Medicare Inpatient Rehabilitation Facility Prospective Payment System for FY 2019
[CMS-1688-P]
Summary of Proposed Rule

On April 27, 2018, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule on the Medicare inpatient rehabilitation facility prospective payment system (IRF PPS) for federal fiscal year (FY) 2019. It will be published in the *Federal Register* on May 8th. **The 60-day public comment period ends at close of business on June 26, 2018.**

The IRF PPS update factor proposed for FY 2019 is 1.35 percent, reflecting current projections of the market basket increase (+2.9 percent) and multifactor productivity adjustment (-0.8 percent), and applying the additional -0.75 percent adjustment required by statute. Along with other budget neutrality adjustments, the standard payment conversion factor would increase from $15,838 in FY 2018 to $16,020 for FY 2019 for facilities meeting the standards in the IRF Quality Reporting Program (QRP), and $15,704 for facilities not meeting the IRF QRP standards and subject to the 2-percentage point penalty. CMS estimates that under the proposed rule Medicare IRF PPS payments in FY 2019 will be about $75 million higher than in FY 2018.

In addition to provisions to update the IRF PPS payment rates for FY 2019, the rule proposes to reduce regulatory burden by modifying several IRF coverage requirements and seeks comments on other possible changes to these provisions; eliminate two measures from the IRF QRP; and make significant changes to the case-mix classification system beginning with FY 2020.

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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 2018, and an operational overview of the current IRF PPS. Among other things, CMS notes that the FY 2016 final rule changed the market basket index used to update IRF payments to reflect the cost structures of only IRF providers, and the FY 2018 final rule revised the ICD-10-CM codes used to classify a hospital as an IRF.

II. Update to the Case-Mix Group (CMG) Relative Weights and Average Length of Stay Values for FY 2019

Updates are proposed for the CMG relative weights and average length of stay values for FY 2019, using the same methodologies that have been used in past years applied to FY 2017 IRF claims and FY 2016 IRF cost report data. The average length of stay for each CMG is used to determine when an IRF discharge meets the definition of a short-stay transfer, which results in a per diem case level adjustment. CMS computes a budget neutrality factor of 0.9980 to account for changes to the FY 2019 relative weights. Table 2 of the proposed rule provides the relative weights and length of stay values by CMG and comorbidity tier.

Table 3 of the proposed rule (reproduced below) shows the distributional effects (increases and decreases compared to FY 2018) of the changes in the CMG relative weights. The vast majority of IRF PPS cases fall into CMGs where the change in the relative weight (increase or decrease) from FY 2018 to FY 2019 would be less than 5 percent. CMS says that the largest increase in the proposed CMG relative weight values that affects a particularly large number of IRF discharges is a 3.4 percent increase for CMG 0806, Replacement of lower extremity joint, with a motor score less than 22.05 — with no tier adjustment. In the 2017 claims data, 1,580 IRF discharges (0.4 percent) were classified in this CMG and tier. The largest decrease that affects the most cases is a 2.1 percent decrease for CMG 0304, Non-traumatic brain injury, with a motor score of less than 26.5 — with no tier adjustment. This would have affected 3, 354 cases (0.8 percent) in 2017.

CMS Table 3: Distributional Effects of the Changes to the CMG Relative Weights (FY 2018 Values Compared with FY 2019 Values)

Percentage Change	# of Cases Affected	% of Cases Affected
Increased by 15% or more	19	0.0%
Increased by between 5% and 15%	1,600	0.4%
Changed by less than 5%	394,149	99.3%
Decreased by between 5% and 15%	1,193	0.3%
Decreased by 15% or more	74	0.0%

CMS says that the changes in average length of stay values for FY 2019 are small and do not show any trend in IRF length of stay patterns.

III. Facility-Level Adjustment Factors

CMS proposes to continue to hold the facility-level adjustment factors (that is, the rural, low income percentage (LIP) and teaching status adjustment factors) at the FY 2014 levels as it continues to monitor the most current IRF claims data available and evaluates the effects of the changes that were adopted in the FY 2014 final rule.

IV. FY 2019 IRF PPS Payment Update

A. FY 2018 Market Basket Update and Productivity Adjustment

CMS proposes an update factor of 1.35 percent to the IRF PPS payment rates for FY 2019, composed of the following elements:

FY 2019 IRF PPS Update Factor	
Market basket[1]	2.90%
Multifactor productivity (MFP)	-0.80%
Statutory adjustment	-0.75%
Total	1.35%

The 2.9 percent FY 2019 market basket increase factor is based on IHS Global Insight's (IGI's) most recent forecast, which is from the first quarter of 2018, with historical data through the fourth quarter of 2017. Similarly, the MFP adjustment called for under section 1886(j)(3)(C)(ii) of the Social Security Act (the Act) is based IGI's first quarter 2018 forecast of the 10-year moving average (ending in 2019) of changes in annual economy-wide private nonfarm business multifactor productivity. Finally, sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(v) of the Act require a further 0.75 percentage point reduction to the update factor. The update factor for IRFs that fail to meet requirements for the IFR QRP is discussed in section VIII.I below and would total -0.65 percent.

The update factor in the final rule will take into account more recent IGI forecasts for the market basket and productivity elements for 2019.

CMS notes that the Medicare Payment Advisory Commission (MedPAC) recommends that for FY 2019 the IRF PPS rates be reduced by 5 percent. The statute does not provide authority to propose an update other than the 1.35 percent increase.

B. Labor-Related Share for FY 2019

CMS proposes a total labor-related share of 70.6 percent for FY 2019. (The FY 2018 labor share is 70.7 percent.) The 70.6 percent comes from the IGI first quarter 2018 estimate of the sum of

[1] CMS in the FY 2016 final rule established a specific 2012-based IRF market basket, using Medicare cost report data for both freestanding and hospital-based IRFs, which replaced the Rehabilitation, Psychiatric and Long-Term Care (RPL) market basket that had been used in prior years. References to the market basket in this summary are references to the 2012-based IRF market basket.

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 (proposed to continue to be 46 percent) of the Capital-Related cost weight from the IRF market basket. Table 4 of the propose rule provides details on the components of this calculation.

C. Wage Adjustment

CMS proposes to continue for FY 2019 the policies and methodologies related to labor market area definitions and calculation of the wage index that were adopted for FY 2018. This includes use of the Core-Based Statistical Area (CBSA) labor market area definitions and the FY 2018 pre-reclassification and pre-floor hospital wage index data (FY 2014 cost report data). Also continued would be the same methodology discussed in the FY 2008 IRF PPS final rule (72 FR 44299) to address those geographic areas where there are no hospitals and, thus, no hospital wage index data on which to base the calculation for the FY 2019 IRF PPS wage index.

The labor market areas and updates previously adopted would be continued. This includes the OMB delineations for Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas described in the February 28, 2013 OMB Bulletin No. 13-01 (available at http://www.whitehouse.gov/sites/default/files/omb/bulletins/2013/b-13-01.pdf) as modified by the July 15, 2015, OMB Bulletin No. 15–10 (available at https://obamawhitehouse.archives.gov/sites/default/files/omb/bulletins/2015/15-01.pdf). The changes made in Bulletin 15-10 involve Garfield County, OK; the county of Bedford City, VA; and Macon, GA and were adopted for the IRF PPS on October 1, 2017. This adoption for FY 2018 is consistent with CMS' practice of implementing changes for the IRF PPS market area definitions after they have been adopted for the acute hospital Inpatient Prospective Payment System (IPPS), which in this case began on October 1, 2016.

One proposed change for FY 2019 would be to begin using only Federal Information Processing Standard (FIPS) codes to identify and crosswalk counties to CBSA codes for purposes of the IRF wage index. CMS notes that these codes are currently used along with the Social Security Administration (SSA) codes for this purpose; the SSA codes are no longer being maintained or updated. Therefore, it views the change as allowing for a more up-to-date payment system. The proposed FIPS-only revision was implemented for the IPPS beginning with October 1, 2017. CMS notes that the proposed change does not affect the constituent counties of any CBSA.

A budget neutral adjustment that was made for IRFs that were classified as rural in FY 2015 under the old CBSA definitions and classified as rural in FY 2016 under the new definitions was phased down in FYs 2016 and 2017 and no longer applies beginning with FY 2018.

For FY 2019, the proposed budget neutrality wage adjustment factor is 1.000.

The proposed wage index for FY 2019 can be found in Table A (urban areas) and Table B (rural areas) available on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Data-Files.html.

D. Description of the IRF Standard Payment Conversion Factor and Payment Rates for FY 2018

Table 5 of the proposed rule (reproduced below) shows the calculations used to determine the FY 2019 IRF standard payment amount. Table 6 of the rule lists the unadjusted FY 2019 payment rates for each CMG, and Table 7 provides a detailed hypothetical example of how the IRF FY 2019 federal prospective payment would be calculated for CMG 0110 (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.

CMS Table 5: Calculations to Determine the Proposed FY 2019 Standard Payment Conversion Factor		
Explanation for Adjustment	**Calculations**	
Standard Payment Conversion Factor for FY 2018		$15,838
Market Basket Increase Factor for FY 2019 (2.9 percent), reduced by 0.8 percentage point for the productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act, reduced by 0.75 percentage point in accordance with sections 1886(j)(3)(C) and (D) of the Act	x	1.0135
Budget Neutrality Factor for the Wage Index and Labor-Related Share	x	1.0000
Budget Neutrality Factor for the Revisions to the CMG Relative Weights	x	0.9980
Proposed FY 2019 Standard Payment Conversion Factor	=	$16,020

V. 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 the proposed rule would continue this policy. CMS believes this policy 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 2019, CMS proposes to use FY 2017 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 2018. To maintain estimated outlier payments at the 3 percent level, CMS proposes to update the outlier threshold amount from $8,679 for FY 2018 to $10,509 for FY 2019.

CMS further proposes updates to the national urban and rural CCRs for IRFs, as well as the national CCR ceiling for FY 2019, based on analysis of the most recent data that are available. 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 2019; and other IRFs for which accurate data to calculate an overall CCR are not available.

CMS proposes that the national CCR ceiling again be set at 3 standard deviations above the mean CCR for FY 2019. If an individual IRF's CCR exceeds the ceiling, CMS would replace the IRF's CCR with the appropriate national average CCR (either urban or rural).

For FY 2019, CMS estimates a national average CCR of 0.392 for urban IRFs and 0.470 for rural IRFs, and a national CCR ceiling of 1.31. These figures reflect cost report data from FY 2016 and will be updated for the final rule if more recent data become available.

VI. Removal of FIM™ Instrument and Associated Function Modifiers and Refinements to Case-Mix Classification

Beginning with FY 2020, CMS proposes to remove the FIM™ Instrument and Associated Function Modifiers from the IRF-Patient Assessment Instrument (IRF-PAI) and to make a series of refinements to the case-mix classification system. The latter includes changes to functional status scores, updates to the score reassignment methodology, and refinements to the CMGs.

A. Removal of FIM™ Instrument and Associated Function Modifiers from the IRF-PAI

IRFs are required to complete the appropriate sections of the IRF-PAI upon the admission and discharge of each Medicare Part A fee-for-service patient and each Medicare Part C (Medicare Advantage) patient. IRF-PAI data are used to classify patients into payment groups based on clinical characteristics and expected resource needs as well as to monitor the quality of care furnished in IRFs.

The IRF-PAI was originally based on a modified version of the Uniform Data System for medical rehabilitation (UDSmr) patient assessment instrument, which is commonly referred to as the FIM™. Item 39 of the IRF-PAI version 2.0 contains 18 of the FIM™ data elements and the FIM™ measurement scale which are used to score motor and cognitive functioning at admission and discharge. (The data elements and measurement scale are together referred to as the FIM™ instrument.) In addition, items 29 through 38 of the IRF-PAI contain Function Modifiers associated with the FIM™ instrument, which are 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.

Because the data in the Quality Indicators section of the IRF-PAI can be used to assign payment under the IRF PPS, CMS proposes to remove the FIM™ instrument and associated Function Modifiers from the IRF-PAI (that is, items 29 through 39) for discharges on or after October 1, 2019. CMS believes this proposal would reduce administrative burden on IRFs because the data collected in the Quality Indicators section of the IRF-PAI overlap with data collected through the FIM™ instrument and associated Function Modifiers. The proposed rule lists the 22 data items collected in the IRF-PAI Quality Indicators section of the IRF-PAI and discusses the similarities between the data captured by the FIM™ instrument and its associated Function Modifiers and these IRF-PAI Quality Indicators. Additionally, CMS notes that the removal of these components would support its goal of standardizing data collection across post-acute care (PAC) settings as several of the data items it proposes to incorporate into the IRF case-mix system (see

item VI.B) are similar to data elements that are also collected on SNF and LTCH assessment instruments.

In the Collection of Information Requirements section of the proposed rule, CMS estimates that the total cost savings from the removal of the FIM™ instrument and associated Function Modifiers from the IRF-PAI would be approximately $10.2 million annually for all IRFs (1,124 IRFs x $9,100).

B. Refinements to the Case-Mix Classification System

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 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.

No changes are proposed to the methodology used to update the CMGs, relative weights and average length of stay values for FY 2019. These updates are discussed in section II above.

Beginning with FY 2020, CMS proposes to incorporate the data items collected on admission and located in the Quality Indicator section of the IRF-PAI into the CMG classification system. This proposal is necessitated by the proposal described above to remove the FIM™ instrument and associated Function Modifiers from the IRF-PAI at that time. These data are needed to assign patients to CMGs for payment under the IRF PPS.

In addition, CMS proposes to update the functional status scores used in the case mix system and to revise the CMGs and update the relative weights and average length of stay values associated with the revised CMGs. These changes would be made in a budget neutral manner.

1. Changes to Functional Status Scores

Currently, functional status scores consist of motor items and cognitive items, and potentially patient age. The motor and cognitive scores are derived from a combination of data elements in the FIM™ instrument (item 39 of the IRF-PAI). 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 are the data elements collected through the FIM™ instrument that are currently used to compute a patient's weighted motor score. Comprehension, expression, social interaction, problem solving, and memory are the data elements collected through the FIM™ instrument that are used to compute a patient's cognitive score. Each data element is recorded on the IRF-PAI and scored on a scale of 1 to 7, with a 7 indicating complete independence in this area of functioning, and a one indicating that a patient is very impaired in this area of functioning. Additionally, a value of zero is used to indicate that an activity did not occur. The scores for each data element above are then

used to determine the patient's weighted motor score and cognitive score, which may be used to group a patient into a CMG for payment purposes under the IRF PPS.

CMS proposes to use 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 would compose the functional status scores in the IRF case-mix classification system. 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. The proposed functional status scoring approach reflects the work of a CMS contractor (Research Triangle Institute, International or RTI) and a Technical Expert Panel conducting and reviewing analyses of items collected at admission. These proposed components were found to best predict costs.

Motor Score: The proposed 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 proposed 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 proposed 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 proposes to derive the scores for each group of the functional status items listed above by calculating the sum of the items that constitute each functional status component. Unlike the current case-mix system, which uses a weighted motor score and an unweighted cognitive score, CMS does not propose a weighting methodology. Readers are referred to the technical report, "Analyses to Inform the Potential Use of Standardized Patient Assessment Data Elements in the Inpatient Rehabilitation Facility Prospective Payment System," available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Research.html.

2. Updates to the Score Reassignment Methodology

As noted above, the rating system used for the proposed 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 7-level scale, compared with a 6-level scale for the self-care and mobility items in the Quality Indicators IRF-PAI and a 4-level scale for cognitive elements. In the FIM™, if an activity did not occur or was not observed, a zero value is assigned. For the IRF-PAI Quality Indicators section, four codes are used: 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).

CMS proposes 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.

Consistent with the current reassignment rules, under the proposal, for the self-care and mobility items identified above, values of 07, 09, 10, 88, and the presence of a dash ("-") would be reassigned to 1, the most dependent level, except the toilet transfer item, which is recoded to 2.

CMS further proposes to change 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 proposes to 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 proposes to reassign 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 proposes to reassign a value of 9 (not rated) to 2 (frequently incontinent). For both items, CMS proposes to reassign 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.

3. Refinements to the CMGs

The methodology used to update the CMGs used to classify IRF patients for payment under the IRF PPS would be modified beginning with FY 2020 to reflect the conversion from use of FIM™ items to data items from the Quality Indicators section of the IRF-PAI. In addition, CMS notes that changes in treatment patterns, technology, case-mix and other factors affecting the relative use of resources in IRFs since the current CMGs were last revised likely require an update to the classification system. A Classification and Regression Trees (CART) analysis was used to determine the current CMGs based on a patient's functional status and age. There are currently 21 diagnosis-based RICs, which are subdivided into 92 CMGs.

A similar CART analysis was used by RTI to modify the CMG definitions to reflect the use of data from the IRF-PAI Quality Indicators section. Restraints were imposed on the groupings to limit the total number CMGs. CMS refers readers to the analysis linked above for more information on the development of the proposed CMGs.

Table 9 in the proposed rule lists the revised relative weights and average length of stay values for the case mix groups proposed to begin with FY 2020. In addition, CMS notes that in

developing the revised CMGs, RTI's analysis generated a set of CMGs for RICs 16 (pain syndrome) and 17 (major multiple trauma without brain or spinal cord injury) that would indicate higher costs for patients with no cognitive impairment compared to those with some level of impairment. These results are shown in Table 8 of the proposed rule. CMS believes this unexpected result might be due to small sample size so it is proposing to combine CMGs within these RICs as shown in Table 9.

CMS makes the following observations about the most significant differences between the current CMGs and the proposed revised CMGs:

- There would be fewer CMGs than before (88 instead of 92 currently).
- There would be fewer CMGs in RICs 1, 2, 5,8,11, and 19, while there would be more CMGs in RICs 3, 4, 10, 13, 15, 17, and 18.
- A patient's age would affect assignment for CMGs in RICs 1, 3, 4, and 13 whereas it currently affects assignment for CMGs in RICs 1, 4, and 8.

Table 10 of the proposed rule, reproduced here, shows the distributional effects of the proposed changes to the CMGs. It shows the largest increases in average payment (3%-4%) to IRF units, government IRFs, those with fewer than 25 beds and those in several regions. The largest decreases would be in rural New England (-6%), and for urban IRFs, urban for-profit IRFs, those with 75-124 beds and IRFs in several regions (-2%).

CMS TABLE 10: Distributional Effects of the Proposed Changes to the CMGs

Facility Classification	Number of IRFs	Number of Cases	% Change in Mean Payment
Total	1,111	369,684	0%
Urban unit	702	155,121	3%
Rural unit	133	20,074	3%
Urban hospital	265	190,431	-2%
Rural hospital	11	4,058	-1%
Urban For-Profit	339	185,702	-2%
Rural For-Profit	37	7,388	2%
Urban Non-Profit	529	137,321	2%
Rural Non-Profit	84	13,338	2%
Urban Government	99	22,529	3%
Rural Government	23	3,406	4%
Urban	967	345,552	0%
Rural	144	24,132	2%
Urban by region			
Urban New England	29	15,514	-2%
Urban Middle Atlantic	134	48,194	-2%
Urban South Atlantic	144	69,040	0%
Urban East North Central	173	46,132	3%

Facility Classification	Number of IRFs	Number of Cases	% Change in Mean Payment
Urban East South Central	56	24,250	-1%
Urban West North Central	73	18,333	0%
Urban West South Central	180	75,717	-1%
Urban Mountain	81	26,683	-1%
Urban Pacific	97	21,689	4%
Rural by region			
Rural New England	4	1,048	-6%
Rural Middle Atlantic	11	1,244	3%
Rural South Atlantic	16	3,491	-1%
Rural East North Central	21	3,599	2%
Rural East South Central	21	4,174	4%
Rural West North Central	21	2,829	2%
Rural West South Central	40	6,765	4%
Rural Mountain	7	722	4%
Rural Pacific	3	260	2%
Teaching status			
Non-teaching	842	303,102	-1%
Teaching	269	66,582	2%
Bed Size			
<25	563	85,835	3%
25-49	314	107,858	1%
50-74	134	85,923	-1%
75-99	58	48,564	-2%
100-124	19	14,527	-2%
125+	23	26,977	-1%

VII. Revisions to Certain IRF Coverage Requirements

CMS discusses its commitment to developing policies that allow providers and physicians to focus most of their time on treating patients rather than completing paperwork. The FY 2018 IRF PPS proposed rule include a Request for Information (RFI) soliciting comments from stakeholders on how to reduce burden for hospitals and physicians, improve quality of care, decrease costs and ensure that patients receive the best care.

In response to comments it received, CMS proposes to revise the IRF coverage criteria, particularly focused on reducing documentation requirements that it believes have become overly burdensome to IRF providers over time. It says some proposals come directly from commenter suggestions while others are offered as responsive to stakeholder feedback for the need to reduce administrative burden.

A. Changes to Physician Supervision Requirement

For an IRF claim to be considered reasonable and necessary, there must be a reasonable expectation at the time of admission to the IRF that the patient requires physician supervision by a rehabilitation physician.[2] The requirement for medical supervision means that the rehabilitation physician must conduct face-to-face visits with the patient at least 3 days per week throughout the patient's stay in the IRF 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 at the IRF must contain a post-admission physician evaluation that meets specified regulatory requirements.

Based on comments it received to the information request, CMS proposes that the post-admission physician evaluation required under 42 CFR 412.622(a)(4)(ii) may count as one of the face-to-face physician visits required under 42 CFR 412.622(a)(3)(iv) for all IRF discharges beginning on or after October 1, 2018. CMC clarifies that no changes are proposed to §412.622(a)(4)(ii), including the 24-hour timeframe within which the post-admission physician evaluation requirement must be completed.

While CMS continues to believe that the post-admission physician evaluation and the face-to-face physician visits are two different types of assessments, it has been convinced that the rehabilitation physician should have the flexibility to assess the patient and conduct the post-admission physician evaluation during one of the three face-to-face physician visits required in the first week of the IRF admission. Additionally, based on the comments that it received CMS 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. CMS concludes that allowing these two requirements to be met concurrently would reduce redundancy and regulatory burden while still ensuring adequate care to the patient.

In the Collection of Information Requirements section of the proposed rule, CMS estimates that savings from this proposal would total $40.5 million (1,124 IRFs x $36,000) annually across the IRF setting. It notes that all these savings would occur on the Medicare Part B side, in the form of reduced Part B payments to physicians under the physician fee schedule.

B. Changes to the Interdisciplinary Team Meeting Requirement

For an IRF claim to be considered reasonable and necessary, the patient must require an interdisciplinary team approach to care as documented in the patient's medical record of weekly interdisciplinary team meetings that meet specified regulatory requirements. For example, team meetings must be led by a rehabilitation physician, and the results and findings of the team meetings and the concurrence of the rehabilitation physician with those findings, must be retained in the patient's record.[3]

[2] In addition to the cited regulations, CMS further refers readers to the Medicare Benefit Policy Manual, chapter 1, sections 110.1.2 and 110.2.4, available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html.

[3] See the Medicare Benefit Policy Manual, chapter 1, section 110.2.5, available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html.

CMS proposes to amend §412.622(a)(5)(A) to specify that the rehabilitation physician may lead the interdisciplinary meeting remotely without any additional documentation requirements. CMS believes that video and telephone conferencing are acceptable ways of leading the meeting, and the proposed change would allow for time management flexibility for rehabilitation physicians, especially those in rural areas who may need to travel greater distances between facilities. The proposed change would not apply to other members of the interdisciplinary team, although CMS says that it may consider expanding the policy in future rulemaking.

C. Changes to the Admission Order Documentation Requirement

In response to comments suggesting that duplicative requirements be eliminated, CMS proposes to remove §412.606(a), which requires an IRF to have physician orders for a patient's care during the hospitalization.[4] CMS says this regulation is duplicative and not necessary because IRFs must satisfy other requirements that address this issue. IRFs must meet the admission order payment requirements at §412.3(a), under which, for purposes of Medicare payment an inpatient is a person admitted under an order for inpatient admission by a physician or other qualified practitioner in accordance with other requirements in §412.3 and certain hospital conditions of participation (CoPs). CMS cites §482.12(c), which requires, for example, that patients be admitted only on the recommendation of a state-licensed practitioner or under the care of a doctor of medicine or osteopathy, and §412.24(c) which relates to documentation in the patient's medical record regarding the basis for the admission and continued stay and medical orders during the patient's stay. IRFs must meet all the inpatient hospital conditions of participation (CoPs).

D. Solicitation of Comments Regarding Additional Changes to the Physician Supervision Requirement

CMS seeks additional comments with respect to the medical supervision requirement discussed in item VII.A above. In particular CMS wants to know whether the rehabilitation physician should have the flexibility to determine that some of the IRF visits can be appropriately conducted remotely via video or telephone conferencing. CMS expresses some concerns about the potential effect of the use of remote visits on quality of care, and says that most visits would need to be performed face-to-face. The following specific questions are asked:

- Do stakeholders believe that the rehabilitation physician would be able to fully assess both the medical and functional needs and progress of the patient remotely?
- Would this assist facilities in rural areas where it may be difficult to employ an abundance of physicians?
- Do stakeholders believe that assessing the patient remotely would affect the quality or intensity of the physician visit in any way?
- How many and what types of visits do stakeholders believe should be able to be performed remotely?

[4] See the Medicare Benefit Policy Manual, chapter 1, section 110.1.4, available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html.

- From an operational standpoint, how would the remote visit work?
- What type of clinician would need to be present in the room with the patient while the rehabilitation physician was in a remote location?

E. Solicitation of Comments Regarding Changes to Use of Non-Physician Practitioners

Several regulatory requirements under §412.622(a)(3), (4), and (5) require IRFs to document that a rehabilitation physician visited and performed an assessment on each patient admitted. As discussed in item VII.B above, there must be a reasonable expectation at the time of admission that the patient requires physician supervision by a rehabilitation physician (§412.622(a)(3)(iv)), and a post-admission evaluation must be completed by a rehabilitation physician (§412.622(a)(4)(ii)).

CMS says that responses to the RFI on reducing regulatory burden included the suggestion that the requirements be modified to enable IRFs to expand the use of non-physician practitioners (physician assistants and nurse practitioners) to fulfill some of the duties that currently must be carried out by rehabilitation physicians. Commenters argued that this would relieve physicians of some documentation burdens. CMS has questions about whether non-physician practitioners have the appropriate training to adequately assess the interaction between patients' medical and functional care needs in an IRF. Comments are sought in general on how the role of non-physician practitioners could be expanded in the IRF setting while maintaining a hospital level high quality of care for IRF patients, and on the following specific questions:

- Do non-physician practitioners have the specialized training in rehabilitation that they need to have to assess IRF patients both medically and functionally?
- How would the non-physician practitioner's credentials be documented and monitored to ensure that IRF patients are receiving high quality care?
- Are non-physician practitioners required to do rotations in inpatient rehabilitation facilities as part of their training, or could this be added to their training programs in the future?
- Do stakeholders believe that utilizing non-physician practitioners to fulfill some of the requirements that are currently required to be completed by a rehabilitation physician would have an impact of the quality of care for IRF patients?

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

A. Background

CMS established the IRF QRP beginning in FY 2014 for IRFs, as required under section 1886(j)(7) of the Act, which was added by the Patient Protection and Affordable Care Act. Further developed in subsequent rulemaking, the IRF QRP follows many of the policies established for the Hospital IQR Program, including the principles for selecting measures and the procedures for hospital participation in the program. Under the statute, an IRF that does not meet the requirements of participation in the IRF QRP for a rate year is subject to a 2.0 percentage point reduction in the update factor for that year.

Under existing policy, measures adopted to the IRF QRP remain in the program until they are removed, suspended or replaced. A subregulatory process is used to incorporate National Quality Forum (NQF) updates to IRF quality measure specifications that do not substantively change the nature of the measure. Substantive changes are proposed and finalized through rulemaking.

A table at the end of this section (VIII.J) displays the measures adopted for the IRF QRP**.**

B. Accounting for Social Risk Factors in the IRF QRP

CMS reviews its past discussion of accounting for social risk factors in its quality reporting and value-based purchasing programs. It cites the July 2017 NQF final report on its 2-year trial period of risk adjustment for social risk factors, and notes that NQF has launched a follow-up 3-year initiative that will continue to include social risk factors in outcome measures submitted for endorsement and will also explore unresolved issues that surfaced in the initial trial.

As a next step, CMS is considering options to increase the transparency of quality measure disparities shown among patient groups within and across hospitals, such as stratification of Inpatient Quality Reporting Program outcome measures. It plans to continue to work with the Assistant Secretary for Planning and Evaluation, the public, and other stakeholders to identify policy solutions that improve health equity while minimizing unintended consequences.

C. New Removal Factor for Previously Adopted IRF QRP Measures

CMS reviews the previously adopted seven factors that it considers for removal of a measure from the IRF QRP and proposes a new eighth factor. The seven current removal factors consider whether 1) measure performance is so high and unvarying and meaningful distinctions in improvements in performance can no longer be made; 2) performance or improvement on the measure does not result in better patient outcomes; 3) the measure does not align with current clinical guidelines or practice; 4) another more broadly applicable measure is available; 5) another measure that is more proximal in time to desired patient outcomes is available; and 7) collection or public reporting of the measure leads to negative unintended consequences other than patient harm. CMS notes that none of the factors results in automatic removal; these are considerations that are taken into account on a case-by-case basis.

The proposed eighth removal factor would be the costs associated with a measure outweigh the benefit of its continued use in the program. CMS reviews the different types of costs associated with measures. It also notes that beneficiaries may find it confusing to see public reporting on the same measure in different programs. CMS says its goal is to move the program forward in the least burdensome manner possible while maintaining a “parsimonious set of meaningful quality measures” and continuing to incentivize quality improvement.

The current and newly proposed removal factors would be codified in regulatory text at 42 CFR 412.634(b)(2). Other changes to §412.634(b) are proposed to remove references to payment from

the header and to eliminate the reference to the 2-percentage point payment reduction because it is codified elsewhere in the IRF regulations. This is discussed further in section VIII.I below.

D. Removal of Two IRF QRP Measures

Two measures are proposed for removal from the IRF QRP measure set beginning with FY 2020 payment.

- NHSN Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (NQF#1716) is proposed for removal under the newly proposed factor 8, (the costs outweigh the benefits). CMS reports that for virtually all IRFs, the expected MRSA incident rate is less than one, which is too low for calculating a reliable standardized infection ratio. Therefore, it believes the burden on IRFs of reporting data for this measure to the NHSN outweighs the benefit of continuing the measure. Under the proposal, IRFs would no longer be required to submit data on this measure for purposes of the IRF QRP beginning with October 1, 2018 admissions and discharges.
- Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680) is proposed for removal under factor 1 (measure performance is high and unvarying and meaningful distinctions in performance can no longer be made) because data for the last two influenza seasons show that nearly every IRF patient was assessed and more than 75 percent of IRFs are vaccinating 90 percent or more of their patients who had not already received a flu vaccination. Nearly 19 percent of IRFs received a perfect score on this measure in the 2016-2017 influenza season. If the proposal is finalized IRFs would no longer be required to submit data on this measure for the purposes of the IRF QRP beginning with patients discharged on or after October 1, 2018. CMS would remove these data elements from the IRF-PAI version 3.0, effective October 1, 2019; beginning with October 1, 2018 discharges, IRFs would enter a dash (–) for O0250A, O0250B, and O0250C until the IRF-PAI version 3.0 is released.

In the Collection of Information Requirements section of the proposed rule, CMS estimates that the two IRF QRP measure removals would result in annual savings of $2160.66 per IRF, totaling $2,428,581.84 for all IRFs.

E. IMPACT Act Implementation Update

The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, enacted on October 6, 2014, requires the Secretary to implement quality measures for specified quality measure domains using standardized data elements to be nested within the assessment instruments currently required for submission by IRFs and other post-acute care providers (LTCHs, SNFs, and HHAs). Other measures are to address resource use, hospitalization, and discharge to the community. The intent of the IMPACT Act is to enable interoperability and access to longitudinal information among post-acute providers to facilitate coordinated care, improve outcomes, and provide for quality comparisons across providers.

In the FY 2018 IRF PPS proposed rule and related post-acute care rules, CMS proposed the adoption of standardized patient assessment data that would form the foundation of cross-cutting quality measures. These data elements were not finalized, however, due to commenter concerns about reporting burden.

In this rule, CMS reports on its ongoing work on developing two measures that would satisfy the IMPACT Act domain of accurately communicating the existence and provision of the transfer of health information and care preferences. It plans on reconvening a Technical Expert Panel in mid-2018 and specifying the measures no later than October 1, 2019. CMS intends then to propose adoption beginning with the FY 2022 IRF QRP. Readers are referred to the CMS IMPACT Act downloads and videos webpage for more information on pilot measure testing: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-Downloads-and-Videos.html.

F. Form, Manner, and Timing of Data Submission

No procedural changes are proposed regarding data submission for the IRF QRP. Measure data reported under the IRF-PAI are submitted by IRFs through the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) System. More information is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Software.html. Other measures are reported by IRFs to the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) https://www.cdc.gov/nhsn/index.html.

CMS proposes to codify a previously finalized policy under which IRFs must submit standardized patient assessment data required under section 1899B(b)(1) of the Act, as specified by the Secretary. This proposal would be made as an amendment to 42 CFR 412.634(b)(1).

G. Changes to Reconsideration Requirements

CMS proposes to modify the regulatory text at 42 CFR 412.634(d)(1) to expand the methods by which it would notify an IRF of non-compliance with the IRF QRP requirements for a year. CMS would notify IRFs of noncompliance via a letter sent through one or more of the following: the QIES ASAP system, the United States Postal Service, or via an email from the Medicare Administrative Contractor (MAC). CMS believes this responds to providers requesting additional modes of notification. The same notification processes would be used to communicate CMS' final decision regarding any reconsideration request.

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

Currently, performance data for 7 IRF QRP measures are publicly displayed on the *IRF Compare* website (https://www.medicare.gov/inpatientrehabilitationfacilitycompare/). They are:

- Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678)

- National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138)
- NHSN Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (NQF #1716)
- NHSN Facility-wide Inpatient Hospital-Onset Clostridium difficile Infection (CDI) Outcome Measure (NQF #1717)
- Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431)
- Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680)
- Rate of unplanned readmission after discharge from an IRF

In this rule, CMS proposes that public reporting on the following four measures begin in 2020 or as soon after that as technically feasible:

- Change in Self-Care (NQF #2633)
- Change in Mobility Score (NQF #2634)
- Discharge Self-Care Score (NQF #2635)
- Discharge Mobility Score (NQF #2636)

CMS proposes to display data for these measures based on four rolling quarters of data, initially using discharges from January 1, 2019 through December 31, 2019. To ensure statistical reliability, if an IRF has fewer than 20 cases for a measure during any four consecutive rolling quarters of data, CMS would note in the public display that the number of cases/patient stays for that IRF is too small to publicly report performance on the measure.

I. Method for Applying the Reduction to the FY 2019 IRF Increase Factor for IRFs That Fail to Meet the Quality Reporting Requirements

An IRF that fails to meet the requirements of the IRF QRP for a year is subject to a 2-percentage point reduction in the applicable update factor for that year. Table 12 of the proposed rule (reproduced below) shows the calculation of the adjusted FY 2019 standard payment conversion factor that would be used for any IRF that failed to meet the IRF QRP reporting requirements for the applicable reporting period.

CMS Table 12: Calculations to Determine the Adjusted FY 2019 Standard Payment Conversion Factor for IRFs that Failed to Meet the Quality Reporting Requirement		
Explanation for Adjustment		**Calculations**
Standard Payment Conversion Factor for FY 2018		$15,838
Market Basket Increase Factor for FY 2019 (2.9 percent), reduced by 0.8 percentage point for the productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act, reduced by 0.75 percentage point in accordance with sections 1886(j)(3)(C) and (D) of the Act and reduced by 2 percentage points for IRFs that failed to meet the quality reporting requirement	x	0.9935
Budget Neutrality Factor for the Wage Index and Labor-Related Share	x	1.0000
Budget Neutrality Factor for the Revisions to the CMG Relative Weights	x	0.9980
Adjusted FY 2019 Standard Payment Conversion Factor	=	$15,704

CMS notes that the 2-percentage point reduction is addressed in two places in the regulatory text (§412.624(c)(4) and§412.624(b)(2)) and proposes to make revisions so that the payment reduction is addressed only in §412.624(c)(4) and to clarify that remaining text.

J. Summary Table of IRF QRP Measures

Quality Measures for the 2020 IRF QRP
Measures Proposed for Removal in Italics

Short Name	**Measure Name & Data Source**
	IRF-PAI
Pressure Ulcer	Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678)*
Pressure Ulcer/Injury	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury*
Patient Influenza Vaccine	*Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680)*
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
CAUTI	National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138)
MRSA	*NHSN Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (NQF #1716)*
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
*The pressure ulcer measure NQF #0678 will be replaced by the pressure ulcer/injury measure effective October 1, 2018.	

IX. Request for Information on Promoting Interoperability and Electronic Healthcare Information Exchange Through CMS Health and Safety Requirements

CMS discusses the status of adoption of health IT among Medicare and Medicaid participating providers. It says that as of 2015, 96 percent of hospitals had adopted certified EHRs with the capability to electronically export a summary of clinical care, yet significant obstacles to electronic exchange of health information remain. It reviews CMS and Office of National Coordinator (ONC) initiatives and regulatory activities aimed at advancing health information exchange. The January 2018 ONC draft Trusted Exchange Framework and Common Agreement (TEFCA)[5] is highlighted.

CMS is interested in feedback from stakeholders on how it should use the Conditions of Participation (CoPs), Conditions of Coverage (CfCs), and Requirements for Participation (RfPs) for Long-Term Care (LTC) Facilities to advance electronic exchange of health information in support of care transitions between hospitals and community providers. As an example, CMS says it might consider revising the hospital CoPs to require that hospitals electronically transfer medically necessary patient information to the other facility when a patient is transferred. Similarly, they might require that hospitals electronically send discharge information to a patient's community provider when possible, and to provide discharge instructions electronically to patients or a third-party application, if requested.

Relevant provisions of proposed CoP regulations are discussed including the November 3, 2015 proposed rule to implement provisions of the IMPACT Act (80 FR 68126), June 16, 2016 proposed changes to CoPs for hospitals and CAHs (81 FR 39448), and an October 4, 2016 final rule on requirements for LTC facilities (81 FR 68688).

In this rule, CMS requests stakeholder feedback on the following questions:

- If CMS were to propose a new CoP/CfC/RfP standard to require electronic exchange of medically necessary information, would this help to reduce information blocking as defined in section 4004 of the 21st Century Cures Act?
- Should CMS propose new CoPs/CfCs/RfPs for hospitals and other participating providers and suppliers to ensure a patient's or resident's (or his or her caregiver's or representative's) right and ability to electronically access his or her health information without undue burden? Would existing portals or other electronic means currently in use by many hospitals satisfy such a requirement regarding patient/resident access as well as interoperability?
- Are new or revised CMS CoPs/CfCs/RfPs for interoperability and electronic exchange of health information necessary to ensure patients/residents and their treating providers routinely receive relevant electronic health information from hospitals on a timely basis or will this be achieved in the next few years through existing Medicare and Medicaid policies, HIPAA, and implementation of relevant policies in the 21st Century Cures Act?

[5] The draft is available at https://www.healthit.gov/topic/interoperability/trusted-exchange-framework-and-common-agreement.

- What would be a reasonable implementation timeframe for compliance with new or revised CMS CoPs/CfCs/RfPs for interoperability and electronic exchange of health information if CMS were to propose and finalize such requirements? Should these requirements have delayed implementation dates for specific participating providers and suppliers, or types of participating providers and suppliers (for example, participating providers and suppliers that are not eligible for the Medicare and Medicaid EHR Incentive Programs)?
- Do stakeholders believe that new or revised CMS CoPs/CfCs/RfPs for interoperability and electronic exchange of health information would help improve routine electronic transfer of health information as well as overall patient/resident care and safety?
- Under new or revised CoPs/CfCs/RfPs, should non-electronic forms of sharing medically necessary information (for example, printed copies of patient/resident discharge/transfer summaries shared directly with the patient/resident or with the receiving provider or supplier, either directly transferred with the patient/resident or by mail or fax to the receiving provider or supplier) be permitted to continue if the receiving provider, supplier, or patient/resident cannot receive the information electronically?
- Are there any other operational or legal considerations (for example, HIPAA), obstacles, or barriers that hospitals and other providers and suppliers would face in implementing changes to meet new or revised interoperability and health information exchange requirements under new or revised CMS CoPs/CfCs/RfPs if they are proposed and finalized in the future?
- What types of exceptions, if any, to meeting new or revised interoperability and health information exchange requirements, should be allowed under new or revised CMS CoPs/CfCs/RfPs if they are proposed and finalized in the future? Should exceptions under the QPP including CEHRT hardship or small practices be extended to new requirements? Would extending such exceptions impact the effectiveness of these requirements?

In addition, CMS discusses the MyHealthEData initiative to promote patient access to their medical records and the Blue Button 2.0 initiative for beneficiary access to Medicare claims information through API technology.

CMS seeks ideas from the public on how best to accomplish the goal of fully interoperable health IT and EHR systems for providers and suppliers and how to advance the MyHealthEData initiative for patients. In particular, it would like to identify fundamental barriers to interoperability and patient access and how they might be reduced through revisions to the CoPs, CfCs, and RfPs for hospitals and other Medicare providers and suppliers. CMS has a particular interest in hearing about issues for providers and suppliers who are ineligible for the Medicare and Medicaid EHR Incentives program, such as long-term care and post-acute care providers, behavioral health providers, clinical laboratories and social service providers.

The usual disclaimers applied to a Request for Information are included.

X. Regulatory Impact Analysis

CMS estimates that the proposed rule will increase Medicare payments to IRFs by $75 million in FY 2019 compared with FY 2018. This represents an aggregate increase of 0.9 percent. Table 14

of the proposed rule, reproduced below, breaks down components of the proposed increase and shows distributional effects by category of IRF.

The proposed rule includes provisions that CMS estimates would reduce costs to IRFs, which are noted in relevant sections above. These reductions total $42.9 million annually beginning in FY 2019 for the combined effects of the proposals for removing IRF coverage requirements and two quality reporting measures, and another $10.2 million annually beginning in FY 2020 from the proposal to remove the FIM™ instrument and associated Function Modifiers from the IRF-PAI.

CMS TABLE 14: IRF Impact Table for FY 2019

Facility Classification	Number of IRFs	Number of Cases	Outlier (%)	FY 2019 CBSA wage index and labor- share (%)	CMG Weights (%)	Total Percent Change[1]
Total	**1,124**	**401,760**	**-0.4**	**0.0**	**0.0**	**0.9**
Urban unit	707	169,671	-0.7	0.0	0.0	0.7
Rural unit	137	22,160	-0.5	-0.3	0.1	0.6
Urban hospital	269	205,565	-0.2	0.0	0.0	1.2
Rural hospital	11	4,364	-0.1	0.2	0.1	1.5
Urban For-Profit	346	202,800	-0.2	0.0	0.0	1.2
Rural For-Profit	40	8,534	-0.3	0.0	0.1	1.2
Urban Non-Profit	534	149,934	-0.6	0.0	0.0	0.8
Rural Non-Profit	87	14,874	-0.6	-0.4	0.1	0.5
Urban Government	96	22,502	-0.8	-0.1	0.0	0.5
Rural Government	21	3,116	-0.5	-0.2	0.1	0.7
Urban	976	375,236	-0.4	0.0	0.0	1.0
Rural	148	26,524	-0.5	-0.2	0.1	0.7
Urban by region						
Urban New England	29	16,647	-0.2	0.0	0.0	1.1
Urban Middle Atlantic	141	53,238	-0.4	0.0	0.0	0.9
Urban South Atlantic	111	49,452	-0.4	-0.3	0.0	0.6
Urban East North Central	172	48,452	-0.5	0.1	0.1	1.0
Urban East South Central	55	35,750	-0.2	0.0	-0.1	1.1
Urban West North Central	109	37,580	-0.4	-0.1	0.0	0.9
Urban West South Central	183	81,790	-0.3	0.4	0.0	1.4
Urban Mountain	78	28,685	-0.4	-0.3	0.0	0.7
Urban Pacific	98	23,642	-0.9	0.1	0.0	0.5
Rural by region						
Rural New England	5	1,279	-0.5	2.0	0.0	2.8
Rural Middle Atlantic	11	1,439	-0.6	-0.5	0.0	0.3
Rural South Atlantic	13	2,703	-0.2	-0.5	0.0	0.6
Rural East North Central	25	4,533	-0.4	-0.6	0.1	0.3
Rural East South Central	15	3,713	-0.2	-0.2	0.1	1.1
Rural West North Central	29	4,665	-0.6	0.0	0.1	0.9

Facility Classification	Number of IRFs	Number of Cases	Outlier (%)	FY 2019 CBSA wage index and labor- share (%)	CMG Weights (%)	Total Percent Change[1]
Rural West South Central	40	7,141	-0.4	-0.5	0.1	0.5
Rural Mountain	6	699	-1.1	0.3	0.2	0.7
Rural Pacific	4	352	-1.9	-0.4	0.0	-0.9
Teaching status						
Non-teaching	1,016	356,200	-0.4	0.0	0.0	1.0
Resident to ADC <10%	65	34,206	-0.5	0.0	0.0	0.8
Resident to ADC 10%-19%	31	9,372	-0.7	0.0	0.0	0.7
Resident to ADC > 19%	12	1,982	-0.5	0.5	0.0	1.4
Disproportionate share patient percentage (DSH PP)						
DSH PP = 0%	36	10,174	-1.2	0.3	0.0	0.5
DSH PP <5%	140	54,050	-0.3	0.0	0.0	1.1
DSH PP 5%-10%	294	126,929	-0.3	0.0	0.0	1.1
DSH PP 10%-20%	371	134,581	-0.4	0.0	0.0	0.9
DSH PP greater than 20%	283	76,026	-0.5	-0.1	0.0	0.7