American Hospital Association™
Advancing Health in America

Regulatory Advisory

August 31, 2018

INPATIENT REHABILITATION FACILITY PPS: FINAL RULE FOR FY 2019

At A Glance

At Issue

The Centers for Medicare & Medicaid Services (CMS) published its fiscal year (FY) 2019 final rule for the inpatient rehabilitation facility (IRF) prospective payment system (PPS) in the Aug. 6 Federal Register. The final rule takes effect Oct. 1.

Our Take

While the field had been calling for a fix to the administrative burden caused by dual FIM™ and IRF-PAI reporting, we are disappointed that the agency will move forward with case-mix refinements based on limited data. We remain concerned that CMS's reliance on only one year of IRF-PAI data to support this change is an inadequate foundation for a new case-mix system. On the quality front in FY 2019, we are pleased that CMS is demonstrating its commitment to the agency's Meaningful Measures initiative by removing measures from the IRF Quality Reporting Program.

Key Takeaways

- **Payment Update:** Increases IRF payments by 1.3 percent in FY 2019.
- **Case-Mix:** Significantly modifies the IRF case-mix system in FY 2020 by replacing FIM™ data elements with data from the IRF patient assessment instrument (PAI), among other changes.
- **Coverage Requirements:** Provides greater flexibility to rehabilitation physicians with regard to post-admission patient evaluations and participation in interdisciplinary team meetings.
- **Quality Measures:** Streamlines IRF quality reporting requirements to reduce administrative burden.

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 2019.
- ✓ **Participate in a members-only conference call Wednesday, Sep. 5 at 3:00 p.m. ET to review and discuss this rule.** AHA members may register here.

Further Questions

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

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Background

The Centers for Medicare & Medicaid Services (CMS) published its fiscal year (FY) 2019 final rule for the inpatient rehabilitation facility (IRF) prospective payment system (PPS) in the Aug. 6 Federal Register. In the rule, CMS finalized a net update of 1.3 percent, a $75 million increase over FY 2018 levels. As detailed below, this net increase takes into account a market-basket update and reductions mandated by the Affordable Care Act (ACA). The rule also will streamline the IRF Quality Reporting Program (QRP) by removing quality measures. In addition, for FY 2020, this rule refines the IRF PPS case-mix system.

Final FY 2019 Payment Update

Market-basket Update

For FY 2019, CMS updates the IRF PPS standard rate using the IRF-specific market basket increase of 2.9 percent, which, as required by the ACA, will be offset by a 0.8 percentage point cut for productivity and an additional 0.75 percentage point cut. For IRFs that complete CMS's quality reporting requirements, the IRF standard payment for FY 2019 will be $16,021, an increase from the FY 2018 rate of $15,838.

Case-mix Group Relative Weights for FY 2019

For FY 2019, CMS updates the case-mix relative weights and average length of stay values using the same methodology applied in FY 2018 – the FY 2017 claims and FY 2016 cost report data. Table 2 in the rule shows the final FY 2019 amounts, after applying a budget neutrality factor of 0.9981. As background, each case is assigned to a case-mix group based on the primary diagnosis and clinical severity of the patient. Each case-mix group is assigned a relative weight based on estimated resource use and has four tiers that reflect the number of comorbidities that are estimated to affect resource use in a significant way.

Labor-related Share

The labor-related share is the national average proportion of total costs that are related to, influenced by, or vary with the local labor market, such as wages, salaries, and benefits. The final labor-related share for FY 2019 is 70.5 percent, which is a slight decrease from the 70.7 percent in FY 2018.

Area Wage Index

For FY 2019, CMS will use the same policies and methodologies applied in FY 2018 and a budget neutrality wage adjustment factor of 1.0. The final FY 2019 wage index values for urban and rural IRFs are found on the CMS website.

Adjustment for High-cost Outliers

CMS allocates 3 percent of total IRF payments for high-cost outlier payments. However, for FY 2018, CMS is estimating that outlier payments will be 3.1 percent of total payments. Therefore, the agency increases the high-cost outlier threshold in FY 2019 to $9,402, from the FY 2018 threshold of $8,679. This change will enable fewer IRF cases to quality for a high-cost outlier payment in FY 2019, relative to FY 2018.

Facility-level Payment Adjustments

CMS extends again the current IRF facility-level payment adjustments, which have been in effect since FY 2014. These adjustments remain:

- Rural adjustment: 14.9 percent;
- Low-income patient adjustment factor: 0.3177; and
- Teaching adjustment factor: 1.0163.

Case-mix System Refinement for FY 2020

For FY 2020, CMS finalized a new IRF PPS case-mix system that is calculated with data already collected through the IRF patient assessment instrument (PAI), thus phasing out use of the FIM™ tool. As rationale for this change, CMS cites its broader effort to standardize data collection across post-acute settings, as selected IRF-PAI items are similar to data elements used by skilled nursing facilities and long-term care hospitals. CMS also notes that the IRF payment units, called case-mix groups (CMG), warrant a revision due to changes that occurred since they were last revised, including changes in treatment patterns, technology, case-mix, and other factors that affect the relative use of resources across the classification system. As such, CMS will expand the use of IRF-PAI data from the tool's quality section, which the agency states then warrants an update to the CMGs and relative weights for FY 2020 to better align IRF payments with the costs of care. CMS estimates that these changes will reduce administration burden by $9,100 per IRF annually, or $10.2 million for the field as a whole. CMS's methodology is intended to make this final change in a budget-neutral manner.

As described below, CMS's final case-mix system refinement includes changes to functional status scores, updates to the score reassignment methodology, and refinements to the CMGs. The agency shared an online technical report to provide more information on the methodology used to develop these changes, *Analyses to Inform the Potential Use of Standardized Patient Assessment Data Elements in the Inpatient Rehabilitation Facility Prospective Payment System*, which is available here.

Background. IRFs are required to conduct an IRF-PAI assessment upon admission and discharge for every beneficiary admitted under Medicare fee-for-service or Medicare Advantage. These data are used to classify patients into CMGs based on clinical characteristics and expected resource needs as well as to monitor the quality of care furnished in IRFs. The IRF case-mix system uses a patient's principal diagnosis or impairment to first classify the patient into one of 21 Rehabilitation Impairment Categories (RIC), which are subdivided into 92 CMGs. Each RIC is matched with a set of CMGs that vary by functional status (motor and cognitive scores) and sometimes age. Other special circumstances (e.g., very short stay or patient death) also are 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.

The IRF-PAI version 2.0 contains FIM™ data elements and a measurement scale, which are collectively referred to as the FIM™ instrument. Specifically, Item 39 of the IRF-PAI contains 18 FIM™ data elements and the measurement scale, which score motor and cognitive functioning at admission and discharge. In addition, IRF-PAI items 29 through 38 contain FIM™ function modifiers used to assign patients into a CMG for payment purposes based on the patient's ability to perform activities of daily living and, in some cases, the patient's cognitive abilities.

Transition from FIM™ Data to IRF-PAI Data

Because the IRF-PAI already collects data that can be used to assign payment under the IRF PPS, the agency will remove the FIM™ instrument and associated function modifiers from the IRF-PAI for discharges on or after Oct. 1, 2019. Specifically, CMS will remove FIM™ items 29 through 39 and instead use 22 data items from the quality indicators section of the IRF-PAI to assign IRF PPS payment under the IRF PPS. On page 20990 of the rule, the agency discusses how these IRF-PAI items are similar to the FIM™ items final for removal.

Refinements to the Case-mix Classification System

While CMS proposed no changes to the IRF PPS RICs, the final case-mix system changes include multiple changes such as updating the case-mix system's functional status scores; updating the score reassignment methodology; and revising the CMGs, including the associated relative weights and average length of stay values.

Changes to Functional Status Scores. Currently, functional status scores consist of motor items and cognitive items, and sometimes patient age. The motor and cognitive elements are derived from a combination of data elements in the FIM™ instrument (item 39 of the

IRF-PAI). These data elements are then used to determine the patient's weighted motor score[1] and cognitive score[2], which group a patient into a CMG for payment purposes under the IRF PPS.

CMS will alter this process by instead using data items from the quality indicators section of the IRF-PAI to calculate a motor score, a memory score, a communication score, which, combined with age, will compose the functional status scores in the IRF case-mix classification system. CMS states that the data items from the IRF-PAI quality indicators section contain "slightly different" information and use a different rating system than the current FIM™ instrument. CMS believes these final components best predict costs:

- *Motor Score*: The final motor items used to derive the additive motor score are eating, oral hygiene, toileting hygiene, shower bathe/self, upper body dressing, lower body dressing, putting on/taking off footwear, bladder continence, bowel continence, roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, walk 10 feet, walk 50 feet with two turns, walk 150 feet, and 1 step (curb).

- *Memory Score*: The final item used to derive the memory score is the Brief Interview for Mental Status (BIMS) summary score, which is based on the repetition of three words, temporal orientation, and recall.

- *Communication Score*: The final communication score is derived from the hearing, speech, and vision items including expression of ideas and wants and understanding verbal and non-verbal content.

CMS will derive functional status scores by summing these three items. In a change from the current case-mix system, which uses a weighted motor score and an unweighted cognitive score, CMS will not weight these scores in its methodology.

Updates to the Score Reassignment Methodology. CMS will modify the methodology used to reassign values indicating an activity did not occur or was not observed when they are recorded on an item used for payment, beginning with FY 2020. Currently, when a code of 0 appears for one of the FIM™ items on the IRF-PAI used to determine payment, the item is reassigned another value to determine the appropriate payment for the patient. Specifically, a code of 1 (indicating the patient needed total assistance) is assigned whenever the recorded code indicates that the activity did not occur, except that a value of 2 is assigned when the transfer to toilet item is coded with a zero value.

[1] Weighted Motor Score. The FIM™ instrument currently uses these data elements to compute a patient's weighted motor score: eating, grooming, bathing, dressing upper body, dressing lower body, toileting, bladder management, bowel management, transfer to bed/chair/wheelchair, transfer to toilet, walking or wheelchair use, and stair climbing.
[2] Cognitive Score. The FIM™ instrument currently uses these data elements to compute a patient's cognitive score: comprehension, expression, social interaction, problem solving, and memory.

As background, the rating system used for the final IRF-PAI Quality Indicators section differs from that of the FIM™ instrument. For example, the FIM™ instrument reflects the patient's lowest functional score during the assessment period while the IRF-PAI Quality Indicators reflect the patient's usual performance during the assessment period. The FIM™ data items use a seven-level scale, compared with a six-level scale for the self-care and mobility items in the Quality Indicators IRF-PAI and a four-level scale for cognitive elements. In the FIM™, if an activity did not occur or was not observed, a zero value is assigned. In contrast, IRF-PAI Quality Indicators section uses four codes: patient refused to complete an activity (07); patient did not perform the activity (09); the activity was not attempted due to environmental limitations (10); or the activity was not attempted due to a medical condition or safety concern (88).

Consistent with the current reassignment rules, the self-care and mobility items identified above, values of 7, 9, 10, 88, and the presence of a dash ("-") would still be reassigned to 1, the most dependent level, except the toilet transfer item, which is recoded to 2.

In addition, CMS changes the way specific values are treated for the bowel continence and bladder continence items, as its analysis of these items and current coding guidelines indicate these changes are necessary. CMS also will recode these values to be able to score the functional status of a patient when these values are coded on the IRF-PAI. For the bladder continence item, CMS reassigns a value of 1 (stress incontinence only) to 0 (always continent), a value of 5 (no urine output) to 0 (always continent), and a value of 9 (not applicable) to 4 (always incontinent). For the bowel continence item, CMS also reassigns a value of 9 (not rated) to 2 (frequently incontinent). For both items, CMS reassigns a missing score to 0 (always continent). CMS believes these changes are necessary to update the score reassignment methodology used to derive the functional status scores to reflect use of the new data items from the Quality Indicators section of the IRF-PAI and to accurately assign payments based on a patients' expected costliness.

Refinements to the CMGs. The current CMGs based on a patient's functional status and age were constructed using a classification and regression trees (CART) analysis. A similar CART analysis was used to develop the new CMG definitions. Restraints were imposed on the groupings to limit the total number CMGs. Table 9 in the rule lists the revised relative weights and average length of stay values for the CMGs.

Under the new case-mix system:

- The number of CMGs will drop from 92 to 88;
- The number of CMGs will drop in RICs 1, 2, 5, 8, 11, and 19;
- The number of CMGs will increase in RICs 3, 4, 10, 13, 15, 17, and 18; and,
- Age will affect CMG assignment for RICs 1, 3, 4, and 13 whereas it currently affects CMG assignment for RICs 1, 4, and 8, as shown in Table 9 of the rule.

IRF Coverage Requirement Changes

Given the input collected following its request for information in the FY 2018 IRF PPS proposed rule, CMS will revise the IRF coverage criteria[3] related to several protocols pertaining to the role and communications of rehabilitation physicians.

Background. For an IRF claim to be considered medically necessary, there must be a reasonable expectation at the time of admission that the patient requires physician supervision by a rehabilitation physician. The requirement for medical supervision in an IRF dictates that rehabilitation physicians conduct face-to-face patient visits at least three days per week to assess the patient both medically and functionally, as well as modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process. In addition, the patient's medical record must document whether the post-admission physician evaluation meets specified regulatory requirements. Further, IRF patients must require an interdisciplinary team approach to care and such teams must meet on a weekly basis and be led by a rehabilitation physician.

Changes to Physician Supervision Requirement

Under this rule, beginning Oct. 1, 2018, the post-admission physician evaluation will be allowed to count as one of the three face-to-face physician visits required per week. CMS's goal is to provide greater flexibility to the rehabilitation physician and to reduce redundancy and regulatory burden while still ensuring adequate care to the patient. Further, the agency believes that the clinical judgment of the rehabilitation physician should determine whether the patient needs to be seen more than three times in the first week of the IRF admission. CMC clarifies that no changes were made to the requirement for a post-admission physician evaluation within 24-hours of admission. The rule reduces from $40.5 million to $20.5 million its estimate of how much savings this change will produce for Medicare Part B due to reduced payments to physicians under the physician fee schedule.

Changes to the Interdisciplinary Team Meeting Requirement

With its goal of reducing burden, CMS will allow rehabilitation physician to participate in weekly meetings of the interdisciplinary team via video and telephone conference. CMS states that this change is intended to increase time management flexibility for rehabilitation physicians, especially those in rural areas who may need to travel greater distances between facilities. The final change will not apply to other members of the interdisciplinary team, although CMS says that it may consider expanding the policy in future rulemaking. In response to the field's concerns, the rule states CMS's view that this change does not restrict IRF's independence in establishing the structure of their medical staff or clinical protocols.

[3] For more details, see Chapter 1, Section 110 of the Medicare Benefit Policy Manual.

Changes to the Admission Order Documentation Requirement

The rule removes §412.606(a) from Section 110 of the Medicare Benefits Policy Manual Chapter 1[4], which states:

> *"At the time that each Medicare Part A fee-for-service patient is admitted to an IRF, a physician must generate admission orders for the patient's care. These admission orders must be retained in the patient's medical record at the IRF."*

CMS states that this regulation is duplicative to other IRF and hospital requirements in this manual and the Medicare conditions of participation.

IRF Quality Reporting Program (IRF QRP)

As mandated by the ACA, failure to comply with IRF QRP requirements will result in a 2 percentage point reduction to the IRF's annual market-basket update.

CMS finalized its proposals to remove two measures from the IRF QRP. One of the measures will be removed beginning with the FY 2020 IRF QRP, and the second will be removed beginning with the FY 2121 IRF QRP. See below for a complete listing of required measures.

Table 1: Finalized and Proposed Measures for the IRF QRP, FY 2018 – FY 2021

Measure	Fiscal Year			
	2018	2019	2020	2021
Central line-associated blood stream infection (CLABSI)	X	X	X	X
Catheter-associated urinary tract infection (CAUTI)	X	X	X	X
Percent of residents or patients with pressure ulcers that are new or worsened	X	X	*	
Percent of residents or patients who were assessed and appropriately given the seasonal influenza vaccine	X	X	X	-
Influenza vaccination coverage among health care personnel	X	X	X	X
Methicillin-resistant Staphylococcus aureus bacteremia	X	X	X	-
Clostridium difficile bacteremia	X	X	X	X
Unplanned all-cause, all-condition readmissions for 30-day post-discharge from IRFs	X			
Percent of residents experiencing one or more falls with major injury (Long stay)	X	X	X	X
Functional Status: Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function	X	X	X	X

[4] See the Medicare Benefit Policy Manual, chapter 1, section 110.1.4.

Measure	Fiscal Year			
	2018	2019	2020	2021
Change in Self-Care Score for Medical Rehabilitation Patients	X	X	X	X
Change in Mobility Score for Medical Rehabilitation Patients	X	X	X	X
Discharge Self-Care Score for Medical Rehabilitation Patients	X	X	X	X
Discharge Mobility Score for Medical Rehabilitation Patients	X	X	X	X
Medicare spending per beneficiary for post-acute care IRF QRP (MSPB – IRF)	X	X	X	X
Discharge to community – PAC IRF	X	X	X	X
Potentially preventable 30-day post-discharge readmission measure for IRF QRP		X	X	X
Drug regimen review conducted with follow-up for identified issues			X	X
Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury			X	X
Potentially Preventable Within Stay Readmission Measure for IRFs	X	X	X	X

X = Finalized
- = Proposal for removal finalized
**= Measure will be replaced with Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury measure effective July 1, 2018*

FY 2020-2021 Measurement Changes

CMS finalized its proposal to remove one measure for the FY 2020 IRF QRP and one measure for the FY 2021 IRF QRP. Detailed specifications for the measures are available on CMS's IRF QRP website.

Finalized New Measure Removal Factor for Previously Adopted IRF QRP Measures. As part of CMS's Meaningful Measures initiative (which applies to all CMS quality reporting programs), the agency is reviewing measures currently in use to determine how quality reporting programs can be developed in the least burdensome manner possible. In previous rulemaking, CMS finalized factors to determine whether a measure should be removed from a quality reporting program on a case-by-case basis. Those factors are:

- Factor 1: Measure performance among providers is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made.
- Factor 2: Performance or improvement on a measure does not result in better patient outcomes.
- Factor 3: The measure does not align with current clinical guidelines or practice.
- Factor 4: A more broadly applicable measure (across settings, populations, or conditions) for the particular topic is available.

- Factor 5: A measure that is more proximal in time to desired patient outcomes for the particular topic is available.
- Factor 6: A measure that is more strongly associated with desired patient outcomes for the particular topic is available.
- Factor 7: Collection or public reporting of a measure leads to negative unintended consequences other than patient harm.

CMS will add an eighth measure removal factor to this list – the costs associated with a measure outweigh the benefit of its continued use in the program. CMS defines "costs" as those affecting providers and clinicians (collection and submission/reporting burden, compliance with other programmatic requirements, participation in multiple quality programs, compliance with other federal or state regulations) as well as the costs to the agency associated with program oversight. CMS reiterates that the measure removal evaluation process will continue to be done on a case-by-case basis with the involvement of a variety of stakeholders, including (but not limited to) patients, caregivers, patient and family advocates, providers and their associations, health care researchers, and data vendors. Measures that are considered burdensome or "costly" might be retained in the quality reporting program if the benefit to beneficiaries justifies the reporting burden. **The AHA supports the addition of this measure removal factor.**

Removal of the National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-Onset Methicillin-Resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure. CMS will remove this healthcare-associated infection outcome measure from the IRF QRP as it meets measure removal Factor 8, "the costs associated with a measure outweigh the benefit of its continued use in the program."

In order to calculate a measure rate for an individual provider, CMS must be able to attribute at least one expected MRSA infection during the reporting period. However, CMS found that for 99.9 percent of IRFs the expected MRSA infection incident rate was less than one; this means that CMS is unable to calculate measure rates for nearly every IRF. Because the burden associated with collecting/submitting data for and maintaining this measure outweighs the benefit (as rates are so low that improvement on the measure would not result in improved patient outcomes), CMS believes the measure meets the criteria of Removal Factor 8.

IRFs will no longer be required to submit data on the MRSA bacteremia measure beginning with Oct. 1, 2018 admissions and discharges. **AHA agrees that this measure should be removed, as performance is so high and unvarying that meaningful distinctions cannot be made and thus the costs to collect and submit data on the measure outweigh the benefits to patients.**

Removal of the Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay). CMS will remove this process measure from the FY 2021 IRF QRP as it meets measure removal Factor 1, "measure performance among IRFs is so high and unvarying that meaningful distinction in improvement in performance can no longer be made."

In an evaluation of measure performance for the 2015-2016 and 2016-2017 flu seasons, CMS found that nearly every IRF patient was assessed for vaccination and more than 75 percent of IRFs are vaccinating patients who had not already received a flu vaccination at 90 percent or higher. In addition, the number of IRFs who achieved a perfect score on the measure has grown by about 50 percent during this period.

CMS notes that influenza continues to be a major public health issue, especially for vulnerable populations like those IRFs routinely serve. However, the agency is confident that providers will continue to appropriately assess and vaccinate patients for the virus even without the quality measure in place. In addition, several commenters noted that removing this measure will allow providers to focus on more meaningful aspects of quality improvement. **AHA agrees that the removal of this measure will not result in lower quality care and supports its removal from the IRF QRP.**

IRFs will no longer be required to report and submit data for this measure beginning with Oct. 1, 2018 admissions and discharges. Even though this measure will no longer be included in the FY 2021 IRF QRP, which is informed by 2019 performance, influenza season (around which the population relevant for particular measure is specified) begins Oct. 1, 2018 and ends Mar. 31, 2019; thus 2019 performance would necessarily include 2018 performance on this measure.

For the same reason, it is too late to remove the measure for the FY 2020 IRF QRP since the 2018 influenza season has already ended. CMS intends to remove the data elements from the IRF-PAI version 3.0, which will be in effect on Oct. 1, 2019. Providers will be instructed to enter a dash (–) for the relevant items (O0250A, O0250B, and O0250C) until the IRF-PAI 3.0 is released. CMS noted that it will provide ongoing guidance to clarify that this dash will not cause a non-compliance determination.

Public Reporting of Measure Data. CMS will begin publicly displaying data on four assessment-based measures in calendar year 2020. These measures are Change in Self-Care, Change in Mobility Score, Discharge Self-Care Score, and Discharge Mobility Score. Data collection on these measures began with patients discharged on or after Oct. 1, 2016.

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

In the final rule, CMS noted that it intends to hold additional training programs on the calculation of the performance data for these measures. The agency also explained that it plans to provide IRFs with the intercept and coefficient values needed for risk-adjustment in the fall of this year, as well as the data on the four measures in the CASPER reports that will be provided to IRFs this fall. This information as well as training by CMS will allow

IRFs to track their performance and ensure that their performance is accurately represented on *IRF Compare*.

Noncompliance and Reconsideration Notifications. CMS sends IRFs written notifications of a decision of noncompliance with IRF QRP requirements for a particular fiscal year, as well as notifications of final decisions regarding any reconsideration requests. In addition to written notification, CMS also uses the QIES ASAP system to provide these notifications. CMS will expand the methods by which the agency will provide notifications to include at least one of the following: the QIES ASAP system, the US Postal Service, or via an email from the Medicare Administrative Contractor. CMS explains that this proposal is in response to feedback from providers requesting additional methods of notification.

In the final rule, CMS clarifies that the agency will use at least one method of notification, and providers will be notified about which method CMS will use via the IRF QRP Reconsideration and Exception & Extension website and announcements via the PAC listserv. These announcements will be posted annually following the May 15 data submission deadline. Notifications are sent to the point of contact on file in the QIES database, which is populated via the Automated Survey Processing Environment (ASPEN) system. The policy will be effective Oct. 1, 2018.

Other Quality Reporting Program Updates

Development of Transfer of Health Information and Patient Preferences Measures. The Improving Medicare Post-Acute Care Transformation (IMPACT) Act requires CMS to develop standardized and interoperable quality measures and implement them across all four post-acute care settings. These measures must meet certain domains, one of which is the transfer of health information and patient care preferences. A detailed summary of the IMPACT Act's requirements can be found in the AHA's Oct. 16, 2014 Legislative Advisory.

In the FY 2018 IRF PPS final rule, CMS stated that the agency intended to specify and propose two measures that would satisfy the transfer of health information and patient preferences domain for the FY 2021 IRF QRP with data collection beginning on April 1, 2019. However, CMS is currently engaging in continued development of these measures and now intends to specify and propose them for the FY 2022 IRF QRP, with data collection beginning with April 1, 2020 admissions and discharges.

CMS made the draft specifications of these measures, known as the Medication Profile Transferred measures, available for a public comment period which ended May 3, 2018. The draft specifications and information about the measures' development can be found on CMS's Public Comment website. **AHA submitted comments on these measures, which can be found here. We support CMS's delayed implementation of these measures, as continued development was necessary to ensure that the measures were as valid as possible.**

Next Steps

The AHA will host a member call on Wednesday, Sep. 5 at 3:00 p.m. ET to discuss this rule. AHA members may register here. Related materials and a recording of this call will be available at: www.aha.org/postacute in the IRF section.

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