimated payments will be 3.3 percent of total IRF payments in FY 2021. To maintain estimated outlier payments at the 3 percent level, CMS updates the outlier threshold amount from $7,906 for FY 2021 to $9,192 for FY 2022.

Updates are proposed to the national urban and rural CCRs for IRFs, as well as the national CCR ceiling for FY 2021, based on analysis of the most recent cost report data that are available (FY 2019). 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 2022; and other IRFs for which accurate data to calculate an overall CCR are not available. The national CCR ceiling for FY 2022 would continue to be set at 3 standard deviations above the mean CCR. If an individual IRF's CCR exceeds the ceiling, CMS replaces the IRF's CCR with the appropriate national average CCR (either urban or rural).

The proposed national average CCRs for FY 2022 are 0.393 for urban IRFs and 0.478 for rural IRFs, and the national CCR ceiling is 1.34. That is, if an individual IRF's CCR were to exceed this ceiling of 1.34 for FY 2022, CMS would replace the IRF's CCR with the appropriate proposed national average CCR (either rural or urban, depending on the geographic location of the IRF).

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

No changes are proposed for IRF QRP measures and policies for FY 2022. Beginning with FY 2023, CMS proposes to add one new measure and modify another, and to revise previously adopted schedules for public display of IRF QRP data in order to adjust for COVID-19 PHE impacts. CMS also makes information requests regarding closing the equity gap in quality measures, adopting standards for digital quality measures, and considerations for future assessment-based measures.

A. Background

CMS established the IRF QRP beginning in FY 2014 as directed by statute. Further developed in subsequent rulemaking, the IRF QRP follows many of the policies established for the Hospital Inpatient Quality Reporting Program (HIQR) including measure selection. Measures remain in the program until they are removed, suspended or replaced. A detailed legislative and regulatory history is available for download from the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS.

By statute, a facility that does not meet IRF QRP participation requirements for a rate year is subject to a 2.0 percentage point reduction in the update factor for that year. A table of required measures previously adopted for FY 2022 reporting is provided below in section VII.H of this summary. This proposed rule would not change these measures.

B. New and Updated Measures for FY 2023

1. New Measure: COVID-19 Vaccination Coverage among Healthcare Personnel

CMS proposes to add one new process measure to the IRF QRP beginning with FY 2023 to track the percentage of healthcare personnel (HCP) who receive a complete COVID-19 vaccination course, calculated as:

Numerator. The cumulative number of HCP eligible to work in the IRF for at least one day in the reporting period who received a complete vaccination course against SARS-CoV-2. Denominator. The cumulative number of HCP eligible to work in the IRF for at least one day in the reporting period, excluding persons with contraindications to COVID-19 vaccination as described by the CDC.[3]

Risk adjustment is not required for this process measure. Full specifications are available on the CDC website: https://www.cdc.gov/nhsn/nqf/index.html.

In discussing the proposed measure, CMS reviews the declaration of COVID-19 as a PHE, methods of viral transmission, vulnerable patient groups, and guidelines for prioritizing vaccine recipients. Following the usual pre-rulemaking process for stakeholder input, the proposed measure was included on the December 21, 2020 Measures Under Consideration List. The Measure Applications Partnership (MAP) conditionally supported the measure contingent upon clarification of measure specifications, and CMS returned to the MAP with results from further measure testing and updated specifications.

CMS states its intention to seek NQF endorsement of the measure, but proposes to adopt the measure for FY 2023 given ongoing COVID-19 PHE impacts and having found no currently available, alternative measure that is comparable, NQF-endorsed, feasible, and practical. The proposed measure could generate actionable quality improvement data on vaccination rates and aid patients with decision-making about post-acute care facilities. CMS notes that the measure most similar to the proposed COVID-19 HCP measure is the NQF-endorsed measure of influenza vaccination among HCP (NQF #0431), an existing IRF QRP measure.

CMS estimates the regulatory burden of data submission for this new measure would be 12 hours per year for each IRF at an annual cost ranging from $330 to $550 per IRF.

2. Updated Measure: Transfer of Health (TOH) Information to the Patient-Post-Acute Care

CMS proposes to update the specifications for this process measure's denominator beginning with FY 2023 to exclude patients discharged home under the care of an organized home health service or hospice. Currently the denominators for the TOH-Patient measure and the companion TOH-Provider measure both include patients discharged home under the care of an organized home health service or hospice. The revised TOH-Patient denominator would be limited to discharges to a private home/apartment, board and care home, assisted living, group home, or transitional living.

[3] Centers for Disease Control and Prevention. Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Authorized in the United States, Appendix B. https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html#Appendix-B

C. Request for Information (RFI) on IRF QRP Quality Measures Under Consideration for Future Years

CMS seeks comment on the importance, relevance, appropriateness and applicability on each of the following assessment-based quality measures and concepts under consideration for future addition to the IRF QRP:

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

CMS states that it will not respond to these comments through the IRF PPS final rule, but they will be considered in future policy making.

D. Request for Information (RFI) on Fast Healthcare Interoperability Resources (FHIR) in support of Digital Quality Measurement in CMS Quality Programs

CMS requests input into the agency's planning for transformation to a fully digital quality enterprise, and specifically asks about the following:

- EHR/IT systems currently used by commenters and if they participate in a health information exchange;
- How commenters share information currently with other providers;
- Approaches by which CMS could incent or reward commenters who use health information technology (HIT) in innovative ways to reduce burden for IRF (and other post-acute care) providers;
- Resources and tools for use by IRFs (and other post-acute care providers) and HIT vendors to facilitate interoperable, fully electronic health information sharing that incorporates FHIR standards and secure application programming interfaces (APIs); and
- Willingness of HIT vendors who work with IRFs (and other post-acute care providers) to participate in pilots or models that align measure collection standards across care settings (e.g., sharing patient data via secure FHIR-based APIs for calculating and reporting digital measures).

CMS indicates that it will not respond to comments received through the IRF PPS final rule, but the input from commenters will be considered in future policy making.

In providing background for this RFI, CMS offers a definition for digital quality measures (dQMs): quality measures that use one or more sources of health information that are captured and can be transmitted electronically via interoperable systems. CMS notes that a dQM's score

includes a calculation that processes digital data; the agency also lists multiple examples of dQM data sources (e.g., electronic health records - EHRs, wearable medical devices).

CMS discusses the potential role of FHIR-based standards for efficient exchange of clinical information across clinical settings by clinicians through APIs. Exploration is underway at the agency regarding the use of FHIR-based APIs to access quality data already being collected through its Quality Improvement and Evaluation System (QIES) and the Internet QIES (iQIES), with consideration also being given to using FHIR interfaces to access standardized assessment data from IRF EHRs.

CMS concludes the discussion of this RFI with a commitment to using policy levers and collaborating with stakeholders to transition to fully digital quality measurement across the agency, with staged implementation of a cohesive portfolio of dQMs and incorporation of principles from the HHS National Health Quality Roadmap.

E. Request for Information (RFI) on Closing the Health Equity Gap in Post-Acute Care Quality Reporting Programs

CMS requests information on potential revisions to the IRF QRP to facilitate comprehensive and actionable reporting of health disparities, specifically:

- Recommendations for measures or measurement domains addressing health equity;
- Guidance on social determinants of health to be added to those already included in the IRF QRP as standardized patient assessment data elements (SPADES);
- Recommendations that promote equity in outcomes, such as providing facility-level performance data to each IRF, stratified by social risk factors (similar to reports being given to hospitals about their readmissions for dual-eligible versus other beneficiaries);
- Data sources and methods already in use by commenters for reducing disparities and improving outcomes; and
- Changes to address current challenges in capturing and exchanging patient information on social determinants of health for use in care delivery and decision making.

CMS states that it will not respond in the IRF PPS final rule to comments received, but will consider the responses in future policy making.

As background for this RFI, CMS provides multiple examples of poor health outcomes that could stem from disparate care across patient populations (e.g., higher COVID-19 complication rates for black, Latino, and Indigenous and Native Americans relative to whites).

CMS uses for this RFI a definition of equity from Executive Order 13985 issued on January 21,2021: “the consistent and systematic fair, just, and impartial treatment of all individuals, including individuals who belong to underserved communities that have been denied such treatment, such as Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities;

lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality".

Finally, examples are provided of ongoing efforts by CMS to enhance the transparency of information about healthcare disparities, such as the addition of SPADES for required reporting of selected social determinants of health in the IRF QRP beginning with FY 2020.

F. Form, Manner, and Timing of Data Submission

No changes are proposed to existing IRF QRP data reporting policies. For the proposed new measure of COVID-19 vaccination coverage among IRF healthcare professionals (described above in summary section VII.B.1), CMS proposes an initial data submission period of October 1, 2021 through December 31, 2021 for use in the FY 2023 IRF QRP. For FY 2024 and subsequently, CMS proposes a full calendar year submission period (e.g., all 12 months of CY 2022 data would be reported for use in the FY 2024 IRF QRP). Data would be submitted through the CDC National Health Safety Network (NHSN) web-based surveillance system for at least one week each month and the CDC would report data quarterly to CMS. IRFs are familiar with NHSN reporting for certain existing measures, such as *Clostridium difficile* infections.

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

1. COVID-19 Vaccination Coverage among Healthcare Personnel (HCP)

CMS proposes to add the new COVID-19 vaccination coverage measure to publicly reported IRF QRP data available in the Inpatient Rehabilitation Facilities sections of Care Compare (https://www.medicare.gov/care-compare/) and the Provider Data Catalog (https://data.cms.gov/provider-data/).[4] Display would begin with the September 2022 Care Compare refresh based on data collected for Q4 2021. One additional quarter of data would be added with each subsequent refresh until four quarters are reached, after which time display would continue using a rolling four quarters of data.

2. Measures with Fewer Quarters Due to COVID-19 PHE Exemptions

a. Overview

CMS proposes temporary changes to the data collection quarters specified in prior rulemaking for IRF QRP measure results that are publicly displayed on Care Compare. The proposed collection period changes are designed to account for incomplete data reporting during the

[4] Beginning in January 2022, Care Compare and the Provider Data Catalog replaced the IRF Compare and Data.Medicare.gov websites, respectively.

COVID-19 pandemic and to return to pre-pandemic public reporting timelines as rapidly as feasible, while preserving the usefulness and accuracy of the displayed results.

Normally four successive quarters of data are used in calculating measures derived from the IRF Patient Assessment Instrument (IRF-PAI), eight quarters for claims-based measures, and two to four quarters for CDC NHSN-based measures. CMS notes that its guidance memo of March 27, 2020 included an exception to extant data reporting policy that allowed all IRFs to voluntarily forgo QRP data reporting for Q4 2019, Q1 2020, and Q2 2020.

b. Analytic Approach and Results

Initial Steps. CMS discusses at length the data analyses used in developing the proposed changes. Analytic steps included 1) identifying all of the quarterly Care Compare refreshes of IRF QRP results that could be impacted by the suspension of data reporting; and 2) separately analyzing the data actually submitted by IRFs during Q4 2019, as those data were generated before the PHE was declared, though may have been submitted after the declaration. CMS lists the Care Compare refreshes identified as being potentially impacted by the PHE in Tables 10, 13, and 14 of the rule. The agency also found that when compared to data from FY 2018 and FY 2019, the Q4 2019 data were similar for level of reporting and for outcomes trends; therefore, the Q4 2019 data were included in the December 2020 refresh as established in prior rulemaking.

Data Freeze and the COVID-19 Affected Reporting (CAR) Scenario. After reviewing the available Q1 2020 and Q2 2020 data, CMS decided not to utilize them for public display. Instead, the agency determined that the most straightforward, efficient, and equitable approach was to freeze the Care Compare-displayed data with the December 2020 refresh values, until reliability of the results for subsequent quarters approached pre-pandemic levels. To shorten the duration of the data freeze, CMS explored reducing the number of data quarters used at each refresh. In this analysis, termed the COVID-19 Affected Reporting (CAR) Scenario, data quarters were decreased from 4 to 3 for measures derived from the IRF-PAI and from 8 to 6 for claims-based measures. Reportability and reliability were found to be acceptable under the CAR scenario.[5]

NHSN-based Measures. CMS proposes to follow CDC recommendations for adjusting the reporting quarters of the three IRF QRP NHSN-based measures.[6] A data freeze would apply initially, followed by data reporting from non-contiguous quarters, and ending with return of reporting to contiguous quarters. The CAR scenario was not explored for these measures.

[5] Reportability was measured as the percentage of IRFs meeting the case minimums for public reporting. Reliability was tested using correlation coefficients and intraclass correlation scores.
[6] The three measures address *Clostridium difficile* infection (CDI), catheter-associated urinary tract infection (CAUTI), and vaccination of healthcare personnel for influenza (HCP Influenza).

c. Revised and Proposed Schedules for Care Compare Display of IRF QRP Measures

The combined revised (data freeze) and proposed (CAR scenario) reporting schedule for IRF QRP measures based on the IRF-PAI is shown in Table 11 of the rule. Data would be frozen through the September 2021 refresh, the CAR scenario would be applied for the December 2021 refresh, and normal (4-quarter) reporting would resume with the March 2022 refresh.

The combined revised (data freeze) and proposed (CAR scenario) reporting schedule for claims-based measures is shown in Table 12 of the rule. Data would be frozen for the September 2021 refresh, the CAR scenario would be applied through the June 2023 refresh, and normal (8-quarter) reporting would resume with the September 2023 refresh.

The combined revised (data freeze) and proposed (CAR scenario) reporting schedule for the NHSN-based measures are shown in Table 15 (CDI and CAUTI) and Table 16 (HCP Influenza) of the rule. For the CDI and CAUTI measures, refreshes would be frozen through the September 2021 refresh, non-contiguous 4-quarter reporting would occur through the March 2022 refresh, and normal contiguous 4-quarter reporting would resume with the June 2022 refresh. For the HCP Influenza measure, refreshes would be frozen through the September 2021 refresh, non-contiguous 2-quarter reporting would occur through the March 2022 refresh, and normal contiguous 2-quarter reporting would resume with the June 2022 refresh.

H. Summary Table of IRF QRP Measures

Quality Measures for the 2020 IRF QRP (Previously Adopted)

Short Name	Measure Name & Data Source
IRF-PAI	
Pressure Ulcer/Injury	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury
Application of Falls	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)
Application of Functional Assessment	Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)
Change in Self-Care	IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633)
Change in Mobility	IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634)
Discharge Self-Care Score	IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635)
Discharge Mobility Score	IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636)
DRR	Drug Regimen Review Conducted with Follow-Up for Identified Issues– PAC IRF QRP
NHSN	

Short Name	Measure Name & Data Source
CAUTI	National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138)
CDI	NHSN Facility-wide Inpatient Hospital-Onset Clostridium difficile Infection (CDI) Outcome Measure (NQF #1717)
HCP Influenza Vaccine	Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431)
Claims-based	
MSPB IRF	Medicare Spending per Beneficiary (MSPB)–PAC IRF QRP
DTC	Discharge to Community–PAC IRF QRP
PPR 30 day	Potentially Preventable 30-Day Post-Discharge Readmission Measure for IRF QRP
PPR Within Stay	Potentially Preventable Within Stay Readmission Measure for IRFs

Source: Modified by HPA from Table 8 of the proposed rule

VI. Collection of Information Requirements

CMS notes that while this proposed rule does not impose any new information collection requirements it does refer to an associated information collection required for purposes of calculating the IRF Annual Increase Factor (AIF). This involves IRFs submitting data on one new quality measure: COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) beginning with the FY 2023 IRF QRP. CDC plans to include this information in a revised information collection request for which CMS has provided an estimate of the burden and cost to IRFs (as discussed previously). In addition, CMS proposes to update the Transfer of Health (TOH) information to the Patient – Post-Acute Care (PAC) measure to exclude residents discharged home under the care of an organized home health service or hospice. CMS states that this proposed update would not affect the information collection burdened already established.

VII. Regulatory Impact Analysis

CMS estimates that the proposed rule will increase Medicare payments to IRFs by $160 million in FY 2022 compared with FY 2021. This reflects the 2.2 percent increase from the update factor and the change in the outlier threshold, which will reduce aggregate payments to IRFs by an estimated 0.3 percent. Table 17 in the proposed rule, reproduced below, shows the effects of these and other policy changes by type of IRF. The other policy changes shown in Table 17 involving the wage index and labor market areas and changes to the CMG weights are all designed to be budget neutral and therefore have no effect on aggregate payments to IRFs. The $160 million figure excludes the effects of payment reductions to IRFs that fail to meet the IRF QRP requirements.

TABLE 17: IRF Impact Table for FY 2022 (Columns 4 through 7 in percentage)

Facility Classification	Number of IRFs	Number of Cases	Outlier	FY 2022 Wage Index and Labor Share	CMG Weights	Total Percent Change
(1)	(2)	(3)	(4)	(5)	(6)	(7)
Total	1,109	381,299	-0.3	0.0	0.0	1.8
Urban unit	662	149,681	-0.5	0.1	-0.2	1.5
Rural unit	133	19,509	-0.6	0.3	-0.3	1.7
Urban hospital	302	207,250	-0.2	-0.1	0.2	2.1
Rural hospital	12	4,859	-0.1	0.5	0.2	2.7
Urban For-Profit	370	200,085	-0.2	0.0	0.2	2.2
Rural For-Profit	34	7,994	-0.2	0.3	0.0	2.3
Urban Non-Profit	507	137,112	-0.5	-0.1	-0.2	1.4
Rural Non-Profit	90	13,614	-0.6	0.4	-0.3	1.6
Urban Government	87	19,734	-0.6	0.5	-0.3	1.9
Rural Government	21	2,760	-0.3	0.3	-0.3	1.9
Urban	964	356,931	-0.3	0.0	0.0	1.8
Rural	145	24,368	-0.5	0.4	-0.2	1.9
Urban by region						
Urban New England	31	14,505	-0.2	-0.6	-0.2	1.1
Urban Middle Atlantic	124	43,245	-0.4	-0.9	0.0	0.9
Urban South Atlantic	154	74,081	-0.3	0.6	0.0	2.5
Urban East North Central	157	45,869	-0.4	0.1	-0.1	1.8
Urban East South Central	54	25,568	-0.2	-0.1	0.1	2.0
Urban West North Central	74	20,284	-0.4	0.8	-0.2	2.4
Urban West South Central	190	80,343	-0.2	-0.4	0.2	1.7
Urban Mountain	81	28,221	-0.3	-0.1	0.0	1.8
Urban Pacific	99	24,815	-0.7	0.6	-0.2	1.9
Rural by region						
Rural New England	5	1,264	-0.5	-0.2	-0.3	1.1
Rural Middle Atlantic	10	981	-0.8	1.1	-0.4	2.0
Rural South Atlantic	16	3,973	-0.2	1.2	0.2	3.4
Rural East North Central	23	3,902	-0.4	0.6	-0.2	2.2
Rural East South Central	21	3,832	-0.3	0.0	-0.3	1.6

Facility Classification	Number of IRFs	Number of Cases	Outlier	FY 2022 Wage Index and Labor Share	CMG Weights	Total Percent Change
Rural West North Central	20	2,837	-0.6	0.0	-0.4	1.2
Rural West South Central	42	6,740	-0.4	0.0	-0.2	1.6
Rural Mountain	5	481	-1.1	0.5	-0.5	1.1
Rural Pacific	3	358	-1.4	0.3	-0.6	0.4
Teaching status						
Non-teaching	1,004	337,797	-0.3	0.0	0.0	1.9
Resident to ADC less than 10%	57	28,282	-0.3	0.0	0.0	1.9
Resident to ADC 10%-19%	37	13,884	-0.7	-0.2	-0.2	1.1
Resident to ADC greater than 19%	11	1,336	-0.4	0.0	-0.4	1.5
Disproportionate share patient percentage (DSH PP)						
DSH PP = 0%	46	9,327	-0.4	-0.8	0.0	1.0
DSH PP <5%	144	55,019	-0.3	-0.1	0.1	1.9
DSH PP 5%-10%	285	116,111	-0.2	0.1	0.1	2.1
DSH PP 10%-20%	387	137,544	-0.4	-0.2	0.0	1.6
DSH PP greater than 20%	247	63,298	-0.5	0.3	-0.1	1.9

[1]This column includes the impact of the updates in columns (4), (5), (6), and (7) above, and of the IRF market basket increase factor for FY 2022 (2.4 percent), reduced by 0.2 percentage point for the productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act

CMS states that it considered utilizing FY 2019 claims data to update the prospective payment rates for FY 2022 due to the potential effects of the COVID-19 PHE on the FY 2020 IRF claims data. It states that its long-standing practice is to utilize the most recent full fiscal year of data to update the prospective payment rates. It also notes that the FY 2019 data does not reflect any of the changes to the CMG definitions or the data used to classify IRF patients into CMGs that became effective in FY 2020 and will continue to be used in FY 2022. Table 19 in the proposed rule shows the estimated effects of the use of the FY 2019 data on aspects of the proposed FY 2022 IRF PPS compared to utilizing the FY 2020 data. In brief, using the FY 2019 data would result in an increase in Medicare payments of $200 million in FY 2022 compared to $160 million using the FY 2020 data. The difference is largely attributed to the difference in the outlier threshold adjustment update, which also has distributional payment effects across providers.

Other alternatives CMS considered were to maintain the existing CMG relative weights and average length of stay values and/or maintaining the existing outlier threshold amount for FY 2022. CMS argues, however, that adjusting these amounts based on the most recent 2020 claims data would result in more accurate payments as well as maintain the targeted 3 percent outlier pool.

CMS seeks comments on the use of FY 2019 data to update the prospective payment rates for FY 2022 as well as other alternatives considered.