

August 26, 2021

Inpatient Rehabilitation Facility PPS: Final Rule for FY 2022

At A Glance

On July 29, the Centers for Medicare & Medicaid Services (CMS) issued its fiscal year (FY) 2022 [final rule](#) for the inpatient rehabilitation facility (IRF) prospective payment system (PPS). Most provisions in the rule take effect Oct. 1.

AHA Take

We appreciate that this relatively brief final rule, which sets forth required payment updates and several COVID-19-related changes to the IRF Quality Reporting Program (QRP), allows the field to concentrate on their local COVID-19 responses. This is especially critical as many communities continue to experience surges of the virus.

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 2022.
- ✓ At www.aha.org/postacute, review the online recording and materials from the Aug. 10 member call that AHA hosted on this and other FY 2022 post-acute final rules.

Further Questions

For questions about payment provisions, contact Rochelle Archuleta, AHA's director of policy, at rarchuleta@aha.org. For quality-related questions, contact Caitlin Gillooley, AHA's senior associate director of policy, at cgillooley@aha.org.

Key Takeaways

The rule:

- Increases IRF payments by 1.5% (\$130 million) in FY 2022.
- Adopts one new measure and revises schedules for publicly reported data affected by COVID-19 reporting exemptions.

Final FY 2022 Payment Update

Market-basket Update

For FY 2022, the IRF PPS standard rate will be updated using the IRF-specific market basket of 2.6%. As required by the Affordable Care Act (ACA), this update will be offset by a 0.7% cut for productivity and 0.4% cut for outlier payments, as mentioned below. For IRFs that complete CMS' quality reporting requirements, the IRF standard payment for FY 2022 will be \$17,240, an increase from FY 2021's rate of \$16,856.

The rule finalized CMS' proposal to update FY 2022 payments using FY 2020 claims data that includes the COVID-19 public health emergency. The agency's analysis suggests that the FY 2020 claims data were not disproportionately impacted by the pandemic, as the vast majority of IRF beneficiaries entered into IRF stays as they would have in any other year.

Labor-related Share

The labor-related share is the national average proportion of total costs that are related to, influenced by or varied with the local labor market, such as wages, salaries and benefits. As proposed, the final labor-related share for FY 2022 will be 72.9%, a slight drop from 73.0% in FY 2021.

Area Wage Index

In a departure from the proposed rule, CMS did not finalize any changes to the FY 2021 wage index methodology. CMS had proposed to incorporate changes from OMB Bulletin No. 20-01 that would affect labor market boundaries, but the agency found that the new boundaries do not impact the labor market delineations adopted in FY 2021. As such, in FY 2022, CMS will continue to use existing labor market boundaries and the prior methodology that uses the concurrent FY 2022 pre-floor, pre-reclassification, unadjusted inpatient PPS wage index, which will be based on FY 2018 hospital cost report data. The update will be applied in a budget-neutral manner.

Adjustment for High-cost Outliers

CMS allocates 3% of total IRF payments for high-cost outlier payments. For FY 2022, CMS finalized the use of the same methodology in effect since FY 2002 to maintain estimated outlier payments at this level, which yielded a slight increase of the fixed loss threshold from \$9,402 in FY 2021 to \$9,491 in FY 2022. This change will result in fewer IRF cases qualifying for a high-cost outlier payment, compared to the current fiscal year. In response to an inquiry from the field, the rule states that freezing the fixed-loss threshold at the FY 2021 level would not be appropriate as it would overpay by 0.4% the established outlier pool of 3% for the IRF PPS.

Facility-level Payment Adjustments

As proposed, CMS again finalized the extension of the current IRF facility-level payment adjustments, which have been in effect since FY 2014. The following adjustments will remain:

- Rural adjustment: 14.9%
- Low-income patient adjustment factor: 0.3177
- Teaching adjustment factor: 1.0163

Refinements to the Case-mix Classification System

CMS updates the IRF case-mix group relative weights and average length-of-stay values for FY 2022, using the same methodology as prior years and now applied to FY 2020 IRF claims and FY 2019 IRF cost report data. The updated weights are implemented in a budget neutral manner.

Table 2 in the final rule displays the final relative weights and length-of-stay values per CMG and comorbidity tier. Table 3 displays the redistributive effect of changes in CMS weights across cases. It shows that 97.2% of IRF cases are in CMGs for which the FY 2022 weight differs from the FY 2021 weight by less than 5% (either increase or decrease).

IRF Quality Reporting Program (IRF QRP)

The ACA mandated that reporting of quality measures for IRFs begin no later than FY 2014. Failure to comply with IRF QRP requirements will result in a 2% reduction to the IRF’s annual market-basket update. See Table 1 for finalized measures.

AHA Table 1: Finalized Measures for the IRF QRP, FY 2021 – FY 2024

Measure	FY 2021	FY 2022	FY 2023	FY 2024
Catheter-associated Urinary Tract Infection (CAUTI)	X	X	X	X
Influenza Vaccination Coverage among Healthcare Personnel	X	X	X	X
<i>Clostridium Difficile Infection (CDI)</i>	X	X	X	X
Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	X	X	X	X
Functional Status: Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function	X	X	X	X
Change in Self-Care Score for Medical Rehabilitation Patients	X	X	X	X
Change in Mobility Score for Medical Rehabilitation Patients	X	X	X	X
Discharge Self-Care Score for Medical Rehabilitation Patients	X	X	X	X
Discharge Mobility Score for Medical Rehabilitation Patients	X	X	X	X
Medicare Spending Per Beneficiary for Post-acute Care IRF QRP (MSPB – IRF)	X	X	X	X
Discharge to Community – PAC IRF	X	X	X	X
Potentially Preventable 30-day Post-discharge Readmission Measure for IRF QRP	X	X	X	X
Drug Regimen Review Conducted with Follow-up for Identified Issues	X	X	X	X

Measure	FY 2021	FY 2022	FY 2023	FY 2024
Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	X	X	X	X
Potentially Preventable Within Stay Readmission Measure for IRFs	X	X	X	X
Transfer of Health Information to Provider		X	X	X
Transfer of Health Information to Patient		X	X	X
COVID-19 Vaccination Coverage among Healthcare Personnel			X	X

X = Finalized

FY 2022 Measurement Provisions

CMS will adopt one new quality measure and adjust the denominator of one measure; this will begin with the FY 2023 IRF QRP. Detailed specifications for the measures are available on CMS' IRF QRP [website](#). The agency also finalized its proposals regarding publicly reported data affected by the COVID-19 pandemic and related reporting exemptions.

Adoption of COVID-19 Vaccination among Health Care Personnel (HCP) Measure.

CMS will adopt this measure that calculates the percentage of HCP eligible to work in the IRF for at least one day during the reporting period who received a complete vaccination course. IRFs will be required to submit data beginning Oct. 1, 2021. The measure excludes persons with contraindications to the COVID-19 vaccination as described by the Centers for Disease Control and Prevention (CDC). For the purposes of this measure, "health care personnel" is defined — regardless of clinical responsibility or patient contact — as:

- Employees (all persons receiving a direct paycheck from the reporting facility);
- Licensed independent practitioners affiliated with, but not directly employed by, the reporting facility (including post-residency fellows); or
- Adult students/trainees and volunteers.

Facilities may include other contract personnel, but are not required to. Detailed specifications for this measure can be found of CDC's [website](#).

To report this data, IRFs will use the CDC's National Healthcare Safety Network (NHSN) Healthcare Personnel Safety Component submission framework, which facilities currently use to report data for other measures. HCP and resident COVID-19 vaccination data reporting modules are currently available for voluntary reporting through NHSN. IRFs will submit data through NHSN for at least one week each month, and the CDC will calculate a summary measure of the data each quarter. If IRFs submit more than one week of data in a month, CDC will use the most recent week's data to calculate the rate. This rate would be publicly reported on the IRF *Care Compare* website beginning with the October 2022 refresh "or as soon as technically feasible." Instead of accumulating data over time and displaying average performance on the measure using four rolling quarters of data as proposed, CMS will display just the quarterly rate based on the most recent quarter's data.

The measure, which is also being adopted in the QRPs for other post-acute and acute care settings, is not endorsed by the NQF. CMS and CDC contend that because the measure is aligned with the Influenza Vaccination Coverage among HCP (NQF #0431), which is currently endorsed by NQF and used in several QRPs, as well as underwent some validity testing using NHSN data, it is sufficiently specified for inclusion in the QRP.

Modification of Transfer of Health Information to the Patient (TOH-Patient) Measure. CMS will exclude residents discharged to home under the care of a home health agency or to a hospice from the denominator of this measure, which was adopted in the FY 2020 IRF PPS final rule for use beginning with the FY 2022 IRF QRP. The measure evaluates whether a medication list was transferred to a patient upon discharge from a post-acute care (PAC) facility to a non-PAC setting. A similar measure, Transfer of Health Information to the Provider, assesses whether the medication list is transferred to a subsequent provider if the patient is discharged to another PAC setting. Patients discharged home under the care of a home health agency or to a hospice are included in both measures. To avoid double-counting these patients, CMS will exclude them from the TOH-Patient measure beginning with the FY 2023 IRF QRP.

Publicly Reported Data Affected by the COVID-19 Pandemic. IRF quality measures are publicly reported on the *Care Compare* website, which uses four quarters of data for IRF-PAI assessment-based measures and eight quarters for claims-based measures. However, due to the COVID-19 pandemic, CMS granted exceptions to reporting requirements for the fourth quarter of 2019 and the first two quarters of 2020; the agency also stated that it would not publicly report any IRF QRP data that might be greatly impacted by these exceptions.

CMS determined that freezing the data displayed on the *Care Compare* website with the December 2020 refresh values — that is, holding the data constant without subsequent updates — would be the best approach. However, these data are becoming increasingly out-of-date and thus less useful for consumers. Therefore, CMS will calculate IRF QRP measures for the December 2021 refresh using three quarters of data for assessment-based measures and six quarters for claims-based measures for the December 2021 through June 2023 refreshes.

Further Questions

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