**Medicare Inpatient Rehabilitation Facility Prospective Payment System for FY 2022 and Updates to the IRF Quality Reporting Program; Payment for Complex Rehabilitative Wheelchairs and Related Accessories (Including Seating Systems) and Seat and Back Cushions Furnished in Connection with Such Wheelchairs Summary of Final Rule**

**[CMS-1748-F, CMS-1687-IFC, and CMS-1738-F]**

On July 29, 2021, the Centers for Medicare & Medicaid Services (CMS) placed on public display a final 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 final rule adds one new measure to the IRF Quality Reporting Program (QRP) and modifies the denominator for another measure currently under the IRF QRP beginning with the FY 2023 IRF QRP. In addition, this rule modifies the number of quarters used for publicly reporting certain IRF QRP measures due to the COVID-19 public health emergency (PHE). This rule also finalizes a Medicare provision adopted in an interim final rule with comment period related to fee schedule adjustments for wheelchair accessories (including seating systems) and seat and back cushions furnished with complex rehabilitative power and manual wheelchairs. The final rule will be published in the August 4, 2021 issue of the *Federal Register.* **These regulations are effective on October 1, 2021.**

CMS estimates that the Medicare IRF PPS payments in FY 2022 will be about $130 million higher than in FY 2021.

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## I. Introduction and Background

The final 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 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 finalized 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. Changes to the CMG weights are made in a budget neutral manner; the budget neutrality factor is 1.0005.

Table 2 in the final rule displays the relative weights and length of stay values by CMG and comorbidity tier. Table 3 displays the distributional effect of changes in CMG weights across cases. It shows that 97.2 percent of IRF cases are in CMGs for which the FY 2022 weight differs from the FY 2021 weight by less than 5 percent (either increase or decrease). CMS says that the changes in the average length of stay values from FY 2021 to FY 2022 are small and do not

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

show any trends in IRF length of stay patterns. Column 7 of Table 17 in the impact section of the final rule (section VIII below) shows the distributional effects of the changes in the CMGs by type of facility.

In response to commenters' request for more details of the analysis for determining how the COVID-19 claims affect the relative weight and ALOS calculations, CMS provides additional detail on using FY 2020 claims data. CMS analysis shows that using FY 2020 claims data does not result in significant different CMG relative weight values or variation the ALOS values obtained using FY 2019 claims data. CMS states that it will continue to monitor the potential impacts of the PHE on future rule updates.

## III. FY 2022 IRF PPS Payment Update

For FY 2022 payment, CMS applies 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 1.9 percent is finalized for the IRF PPS payment rates for FY 2022, composed of the following elements.

| Final FY 2022 IRF PPS Update Factor | |
|---|---|
| Market basket | 2.6% |
| Productivity Adjustment | -0.7% |
| Total | 1.9% |

The 1.9 percent FY 2022 market basket increase factor is based on IHS Global Insight's (IGI's) forecast from the second quarter of 2021, based on actual data through the first quarter. Similarly, the statutorily required productivity adjustment is based on IGI's second quarter 2021 forecast of the 10-year moving average (ending in 2022) of changes in annual economy-wide private nonfarm business multifactor productivity.[2] The update factor for IRFs that fail to meet requirements for the IRF QRP is discussed in section V below and totals -0.1 percent (1.9 percent full update minus 2.0 percentage points).

The productivity adjustment changed significantly from the proposed to the final rule increasing from 0.2 to 0.7 percentage points. If the productivity adjustment, for example, had remained the same, the overall update factor would have been 2.4% instead of 1.9%. CMS does not discuss this change but the large difference in forecasts between the proposed and final rule may be due to the economic uncertainty associated with the COVID-19 pandemic.

[2] CMS notes that effective with 2022 and beyond, CMS is changing the name of this adjustment to refer to it as the productivity adjustment rather than the multifactor productivity adjustment (MFP). This is not a change in policy or how the adjustment is calculated rather a terminology change to be more consistent with the statutory language.

CMS makes 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 will 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).

In response to comments about adjusting the productivity adjustment or the market basket update, CMS notes that it does not have the statutory authority to apply a different update factor to IRF PPS payments rates for FY 2022.

**B. Labor-Related Share**

CMS finalizes 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 most recent forecast (IGI's second quarter 2021) 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 final rule compares the components of the FY 2021 and 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 will 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[3] 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 a 1-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 does not 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 final rule to be 1.0032. 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 FY 2022 labor share and wage index values. The ratio of the amount based on the FY 2021 index to the amount estimated using the FY 2022 index is the budget neutrality adjustment to be applied to the federal per diem base rate for FY 2022.

**D. Description of the IRF Standard Payment Conversion Factor and Payment Rates**

Table 5 of the final rule (reproduced below) shows the calculations used to determine the FY 2022 IRF standard payment amount. In addition, Table 6 of the final 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 final rule.

| Table 5: Calculations to Determine the 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 (2.6 percent), reduced by 0.7 percentage point for the productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act | x 1.019 |
| Budget Neutrality Factor for the Updates to the Wage Index and Labor-Related Share | x 1.0032 |
| Budget Neutrality Factor for the Revisions to the CMGs and CMG Relative Weights | x 1.0005 |
| FY 2022 Standard Payment Conversion Factor | = $17,240 |

[3] 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.

## 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 uses 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 3.4 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 $9,491 for FY 2022.

Updates are finalized for the national urban and rural CCRs for IRFs, as well as the national CCR ceiling for FY 2022, 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 final national average CCRs for FY 2022 are 0.394 for urban IRFs and 0.478 for rural IRFs, and the national CCR ceiling is 1.35. That is, if an individual IRF's CCR were to exceed this ceiling of 1.35 for FY 2022, CMS would replace the IRF's CCR with the appropriate national average CCR (either rural or urban, depending on the geographic location of the IRF).

Several commenters requested that CMS freeze the fixed-loss threshold amount at the FY 2021 level, which was based on FY 2019 claims. Commenters were concerned that the use of 2020 data would result in an excessively high fixed-loss threshold and that the net results would be a substantial underpayment of outliers. In its response, CMS states that freezing the fixed-loss threshold at the FY 2021 level would not be appropriate as it would overpay by 0.4 percent the established outlier pool of 3 percent for the IRF PPS. It also notes that providers have access to Provider Relief Funds to assist with COVID-19 related costs and does not find any justification for continuing to overpay the established outlier pool of 3 percent.

## V. Revisions and Updates to the IRF Quality Reporting Program

### A. Background

CMS established the IRF QRP beginning in 2014 as directed by statute. Measures remain in the program until they are removed, suspended or replaced. 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 at the end of this section (see V.H) displays the measures finalized for FY 2022 and FY 2023. More information about the measure set is available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Program-Measures-Information-.

CMS did not propose any changes to the IRF QRP measure set for FY 2022. For FY 2023, one measure addition and one measure revision were proposed, described below. CMS also proposed changes to the refresh schedule for public display of IRF QRP data on Care Compare to adjust for effects of the COVID-19 PHE on healthcare delivery and for flexibility granted by the agency to IRFs regarding data collection and submission during CY 2020. CMS also requested information regarding closing the equity gap in quality measures, adopting standards for digital quality measures, and considerations for future assessment-based IRF QRP measures.

### B. New and Updated Measures for FY 2023

1. COVID-19 Vaccination Coverage among Healthcare Personnel

CMS finalizes as proposed the adoption of this measure into the IRF QRP measure set beginning with FY 2023. This process measure tracks the rate of vaccination among healthcare facility workers and is applicable to IRF staff members.

This measure went through the standard pre-rulemaking process. The Measure Applications Partnership (MAP) awarded conditional support for rulemaking, requesting clarification of the measure's specifications, which CMS provided to the MAP in March, 2021. The measure is not NQF-endorsed, but CMS adopts the measure under the exception at section 1886(j)(7)(D)(ii) of the Act, which allows the Secretary to select non-NQF-endorsed measures when the Secretary is unable to identify a suitable NQF-endorsed measure that is available, feasible, and practical.

Support for the measure from commenters was mixed: areas of concern included that IRF staff members may feel intimidated into receiving the vaccine and lack of NQF endorsement. CMS reviews in detail the interplay of state laws and regulations, Equal Employment Opportunity Commission policies, contraindications to vaccination, and other factors affecting willingness of facility staff members to be vaccinated. The agency concludes that sufficient protections are in place for staff members to preclude intimidation and encourages continued efforts by IRFs to educate staff about the value of vaccination.

CMS also disagrees that facilities are being forced to meet a requirement -- staff vaccination -- that is out of their control; CMS notes that facilities are simply being required to report the measure and are not subject to payment adjustments based on measure results. CMS states an intent to submit the measure to the NQF in the future, but believes the measure is needed now to provide facilities with process improvement feedback and patients and families with valuable information for healthcare decision-making.

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

CMS finalizes as proposed revising the denominator of the TOH-PAC-Patient measure by excluding patients discharged to home health or hospice care, as these patients are already included in the denominator of a companion measure (TOH-PAC-Provider).

Commenters were strongly supportive but raised concern about delay of the measure's effective date, done as part of the CMS response to the COVID-19 PHE to reduce reporting burden. In the May 8, 2020 COVID-19 IFC (85 FR 27595), the compliance date for reporting this measure was changed to January 1st of the year that is at least one full CY after the end of the PHE. However, CMS calls stakeholder attention to the CY 2022 Home Health PPS proposed rule, in which the agency has proposed to modify the compliance date for reporting to begin October 1, 2022 (86 FR 35983).

## C. Request for Information on Quality Measures for Future Years

CMS solicited input on the importance and suitability of IRF QRP future additions in several topic areas: frailty, opioid use and frequency, patient reported outcomes, shared decision-making process, appropriate pain assessment and pain management processes, and health equity. Commenters supported, though to varying degrees, potential additions to all of these areas. CMS indicates that responses will be used to inform future measure development.

## D. Request for Information on Support of Digital Quality Measurement

CMS requested input into the agency's planning for transformation to a fully digital quality enterprise by 2025, to include the IRF QRP, with special emphasis on the potential role of Health Level Seven International (HL7®) Fast Healthcare Interoperability Resources® (FHIR)-based standards for efficient exchange of clinical information across clinical settings by clinicians through APIs. CMS acknowledges comment receipt and states that any updates to the IRF QRP requirements related to digital transformation would be addressed through rulemaking.

## E. Request for Information on Closing the Health Equity Gap

CMS requested information on potential revisions to the IRF QRP to facilitate comprehensive and actionable reporting of health disparities, including adding measures and standardized patient data assessment elements as well as providing performance results stratified by one or

more social risk factors (e.g., race and ethnicity). CMS acknowledges receiving comments and states that any updates to the IRF QRP requirements related to health equity would be addressed through rulemaking.

## F. Form, Manner, and Timing of Data Submission

As noted above, CMS finalized as proposed the *COVID-19 Vaccination Coverage among Healthcare Personnel* measure with an initial data submission period of October 1, 2021-December 31, 2021. IRFs will report data for one self-selected week each month to the Centers for Disease Control and Prevention (CDC) through the CDC's National Health Safety Network (NHSN). CDC will calculate rates for IRFs quarterly and report the rates to CMS. The rates will be publicly reported on Care Compare (see additional information in the next section below).

Commenters raised concerns about added NHSN reporting burden given ongoing, parallel reporting requirements for COVID-related data, such as the HHS TeleTracking system, and suggested that overlapping requirements be eliminated. CMS notes that IRFs are not reporting under TeleTracking and that IRFs are experienced with reporting via the NHSN. The agency concludes that the reporting requirements balance burden and the public health value of the information being required with flexibility (e.g., self-selected reporting one week per month).

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

### 1. COVID-19 Vaccination Coverage among Healthcare Personnel

CMS finalizes with modification its proposal for public display of this measure's results on Care Compare. CMS had proposed that after the initial quarterly rate data were posted, subsequent quarters' results would be added as they became available; once four quarters of data were displayed, then future quarters' results would be added on a rolling basis. As modified, only data for the most recent quarter available will be displayed. CMS was persuaded to make this modification by commenters' concerns about creating potential confusion of the public by the rolling data display and the overarching importance of focusing clearly on the most timely, feasible, data display.

### 2. Public Reporting of Measures with Fewer Quarters Due to COVID-19 PHE Exemptions

CMS finalizes without modifications its proposal to use the COVID-19 Affected Reporting (CAR) Scenario for public reporting of measure results for the IRF Care Compare data refreshes for December 2021 through June 2023.

Refreshes on Care Compare for the IRF QRP measures are specific to each measure's source data: the IRF-Patient Assessment Instrument (IRF-PAI); Medicare claims; or the CDC NHSN. Normally, four contiguous quarters of data are used for IRF-PAI-derived and NHSN measures while eight quarters are used for claims-based measures. In response to the COVID-19 PHE, CMS granted a nationwide exemption to the IRF QRP reporting requirements for Q4 2019 and

Q1 and Q2 2020, although facilities were able to report data voluntarily. CMS subsequently determined that the Q4 2019 data were suitable for use in Care Compare refreshes as usual. However, CMS also determined that freezing the publicly displayed results beginning with the December 2020 refresh would be appropriate until such time as the data to be added were no longer affected by the Q1 and Q2 2020 nationwide data reporting exemption.

In order to limit the data display freeze, CMS simulated a scenario in which the number of quarters of data collected for each refresh were shortened, to 3 for IRF-PAI-derived measures and 6 for claims-based measures. This scenario (the CAR scenario) was compared to the Standard Public Reporting (SPR) Scenario which simulated Care Compare refreshes using available data and the previously established refresh schedule. Reportability and reliability of the refresh data were found to be acceptable for the CAR Scenario and CMS constructed a schedule for IRF QRP data refreshes based on that scenario. The CAR-based timetable allows return to "normal" refreshes (i.e., using the full four or eight quarters of data for IRF-PAI-derived measures and claims-based measures, respectively) by March 2022 for IRF-PAI-derived measures and September 2023 for claims-based measures. For the CDC NHSN measures, CMS adopted the CDC's recommendation to use the four most recent quarters but allowing the use of non-contiguous quarters (i.e., skipping over the exempted quarters). Normal refreshes will resume with the December 2022 refresh.

Commenters expressed appreciation for the nationwide IRF quality data reporting exemption granted in March 2020. Some raised concerns with the CAR Scenario, which includes the use of Q3 and Q4 data, periods during which COVID-19 PHE effects were still being felt and those effects were not distributed uniformly nationwide. CMS reprises the agency's analytic findings and believes the CAR Scenario is statistically sound. Commuters asked that explanatory notes be included on Care Compare to explain the reporting changes. CMS agrees that a notice about using fewer quarters of data than usual will be posted but declines offering any more detailed explanation in order not to reduce public confidence in the data's accuracy or propriety for use in healthcare decision-making. A similar objection to use of Q3 and Q4 2020 data was made in regards to the NHSN refresh schedule changes.

In conclusion, CMS emphasizes its belief that neither further exempting providers from reporting requirements nor continued suspension of public reporting are actionable solutions for the IRF QRP program going forward. The finalized Care Compare IRF QRP refresh schedules for all three measure-source types are shown as Tables 11, 12, 15, and 16 of the rule.

## H. Summary Table of IRF QRP Measures for FY 2022 and FY 2023 as Finalized

| IRF QRP Measure Set for FY 2022 and FY 2023 as Finalized | |
|---|---|
| **Short Name** | **Measure Name & Data Source** *(new or revised are in italics)* |
| **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 |
| *Transfer of Health Information* * | *Transfer of Health Information to the Patient-PAC Measure*<br>*Transfer of Health Information to the Provider-PAC Measure* |
| **NHSN** | |
| 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) |
| *COVID-19 Vaccine*** | *COVID-19 Vaccination Coverage among Healthcare Personnel* |
| **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 |

* Delay in compliance date implemented due to COVID-19 PHE until one full year following end of the PHE; October 2022 compliance start date now pending, as proposed in Home Health PPS CY 2022 Proposed Rule (86 FR 35983).

**Finalized for reporting beginning with FY 2023.

## VI. Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Policy Issues

In this section, CMS finalizes a Medicare provision adopted in an interim final rule with comment period (IFC) issued on May 11, 2018 related to fee schedule adjustments for wheelchair accessories (including seating systems) and seat and back cushions furnished in connection with group 3 or higher complex rehabilitative power wheelchairs as well as changes to the regulations related to the Further Consolidated Appropriations Act, 2020 (FCAA) governing payment for these and other items.[4]

### A. Fee Schedule Adjustments for Accessories (Including Seating Systems) and Seat and Back Cushions Furnished in Connection with Group 3 or Higher Complex Rehabilitative Power Wheelchairs and Complex Rehabilitative Manual Wheelchairs

In this final rule, CMS finalizes a policy exempting wheelchair accessories furnished in connection with Group 3 complex rehabilitative power wheelchairs from fee schedule adjustments based on information from the DMEPOS Competitive Bidding Program (CBP). In the May 2018 IFC and continuation notice in 2021(86 FR 21949), CMS stated that the fee schedule amounts for all other accessories and cushions used with other wheelchairs would continue to be adjusted based on information from the CBP. CMS is changing its position in this final rule and thus the DMEPOS fee schedule amounts will not be adjusted based on information from the CBP. This payment policy for wheelchair accessories and back and seat cushions used in conjunction with *group 3 power wheelchairs* would also apply for accessories used in conjunction with *complex rehabilitative manual wheelchair*s. It believes that by doing so it will further safeguard beneficiaries with significant disabilities who rely on this technology to function independently on a daily basis.

CMS also finalizes a policy exempting wheelchair accessories furnished in connection with complex rehabilitative manual wheelchairs from fee schedule adjustments based on information from the DMEPOS CBP. CMS modified its policy in light of comments it received that correctly point out that this issue is the same for complex rehabilitative manual wheelchairs as it is for Group 3 or higher complex rehabilitative power wheelchairs. Specifically, CMS will exempt accessories (including seating systems) and seat and back cushions furnished in connection with complex rehabilitative manual wheelchairs and other complex manual wheelchairs described by HCPCS codes E1235, E1236, E1237, E1238, and K0008 from the fee schedule adjustments based on information from the CBP.

[4] Medicare Program; Durable Medical Equipment Fee Schedule Adjustments to Resume the Transitional 50/50 Blended Rates to Provide Relief in Rural Areas and Non-Contiguous Areas" (83 FR 21912).

**B. Exclusion of Complex Rehabilitative Manual Wheelchairs and Certain other Manual Wheelchairs from the DMEPOS CBP**

This rule finalizes conforming changes to the regulations at 42 CFR 414.402 to revise the definition of "item" at 42 CFR 414.402 under the CBP to exclude complex rehabilitative manual wheelchairs and certain other wheelchairs from the CBP. Specifically, CMS edits the definition of item in §414.202 to exclude power wheelchairs, complex rehabilitative manual wheelchairs, manual wheelchairs described by HCPCS codes E1235, E1236, E1237, E1238, and K0008, and related accessories when furnished in connection with such wheelchairs. All commenters supported the exclusion of the complex rehabilitative manual wheelchairs, other manual wheelchairs and related accessories furnished in connection with these wheelchairs from the DMEPOS CBP.

**C. Regulatory Impact of DMEPOS Policy Issues**

CMS estimates a $170 million dollar increase in Medicare payments for the provisions related to paying higher rates for wheelchair accessories used with complex power and manual wheelchairs for the period from FY 2022 to FY 2026.

**VII. Collection of Information Requirements**

CMS notes that while this 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 finalizes its plans 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 update will not affect the information collection burdened already established.

**VIII. Regulatory Impact Analysis**

CMS estimates that the final rule will increase Medicare payments to IRFs by $130 million in FY 2022 compared with FY 2021. This reflects the 1.9 percent increase from the update factor and the change in the outlier threshold, which will reduce aggregate payments to IRFs by an estimated 0.4 percent. Table 17 in the final 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 $130 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 | 1,114 | 381,770 | -0.4 | 0.0 | 0.0 | 1.5 |
| Urban unit | 665 | 150,120 | -0.6 | 0.1 | -0.2 | 1.2 |
| Rural unit | 133 | 19,484 | -0.6 | 0.4 | -0.3 | 1.4 |
| Urban hospital | 304 | 207,312 | -0.2 | -0.1 | 0.2 | 1.8 |
| Rural hospital | 12 | 4,854 | -0.1 | 0.4 | 0.1 | 2.3 |
| Urban For-Profit | 373 | 200,172 | -0.2 | 0.0 | 0.2 | 1.9 |
| Rural For-Profit | 34 | 7,988 | -0.2 | 0.3 | 0.0 | 2.0 |
| Urban Non-Profit | 509 | 137,347 | -0.6 | -0.1 | -0.2 | 1.0 |
| Rural Non-Profit | 90 | 13,571 | -0.7 | 0.5 | -0.3 | 1.4 |
| Urban Government | 87 | 19,913 | -0.6 | 0.5 | -0.3 | 1.5 |
| Rural Government | 21 | 2,779 | -0.4 | 0.3 | -0.3 | 1.5 |
| Urban | 969 | 357,432 | -0.4 | 0.0 | 0.0 | 1.5 |
| Rural | 145 | 24,338 | -0.5 | 0.4 | -0.2 | 1.6 |
| **Urban by region** | | | | | | |
| Urban New England | 31 | 14,531 | -0.3 | -0.6 | -0.2 | 0.8 |
| Urban Middle Atlantic | 125 | 43,217 | -0.4 | -1.0 | 0.0 | 0.5 |
| Urban South Atlantic | 154 | 74,192 | -0.3 | 0.5 | 0.0 | 2.2 |
| Urban East North Central | 157 | 45,939 | -0.4 | 0.0 | -0.1 | 1.4 |
| Urban East South Central | 55 | 25,615 | -0.2 | 0.0 | 0.1 | 1.8 |
| Urban West North Central | 75 | 20,395 | -0.4 | 0.7 | -0.2 | 2.0 |
| Urban West South Central | 191 | 80,374 | -0.3 | -0.3 | 0.2 | 1.5 |
| Urban Mountain | 82 | 28,228 | -0.2 | 0.1 | 0.0 | 1.7 |
| Urban Pacific | 99 | 24,941 | -0.7 | 0.5 | -0.2 | 1.5 |
| **Rural by region** | | | | | | |
| Rural New England | 5 | 1,264 | -0.5 | -0.2 | -0.4 | 0.7 |
| Rural Middle Atlantic | 10 | 989 | -1.0 | 1.0 | -0.4 | 1.6 |
| Rural South Atlantic | 16 | 3,976 | -0.2 | 1.1 | 0.2 | 3.0 |
| Rural East North Central | 23 | 3,931 | -0.5 | 0.6 | -0.2 | 1.8 |
| Rural East South Central | 21 | 3,702 | -0.3 | 0.1 | -0.3 | 1.4 |

| 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 | 5 | 486 | -0.9 | 0.7 | -0.5 | 1.2 |
| Rural West South Central | 3 | 358 | -1.4 | 0.1 | -0.7 | -0.1 |
| Rural Mountain | | | | | | |
| Rural Pacific | 1,008 | 337,505 | -0.3 | 0.0 | 0.0 | 1.6 |
| **Teaching status** | 59 | 29,605 | -0.4 | 0.1 | 0.0 | 1.6 |
| Non-teaching | 36 | 13,318 | -0.7 | -0.4 | -0.2 | 0.5 |
| Resident to ADC less than 10% | 11 | 1,342 | -0.4 | 0.0 | -0.4 | 1.1 |
| Resident to ADC 10%-19% | 49 | 8,050 | -0.6 | -0.9 | 0.1 | 0.5 |
| Resident to ADC greater than 19% | 5 | 486 | -0.9 | 0.7 | -0.5 | 1.2 |
| **Disproportionate share patient percentage (DSH PP)** | 3 | 358 | -1.4 | 0.1 | -0.7 | -0.1 |
| DSH PP = 0% | 49 | 8,050 | -0.6 | -0.9 | 0.1 | 0.5 |
| DSH PP <5% | 143 | 52,695 | -0.3 | -0.2 | 0.1 | 1.5 |
| DSH PP 5%-10% | 280 | 116,312 | -0.3 | 0.1 | 0.1 | 1.8 |
| DSH PP 10%-20% | 387 | 139,160 | -0.4 | -0.1 | 0.0 | 1.4 |
| DSH PP greater than 20% | 255 | 65,553 | -0.5 | 0.2 | -0.1 | 1.5 |

[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 (2.6 percent), reduced by 0.7 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.

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.

The majority of commenters supported the use of FY 2020 data to update the prospective payment rates for FY 2022 as it was reflective of changes in IRF care related to the pandemic and that it reflects changes to the CMG definitions that were implemented in FY 2020. Other commenters expressed concern that the FY 2020 data were heavily impacted by the pandemic and its use would result in skewed relative weights and an inflated outlier threshold. CMS states that its analysis, however, suggests that the FY 2020 claims data were not disproportionally impacted by the PHE, as the vast majority of IRF beneficiaries entered into IRF stays as they would have in any other year. For this reason and others, CMS finalizes the use of FY 2020 claims data to update the prospective payment rates for FY 2022.