DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS–1688–P]

RIN 0938–AT25

Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2019

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would update the prospective payment rates for inpatient rehabilitation facilities (IRFs) for federal fiscal year (FY) 2019. As required by the Social Security Act (the Act), this proposed rule includes the classification and weighting factors for the IRF prospective payment system's (PPS) case-mix groups and a description of the methodologies and data used in computing the prospective payment rates for FY 2019. We are also proposing to alleviate administrative burden for IRFs by removing the Functional Independence Measure (FIM™) instrument and associated Function Modifiers from the IRF Patient Assessment Instrument (IRF–PAI) and revising certain IRF coverage requirements to reduce the amount of required paperwork in the IRF setting. In addition, we are soliciting comments on removing the face-to-face requirement for rehabilitation physician visits and expanding the use of non-physician practitioners (that is, nurse practitioners and physician assistants) in meeting the IRF coverage requirements. For the IRF Quality Reporting Program (QRP), we are proposing to adopt a new measure removal factor, remove two measures from the IRF QRP measure set, and codify in our regulations a number of requirements.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, not later than 5 p.m. on June 26, 2018.

ADDRESSES: In commenting, please refer to file code CMS–1688–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the ''Submit a comment'' instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1688–P, P.O. Box 8016, Baltimore, MD 21244–8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1688–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT:

Gwendolyn Johnson, (410) 786–6954, for general information.

Catie Kraemer, (410) 786–0179, for information about the proposed payment policies and payment rates.

Kadie Derby, (410) 786–0468, for information about the IRF coverage policies.

Christine Grose, (410) 786–1362, for information about the quality reporting program.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period as soon as possible after they have been received at *http://www.regulations.gov.* Follow the search instructions on that website to view public comments.

The IRF PPS Addenda along with other supporting documents and tables referenced in this proposed rule are available through the internet on the CMS website at *http://www.cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/.*

To assist readers in referencing sections contained in this document, we are providing the following Table of Contents.

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Executive Summary

A. Purpose

This proposed rule would update the prospective payment rates for IRFs for FY 2019 (that is, for discharges occurring on or after October 1, 2018, and on or before September 30, 2019) as required under section 1886(j)(3)(C) of the Act. As required by section 1886(j)(5) of the Act, this rule includes the classification and weighting factors for the IRF PPS's case-mix groups and a description of the methodologies and data used in computing the prospective payment rates for FY 2019. In addition, this proposed rule would reduce the regulatory burden for IRFs by removing data items from the IRF–PAI and revising certain IRF coverage and paperwork requirements. In addition, this proposed rule solicits comments regarding removing the face-to-face requirement for rehabilitation physician visits and expanding the use of non-physician practitioners (that is, nurse practitioners and physician assistants) in meeting the IRF coverage requirements. We are also proposing to update the requirements for the IRF QRP, including adding a new quality measure removal factor, removing two measures from the measure set, and codifying in our regulations a number of requirements.

B. Summary of Major Provisions

In this proposed rule, we use the methods described in the FY 2018 IRF PPS final rule (82 FR 36238) to update the prospective payment rates for FY 2019 using updated FY 2017 IRF claims and the most recent available IRF cost report data, which is FY 2016 IRF cost report data. (*Note:* In the interest of brevity, the rates previously referred to as the ''Federal prospective payment rates'' are now referred to as the ''prospective payment rates''. No change in meaning is intended.) We are also proposing to alleviate administrative burden for IRFs by removing the FIM™ instrument and associated Function Modifiers from the IRF–PAI and revising certain IRF coverage requirements to reduce the amount of required paperwork in the IRF setting. In addition, we are soliciting comments on removing the face-to-face requirement for rehabilitation physician visits and expanding the use of non-physician practitioners (that is, nurse practitioners and physician assistants) in meeting the IRF coverage requirements. We are also proposing to update requirements for the IRF QRP.

C. Summary of Impacts

Provision description	Transfers
FY 2019 IRF PPS payment rate update	The overall economic impact of this proposed rule is an estimated $75 million in increased payments from the Federal government to IRFs during FY 2019.
Provision description	**Costs**
Removal of FIM™ Items from IRF–PAI	The total reduction in costs in FY 2020 for IRFs as a result of the removal of the FIM™ instrument and associated Function Modifiers from the IRF–PAI is estimated to be $10.2 million.
Removal of certain IRF coverage requirements	The total reduction in costs in FY 2019 for IRFs as a result of the removal of certain IRF coverage requirements is estimated to be $40.5 million.
New IRF QRP requirements	The total reduction in costs in FY 2019 for IRFs as a result of the new quality reporting requirements is estimated to be $2.4 million.

D. Improving Patient Outcomes and Reducing Burden Through Meaningful Measures

Regulatory reform and reducing regulatory burden are high priorities for CMS. To reduce the regulatory burden on the healthcare industry, lower health care costs, and enhance patient care, in October 2017, we launched the Meaningful Measures Initiative.[1] This initiative is one component of our agency-wide Patients Over Paperwork Initiative,[2] which is aimed at evaluating and streamlining regulations with a goal to reduce unnecessary cost and burden, increase efficiencies, and improve beneficiary experience. The Meaningful Measures Initiative is aimed at identifying the highest priority areas for quality measurement and quality improvement in order to assess the core quality of care issues that are most vital to advancing our work to improve patient outcomes. The Meaningful Measures Initiative represents a new approach to quality measures that fosters operational efficiencies, and will reduce costs, including collection and reporting burden while producing quality measurement that is more focused on meaningful outcomes.

The Meaningful Measures Framework has the following objectives:

- Address high-impact measure areas that safeguard public health;
- Patient-centered and meaningful to patients;
- Outcome-based where possible;
- Fulfill each program's statutory requirements;
- Minimize the level of burden for health care providers (for example,

[1] Meaningful Measures web page: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/MMF/General-info-Sub-Page.html.*

[2] See Remarks by Administrator Seema Verma at the Health Care Payment Learning and Action Network (LAN) Fall Summit, as prepared for delivery on October 30, 2017 *https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-10-30.html.*

through a preference for EHR-based measures where possible, such as electronic clinical quality measures);

- Significant opportunity for improvement;
- Address measure needs for population based payment through alternative payment models; and
- Align across programs and/or with other payers.

In order to achieve these objectives, we have identified 19 Meaningful Measures areas and mapped them to six overarching quality priorities as shown in the Table 1:

TABLE 1—MEANINGFUL MEASURES FRAMEWORK DOMAINS AND MEASURE AREAS

Quality priority	Meaningful measure area
Making Care Safer by Reducing Harm Caused in the Delivery of Care	Healthcare-Associated Infections. Preventable Healthcare Harm.
Strengthen Person and Family Engagement as Partners in Their Care	Care is Personalized and Aligned with Patient's Goals. End of Life Care according to Preferences. Patient's Experience of Care. Patient Reported Functional Outcomes.
Promote Effective Communication and Coordination of Care	Medication Management. Admissions and Readmissions to Hospitals. Transfer of Health Information and Interoperability.
Promote Effective Prevention and Treatment of Chronic Disease	Preventive Care. Management of Chronic Conditions. Prevention, Treatment, and Management of Mental Health. Prevention and Treatment of Opioid and Substance Use Disorders. Risk Adjusted Mortality.
Work with Communities to Promote Best Practices of Healthy Living	Equity of Care. Community Engagement.
Make Care Affordable	Appropriate Use of Healthcare. Patient-focused Episode of Care. Risk Adjusted Total Cost of Care.

By including Meaningful Measures in our programs, we believe that we can also address the following cross-cutting measure criteria:

- Eliminating disparities;
- Tracking measurable outcomes and impact;
- Safeguarding public health;
- Achieving cost savings;
- Improving access for rural communities; and
- Reducing burden.

We believe that the Meaningful Measures Initiative will improve outcomes for patients, their families, and health care providers while reducing burden and costs for clinicians and providers as well as promoting operational efficiencies.

I. Background

A. Historical Overview of the IRF PPS

Section 1886(j) of the Act provides for the implementation of a per-discharge prospective payment system (PPS) for inpatient rehabilitation hospitals and inpatient rehabilitation units of a hospital (collectively, hereinafter referred to as IRFs). Payments under the IRF PPS encompass inpatient operating and capital costs of furnishing covered rehabilitation services (that is, routine, ancillary, and capital costs), but not direct graduate medical education costs, costs of approved nursing and allied health education activities, bad debts, and other services or items outside the scope of the IRF PPS. Although a complete discussion of the IRF PPS provisions appears in the original FY 2002 IRF PPS final rule (66 FR 41316) and the FY 2006 IRF PPS final rule (70 FR 47880), we are providing a general description of the IRF PPS for FYs 2002 through 2018.

Under the IRF PPS from FY 2002 through FY 2005, the prospective payment rates were computed across 100 distinct case-mix groups (CMGs), as described in the FY 2002 IRF PPS final rule (66 FR 41316). We constructed 95 CMGs using rehabilitation impairment categories (RICs), functional status (both motor and cognitive), and age (in some cases, cognitive status and age may not be a factor in defining a CMG). In addition, we constructed five special CMGs to account for very short stays and for patients who expire in the IRF.

For each of the CMGs, we developed relative weighting factors to account for a patient's clinical characteristics and expected resource needs. Thus, the weighting factors accounted for the relative difference in resource use across all CMGs. Within each CMG, we created tiers based on the estimated effects that certain comorbidities would have on resource use.

We established the federal PPS rates using a standardized payment conversion factor (formerly referred to as the budget-neutral conversion factor). For a detailed discussion of the budget-neutral conversion factor, please refer to our FY 2004 IRF PPS final rule (68 FR 45684 through 45685). In the FY 2006 IRF PPS final rule (70 FR 47880), we discussed in detail the methodology for determining the standard payment conversion factor.

We applied the relative weighting factors to the standard payment conversion factor to compute the unadjusted prospective payment rates under the IRF PPS from FYs 2002 through 2005. Within the structure of the payment system, we then made adjustments to account for interrupted stays, transfers, short stays, and deaths. Finally, we applied the applicable adjustments to account for geographic variations in wages (wage index), the percentage of low-income patients, location in a rural area (if applicable), and outlier payments (if applicable) to the IRFs' unadjusted prospective payment rates.

For cost reporting periods that began on or after January 1, 2002, and before October 1, 2002, we determined the final prospective payment amounts using the transition methodology prescribed in section 1886(j)(1) of the Act. Under this provision, IRFs transitioning into the PPS were paid a blend of the federal IRF PPS rate and the payment that the IRFs would have received had the IRF PPS not been implemented. This provision also allowed IRFs to elect to bypass this blended payment and immediately be paid 100 percent of the federal IRF PPS rate. The transition methodology expired as of cost reporting periods beginning on or after October 1, 2002 (FY 2003), and payments for all IRFs

now consist of 100 percent of the federal IRF PPS rate.

We established a CMS website as a primary information resource for the IRF PPS which is available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/index.html.* The website may be accessed to download or view publications, software, data specifications, educational materials, and other information pertinent to the IRF PPS.

Section 1886(j) of the Act confers broad statutory authority upon the Secretary to propose refinements to the IRF PPS. In the FY 2006 IRF PPS final rule (70 FR 47880) and in correcting amendments to the FY 2006 IRF PPS final rule (70 FR 57166) that we published on September 30, 2005, we finalized a number of refinements to the IRF PPS case-mix classification system (the CMGs and the corresponding relative weights) and the case-level and facility-level adjustments. These refinements included the adoption of the Office of Management and Budget's (OMB) Core-Based Statistical Area (CBSA) market definitions, modifications to the CMGs, tier comorbidities, and CMG relative weights, implementation of a new teaching status adjustment for IRFs, revision and rebasing of the market basket index used to update IRF payments, and updates to the rural, low-income percentage (LIP), and high-cost outlier adjustments. Beginning with the FY 2006 IRF PPS final rule (70 FR 47908 through 47917), the market basket index used to update IRF payments was a market basket reflecting the operating and capital cost structures for freestanding IRFs, freestanding inpatient psychiatric facilities (IPFs), and long-term care hospitals (LTCHs) (hereinafter referred to as the rehabilitation, psychiatric, and long-term care (RPL) market basket). Any reference to the FY 2006 IRF PPS final rule in this proposed rule also includes the provisions effective in the correcting amendments. For a detailed discussion of the final key policy changes for FY 2006, please refer to the FY 2006 IRF PPS final rule (70 FR 47880 and 70 FR 57166).

In the FY 2007 IRF PPS final rule (71 FR 48354), we further refined the IRF PPS case-mix classification system (the CMG relative weights) and the case-level adjustments, to ensure that IRF PPS payments would continue to reflect as accurately as possible the costs of care. For a detailed discussion of the FY 2007 policy revisions, please refer to the FY 2007 IRF PPS final rule (71 FR 48354).

In the FY 2008 IRF PPS final rule (72 FR 44284), we updated the prospective payment rates and the outlier threshold, revised the IRF wage index policy, and clarified how we determine high-cost outlier payments for transfer cases. For more information on the policy changes implemented for FY 2008, please refer to the FY 2008 IRF PPS final rule (72 FR 44284), in which we published the final FY 2008 IRF prospective payment rates.

After publication of the FY 2008 IRF PPS final rule (72 FR 44284), section 115 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Pub. L. 110–173, enacted on December 29, 2007) (MMSEA) amended section 1886(j)(3)(C) of the Act to apply a zero percent increase factor for FYs 2008 and 2009, effective for IRF discharges occurring on or after April 1, 2008. Section 1886(j)(3)(C) of the Act required the Secretary to develop an increase factor to update the IRF prospective payment rates for each FY. Based on the legislative change to the increase factor, we revised the FY 2008 prospective payment rates for IRF discharges occurring on or after April 1, 2008. Thus, the final FY 2008 IRF prospective payment rates that were published in the FY 2008 IRF PPS final rule (72 FR 44284) were effective for discharges occurring on or after October 1, 2007, and on or before March 31, 2008, and the revised FY 2008 IRF prospective payment rates were effective for discharges occurring on or after April 1, 2008, and on or before September 30, 2008. The revised FY 2008 prospective payment rates are available on the CMS website at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Data-Files.html.*

In the FY 2009 IRF PPS final rule (73 FR 46370), we updated the CMG relative weights, the average length of stay values, and the outlier threshold; clarified IRF wage index policies regarding the treatment of ''New England deemed'' counties and multi-campus hospitals; and revised the regulation text in response to section 115 of the MMSEA to set the IRF compliance percentage at 60 percent (the ''60 percent rule'') and continue the practice of including comorbidities in the calculation of compliance percentages. We also applied a zero percent market basket increase factor for FY 2009 in accordance with section 115 of the MMSEA. For more information on the policy changes implemented for FY 2009, please refer to the FY 2009 IRF PPS final rule (73 FR 46370), in which we published the final FY 2009 IRF prospective payment rates.

In the FY 2010 IRF PPS final rule (74 FR 39762) and in correcting amendments to the FY 2010 IRF PPS final rule (74 FR 50712) that we published on October 1, 2009, we updated the prospective payment rates, the CMG relative weights, the average length of stay values, the rural, LIP, teaching status adjustment factors, and the outlier threshold; implemented new IRF coverage requirements for determining whether an IRF claim is reasonable and necessary; and revised the regulation text to require IRFs to submit patient assessments on Medicare Advantage (MA) (formerly called Medicare Part C) patients for use in the 60 percent rule calculations. Any reference to the FY 2010 IRF PPS final rule in this proposed rule also includes the provisions effective in the correcting amendments. For more information on the policy changes implemented for FY 2010, please refer to the FY 2010 IRF PPS final rule (74 FR 39762 and 74 FR 50712), in which we published the final FY 2010 IRF prospective payment rates.

After publication of the FY 2010 IRF PPS final rule (74 FR 39762), section 3401(d) of the Patient Protection and Affordable Care Act (Pub. L. 111–148, enacted on March 23, 2010), as amended by section 10319 of the same Act and by section 1105 of the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152, enacted on March 30, 2010) (collectively, hereinafter referred to as ''PPACA''), amended section 1886(j)(3)(C) of the Act and added section 1886(j)(3)(D) of the Act. Section 1886(j)(3)(C) of the Act requires the Secretary to estimate a multifactor productivity (MFP) adjustment to the market basket increase factor, and to apply other adjustments as defined by the Act. The productivity adjustment applies to FYs from 2012 forward. The other adjustments apply to FYs 2010 to 2019.

Sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(i) of the Act defined the adjustments that were to be applied to the market basket increase factors in FYs 2010 and 2011. Under these provisions, the Secretary was required to reduce the market basket increase factor in FY 2010 by a 0.25 percentage point adjustment. Notwithstanding this provision, in accordance with section 3401(p) of the PPACA, the adjusted FY 2010 rate was only to be applied to discharges occurring on or after April 1, 2010. Based on the self-implementing legislative changes to section 1886(j)(3) of the Act, we adjusted the FY 2010 federal prospective payment rates as required, and applied these rates to IRF discharges occurring on or after April 1, 2010, and on or before September 30,

2010. Thus, the final FY 2010 IRF prospective payment rates that were published in the FY 2010 IRF PPS final rule (74 FR 39762) were used for discharges occurring on or after October 1, 2009, and on or before March 31, 2010, and the adjusted FY 2010 IRF prospective payment rates applied to discharges occurring on or after April 1, 2010, and on or before September 30, 2010. The adjusted FY 2010 prospective payment rates are available on the CMS website at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Data-Files.html.*

In addition, sections 1886(j)(3)(C) and (D) of the Act also affected the FY 2010 IRF outlier threshold amount because they required an adjustment to the FY 2010 RPL market basket increase factor, which changed the standard payment conversion factor for FY 2010. Specifically, the original FY 2010 IRF outlier threshold amount was determined based on the original estimated FY 2010 RPL market basket increase factor of 2.5 percent and the standard payment conversion factor of $13,661. However, as adjusted, the IRF prospective payments are based on the adjusted RPL market basket increase factor of 2.25 percent and the revised standard payment conversion factor of $13,627. To maintain estimated outlier payments for FY 2010 equal to the established standard of 3 percent of total estimated IRF PPS payments for FY 2010, we revised the IRF outlier threshold amount for FY 2010 for discharges occurring on or after April 1, 2010, and on or before September 30, 2010. The revised IRF outlier threshold amount for FY 2010 was $10,721.

Sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(i) of the Act also required the Secretary to reduce the market basket increase factor in FY 2011 by a 0.25 percentage point adjustment. The FY 2011 IRF PPS notice (75 FR 42836) and the correcting amendments to the FY 2011 IRF PPS notice (75 FR 70013) described the required adjustments to the FY 2010 and FY 2011 IRF PPS prospective payment rates and outlier threshold amount for IRF discharges occurring on or after April 1, 2010, and on or before September 30, 2011. It also updated the FY 2011 prospective payment rates, the CMG relative weights, and the average length of stay values. Any reference to the FY 2011 IRF PPS notice in this proposed rule also includes the provisions effective in the correcting amendments. For more information on the FY 2010 and FY 2011 adjustments or the updates for FY 2011, please refer to the FY 2011 IRF PPS notice (75 FR 42836 and 75 FR 70013).

In the FY 2012 IRF PPS final rule (76 FR 47836), we updated the IRF prospective payment rates, rebased and revised the RPL market basket, and established a new quality reporting program (QRP) for IRFs in accordance with section 1886(j)(7) of the Act. We also consolidated, clarified, and revised existing policies regarding IRF hospitals and IRF units of hospitals to eliminate unnecessary confusion and enhance consistency. For more information on the policy changes implemented for FY 2012, please refer to the FY 2012 IRF PPS final rule (76 FR 47836), in which we published the final FY 2012 IRF prospective payment rates.

The FY 2013 IRF PPS notice (77 FR 44618) described the required adjustments to the FY 2013 prospective payment rates and outlier threshold amount for IRF discharges occurring on or after October 1, 2012, and on or before September 30, 2013. It also updated the FY 2013 prospective payment rates, the CMG relative weights, and the average length of stay values. For more information on the updates for FY 2013, please refer to the FY 2013 IRF PPS notice (77 FR 44618).

In the FY 2014 IRF PPS final rule (78 FR 47860), we updated the prospective payment rates, the CMG relative weights, and the outlier threshold amount. We also updated the facility-level adjustment factors using an enhanced estimation methodology, revised the list of diagnosis codes that count toward an IRF's 60 percent rule compliance calculation to determine ''presumptive compliance,'' revised sections of the inpatient rehabilitation facility patient assessment instrument (IRF–PAI), revised requirements for acute care hospitals that have IRF units, clarified the IRF regulation text regarding limitation of review, updated references to previously changed sections in the regulations text, and updated requirements for the IRF QRP. For more information on the policy changes implemented for FY 2014, please refer to the FY 2014 IRF PPS final rule (78 FR 47860), in which we published the final FY 2014 IRF prospective payment rates.

In the FY 2015 IRF PPS final rule (79 FR 45872), we updated the prospective payment rates, the CMG relative weights, and the outlier threshold amount. We also revised the list of diagnosis codes that count toward an IRF's 60 percent rule compliance calculation to determine ''presumptive compliance,'' revised sections of the IRF–PAI, and updated requirements for the IRF QRP. For more information on the policy changes implemented for FY 2015, please refer to the FY 2015 IRF PPS final rule (79 FR 45872) and the FY 2015 IRF PPS correction notice (79 FR 59121).

In the FY 2016 IRF PPS final rule (80 FR 47036), we updated the prospective payment rates, the CMG relative weights, and the outlier threshold amount. We also adopted an IRF-specific market basket that reflects the cost structures of only IRF providers, a blended 1-year transition wage index based on the adoption of new OMB area delineations, a 3-year phase-out of the rural adjustment for certain IRFs due to the new OMB area delineations, and updates for the IRF QRP. For more information on the policy changes implemented for FY 2016, please refer to the FY 2016 IRF PPS final rule (80 FR 47036).

In the FY 2017 IRF PPS final rule (81 FR 52056), we updated the prospective payment rates, the CMG relative weights, and the outlier threshold amount. We also updated requirements for the IRF QRP. For more information on the policy changes implemented for FY 2017, please refer to the FY 2017 IRF PPS final rule (81 FR 52056) and the FY 2017 IRF PPS correction notice (81 FR 59901).

In the FY 2018 IRF PPS final rule (82 FR 36238), we updated the prospective payment rates, the CMG relative weights, and the outlier threshold amount. We also revised the International Classification of Diseases, 10th Revision, Clinical Modification (ICD–10–CM) diagnosis codes that are used to determine presumptive compliance under the ''60 percent rule,'' removed the 25 percent payment penalty for IRF–PAI late transmissions, removed the voluntary swallowing status item (Item 27) from the IRF–PAI, summarized comments regarding the criteria used to classify facilities for payment under the IRF PPS, provided for a subregulatory process for certain annual updates to the presumptive methodology diagnosis code lists, adopted the use of height/weight items on the IRF–PAI to determine patient body mass index (BMI) greater than 50 for cases of single-joint replacement under the presumptive methodology, and updated requirements for the IRF QRP. For more information on the policy changes implemented for FY 2018, please refer to the FY 2018 IRF PPS final rule (82 FR 36238).

B. Provisions of the PPACA Affecting the IRF PPS in FY 2012 and Beyond

The PPACA included several provisions that affect the IRF PPS in FYs 2012 and beyond. In addition to what

was previously discussed, section 3401(d) of the PPACA also added section 1886(j)(3)(C)(ii)(I) of the Act (providing for a ''productivity adjustment'' for fiscal year 2012 and each subsequent fiscal year). The productivity adjustment for FY 2019 is discussed in section V.B. of this proposed rule. Section 3401(d) of the PPACA requires an additional 0.75 percentage point adjustment to the IRF increase factor for each of FYs 2017, 2018, and 2019. The applicable adjustment for FY 2019 is discussed in section V.B. of this proposed rule. Section 1886(j)(3)(C)(ii)(II) of the Act provides that the application of these adjustments to the market basket update may result in an update that is less than 0.0 for a fiscal year and in payment rates for a fiscal year being less than such payment rates for the preceding fiscal year.

Sections 3004(b) of the PPACA and section 411(b) of the Medicare Access and CHIP Reauthorization Act of 2015 (Pub. L. 114–10, enacted on April 16, 2015) (MACRA) also addressed the IRF PPS. Section 3004(b) of PPACA reassigned the previously designated section 1886(j)(7) of the Act to section 1886(j)(8) and inserted a new section 1886(j)(7), which contains requirements for the Secretary to establish a QRP for IRFs. Under that program, data must be submitted in a form and manner and at a time specified by the Secretary. Section 411(b) of MACRA amended section 1886(j)(3)(C) of the Act by adding clause (iii), which required us to apply for FY 2018, after the application of section 1886(j)(3)(C)(ii) of the Act, an increase factor of 1.0 percent to update the IRF prospective payment rates. Beginning in FY 2014, section 1886(j)(7)(A)(i) of the Act requires the application of a 2 percentage point reduction to the market basket increase factor otherwise applicable to an IRF (after application of subparagraphs (C)(iii) and (D) of section 1886(j)(3) of the Act) for a fiscal year if the IRF does not comply with the requirements of the IRF QRP for that fiscal year. Application of the 2 percentage point reduction may result in an update that is less than 0.0 for a fiscal year and in payment rates for a fiscal year being less than such payment rates for the preceding fiscal year. Reporting-based reductions to the market basket increase factor are not cumulative; they only apply for the FY involved.

C. Operational Overview of the Current IRF PPS

As described in the FY 2002 IRF PPS final rule (66 FR 41316), upon the admission and discharge of a Medicare Part A Fee-for-Service (FFS) patient, the IRF is required to complete the appropriate sections of a patient assessment instrument (PAI), designated as the IRF–PAI. In addition, beginning with IRF discharges occurring on or after October 1, 2009, the IRF is also required to complete the appropriate sections of the IRF–PAI upon the admission and discharge of each Medicare Advantage (MA) patient, as described in the FY 2010 IRF PPS final rule (74 FR 39762 and 74 FR 50712). All required data must be electronically encoded into the IRF–PAI software product. Generally, the software product includes patient classification programming called the Grouper software. The Grouper software uses specific IRF–PAI data elements to classify (or group) patients into distinct CMGs and account for the existence of any relevant comorbidities.

The Grouper software produces a five-character CMG number. The first character is an alphabetic character that indicates the comorbidity tier. The last four characters are numeric characters that represent the distinct CMG number. Free downloads of the Inpatient Rehabilitation Validation and Entry (IRVEN) software product, including the Grouper software, are available on the CMS website at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Software.html.*

Once a Medicare Part A FFS patient is discharged, the IRF submits a Medicare claim as a Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191, enacted on August 21, 1996) (HIPAA) compliant electronic claim or, if the Administrative Simplification Compliance Act of 2002 (Pub. L. 107–105, enacted on December 27, 2002) (ASCA) permits, a paper claim (a UB–04 or a CMS–1450 as appropriate) using the five-character CMG number and sends it to the appropriate Medicare Administrative Contractor (MAC). In addition, once a MA patient is discharged, in accordance with the Medicare Claims Processing Manual, chapter 3, section 20.3 (Pub. L. 100–04), hospitals (including IRFs) must submit an informational-only bill (Type of Bill (TOB) 111), which includes Condition Code 04 to their MAC. This will ensure that the MA days are included in the hospital's Supplemental Security Income (SSI) ratio (used in calculating the IRF LIP adjustment) for fiscal year 2007 and beyond. Claims submitted to Medicare must comply with both ASCA and HIPAA.

Section 3 of the ASCA amended section 1862(a) of the Act by adding paragraph (22), which requires the Medicare program, subject to section 1862(h) of the Act, to deny payment under Part A or Part B for any expenses for items or services for which a claim is submitted other than in an electronic form specified by the Secretary. Section 1862(h) of the Act, in turn, provides that the Secretary shall waive such denial in situations in which there is no method available for the submission of claims in an electronic form or the entity submitting the claim is a small provider. In addition, the Secretary also has the authority to waive such denial in such unusual cases as the Secretary finds appropriate. For more information, see the ''Medicare Program; Electronic Submission of Medicare Claims'' final rule (70 FR 71008). Our instructions for the limited number of Medicare claims submitted on paper are available at *http://www.cms.gov/manuals/downloads/clm104c25.pdf.*

Section 3 of the ASCA operates in the context of the administrative simplification provisions of HIPAA, which include, among others, the requirements for transaction standards and code sets codified in 45 CFR, parts 160 and 162, subparts A and I through R (generally known as the Transactions Rule). The Transactions Rule requires covered entities, including covered health care providers, to conduct covered electronic transactions according to the applicable transaction standards. (See the CMS program claim memoranda at *http://www.cms.gov/ElectronicBillingEDITrans/* and listed in the addenda to the Medicare Intermediary Manual, Part 3, section 3600).

The MAC processes the claim through its software system. This software system includes pricing programming called the ''Pricer'' software. The Pricer software uses the CMG number, along with other specific claim data elements and provider-specific data, to adjust the IRF's prospective payment for interrupted stays, transfers, short stays, and deaths, and then applies the applicable adjustments to account for the IRF's wage index, percentage of low-income patients, rural location, and outlier payments. For discharges occurring on or after October 1, 2005, the IRF PPS payment also reflects the teaching status adjustment that became effective as of FY 2006, as discussed in the FY 2006 IRF PPS final rule (70 FR 47880).

D. Advancing Health Information Exchange

The Department of Health and Human Services (HHS) has a number of initiatives designed to encourage and

support the adoption of interoperable health information technology and to promote nationwide health information exchange to improve health care. The Office of the National Coordinator for Health Information Technology (ONC) and CMS work collaboratively to advance interoperability across settings of care, including post-acute care.

The Improving Medicare Post-Acute Care Transformation Act of 2014 (Pub. L. 113–185) (IMPACT Act) requires assessment data to be standardized and interoperable to allow for exchange of the data among post-acute providers and other providers. To further interoperability in post-acute care, CMS is developing a Data Element Library to serve as a publically available centralized, authoritative resource for standardized data elements and their associated mappings to health IT standards. These interoperable data elements can reduce provider burden by supporting the use and reuse of healthcare data, support provider exchange of electronic health information for care coordination, person-centered care, and support real-time, data driven, clinical decision making. Once available, standards in the Data Element Library can be referenced on the CMS website and in the ONC Interoperability Standards Advisory (ISA). The 2018 Interoperability Standards Advisory (ISA) is available at: *https://www.healthit.gov/isa/*.

Most recently, the 21st Century Cures Act (Pub. L. 114–255), enacted in 2016, requires HHS to take new steps to enable the electronic sharing of health information ensuring interoperability for providers and settings across the care continuum. Specifically, Congress directed ONC to ''develop or support a trusted exchange framework, including a common agreement among health information networks nationally.'' This framework (*https://beta.healthit.gov/topic/interoperability/trusted-exchange-framework-and-common-agreement*) outlines a common set of principles for trusted exchange and minimum terms and conditions for trusted exchange in order to enable interoperability across disparate health information networks. In another important provision, Congress defined ''information blocking'' as practices likely to interfere with, prevent, or materially discourage access, exchange, or use of electronic health information, and established new authority for HHS to discourage these practices. We invite providers to learn more about these important developments and how they are likely to affect IRFs.

II. Summary of Provisions of the Proposed Rule

In this rule, we propose to update the IRF prospective payment rates for FY 2019 and to alleviate administrative burden for IRFs by removing the FIM™ instrument and associated Function Modifiers from the IRF–PAI in accordance with section 1886(j)(2)(D) of the Act and revising certain IRF coverage requirements to reduce the amount of required paperwork in the IRF setting. In addition, we are soliciting comments on removing the face-to-face requirement for rehabilitation physician visits and expanding the use of non-physician practitioners (that is, nurse practitioners and physician assistants) in meeting the IRF coverage requirements. For the IRF QRP, we are proposing to add a new quality measure removal factor, remove two quality measures from the measure set, and codify in our regulations a number of requirements.

The proposed updates to the IRF prospective payment rates for FY 2019 are as follows:

- Update the IRF PPS relative weights and average length of stay values for FY 2019 using the most current and complete Medicare claims and cost report data in a budget-neutral manner, as discussed in section III. of this proposed rule.
- Describe the continued use of FY 2014 facility-level adjustment factors, as discussed in section IV. of this proposed rule.
- Update the IRF PPS payment rates for FY 2019 by the proposed market basket increase factor, based upon the most current data available, with a 0.75 percentage point reduction as required by sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(v) of the Act and a proposed productivity adjustment required by section 1886(j)(3)(C)(ii)(I) of the Act, as described in section V. of this proposed rule.
- Update the FY 2019 IRF PPS payment rates by the FY 2019 wage index and the labor-related share in a budget-neutral manner, as discussed in section V. of this proposed rule.
- Describe the calculation of the IRF standard payment conversion factor for FY 2019, as discussed in section V. of this proposed rule.
- Update the outlier threshold amount for FY 2019, as discussed in section VI. of this proposed rule.
- Update the cost-to-charge ratio (CCR) ceiling and urban/rural average CCRs for FY 2019, as discussed in section VI. of this proposed rule.
- Remove the FIM™ instrument and associated Function Modifiers from the IRF–PAI beginning with FY 2020 to reduce administrative burden for IRFs, as discussed in section VII. of this proposed rule.
- Revise certain IRF coverage requirements to reduce administrative burden for IRFs beginning with FY 2019, as discussed in section VIII. of this proposed rule.
- Solicit comments on removing the face-to-face requirement for rehabilitation physician visits, as discussed in section VIII. of this proposed rule.
- Solicit comments on expanding the use of non-physician practitioners (that is, nurse practitioners and physician assistants) in meeting the IRF coverage requirements, as discussed in section VIII. of this proposed rule.
- Update the requirements for the IRF QRP, as discussed in section IX. of this proposed rule.

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

As specified in § 412.620(b)(1), we calculate a relative weight for each CMG that is proportional to the resources needed by an average inpatient rehabilitation case in that CMG. For example, cases in a CMG with a relative weight of 2, on average, will cost twice as much as cases in a CMG with a relative weight of 1. Relative weights account for the variance in cost per discharge due to the variance in resource utilization among the payment groups, and their use helps to ensure that IRF PPS payments support beneficiary access to care, as well as provider efficiency.

In this proposed rule, we propose to update the CMG relative weights and average length of stay values for FY 2019. As required by statute, we always use the most recent available data to update the CMG relative weights and average lengths of stay. For FY 2019, we propose to use the FY 2017 IRF claims and FY 2016 IRF cost report data. These data are the most current and complete data available at this time. Currently, only a small portion of the FY 2017 IRF cost report data are available for analysis, but the majority of the FY 2017 IRF claims data are available for analysis.

In this rule, we propose to apply these data using the same methodologies that we have used to update the CMG relative weights and average length of stay values each fiscal year since we implemented an update to the methodology to use the more detailed CCR data from the cost reports of IRF subprovider units of primary acute care

hospitals, instead of CCR data from the associated primary care hospitals, to calculate IRFs' average costs per case, as discussed in the FY 2009 IRF PPS final rule (73 FR 46372). In calculating the CMG relative weights, we use a hospital-specific relative value method to estimate operating (routine and ancillary services) and capital costs of IRFs. The process used to calculate the CMG relative weights for this proposed rule is as follows:

Step 1. We estimate the effects that comorbidities have on costs.

Step 2. We adjust the cost of each Medicare discharge (case) to reflect the effects found in the first step.

Step 3. We use the adjusted costs from the second step to calculate CMG relative weights, using the hospital-specific relative value method.

Step 4. We normalize the FY 2019 CMG relative weights to the same average CMG relative weight from the CMG relative weights implemented in the FY 2018 IRF PPS final rule (82 FR 36238).

Consistent with the methodology that we have used to update the IRF classification system in each instance in the past, we propose to update the CMG relative weights for FY 2019 in such a way that total estimated aggregate payments to IRFs for FY 2019 are the same with or without the changes (that is, in a budget-neutral manner) by applying a budget neutrality factor to the standard payment amount. To calculate the appropriate budget neutrality factor for use in updating the FY 2019 CMG relative weights, we use the following steps:

Step 1. Calculate the estimated total amount of IRF PPS payments for FY 2019 (with no changes to the CMG relative weights).

Step 2. Calculate the estimated total amount of IRF PPS payments for FY 2019 by applying the changes to the CMG relative weights (as discussed in this proposed rule).

Step 3. Divide the amount calculated in step 1 by the amount calculated in step 2 to determine the budget neutrality factor (0.9980) that would maintain the same total estimated aggregate payments in FY 2019 with and without the changes to the CMG relative weights.

Step 4. Apply the budget neutrality factor (0.9980) to the FY 2018 IRF PPS standard payment amount after the application of the budget-neutral wage adjustment factor.

In section V.E. of this proposed rule, we discuss the proposed use of the existing methodology to calculate the standard payment conversion factor for FY 2019.

In Table 2, ''Proposed Relative Weights and Average Length of Stay Values for Case-Mix Groups,'' we present the proposed CMGs, the comorbidity tiers, the corresponding relative weights, and the average length of stay values for each CMG and tier for FY 2019. 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.

TABLE 2—PROPOSED RELATIVE WEIGHTS AND AVERAGE LENGTH OF STAY VALUES FOR CASE-MIX GROUPS

CMG	CMG Description (M=motor, C=cognitive, A=age)	Relative weight				Average length of stay			
		Tier 1	Tier 2	Tier 3	No comorbidities tier	Tier 1	Tier 2	Tier 3	No comorbidities tier
0101	Stroke M>51.05	0.8486	0.7367	0.6761	0.6461	8	11	8	8
0102	Stroke M>44.45 and M<51.05 and C>18.5	1.0722	0.9308	0.8542	0.8164	11	12	10	10
0103	Stroke M>44.45 and M<51.05 and C<18.5	1.2409	1.0772	0.9886	0.9448	12	13	11	12
0104	Stroke M>38.85 and M<44.45	1.2952	1.1244	1.0319	0.9862	12	13	12	12
0105	Stroke M>34.25 and M<38.85	1.4885	1.2922	1.1859	1.1333	14	14	14	13
0106	Stroke M>30.05 and M<34.25	1.6651	1.4455	1.3266	1.2678	16	16	15	15
0107	Stroke M>26.15 and M<30.05	1.8665	1.6203	1.4871	1.4211	18	18	16	16
0108	Stroke M<26.15 and A>84.5	2.3075	2.0031	1.8384	1.7569	22	21	20	20
0109	Stroke M>22.35 and M<26.15 and A<84.5	2.0873	1.8120	1.6630	1.5893	19	19	18	18
0110	Stroke M<22.35 and A<84.5	2.7646	2.4000	2.2027	2.1049	26	26	23	23
0201	Traumatic brain injury M>53.35 and C>23.5	0.8228	0.6676	0.5960	0.5565	9	9	8	7
0202	Traumatic brain injury M>44.25 and M<53.35 and C>23.5.	1.1423	0.9270	0.8274	0.7726	10	11	10	10
0203	Traumatic brain injury M>44.25 and C<23.5	1.2601	1.0225	0.9128	0.8523	13	13	11	10
0204	Traumatic brain injury M>40.65 and M<44.25	1.3722	1.1135	0.9940	0.9281	13	13	11	11
0205	Traumatic brain injury M>28.75 and M<40.65	1.6209	1.3153	1.1741	1.0963	14	15	13	13
0206	Traumatic brain injury M>22.05 and M<28.75	1.9535	1.5852	1.4150	1.3212	18	18	15	15
0207	Traumatic brain injury M<22.05	2.4678	2.0025	1.7875	1.6691	31	22	19	18
0301	Non-traumatic brain injury M>41.05	1.1740	0.9497	0.8712	0.8146	11	11	10	10
0302	Non-traumatic brain injury M>35.05 and M<41.05.	1.4336	1.1597	1.0639	0.9948	12	13	12	12
0303	Non-traumatic brain injury M>26.15 and M<35.05.	1.6587	1.3419	1.2309	1.1510	15	14	13	13
0304	Non-traumatic brain injury M<26.15	2.1196	1.7147	1.5729	1.4708	20	19	16	16
0401	Traumatic spinal cord injury M>48.45	1.0031	0.8112	0.7498	0.6853	10	10	9	9
0402	Traumatic spinal cord injury M>30.35 and M<48.45.	1.4909	1.2056	1.1144	1.0186	14	13	13	12
0403	Traumatic spinal cord injury M>16.05 and M<30.35.	2.3615	1.9096	1.7650	1.6133	25	22	19	18
0404	Traumatic spinal cord injury M<16.05 and A>63.5.	4.0165	3.2479	3.0021	2.7440	45	36	31	30
0405	Traumatic spinal cord injury M<16.05 and A<63.5.	3.5422	2.8643	2.6476	2.4199	26	33	27	26
0501	Non-traumatic spinal cord injury M>51.35	0.9175	0.7147	0.6615	0.6076	9	10	8	8
0502	Non-traumatic spinal cord injury M>40.15 and M<51.35.	1.2206	0.9508	0.8800	0.8083	11	11	10	10
0503	Non-traumatic spinal cord injury M>31.25 and M<40.15.	1.5123	1.1781	1.0903	1.0015	14	13	12	12
0504	Non-traumatic spinal cord injury M>29.25 and M<31.25.	1.7404	1.3557	1.2548	1.1526	16	14	14	13
0505	Non-traumatic spinal cord injury M>23.75 and M<29.25.	1.9922	1.5519	1.4363	1.3194	18	17	16	15
0506	Non-traumatic spinal cord injury M<23.75	2.6966	2.1006	1.9441	1.7858	26	23	21	20

TABLE 2—PROPOSED RELATIVE WEIGHTS AND AVERAGE LENGTH OF STAY VALUES FOR CASE-MIX GROUPS—Continued

CMG	CMG Description (M=motor, C=cognitive, A=age)	Relative weight				Average length of stay			
		Tier 1	Tier 2	Tier 3	No comorbidities tier	Tier 1	Tier 2	Tier 3	No comorbidities tier
0601	Neurological M>47.75	1.0727	0.8220	0.7615	0.6941	9	9	9	8
0602	Neurological M>37.35 and M<47.75	1.3940	1.0681	0.9896	0.9019	12	12	11	10
0603	Neurological M>25.85 and M<37.35	1.7135	1.3130	1.2164	1.1087	14	14	13	13
0604	Neurological M<25.85	2.2159	1.6979	1.5730	1.4337	19	17	16	16
0701	Fracture of lower extremity M>42.15	1.0293	0.8388	0.7954	0.7177	10	10	9	9
0702	Fracture of lower extremity M>34.15 and M<42.15.	1.3091	1.0668	1.0115	0.9128	12	12	12	11
0703	Fracture of lower extremity M>28.15 and M<34.15.	1.5608	1.2720	1.2061	1.0883	15	14	14	13
0704	Fracture of lower extremity M<28.15	1.9933	1.6244	1.5402	1.3899	18	18	17	16
0801	Replacement of lower extremity joint M>49.55	0.8362	0.6820	0.6159	0.5727	8	8	8	7
0802	Replacement of lower extremity joint M>37.05 and M<49.55.	1.0782	0.8793	0.7941	0.7384	11	9	9	9
0803	Replacement of lower extremity joint M>28.65 and M<37.05 and A>83.5.	1.4172	1.1557	1.0438	0.9706	13	13	12	11
0804	Replacement of lower extremity joint M>28.65 and M<37.05 and A<83.5.	1.2741	1.0390	0.9384	0.8726	12	12	11	10
0805	Replacement of lower extremity joint M>22.05 and M<28.65.	1.5185	1.2383	1.1184	1.0399	14	14	12	12
0806	Replacement of lower extremity joint M<22.05	1.8736	1.5279	1.3800	1.2832	17	17	15	14
0901	Other orthopedic M>44.75	1.0336	0.8091	0.7490	0.6903	11	10	9	8
0902	Other orthopedic M>34.35 and M<44.75	1.3077	1.0236	0.9476	0.8734	12	12	11	10
0903	Other orthopedic M>24.15 and M<34.35	1.6323	1.2777	1.1828	1.0902	14	14	13	12
0904	Other orthopedic M<24.15	2.0449	1.6006	1.4818	1.3657	17	17	16	15
1001	Amputation, lower extremity M>47.65	1.0914	0.9202	0.8209	0.7566	11	10	10	9
1002	Amputation, lower extremity M>36.25 and M<47.65.	1.3986	1.1792	1.0520	0.9696	13	13	12	12
1003	Amputation, lower extremity M<36.25	2.0249	1.7073	1.5231	1.4038	18	18	16	15
1101	Amputation, non-lower extremity M>36.35	1.3802	0.9958	0.9958	0.8947	12	11	11	11
1102	Amputation, non-lower extremity M<36.35	1.9397	1.3995	1.3995	1.2574	17	14	15	13
1201	Osteoarthritis M>37.65	1.1131	0.9558	0.8693	0.7900	11	10	10	9
1202	Osteoarthritis M>30.75 and M<37.65	1.4086	1.2096	1.1001	0.9998	13	13	12	12
1203	Osteoarthritis M<30.75	1.7059	1.4648	1.3323	1.2108	15	16	15	14
1301	Rheumatoid, other arthritis M>36.35	1.0974	0.9616	0.8870	0.8378	10	10	10	10
1302	Rheumatoid, other arthritis M>26.15 and M<36.35.	1.4376	1.2598	1.1620	1.0976	12	13	13	13
1303	Rheumatoid, other arthritis M<26.15	1.7313	1.5171	1.3994	1.3218	14	17	15	15
1401	Cardiac M>48.85	0.9240	0.7515	0.6781	0.6099	9	8	8	7
1402	Cardiac M>38.55 and M<48.85	1.2392	1.0078	0.9093	0.8180	11	11	10	10
1403	Cardiac M>31.15 and M<38.55	1.4776	1.2017	1.0843	0.9753	13	13	12	11
1404	Cardiac M<31.15	1.8592	1.5120	1.3643	1.2272	17	16	14	13
1501	Pulmonary M>49.25	1.0096	0.8767	0.7953	0.7609	9	10	9	8
1502	Pulmonary M>39.05 and M<49.25	1.2873	1.1178	1.0140	0.9702	11	11	10	11
1503	Pulmonary M>29.15 and M<39.05	1.5272	1.3262	1.2030	1.1511	14	13	12	12
1504	Pulmonary M<29.15	1.9278	1.6740	1.5186	1.4530	19	16	15	14
1601	Pain syndrome M>37.15	1.2093	0.9269	0.8786	0.7937	9	11	10	10
1602	Pain syndrome M>26.75 and M<37.15	1.5344	1.1760	1.1148	1.0070	11	12	12	12
1603	Pain syndrome M<26.75	1.8652	1.4295	1.3551	1.2241	12	16	15	14
1701	Major multiple trauma without brain or spinal cord injury M>39.25.	1.2867	0.9776	0.9126	0.8224	14	11	11	10
1702	Major multiple trauma without brain or spinal cord injury M>31.05 and M<39.25.	1.5500	1.1777	1.0993	0.9907	13	14	12	12
1703	Major multiple trauma without brain or spinal cord injury M>25.55 and M<31.05.	1.8117	1.3765	1.2849	1.1580	15	15	14	13
1704	Major multiple trauma without brain or spinal cord injury M<25.55.	2.3035	1.7502	1.6337	1.4724	20	19	17	16
1801	Major multiple trauma with brain or spinal cord injury M>40.85.	1.1210	1.0101	0.8484	0.7937	12	11	10	10
1802	Major multiple trauma with brain or spinal cord injury M>23.05 and M<40.85.	1.6611	1.4967	1.2572	1.1761	16	17	14	13
1803	Major multiple trauma with brain or spinal cord injury M<23.05.	2.5942	2.3375	1.9634	1.8368	30	25	20	20
1901	Guillian Barre M>35.95	1.4128	1.0101	0.9494	0.9109	15	13	11	11
1902	Guillian Barre M>18.05 and M<35.95	2.4873	1.7782	1.6714	1.6037	24	21	18	18
1903	Guillian Barre M<18.05	4.2909	3.0677	2.8833	2.7665	46	31	30	30
2001	Miscellaneous M>49.15	0.9692	0.7714	0.7164	0.6501	9	9	8	8
2002	Miscellaneous M>38.75 and M<49.15	1.2596	1.0025	0.9311	0.8449	11	11	10	10
2003	Miscellaneous M>27.85 and M<38.75	1.5478	1.2319	1.1442	1.0382	14	14	12	12
2004	Miscellaneous M<27.85	1.9731	1.5704	1.4585	1.3235	18	17	15	15
2101	Burns M>0	1.9150	1.5473	1.5040	1.3189	22	16	16	14
5001	Short-stay cases, length of stay is 3 days or fewer.	.....	.....	.....	0.1601	.....	.....	.....	2
5101	Expired, orthopedic, length of stay is 13 days or fewer.	.....	.....	.....	0.7561	.....	.....	.....	8
5102	Expired, orthopedic, length of stay is 14 days or more.	.....	.....	.....	1.6523	.....	.....	.....	18
5103	Expired, not orthopedic, length of stay is 15 days or fewer.	.....	.....	.....	0.8114	.....	.....	.....	8

TABLE 2—PROPOSED RELATIVE WEIGHTS AND AVERAGE LENGTH OF STAY VALUES FOR CASE-MIX GROUPS—Continued

CMG	CMG Description (M=motor, C=cognitive, A=age)	Relative weight				Average length of stay			
		Tier 1	Tier 2	Tier 3	No comorbidities tier	Tier 1	Tier 2	Tier 3	No comorbidities tier
5104	Expired, not orthopedic, length of stay is 16 days or more.	.....	.....	.....	2.1193	.....	.....	.....	21

Generally, updates to the CMG relative weights result in some increases and some decreases to the CMG relative weight values. Table 3 shows how we estimate that the application of the proposed revisions for FY 2019 would affect particular CMG relative weight values, which would affect the overall distribution of payments within CMGs and tiers. Note that, because we propose to implement the CMG relative weight revisions in a budget-neutral manner (as previously described), total estimated aggregate payments to IRFs for FY 2019 would not be affected as a result of the proposed CMG relative weight revisions. However, the proposed revisions would affect the distribution of payments within CMGs and tiers.

TABLE 3—DISTRIBUTIONAL EFFECTS OF THE PROPOSED CHANGES TO THE CMG RELATIVE WEIGHTS

[FY 2018 values compared with FY 2019 values]

Percentage change in CMG relative weights	Number of cases affected	Percentage 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

As Table 3 shows, 99.3 percent of all IRF cases are in CMGs and tiers that would experience less than a 5 percent change (either increase or decrease) in the CMG relative weight value as a result of the revisions for FY 2019. The largest estimated increase in the proposed CMG relative weight values that affects the largest number of IRF discharges would be a 3.4 percent change in the CMG relative weight value for CMG 0806 Replacement of lower extremity joint, with a motor score less than 22.05—with no tier adjustment. In the FY 2017 claims data, 1,580 IRF discharges (0.4 percent of all IRF discharges) were classified into this CMG and tier.

The largest estimated decrease in a CMG relative weight value affecting the largest number of IRF cases would be a 2.1 percent decrease in the CMG relative weight for CMG 0304—Non-traumatic brain injury, with a motor score less than 26.5—with no tier adjustment. In the FY 2017 IRF claims data, this change would have affected 3,354 cases (0.8 percent of all IRF cases).

The proposed changes in the average length of stay values for FY 2019, compared with the FY 2018 average length of stay values, are small and do not show any particular trends in IRF length of stay patterns.

We invite public comment on our proposed updates to the CMG relative weights and average length of stay values for FY 2019.

IV. Facility-Level Adjustment Factors

Section 1886(j)(3)(A)(v) of the Act confers broad authority upon the Secretary to adjust the per unit payment rate by such factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities. Under this authority, we currently adjust the prospective payment amount associated with a CMG to account for facility-level characteristics such as an IRF's LIP, teaching status, and location in a rural area, if applicable, as described in § 412.624(e).

Based on the substantive changes to the facility-level adjustment factors that were adopted in the FY IRF PPS 2014 final rule (78 FR 47860, 47868 through 47872), in the FY 2015 IRF PPS final rule (79 FR 45872, 45882 through 45883), we froze the facility-level adjustment factors at the FY 2014 levels for FY 2015 and all subsequent years (unless and until we propose to update them again through future notice-and-comment rulemaking). For FY 2019, we will continue to hold the adjustment factors at the FY 2014 levels as we continue to monitor the most current IRF claims data available and continue to evaluate and monitor the effects of the FY 2014 changes.

V. Proposed FY 2019 IRF PPS Payment Update

A. Background

Section 1886(j)(3)(C) of the Act requires the Secretary to establish an increase factor that reflects changes over time in the prices of an appropriate mix of goods and services included in the IRF PPS payment, which is referred to as a market basket index. According to section 1886(j)(3)(A)(i) of the Act, the increase factor shall be used to update the IRF prospective payment rates for each FY. Section 1886(j)(3)(C)(ii)(I) of the Act requires the application of a productivity adjustment. In addition, sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(v) of the Act require the application of a 0.75 percentage point reduction to the market basket increase factor for FY 2019. Thus, we propose to update the IRF PPS payments for FY 2019 by a market basket increase factor as required by section 1886(j)(3)(C) of the Act, with a productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act, and a 0.75 percentage point reduction as required by sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(v) of the Act.

Beginning with the FY 2016 IRF PPS, we created and adopted a stand-alone IRF market basket, which was referred to as the 2012-based IRF market basket, reflecting the operating and capital cost structures for freestanding IRFs and hospital-based IRFs. The FY 2016 IRF

PPS final rule (80 FR 47046 through 47068) contains a complete discussion of the development of the 2012-based IRF market basket.

B. Proposed FY 2019 Market Basket Update and Productivity Adjustment

For FY 2018, we applied an increase factor of 1.0 percent to update the IRF prospective payment rates in accordance with section 1886(j)(3)(C)(iii) of the Act, as added by section 411(b) of MACRA. However, as discussed previously, for FY 2019, we propose to update the IRF PPS payments by a market basket increase factor as required by section 1886(j)(3)(C) of the Act, with a productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act, and a 0.75 percentage point reduction as required by sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(v) of the Act. For FY 2019, we propose to use the same methodology described in the FY 2017 IRF PPS final rule (81 FR 52071) to compute the FY 2019 market basket increase factor to update the IRF PPS base payment rate.

Consistent with historical practice, we are proposing to estimate the market basket update for the IRF PPS based on the most up-to-date forecast of price indexes used in the market basket as forecasted by IHS Global Inc. (''IGI''). IGI is a nationally recognized economic and financial forecasting firm with which we contract to forecast the components of the market baskets and MFP. Based on IGI's first quarter 2018 forecast with historical data through the fourth quarter of 2017, the 2012-based IRF market basket increase factor for FY 2019 is projected to be 2.9 percent. Therefore, consistent with our historical practice of estimating market basket increases based on the best available data, we are proposing that the 2012-based IRF market basket increase factor for FY 2019 would be 2.9 percent. We are also proposing that if more recent data are subsequently available (for example, a more recent estimate of the market basket update), we would use such data to determine the FY 2019 market basket update in the final rule.

According to section 1886(j)(3)(C)(i) of the Act, the Secretary shall establish an increase factor based on an appropriate percentage increase in a market basket of goods and services. Section 1886(j)(3)(C)(ii) of the Act then requires that, after establishing the increase factor for a FY, the Secretary shall reduce such increase factor for FY 2012 and each subsequent FY, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act. Section 1886(b)(3)(B)(xi)(II) of the Act sets forth the definition of this productivity adjustment. The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multifactor productivity (MFP) (as projected by the Secretary for the 10- year period ending with the applicable FY, year, cost reporting period, or other annual period) (the ''MFP adjustment''). The BLS publishes the official measure of private nonfarm business MFP. Please see *http://www.bls.gov/mfp* for the BLS historical published MFP data. A complete description of the MFP projection methodology is available on the CMS website at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketResearch.html.*

Using IGI's first quarter 2018 forecast, the MFP adjustment for FY 2019 (the 10-year moving average of MFP for the period ending FY 2019) is projected to be 0.8 percent. Thus, in accordance with section 1886(j)(3)(C) of the Act, we are proposing to base the FY 2019 market basket update, which is used to determine the applicable percentage increase for the IRF payments, on the most recent estimate of the 2012-based IRF market basket. We are proposing to then reduce this percentage increase by the most recent estimate of the MFP adjustment for FY 2019 of 0.8 percentage point. Following application of the MFP adjustment, we are proposing to further reduce the applicable percentage increase by 0.75 percentage point, as required by sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(v) of the Act. Therefore, the proposed FY 2019 IRF update is 1.35 percent (2.9 percent market basket update, less 0.8 percentage point MFP adjustment, less 0.75 percentage point statutorily required adjustment). Furthermore, we propose that if more recent data are subsequently available (for example, a more recent estimate of the MFP adjustment), we will use such data to determine the FY 2019 MFP adjustment in the final rule.

For FY 2019, the Medicare Payment Advisory Commission (MedPAC) recommends that we reduce IRF PPS payment rates by 5 percent. As discussed, and in accordance with sections 1886(j)(3)(C) and 1886(j)(3)(D) of the Act, the Secretary is proposing to update the IRF PPS payment rates for FY 2019 by an adjusted market basket increase factor of 1.35 percent, as section 1886(j)(3)(C) of the Act does not provide the Secretary with the authority to apply a different update factor to IRF PPS payment rates for FY 2019.

We invite public comment on the proposed market basket update and productivity adjustment.

C. Proposed Labor-Related Share for FY 2019

Section 1886(j)(6) of the Act specifies that the Secretary is to adjust the proportion (as estimated by the Secretary from time to time) of rehabilitation facilities' costs which are attributable to wages and wage-related costs of the prospective payment rates computed under section 1886(j)(3) of the Act for area differences in wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the rehabilitation facility compared to the national average wage level for such facilities. The labor-related share is determined by identifying the national average proportion of total costs that are related to, influenced by, or vary with the local labor market. We continue to classify a cost category as labor-related if the costs are labor-intensive and vary with the local labor market.

Based on our definition of the labor-related share and the cost categories in the 2012-based IRF market basket, we propose to calculate the labor-related share for FY 2019 as the sum of the FY 2019 relative importance of Wages and Salaries, Employee Benefits, Professional Fees: Labor- Related, Administrative and Facilities Support Services, Installation, Maintenance, and Repair Services, All Other: Labor-related Services, and a portion of the Capital-Related cost weight from the 2012-based IRF market basket. For more details regarding the methodology for determining specific cost categories for inclusion in the 2012-based IRF labor-related share, see the FY 2016 IRF final rule (80 FR 47066 through 47068).

Using this method and IGI's first quarter 2018 forecast for the 2012-based IRF market basket, the proposed IRF labor-related share for FY 2019 is 70.6 percent. We propose that if more recent data are subsequently available (for example, a more recent estimate of the labor-related share), we will use such data to determine the FY 2019 IRF labor-related share in the final rule.

Incorporating the most recent estimate of the 2012-based IRF market basket based on IGI's first quarter 2018 forecast with historical data through the fourth quarter of 2017, the sum of the relative importance for FY 2019 operating costs (Wages and Salaries, Employee Benefits, Professional Fees: Labor-related, Administrative and Facilities Support Services, Installation Maintenance & Repair Services, and All Other: Labor-related Services) using the 2012-based

IRF market basket is 66.8 percent. We propose that the portion of Capital-Related Costs that is influenced by the local labor market is estimated to be 46 percent. Incorporating the most recent estimate of the FY 2019 relative importance of Capital-Related costs from the 2012-based IRF market basket based on IGI's first quarter 2018 forecast with historical data through the fourth quarter of 2017, which is 8.2 percent, we take 46 percent of 8.2 percent to determine the labor-related share of Capital for FY 2019. We propose to then add this amount (3.8 percent) to the sum of the relative importance for FY 2019 operating costs (66.8 percent) to determine the total labor-related share for FY 2019 of 70.6 percent. Thus, the proposed FY 2019 labor-related share is 70.6 percent. By comparison, the FY 2018 labor-related share was 70.7 percent.

TABLE 4—IRF LABOR-RELATED SHARE

	FY 2019 proposed labor-related share [1]	FY 2018 final labor related share [2]
Wages and salaries	47.8	47.8
Employee Benefits	11.1	11.2
Professional Fees: Labor-related	3.4	3.4
Administrative and Facilities Support Services	0.8	0.8
Installation, Maintenance, and Repair Services	1.9	1.9
All Other: Labor-related Services	1.8	1.8
Subtotal	66.8	66.9
Labor-related portion of capital (46%)	3.8	3.8
Total Labor-Related Share	70.6	70.7

[1] Based on the 2012-based IRF Market Basket, IGI's 1st quarter 2018 forecast with historical data through the 4th quarter of 2017.
[2] **Federal Register** (82 FR 36249).

We invite public comment on the proposed labor-related share for FY 2019.

D. Proposed Wage Adjustment for FY 2019

1. Background

Section 1886(j)(6) of the Act requires the Secretary to adjust the proportion of rehabilitation facilities' costs attributable to wages and wage-related costs (as estimated by the Secretary from time to time) by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the rehabilitation facility compared to the national average wage level for those facilities. The Secretary is required to update the IRF PPS wage index on the basis of information available to the Secretary on the wages and wage-related costs to furnish rehabilitation services. Any adjustment or updates made under section 1886(j)(6) of the Act for a FY are made in a budget-neutral manner.

For FY 2019, we propose to maintain the policies and methodologies described in the FY 2018 IRF PPS final rule (82 FR 36238, 36249 through 36250) related to the labor market area definitions and the wage index methodology for areas with wage data. Thus, we propose to use the CBSA labor market area definitions and the FY 2018 pre-reclassification and pre-floor hospital wage index data. In accordance with section 1886(d)(3)(E) of the Act, the FY 2018 pre-reclassification and pre-floor hospital wage index is based on data submitted for hospital cost reporting periods beginning on or after October 1, 2013, and before October 1, 2014 (that is, FY 2014 cost report data).

The labor market designations made by the OMB include some geographic areas where there are no hospitals and, thus, no hospital wage index data on which to base the calculation of the IRF PPS wage index. We propose to continue to use 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.

We invite public comment on this proposal.

2. Core-Based Statistical Areas (CBSAs) for the Proposed FY 2019 IRF Wage Index

The wage index used for the IRF PPS is calculated using the pre-reclassification and pre-floor acute care hospital wage index data and is assigned to the IRF on the basis of the labor market area in which the IRF is geographically located. IRF labor market areas are delineated based on the CBSAs established by the OMB. The current CBSA delineations (which were implemented for the IRF PPS beginning with FY 2016) are based on revised OMB delineations issued on February 28, 2013, in OMB Bulletin No. 13–01. OMB Bulletin No. 13–01 established revised delineations for Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas in the United States and Puerto Rico based on the 2010 Census, and provided guidance on the use of the delineations of these statistical areas using standards published on June 28, 2010, in the **Federal Register** (75 FR 37246 through 37252). We refer readers to the FY 2016 IRF PPS final rule (80 FR 47068 through 47076) for a full discussion of our implementation of the OMB labor market area delineations beginning with the FY 2016 wage index.

Generally, OMB issues major revisions to statistical areas every 10 years, based on the results of the decennial census. However, OMB occasionally issues minor updates and revisions to statistical areas in the years between the decennial censuses. On July 15, 2015, OMB issued OMB Bulletin No. 15–01, which provides minor updates to and supersedes OMB Bulletin No. 13–01 that was issued on February 28, 2013. The attachment to OMB Bulletin No. 15–01 provides detailed information on the update to statistical areas since February 28, 2013. The updates provided in OMB Bulletin No. 15–01 are based on the application of the 2010 Standards for Delineating Metropolitan and Micropolitan Statistical Areas to Census Bureau population estimates for July 1, 2012 and July 1, 2013. The complete list of statistical areas incorporating these changes is provided in OMB Bulletin No. 15–01. In the FY 2018 IRF PPS final rule (82 FR 36250 through 36251), we

adopted the updates set forth in OMB Bulletin No. 15–01 effective October 1, 2017, beginning with the FY 2018 wage index. For a complete discussion of the adoption of the updates set forth in OMB Bulletin No. 15–01, we refer readers to the FY 2018 IRF PPS final rule.

For FY 2019, we propose to continue using the OMB delineations that we adopted beginning with FY 2016 to calculate the area wage indexes, with the updates set forth in OMB Bulletin No. 15–01 that we adopted beginning with the FY 2018 wage index.

We invite public comment on this proposal.

3. Codes for Constituent Counties in CBSAs

CBSAs are made up of one or more constituent counties. Each CBSA and constituent county has its own unique identifying codes. There are two different lists of codes associated with counties: Social Security Administration (SSA) codes and Federal Information Processing Standard (FIPS) codes. Historically, we have used SSA and FIPS county codes to identify and crosswalk counties to CBSA codes for purposes of the IRF wage index. We have learned that SSA county codes are no longer being maintained and updated. However, the FIPS codes continue to be maintained by the U.S. Census Bureau. The Census Bureau's most current statistical area information is derived from ongoing census data received since 2010; the most recent data are from 2015. For purposes of cross-walking counties to CBSA codes, we are proposing to discontinue the use of SSA county codes and continue using only the FIPS county codes. We are proposing to use the FIPS county codes to calculate area wage indexes in a manner that is generally consistent with the CBSA-based methodologies finalized in the FY 2006 IRF final rule (70 FR 47880) and the FY 2016 IRF final rule (80 FR 47036). The use of the FIPS codes for cross-walking counties to CBSAs does not result in any changes to the constituent counties of any CBSA. Thus, there is no impact or change for any IRF due to the use of the FIPS county codes. We believe that using the latest FIPS codes will allow us to maintain a more accurate and up-to-date payment system that reflects the reality of population shifts and labor market conditions.

As discussed in the FY 2018 Inpatient prospective payment system (IPPS) and Long-Term Care Hospital (LTCH) PPS final rule (82 FR 38130), this change was implemented under the IPPS beginning on October 1, 2017. Therefore, we are proposing to implement this revision for the IRF PPS beginning October 1, 2018, consistent with our historical practice of modeling IRF PPS adoption of updates to labor market areas after IPPS adoption of these changes.

We invite public comments on this proposal.

4. Wage Adjustment

The proposed wage index applicable to FY 2019 is available on the CMS website at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Data-Files.html.* Table A is for urban areas, and Table B is for rural areas.

To calculate the wage-adjusted facility payment for the payment rates set forth in this proposed rule, we multiply the unadjusted federal payment rate for IRFs by the FY 2019 labor-related share based on the 2012-based IRF market basket (70.6 percent) to determine the labor-related portion of the standard payment amount. A full discussion of the calculation of the labor-related share is located in section V.C of this proposed rule. We then multiply the labor-related portion by the applicable IRF wage index from the tables in the addendum to this proposed rule. These tables are available on the CMS website at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Data-Files.html.*

Adjustments or updates to the IRF wage index made under section 1886(j)(6) of the Act must be made in a budget-neutral manner. We propose to calculate a budget-neutral wage adjustment factor as established in the FY 2004 IRF PPS final rule (68 FR 45689), codified at § 412.624(e)(1), as described in the steps below. We propose to use the listed steps to ensure that the FY 2019 IRF standard payment conversion factor reflects the proposed update to the wage indexes (based on the FY 2014 hospital cost report data) and the labor-related share in a budget-neutral manner:

Step 1. Determine the total amount of the estimated FY 2018 IRF PPS payments, using the FY 2018 standard payment conversion factor and the labor-related share and the wage indexes from FY 2018 (as published in the FY 2018 IRF PPS final rule (82 FR 36238)).

Step 2. Calculate the total amount of estimated IRF PPS payments using the proposed FY 2019 standard payment conversion factor and the proposed FY 2019 labor-related share and CBSA urban and rural wage indexes.

Step 3. Divide the amount calculated in step 1 by the amount calculated in step 2. The resulting quotient is the proposed FY 2019 budget-neutral wage adjustment factor of 1.0000.

Step 4. Apply the proposed FY 2019 budget-neutral wage adjustment factor from step 3 to the FY 2018 IRF PPS standard payment conversion factor after the application of the increase factor to determine the proposed FY 2019 standard payment conversion factor.

We discuss the calculation of the proposed standard payment conversion factor for FY 2019 in section V.E. of this proposed rule.

We invite public comment on the proposed IRF wage adjustment for FY 2019.

E. Description of the Proposed IRF Standard Payment Conversion Factor and Payment Rates for FY 2019

To calculate the proposed standard payment conversion factor for FY 2019, as illustrated in Table 5, we begin by applying the proposed increase factor for FY 2019, as adjusted in accordance with sections 1886(j)(3)(C) and (D) of the Act, to the standard payment conversion factor for FY 2018 ($15,838). Applying the proposed 1.35 percent increase factor for FY 2019 to the standard payment conversion factor for FY 2018 of $15,838 yields a standard payment amount of $16,052. Then, we apply the proposed budget neutrality factor for the FY 2019 wage index and labor-related share of 1.0000, which results in a proposed standard payment amount of $16,052. We next apply the proposed budget neutrality factor for the revised CMG relative weights of 0.9980, which results in the proposed standard payment conversion factor of $16,020 for FY 2019.

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

TABLE 5—CALCULATIONS TO DETERMINE THE PROPOSED FY 2019 STANDARD PAYMENT CONVERSION FACTOR—Continued

Explanation for adjustment	Calculations
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, and reduced by 0.75 percentage point in accordance with sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(v) 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

We invite public comment on the proposed FY 2019 standard payment conversion factor.

After the application of the proposed CMG relative weights described in section III of this proposed rule to the proposed FY 2019 standard payment conversion factor ($16,020), the resulting unadjusted IRF prospective payment rates for FY 2019 are shown in Table 6.

TABLE 6—PROPOSED FY 2019 PAYMENT RATES

CMG	Payment rate tier 1	Payment rate tier 2	Payment rate tier 3	Payment rate no comorbidity
0101	$13,594.57	$11,801.93	$10,831.12	$10,350.52
0102	17,176.64	14,911.42	13,684.28	13,078.73
0103	19,879.22	17,256.74	15,837.37	15,135.70
0104	20,749.10	18,012.89	16,531.04	15,798.92
0105	23,845.77	20,701.04	18,998.12	18,155.47
0106	26,674.90	23,156.91	21,252.13	20,310.16
0107	29,901.33	25,957.21	23,823.34	22,766.02
0108	36,966.15	32,089.66	29,451.17	28,145.54
0109	33,438.55	29,028.24	26,641.26	25,460.59
0110	44,288.89	38,448.00	35,287.25	33,720.50
0201	13,181.26	10,694.95	9,547.92	8,915.13
0202	18,299.65	14,850.54	13,254.95	12,377.05
0203	20,186.80	16,380.45	14,623.06	13,653.85
0204	21,982.64	17,838.27	15,923.88	14,868.16
0205	25,966.82	21,071.11	18,809.08	17,562.73
0206	31,295.07	25,394.90	22,668.30	21,165.62
0207	39,534.16	32,080.05	28,635.75	26,738.98
0301	18,807.48	15,214.19	13,956.62	13,049.89
0302	22,966.27	18,578.39	17,043.68	15,936.70
0303	26,572.37	21,497.24	19,719.02	18,439.02
0304	33,955.99	27,469.49	25,197.86	23,562.22
0401	16,069.66	12,995.42	12,011.80	10,978.51
0402	23,884.22	19,313.71	17,852.69	16,317.97
0403	37,831.23	30,591.79	28,275.30	25,845.07
0404	64,344.33	52,031.36	48,093.64	43,958.88
0405	56,746.04	45,886.09	42,414.55	38,766.80
0501	14,698.35	11,449.49	10,597.23	9,733.75
0502	19,554.01	15,231.82	14,097.60	12,948.97
0503	24,227.05	18,873.16	17,466.61	16,044.03
0504	27,881.21	21,718.31	20,101.90	18,464.65
0505	31,915.04	24,861.44	23,009.53	21,136.79
0506	43,199.53	33,651.61	31,144.48	28,608.52
0601	17,184.65	13,168.44	12,199.23	11,119.48
0602	22,331.88	17,110.96	15,853.39	14,448.44
0603	27,450.27	21,034.26	19,486.73	17,761.37
0604	35,498.72	27,200.36	25,199.46	22,967.87
0701	16,489.39	13,437.58	12,742.31	11,497.55
0702	20,971.78	17,090.14	16,204.23	14,623.06
0703	25,004.02	20,377.44	19,321.72	17,434.57
0704	31,932.67	26,022.89	24,674.00	22,266.20
0801	13,395.92	10,925.64	9,866.72	9,174.65
0802	17,272.76	14,086.39	12,721.48	11,829.17
0803	22,703.54	18,514.31	16,721.68	15,549.01
0804	20,411.08	16,644.78	15,033.17	13,979.05
0805	24,326.37	19,837.57	17,916.77	16,659.20
0806	30,015.07	24,476.96	22,107.60	20,556.86
0901	16,558.27	12,961.78	11,998.98	11,058.61
0902	20,949.35	16,398.07	15,180.55	13,991.87
0903	26,149.45	20,468.75	18,948.46	17,465.00
0904	32,759.30	25,641.61	23,738.44	21,878.51
1001	17,484.23	14,741.60	13,150.82	12,120.73
1002	22,405.57	18,890.78	16,853.04	15,532.99

TABLE 6—PROPOSED FY 2019 PAYMENT RATES—Continued

CMG	Payment rate tier 1	Payment rate tier 2	Payment rate tier 3	Payment rate no comorbidity
1003	32,438.90	27,350.95	24,400.06	22,488.88
1101	22,110.80	15,952.72	15,952.72	14,333.09
1102	31,073.99	22,419.99	22,419.99	20,143.55
1201	17,831.86	15,311.92	13,926.19	12,655.80
1202	22,565.77	19,377.79	17,623.60	16,016.80
1203	27,328.52	23,466.10	21,343.45	19,397.02
1301	17,580.35	15,404.83	14,209.74	13,421.56
1302	23,030.35	20,182.00	18,615.24	17,583.55
1303	27,735.43	24,303.94	22,418.39	21,175.24
1401	14,802.48	12,039.03	10,863.16	9,770.60
1402	19,851.98	16,144.96	14,566.99	13,104.36
1403	23,671.15	19,251.23	17,370.49	15,624.31
1404	29,784.38	24,222.24	21,856.09	19,659.74
1501	16,173.79	14,044.73	12,740.71	12,189.62
1502	20,622.55	17,907.16	16,244.28	15,542.60
1503	24,465.74	21,245.72	19,272.06	18,440.62
1504	30,883.36	26,817.48	24,327.97	23,277.06
1601	19,372.99	14,848.94	14,075.17	12,715.07
1602	24,581.09	18,839.52	17,859.10	16,132.14
1603	29,880.50	22,900.59	21,708.70	19,610.08
1701	20,612.93	15,661.15	14,619.85	13,174.85
1702	24,831.00	18,866.75	17,610.79	15,871.01
1703	29,023.43	22,051.53	20,584.10	18,551.16
1704	36,902.07	28,038.20	26,171.87	23,587.85
1801	17,958.42	16,181.80	13,591.37	12,715.07
1802	26,610.82	23,977.13	20,140.34	18,841.12
1803	41,559.08	37,446.75	31,453.67	29,425.54
1901	22,633.06	16,181.80	15,209.39	14,592.62
1902	39,846.55	28,486.76	26,775.83	25,691.27
1903	68,740.22	49,144.55	46,190.47	44,319.33
2001	15,526.58	12,357.83	11,476.73	10,414.60
2002	20,178.79	16,060.05	14,916.22	13,535.30
2003	24,795.76	19,735.04	18,330.08	16,631.96
2004	31,609.06	25,157.81	23,365.17	21,202.47
2101	30,678.30	24,787.75	24,094.08	21,128.78
5001	.....	.....	.....	2,564.80
5101	.....	.....	.....	12,112.72
5102	.....	.....	.....	26,469.85
5103	.....	.....	.....	12,998.63
5104	.....	.....	.....	33,951.19

F. Example of the Methodology for Adjusting the Proposed Prospective Payment Rates

Table 7 illustrates the methodology for adjusting the proposed federal prospective payments (as described in section V. of this proposed rule). The following examples are based on two hypothetical Medicare beneficiaries, both classified into CMG 0110 (without comorbidities). The proposed unadjusted prospective payment rate for CMG 0110 (without comorbidities) appears in Table 6.

Example: One beneficiary is in Facility A, an IRF located in rural Spencer County, Indiana, and another beneficiary is in Facility B, an IRF located in urban Harrison County, Indiana. Facility A, a rural non-teaching hospital has a Disproportionate Share Hospital (DSH) percentage of 5 percent (which would result in a LIP adjustment of 1.0156), a wage index of 0.8088, and a rural adjustment of 14.9 percent. Facility B, an urban teaching hospital, has a DSH percentage of 15 percent (which would result in a LIP adjustment of 1.0454 percent), a wage index of 0.8689, and a teaching status adjustment of 0.0784.

To calculate each IRF's labor and non-labor portion of the proposed prospective payment, we begin by taking the unadjusted prospective payment rate for CMG 0110 (without comorbidities) from Table 6. Then, we multiply the proposed labor-related share for FY 2019 (70.6 percent) described in section V.C. of this proposed rule by the proposed unadjusted prospective payment rate. To determine the non-labor portion of the proposed prospective payment rate, we subtract the labor portion of the proposed federal payment from the proposed unadjusted prospective payment.

To compute the proposed wage-adjusted prospective payment, we multiply the labor portion of the proposed federal payment by the appropriate wage index located in Tables A and B. These tables are available on the CMS website at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Data-Files.html.* The resulting figure is the wage-adjusted labor amount. Next, we compute the proposed wage-adjusted federal payment by adding the wage-adjusted labor amount to the non-labor portion of the proposed federal payment.

Adjusting the proposed wage-adjusted federal payment by the facility-level adjustments involves several steps. First, we take the wage-adjusted prospective payment and multiply it by the appropriate rural and LIP adjustments (if applicable). Second, to determine the appropriate amount of additional payment for the teaching status adjustment (if applicable), we multiply the teaching status adjustment (0.0784, in this example) by the wage-adjusted and rural-adjusted amount (if applicable). Finally, we add the

additional teaching status payments (if applicable) to the wage, rural, and LIP-adjusted prospective payment rates. Table 7 illustrates the components of the adjusted payment calculation.

TABLE 7—EXAMPLE OF COMPUTING THE FY 2019 IRF PROSPECTIVE PAYMENT

Steps		Rural facility A (Spencer Co., IN)	Urban facility B (Harrison Co., IN)
1	Unadjusted Payment	$33,720.50	$33,720.50
2	Labor Share	× 0.706	× 0.706
3	Labor Portion of Payment	= $23,806.67	= $23,806.67
4	CBSA-Based Wage Index (shown in the Addendum, Tables A and B).	× 0.8088	× 0.8689
5	Wage-Adjusted Amount	= $19,254.83	= $20,685.62
6	Non-Labor Amount	+ $9,913.83	+ $9,913.83
7	Wage-Adjusted Payment	= $29,168.66	= $30,599.45
8	Rural Adjustment	× 1.149	× 1.000
9	Wage- and Rural-Adjusted Payment	= $33,514.79	= $30,599.45
10	LIP Adjustment	× 1.0156	× 1.0454
11	Wage-, Rural- and LIP-Adjusted Payment	= $34,037.62	= $31,988.67
12	Wage- and Rural-Adjusted Payment	$33,514.79	$30,599.45
13	Teaching Status Adjustment	× 0	× 0.0784
14	Teaching Status Adjustment Amount	= $0.00	= $2,399.00
15	Wage-, Rural-, and LIP-Adjusted Payment	+ $34,037.62	+ $31,988.67
16	Total Adjusted Payment	= $34,037.62	= $34,387.67

Thus, the proposed adjusted payment for Facility A would be $34,037.62, and the proposed adjusted payment for Facility B would be $34,387.67.

VI. Proposed Update to Payments for High-Cost Outliers Under the IRF PPS for FY 2019

A. Proposed Update to the Outlier Threshold Amount for FY 2019

Section 1886(j)(4) of the Act provides the Secretary with the authority to make payments in addition to the basic IRF prospective payments for cases incurring extraordinarily high costs. A case qualifies for an outlier payment if the estimated cost of the case exceeds the adjusted outlier threshold. We calculate the adjusted outlier threshold by adding the IRF PPS payment for the case (that is, the CMG payment adjusted by all of the relevant facility-level adjustments) and the adjusted threshold amount (also adjusted by all of the relevant facility-level adjustments). Then, we calculate the estimated cost of a case by multiplying the IRF's overall CCR by the Medicare allowable covered charge. If the estimated cost of the case is higher than the adjusted outlier threshold, we make an outlier payment for the case equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold.

In the FY 2002 IRF PPS final rule (66 FR 41362 through 41363), we discussed our rationale for setting the outlier threshold amount for the IRF PPS so that estimated outlier payments would equal 3 percent of total estimated payments. For the 2002 IRF PPS final rule, we analyzed various outlier policies using 3, 4, and 5 percent of the total estimated payments, and we concluded that an outlier policy set at 3 percent of total estimated payments would optimize the extent to which we could reduce the financial risk to IRFs of caring for high-cost patients, while still providing for adequate payments for all other (non-high cost outlier) cases.

Subsequently, we updated the IRF outlier threshold amount in the FYs 2006 through 2018 IRF PPS final rules and the FY 2011 and FY 2013 notices (70 FR 47880, 71 FR 48354, 72 FR 44284, 73 FR 46370, 74 FR 39762, 75 FR 42836, 76 FR 47836, 76 FR 59256, 77 FR 44618, 78 FR 47860, 79 FR 45872, 80 FR 47036, 81 FR 52056, and 82 FR 36238, respectively) to maintain estimated outlier payments at 3 percent of total estimated payments. We also stated in the FY 2009 final rule (73 FR 46370 at 46385) that we would continue to analyze the estimated outlier payments for subsequent years and adjust the outlier threshold amount as appropriate to maintain the 3 percent target.

To update the IRF outlier threshold amount for FY 2019, we propose to use FY 2017 claims data and the same methodology that we used to set the initial outlier threshold amount in the FY 2002 IRF PPS final rule (66 FR 41316 and 41362 through 41363), which is also the same methodology that we used to update the outlier threshold amounts for FYs 2006 through 2018. The outlier threshold is calculated by simulating aggregate payments and using an iterative process to determine a threshold that results in outlier payments being equal to 3 percent of total payments under the simulation. To determine the outlier threshold for FY 2019, we estimate the amount of FY 2019 IRF PPS aggregate and outlier payments using the most recent claims available (FY 2017) and the proposed FY 2019 standard payment conversion factor, labor-related share, and wage indexes, incorporating any applicable budget-natural adjustment factors. The outlier threshold is adjusted either up or down in this simulation until the estimated outlier payments equal 3 percent of the estimated aggregate payments. Based on an analysis of the preliminary data used for the proposed rule, we estimated that IRF outlier payments as a percentage of total estimated payments would be approximately 3.4 percent in FY 2018. Therefore, we propose to update the outlier threshold amount from $8,679 for FY 2018 to $10,509 for FY 2019 to maintain estimated outlier payments at approximately 3 percent of total estimated aggregate IRF payments for FY 2019.

We invite public comment on the proposed update to the FY 2019 outlier threshold amount to maintain estimated outlier payments at approximately 3 percent of total estimated IRF payments.

B. Proposed Update to the IRF Cost-to-Charge Ratio Ceiling and Urban/Rural Averages for FY 2019

Cost-to-charge ratios are used to adjust charges from Medicare claims to costs and are computed annually from facility-specific data obtained from Medicare cost reports. IRF specific cost-

to-charge ratios are used in the development of the CMG relative weights and the calculation of outlier payments under the IRF prospective payment system. In accordance with the methodology stated in the FY 2004 IRF PPS final rule (68 FR 45674, 45692 through 45694), we propose to apply a ceiling to IRFs' CCRs. Using the methodology described in that final rule, we propose to update 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 is available. We apply the national urban and rural CCRs in the following situations:

- New IRFs that have not yet submitted their first Medicare cost report.
- IRFs whose overall CCR is in excess of the national CCR ceiling for FY 2019, as discussed below in this section.
- Other IRFs for which accurate data to calculate an overall CCR are not available.

Specifically, for FY 2019, we propose to estimate a national average CCR of 0.470 for rural IRFs, which we calculated by taking an average of the CCRs for all rural IRFs using their most recently submitted cost report data. Similarly, we propose to estimate a national average CCR of 0.392 for urban IRFs, which we calculated by taking an average of the CCRs for all urban IRFs using their most recently submitted cost report data. We apply weights to both of these averages using the IRFs' estimated costs, meaning that the CCRs of IRFs with higher total costs factor more heavily into the averages than the CCRs of IRFs with lower total costs. For this proposed rule, we have used the most recent available cost report data (FY 2016). This includes all IRFs whose cost reporting periods begin on or after October 1, 2015, and before October 1, 2016. If, for any IRF, the FY 2016 cost report was missing or had an ''as submitted'' status, we used data from a previous fiscal year's (that is, FY 2004 through FY 2015) settled cost report for that IRF. We do not use cost report data from before FY 2004 for any IRF because changes in IRF utilization since FY 2004 resulting from the 60 percent rule and IRF medical review activities suggest that these older data do not adequately reflect the current cost of care.

In accordance with past practice, we propose to set the national CCR ceiling at 3 standard deviations above the mean CCR. Using this method, we proposed a national CCR ceiling of 1.31 for FY 2019. This means that, if an individual IRF's CCR were to exceed this proposed ceiling of 1.31 for FY 2019, we would replace the IRF's CCR with the appropriate proposed national average CCR (either rural or urban, depending on the geographic location of the IRF). We calculated the proposed national CCR ceiling by:

Step 1. Taking the national average CCR (weighted by each IRF's total costs, as previously discussed) of all IRFs for which we have sufficient cost report data (both rural and urban IRFs combined).

Step 2. Estimating the standard deviation of the national average CCR computed in step 1.

Step 3. Multiplying the standard deviation of the national average CCR computed in step 2 by a factor of 3 to compute a statistically significant reliable ceiling.

Step 4. Adding the result from step 3 to the national average CCR of all IRFs for which we have sufficient cost report data, from step 1.

The proposed national average rural and urban CCRs and the proposed national CCR ceiling in this section will be updated in the final rule if more recent data becomes available to use in these analyses.

We invite public comment on the proposed update to the IRF CCR ceiling and the urban/rural averages for FY 2019.

VII. Proposed Removal of the FIM™ Instrument and Associated Function Modifiers From the IRF–PAI Beginning With FY 2020 and Proposed Refinements to the Case-Mix Classification System Beginning With FY 2020

A. Proposed Removal of the FIM™ Instrument and Associated Function Modifiers From the IRF–PAI Beginning With FY 2020

Under section 1886(j)(2)(D) of the Act, the Secretary is authorized to require rehabilitation facilities that provide inpatient hospital services to submit such data as the Secretary deems necessary to establish and administer the IRF PPS. In the FY 2002 IRF PPS final rule (66 FR 41324 through 41328), we finalized the use of the IRF–PAI, through which IRFs are now required to collect and electronically submit patient data for all Medicare Part A FFS and Medicare Part C (Medicare Advantage) patients. Data collected in the IRF–PAI is used to classify patients into distinct 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 currently in use under the IRF PPS (IRF–PAI version 2.0) was originally developed based on a modified version of the Uniform Data System for medical rehabilitation (UDSmr) patient assessment instrument, 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 that are used to score both motor and cognitive functioning at admission and discharge. The FIM™ data elements and measurement scale are collectively referred to as the FIM™ instrument. Additionally, items 29 through 38 of the IRF–PAI version 2.0 contain Function Modifiers associated with the FIM™ instrument. The FIM™ instrument and associated Function Modifiers are currently used to assign a patient into a CMG for payment purposes under the IRF PPS based on the patient's ability to perform specific activities of daily living and, in some cases, the patient's cognitive ability.

In the FY 2012 IRF PPS final rule (76 FR 47873 through 47883), we established the IRF QRP in accordance with section 1886(j)(7) of the Act and finalized revisions to the IRF–PAI to begin collecting data items under the IRF QRP. Under the IRF QRP, the following data items are collected in the Quality Indicators section of the IRF–PAI:

- GG0130A1 Eating
- GG0130B1 Oral hygiene
- GG0130C1 Toileting hygiene
- GG0130E1 Shower/bathe self
- GG0130F1 Upper-body dressing
- GG0130G1 Lower-body dressing
- GG0130H1 Putting on/taking off footwear
- GG0170A1 Roll left and right
- GG0170B1 Sit to lying
- GG0170C1 Lying to sitting on side of bed
- GG0170D1 Sit to stand
- GG0170E1 Chair/bed-to-chair transfer
- GG0170F1 Toilet transfer
- GG0170I1 Walk 10 feet
- GG0170J1 Walk 50 feet with two turns
- GG0170K1 Walk 150 feet
- GG0170M1 One step curb
- H0350 Bladder continence
- H0400 Bowel continence
- BB0700 Expression of ideas and wants
- BB0800 Understanding verbal content
- C0500 Brief Interview for Mental Status (BIMS) summary score

Because these data items collect data that are similar in nature to, and overlap with, data collected through the FIM™ instrument and associated Function Modifiers, we are proposing to remove the FIM™ instrument and associated Function Modifiers from the IRF–PAI beginning with FY 2020 to reduce administrative burden on IRFs.

Currently, data elements in the FIM™ instrument and associated Function Modifiers capture data on eating, grooming, bathing, dressing upper body, dressing lower body, toileting, bladder management, bowel management, transfer to bed/chair/wheelchair, transfer to toilet, transfer to tub/shower, walking or wheelchair use, stair climbing, comprehension, expression, social interaction, problem solving, and memory. The Function Modifiers are used to assist in the scoring of the related FIM™ instrument data elements and provide additional information as to how the FIM™ instrument data element score has been determined. For example, item 29 (Bladder Level of Assistance) and item 30 (Bladder Frequency of Accidents) are used to determine the score for the item 39G, the Bladder data element contained in the FIM™ instrument.

Data items in the Quality Indicators section of the IRF–PAI capture data on functional status, cognitive function, and changes in function and cognitive function among other elements used for quality reporting. For example, the data items in the Quality Indicators section of the IRF–PAI capture data on eating, oral hygiene, toileting hygiene, shower/bathing, dressing upper body, dressing lower body, bowel continence, bladder continence, chair/bed-to-chair transfer, toilet transfer, walking, stair climbing, expression of ideas and wants, understanding verbal and non-verbal content, temporal orientation, and memory/recall ability.

As the data elements in the FIM™ instrument (item 39 of the IRF–PAI) and associated Function Modifiers (items 29 through 38 of the IRF–PAI) overlap, directly or indirectly, with data items in the Quality Indicators section of the IRF–PAI, and as we can now use data items in the Quality Indicators section of the IRF–PAI to assign patients to CMGs for payment under the IRF PPS, we believe that the collection of the FIM™ instrument and associated Function Modifiers is no longer necessary. Accordingly, we believe that continuing to collect the FIM™ instrument and associated Function Modifiers places undue burden on IRFs. Additionally, the removal of the FIM™ instrument and associated Function Modifiers from the IRF–PAI supports the broader goal to standardize data collection across PAC settings as several of the data items we are proposing to incorporate into the IRF case-mix system are similar to data elements that are also collected on Skilled Nursing Facility (SNF) and LTCH assessment instruments. For a discussion of how the data items located in the Quality Indicators section of the IRF–PAI will be incorporated into the case-mix classification system please refer to section VII.B of this proposed rule. In support of our goal to reduce administrative burden on providers, we are proposing to remove the FIM™ instrument (item 39) and associated Function Modifiers (items 29 through 38) from the IRF–PAI beginning with FY 2020, that is, for all IRF discharges beginning on or after October 1, 2019.

We invite public comment on our proposal to remove the FIM™ instrument and associated Function Modifiers from the IRF–PAI beginning with FY 2020, that is, for all IRF discharges beginning on or after October 1, 2019.

B. Proposed Refinements to the Case-Mix Classification System Beginning With FY 2020

1. IRF Classification System Overview

Section 1886(j)(2) of the Act requires the Secretary to establish case-mix groups for payment under the IRF PPS. Under section 1886(j)(2)(B) of the Act, the Secretary must assign each case-mix group a weighting factor that reflects the relative facility resources used for patients classified within the group as compared to patients classified within other groups. Additionally, section 1886(j)(2)(C)(i) of the Act requires the Secretary from time to time to adjust the classifications and weighting factors as appropriate to reflect changes in treatment patterns, technology, case-mix, number of payment units for which payment is made under title XVIII of the Act, and other factors which may affect the relative use of resources. Such adjustments must be made in a manner so that changes in aggregate payments under the classification system are a result of real changes and are not a result of changes in coding that are unrelated to real changes in case mix.

In the FY 2002 IRF PPS final rule (66 FR 41316), we established a case-mix classification system for IRFs under the IRF PPS. Under the case-mix classification system, a patient's principal diagnosis or impairment is used to classify the patient into a 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, such as the occurrence of very short stays, or cases where the patient expired, are also considered in determining the appropriate CMG. CMGs are further divided into tiers based on the presence of certain comorbidities. These tiers reflect the differential cost of care compared with the average beneficiary in a CMG. We refer readers to the FY 2002 final rule (66 FR 41316) and the FY 2006 IRF final rule (70 FR 47886) for a detailed discussion of the development of, and refinements to, the IRF case-mix classification system.

As discussed in section VII.A of this proposed rule, we are proposing to remove the FIM™ instrument and associated Function Modifiers from the IRF–PAI beginning with FY 2020, that is, for all IRF discharges beginning on or after October 1, 2019. This would necessitate the incorporation of the data items collected on admission and located in the Quality Indicators section of the IRF–PAI version 2.0 into the CMG classification system, as the FIM™ data would no longer be available to assign patients to CMGs for purposes of payment under the IRF PPS. In accordance with section 1886(j)(2)(C)(i) of the Act and as specified in § 412.620(c) we are proposing to replace our use of the FIM™ items in assigning CMGs with use of data items located in the Quality Indicators section of the IRF–PAI. In addition, to ensure that IRF payments are accurately calculated using the data items located in the Quality Indicators section of the IRF–PAI, we also propose 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. We propose to implement these revisions to the case-mix classification system in a budget neutral manner.

We are proposing to make these changes effective beginning with FY 2020, that is, for discharges occurring on or after October 1, 2019, as they require extensive systems changes. That is, we are proposing to implement these changes with a one-year delayed effective date to allow adequate time for providers and vendors to make the necessary systems changes. These proposals are discussed in detail below. We are not proposing any changes to the methodology used to update the CMGs, relative weights and average length of stay values for FY 2019, that is, for discharges occurring on or after October 1, 2018, and on or before September 30, 2019. For information on the proposed updates to the CMG relative weights and average length of stay values for FY 2019, please refer to section III of this proposed rule.

2. Proposed Changes to the Functional Status Scores Beginning With FY 2020

As discussed in the FY 2006 IRF final rule (70 FR 47886), under the CMG case-mix classification system, a patient's

principal diagnosis or impairment is used to classify the patient into a RIC. After using the RIC to define the first division among the inpatient rehabilitation groups, a patient's motor and cognitive scores and age are used to partition the cases further. To classify a patient into a CMG, IRFs use the admission assessment data from the IRF–PAI to score a patient's functional status. Currently, the functional status scores consist of what are termed ''motor'' items and ''cognitive'' items. In addition to the functional status scores, the patient's age may also influence the patient's CMG classification. The motor items are generally indications of the patient's physical functioning level. The cognitive items are generally indications of the patient's mental functioning level, and are related to the patient's ability to process and respond to empirical factual information, use judgment, and accurately perceive what is happening. Under the current case-mix system, 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.

As discussed in section VII.A of this proposed rule, we are proposing to remove the FIM™ instrument and associated Function Modifiers from the IRF–PAI beginning with FY 2020. As the data in the FIM™ instrument section will no longer be available to determine the motor and cognitive scores used to assign patients to CMGs, we are proposing to use data items collected on admission and located in the Quality Indicators section of the IRF–PAI to derive the functional status scores used to assign patients to a CMG for payment purposes under the IRF PPS. The Quality Indicators section of the IRF–PAI includes data items that are similar to the data elements located in the FIM™ instrument, in addition to new data elements that capture additional functional status information.

In the summer of 2013, we contracted with Research Triangle Institute, International (RTI) to explore use of the data items collected in the Quality Indicators section of the IRF–PAI in setting IRF PPS payments. Some of the data items collected in the Quality Indicators section of the IRF–PAI were originally developed and tested as part of the Post-Acute Care Payment Reform Demonstration (PAC–PRD) version of the Continuity Assessment Record and Evaluation (CARE) Item Set. The CARE item set was developed in response to a mandate in section 5008 of the Deficit Reduction Act of 2005 (Pub. L. 109–171, enacted on February 8, 2006) (DRA) to develop a uniform patient assessment instrument to assess patients across all types of acute and PAC providers.

In the first stage of this analysis, RTI hosted a Technical Expert Panel (TEP) on September 18, 2014, which brought together researchers, clinicians, and representatives from provider associations to discuss exploratory research on the potential to incorporate the CARE data items in the current case-mix system utilized in the IRF PPS. We received helpful feedback on the exploratory research including clinicians' views of the importance and significance of various findings, input on the methodology used to incorporate the CARE items, and potential limitations of the analysis. RTI's analysis of the original CARE data set, along with guidance from the TEP, suggested the need to derive different functional status measures from the data collected in the Quality Indicators section of the IRF–PAI. The data items from the Quality Indicators section of the IRF–PAI contain slightly different information and utilize a different rating system than the items collected on the FIM™ instrument. Thus, we are proposing to modify the IRF case-mix classification system to calculate IRF PPS payments correctly using the admission data items from the Quality Indicators section of the IRF–PAI. RTI considered a broad range of the data items in the Quality Indicators section of the IRF–PAI to identify the best predictors of IRF costs. These analyses examined all motor, cognitive, and additional items collected at admission to predict costs. The regression analysis indicated that the components of functional status that were found to best predict costs were the patient's motor function, a memory function, a communication function based on comprehension and expression, and age.

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). The proposed item used to derive the memory score is the BIMS summary score, which is based on the repetition of three words, temporal orientation, and recall. 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. We are proposing to incorporate a motor score, a memory score, a communication score, and age into the IRF case-mix classification system. Currently, the IRF case-mix system uses a weighted motor score and an unweighted cognitive score. We are not proposing to apply a weighting methodology to the motor score at this time. We are proposing to derive the scores for each respective group of the functional status items described above by calculating the sum of the items that constitute each functional status component. For a more detailed discussion of these analysis please refer 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.*

At this time, we believe that it is appropriate to utilize the admission data items located in the Quality Indicators section of the IRF–PAI, as described above, in place of the FIM™ items to determine functional status, as the data items located in the Quality Indicators section are now available and collected by all IRF providers for purposes of the IRF QRP. We believe the proposed motor score, a memory score, a communication score, and age should compose the functional status scores in the IRF case-mix classification system, as our analysis determined these to be the best predictors of cost. The proposed removal of the FIM™ instrument and the proposed incorporation of certain

items from the Quality Indicators section of the IRF–PAI to assign patients to CMGs support our efforts to reduce burden on providers. Additionally, the removal of the FIM™ instrument and the incorporation of certain items from the Quality Indicators section of the IRF–PAI into the CMG case-mix system support our broader goal of standardizing assessment data collection across PAC settings.

We are proposing to utilize certain data items located in the Quality Indicators section of the IRF–PAI, as described above, to generate the functional status scores that will be used to group patients into CMGs for payment purposes under the IRF PPS beginning in FY 2020.

We invite public comments on the proposed use of certain data items located in the Quality Indicators section of the IRF–PAI, as described above, for payment purposes under the IRF PPS beginning with FY 2020, that is, for all IRF discharges beginning on or after October 1, 2019.

3. Proposed Updates to the Score Reassignment Methodology Beginning With FY 2020

As previously noted, the data items located in the Quality Indicators section of the IRF–PAI utilize a different rating system than the FIM™ instrument. There are several important differences to note regarding the rating systems for the data items from the Quality Indicators section of the IRF–PAI and the data contained in the FIM™ instrument. First, the data items from the Quality Indicators section of the IRF–PAI are assessed based on a patient's usual performance during the assessment period in contrast to the FIM™ items, which are assessed based on the patients lowest functional score during the assessment period. The data items from the Quality Indicators section of the IRF–PAI are generally assessed using a 6 level rating scale for the self-care and mobility elements and a 4 level scale for the cognitive elements. The FIM™ data items use a 7 level scale. Additionally, the FIM™ scale includes a value of zero to indicate an activity did not occur or was not observed. The data items from the Quality Indicators section of the IRF–PAI utilize the following four codes to indicate why an activity did not occur: the patient refused to complete an activity (code 07), the patient did not perform this activity (code 09), the activity was not attempted due to environmental limitations (code 10), or the activity was not attempted due to a medical condition or safety concern (code 88).

As the rating scale for the data items in the Quality Indicators section of the IRF–PAI captures multiple reasons an activity did not occur, we are proposing to modify the methodology currently 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. In the FY 2002 IRF PPS final rule (66 FR 41316), we finalized a methodology to assign a code of 1 (indicating the patient needed total assistance) whenever the recorded code indicated that the activity did not occur. Subsequently, in the FY 2006 IRF PPS final rule, we revised this methodology to assign a value of 2 when the transfer to toilet item was coded with a zero value. For more information on the rationale behind this decision we refer readers to the 2006 IRF PPS final rule (70 FR 47896 through 47902). As the data items from the Quality Indicators section of the IRF–PAI now utilize 4 values to indicate an activity did not occur and a dash to indicate ''no information'', we are proposing to modify the reassignment methodology to incorporate the new codes. For the self-care and mobility items identified above, we are proposing to recode values of 07, 09, 10, 88, and the presence of a dash (''-'') to 1, the most dependent level, except the toilet transfer item, which is recoded to 2. These recodes are consistent with the current reassignment methodology rules. We are also proposing to change the way we treat specific values for the bowel continence and bladder continence items, as our analysis of these items and current coding guidelines indicate these changes are necessary. The bladder continence and bowel continence items utilize a different scale than the other function items and may capture clinical information that is not necessarily reflective of a patient's functional ability. For instance, the bladder continence scale includes the options ''no urine output'' or ''not applicable'' for cases where a patient may have renal failure or an indwelling catheter. A clinical review of these cases determined that patients for whom these values are coded are similar in terms of resource needs and costliness to patients for whom functional ability is captured. Based on this review, we are proposing 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, we are proposing 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, we are proposing to reassign a value of 9 (not rated) to 2 (frequently incontinent). For both items, we are proposing to reassign a missing score to 0 (always continent). We believe 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.

We welcome public comments on the proposed updates to the score reassignment methodology beginning with FY 2020, that is, for all IRF discharges beginning on or after October 1, 2019.

4. Proposed Refinements to the CMGs Beginning With FY 2020

As previously noted, we are proposing to modify the methodology used to update the CMGs used to classify IRF patients for purposes of establishing payment amounts, beginning with FY 2020. We are proposing to implement revisions to the CMGs in a budget-neutral manner. As discussed in the FY 2006 IRF PPS final rule (70 FR 47886 through 47887), the current CMGs were derived through Classification and Regression Trees (CART) analysis that incorporated a patient's functional status (motor score and cognitive score) and age into the construction of the CMGs. Under the IRF case-mix classification system, a patient's principal diagnosis or impairment is used to classify the patient into a RIC. Currently, there are 21 diagnosis-based RICs. The RICs are then further subdivided into 92 CMGs. Of the 92 CMGs, patients are assigned to 87 of the CMGs based on the patient's primary reason for rehabilitation care, age and functional status. There are also five special CMGs to account for very short stays and for patients who expire in the IRF.

The CART method is useful in identifying statistical relationships among data and, using these relationships, constructing a predictive model for organizing and separating a large set of data into smaller, similar groups. CART ensures that the proposed CMGs recognize that patients with clinically distinct resource needs are appropriately grouped in the case-mix

classification system. CART is an iterative process that creates initial groups of patients then searches for ways to split the initial groups to further decrease the clinical and cost variances within a group and increase the explanatory power of the CMGs.

As noted previously, the data items from the Quality Indicators section of the IRF–PAI contain slightly different information and utilize a different rating system than the items collected on the FIM ™ instrument. Thus, we have to update the IRF case-mix classification system to ensure that IRF PPS payments reflect as closely as possible the costs of care when we convert to using the admission data items from the Quality Indicators section of the IRF–PAI. To convert from using the FIM ™ items to using the data items from the Quality Indicators section of the IRF–PAI, RTI first had to identify which quality indicator data items would be the best predictors of cost, as previously discussed. Then, RTI used CART analysis to modify the CMG definitions to reflect the use of the different assessment items.

To develop CMGs based on the data items from the Quality Indicators section of the IRF–PAI, RTI used CART analysis to divide patients into payment groups based on similarities in their clinical characteristics and relative costs. As part of this analysis, RTI imposed certain restraints on these groupings to decrease the resulting number of CMGs (to ensure that the payment system did not become unduly complicated). For a more detailed discussion of these analyses or for more information on the development of the CMGs, we refer readers 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.*

In developing the revised CMGs, RTI's analysis indicated that RIC 16 and RIC 17 should incorporate the CMGs shown in Table 8, based on motor score and cognitive function, derived from the memory and communication scores.

TABLE 8—CART-BASED CMGS FOR RIC 16 (PAIN SYNDROME) AND RIC 17 (MAJOR MULTIPLE TRAUMA WITHOUT BRAIN OR SPINAL CORD INJURY)

RIC	CMG	Cases	Average Cost	Rule 1	Rule 2	Rule 3
16	1	255	$ 11,088.65	Motor >= 70		
16	2	270	13,402.22	Motor < 70	Motor >= 61	
16	3	188	14,775.04	Motor < 61	Cognition < 7	
16	4	260	16,806.16	Motor < 61	Cognition >= 7	
17	1	1149	12,911.91	Motor >= 62		
17	2	1557	15,504.35	Motor < 62	Motor >= 51	
17	3	624	17,273.01	Motor < 51	Motor >= 47	
17	4	927	19,209.23	Motor < 47	Motor >= 39	
17	5	289	20,245.80	Motor < 51	Motor < 39	Cognition < 8
17	6	205	23,465.77	Motor < 51	Motor < 39	Cognition >= 8

We considered proposing to revise the CMGs for RIC 16 and RIC 17 as shown above. However, these CMGs indicate higher costs for patients with no cognitive impairment as compared to those with any level of impairment. As this unexpected result may be driven by small sample size, we are proposing to combine CMG 03 and 04 for RIC 16 and to combine CMG 05 and 06 for RIC 17 as shown in Table 9.

Table 9 contains the proposed new CMGs and their respective descriptions, including the functional status scores and age that we are proposing to use to classify discharges into CMGs. Table 9 also contains the proposed CMG relative weights and average length of stay values for the proposed CMGs. We are not proposing any changes to methodology used to determine the CMG relative weights that was finalized in the FY 2002 IRF final rule (66 FR 41351 through 41357) and revised in the FY 2009 IRF final rule (73 FR 46372 through 46374). For more information on the methodology used to calculate the CMG relative weights please refer to section III. of this proposed rule.

TABLE 9—PROPOSED REVISED RELATIVE WEIGHTS AND AVERAGE LENGTH OF STAY VALUES FOR THE PROPOSED CASE-MIX GROUPS

CMG	CMG Description (M=motor, A=age)	Relative weight				Average length of stay			
		Tier 1	Tier 2	Tier 3	No comorbidity tier	Tier 1	Tier 2	Tier 3	No comorbidity tier
0101	Stroke M >= 77	1.0570	0.9232	0.8492	0.8050	11	11	10	10
0102	Stroke M < 77 and M >= 68	1.3370	1.1678	1.0741	1.0182	13	13	12	12
0103	Stroke M < 68 and M >= 55	1.6848	1.4715	1.3535	1.2831	15	16	15	15
0104	Stroke M < 55 and M >= 47	2.1484	1.8764	1.7260	1.6361	19	20	19	19
0105	Stroke M < 47 and A >= 85	2.4137	2.1081	1.9391	1.8382	22	22	21	20
0106	Stroke M < 47 and A < 85	2.7956	2.4417	2.2460	2.1291	26	27	24	23
0201	Traumatic Brain Injury M >= 73	1.2418	1.0426	0.9376	0.8708	12	12	11	11
0202	Traumatic Brain Injury M < 73 and M >= 64.	1.4929	1.2534	1.1272	1.0468	14	14	13	12
0203	Traumatic Brain Injury M < 64 and M >= 51.	1.7699	1.4859	1.3363	1.2411	16	17	15	14
0204	Traumatic Brain Injury M < 51 and M >= 36.	2.1753	1.8263	1.6424	1.5254	21	20	18	17
0205	Traumatic Brain Injury M < 36	2.6959	2.2634	2.0355	1.8904	36	24	22	19
0301	Non-Traumatic Brain Injury M >= 70	1.2192	1.0096	0.9348	0.8735	11	11	11	10
0302	Non-Traumatic Brain Injury M < 70 and M >= 57.	1.5403	1.2755	1.1810	1.1034	14	14	13	13

TABLE 9—PROPOSED REVISED RELATIVE WEIGHTS AND AVERAGE LENGTH OF STAY VALUES FOR THE PROPOSED CASE-MIX GROUPS—Continued

CMG	CMG Description (M=motor, A=age)	Relative weight				Average length of stay			
		Tier 1	Tier 2	Tier 3	No comorbidity tier	Tier 1	Tier 2	Tier 3	No comorbidity tier
0303	Non-Traumatic Brain Injury M < 57 and M >= 45.	1.8496	1.5316	1.4182	1.3251	17	16	15	15
0304	Non-Traumatic Brain Injury M < 45 and A >= 79.	2.0666	1.7113	1.5846	1.4806	20	18	17	16
0305	Non-Traumatic Brain Injury M < 45 and A < 79.	2.2755	1.8843	1.7447	1.6302	21	21	18	17
0401	Traumatic Spinal Cord Injury M >= 64.	1.2999	1.0952	1.0122	0.9370	13	12	12	11
0402	Traumatic Spinal Cord Injury M < 64 and M >= 57.	1.6630	1.4011	1.2949	1.1987	15	15	15	14
0403	Traumatic Spinal Cord Injury M < 57 and M >= 46.	1.9672	1.6574	1.5318	1.4180	15	18	17	16
0404	Traumatic Spinal Cord Injury M < 46 and M >= 36.	2.6209	2.2082	2.0408	1.8892	25	24	23	21
0405	Traumatic Spinal Cord Injury M < 36 and A < 63.	3.1923	2.6895	2.4857	2.3010	34	29	27	24
0406	Traumatic Spinal Cord Injury M < 36 and A >= 63.	3.6963	3.1142	2.8782	2.6643	46	34	28	29
0501	Non-Traumatic Spinal Cord Injury M >= 75.	1.1291	0.9068	0.8382	0.7642	10	11	10	9
0502	Non-Traumatic Spinal Cord Injury M < 75 and M >= 63.	1.4096	1.1322	1.0464	0.9541	14	13	12	11
0503	Non-Traumatic Spinal Cord Injury M < 63 and M >= 52.	1.7905	1.4381	1.3292	1.2119	16	15	15	14
0504	Non-Traumatic Spinal Cord Injury M < 52 and M >= 44.	2.2191	1.7823	1.6473	1.5020	21	19	18	17
0505	Non-Traumatic Spinal Cord Injury M < 44.	2.8377	2.2792	2.1065	1.9206	27	24	22	21
0601	Neurological M >= 69	1.3205	1.0500	0.9795	0.8873	12	12	11	10
0602	Neurological M < 69 and M >= 57	1.6324	1.2981	1.2109	1.0969	14	14	13	13
0603	Neurological M < 57 and M >= 47	1.9170	1.5244	1.4220	1.2882	16	16	15	14
0604	Neurological M < 47	2.2218	1.7667	1.6481	1.4929	20	18	17	16
0701	Fracture of Lower Extremity M >= 67.	1.1960	0.9851	0.9487	0.8595	11	11	11	10
0702	Fracture of Lower Extremity M < 67 and M >= 55.	1.5308	1.2608	1.2142	1.1001	14	14	14	13
0703	Fracture of Lower Extremity M < 55 and M >= 45.	1.8510	1.5245	1.4682	1.3302	17	17	16	15
0704	Fracture of Lower Extremity M < 45	2.0790	1.7124	1.6491	1.4941	18	18	18	17
0801	Replacement of Lower Extremity Joint M >= 67.	1.0475	0.8892	0.8044	0.7437	10	10	9	9
0802	Replacement of Lower Extremity Joint M < 67 and M >= 56.	1.2925	1.0972	0.9926	0.9176	12	12	11	11
0803	Replacement of Lower Extremity Joint M < 56 and M >= 47.	1.5469	1.3132	1.1880	1.0982	15	15	13	12
0804	Replacement of Lower Extremity Joint M < 47.	1.8517	1.5719	1.4220	1.3146	16	17	15	15
0901	Other Orthopedic M >= 69	1.1749	0.9376	0.8792	0.8083	11	11	10	10
0902	Other Orthopedic M < 69 and M >= 55.	1.5103	1.2052	1.1302	1.0390	13	14	13	12
0903	Other Orthopedic M < 55 and M >= 47.	1.8117	1.4457	1.3557	1.2463	15	16	15	14
0904	Other Orthopedic M < 47	2.0393	1.6273	1.5261	1.4029	17	17	16	16
1001	Amputation Lower Extremity M >= 67.	1.3231	1.1340	1.0276	0.9487	12	13	12	11
1002	Amputation Lower Extremity M < 67 and M >= 59.	1.6372	1.4032	1.2715	1.1739	15	15	14	14
1003	Amputation Lower Extremity M < 59 and M >= 49.	1.8961	1.6251	1.4726	1.3596	17	16	16	15
1004	Amputation Lower Extremity M < 49	2.1617	1.8527	1.6788	1.5500	19	20	18	17
1101	Amputation Non-Lower Extremity	1.8322	1.3022	1.3022	1.0585	15	14	13	12
1201	Osteoarthritis M >= 65	1.3071	1.0757	0.9575	0.8777	11	12	11	11
1202	Osteoarthritis M < 65 and M >= 49	1.6787	1.3816	1.2297	1.1273	14	15	14	13
1203	Osteoarthritis M < 49	1.9145	1.5756	1.4024	1.2857	16	16	16	15
1301	Rheumatoid Other Arthritis M >= 69	1.1111	0.9753	0.9076	0.8570	10	11	10	11
1302	Rheumatoid Other Arthritis M < 69 and M >= 58.	1.3176	1.1567	1.0764	1.0164	12	13	12	12
1303	Rheumatoid Other Arthritis M < 58 and A >= 72.	1.6691	1.4652	1.3635	1.2875	13	17	14	14
1304	Rheumatoid Other Arthritis M < 58 and A < 72.	1.7642	1.5487	1.4412	1.3609	14	17	15	15
1401	Cardiac M >= 70	1.1839	0.9920	0.8991	0.8023	11	11	10	9
1402	Cardiac M < 70 and M >= 59	1.4635	1.2263	1.1115	0.9918	13	13	12	11
1403	Cardiac M < 59 and M >= 51	1.7034	1.4272	1.2936	1.1544	15	15	14	13
1404	Cardiac M < 51	1.9704	1.6510	1.4964	1.3353	18	17	16	14
1501	Pulmonary M >= 84	1.0149	0.9214	0.8346	0.7907	7	10	9	9
1502	Pulmonary M < 84 and M >= 74	1.2323	1.1187	1.0133	0.9601	11	12	11	10

TABLE 9—PROPOSED REVISED RELATIVE WEIGHTS AND AVERAGE LENGTH OF STAY VALUES FOR THE PROPOSED CASE-MIX GROUPS—Continued

CMG	CMG Description (M=motor, A=age)	Relative weight				Average length of stay			
		Tier 1	Tier 2	Tier 3	No comorbidity tier	Tier 1	Tier 2	Tier 3	No comorbidity tier
1503	Pulmonary M < 74 and M >= 59	1.4557	1.3215	1.1970	1.1341	13	13	12	12
1504	Pulmonary M < 59 and M >= 46	1.7464	1.5853	1.4360	1.3606	15	15	14	14
1505	Pulmonary M < 46	2.0273	1.8404	1.6670	1.5794	20	17	15	16
1601	Pain Syndrome M >= 70	1.2293	0.9242	0.8776	0.7774	10	11	10	10
1602	Pain Syndrome M < 70 and M >= 61.	1.5216	1.1439	1.0863	0.9622	12	12	12	11
1603	Pain Syndrome M < 61	1.8391	1.3826	1.3129	1.1630	13	15	14	13
1701	Major Multiple Trauma Without Brain or Spinal Cord Injury M >= 62.	1.4355	1.1154	1.0668	0.9504	14	13	12	11
1702	Major Multiple Trauma Without Brain or Spinal Cord Injury M < 62 and M >= 51.	1.7939	1.3938	1.3330	1.1876	16	15	15	14
1703	Major Multiple Trauma Without Brain or Spinal Cord Injury M < 51 and M >= 47.	2.0059	1.5585	1.4906	1.3280	17	16	16	15
1704	Major Multiple Trauma Without Brain or Spinal Cord Injury M < 47 and M >= 39.	2.1848	1.6975	1.6236	1.4465	19	18	17	16
1705	Major Multiple Trauma Without Brain or Spinal Cord Injury M < 39.	2.4250	1.8841	1.8020	1.6055	21	21	19	17
1801	Major Multiple Trauma With Brain or Spinal Cord Injury M >= 72.	1.1980	1.0351	0.8752	0.8233	13	11	10	10
1802	Major Multiple Trauma With Brain or Spinal Cord Injury M < 72 and M >= 58.	1.5335	1.3250	1.1204	1.0539	14	16	12	12
1803	Major Multiple Trauma With Brain or Spinal Cord Injury M < 58 and M >= 42.	2.0608	1.7806	1.5056	1.4162	23	19	16	16
1804	Major Multiple Trauma With Brain or Spinal Cord Injury M < 42.	2.9220	2.5248	2.1348	2.0081	34	25	23	22
1901	Guillain-Barré M >= 54	1.5211	1.2331	1.1228	1.0834	16	15	12	13
1902	Guillain-Barré M < 54	3.4558	2.8014	2.5507	2.4613	39	28	27	27
2001	Miscellaneous M >= 70	1.2339	1.0047	0.9349	0.8447	11	11	10	10
2002	Miscellaneous M < 70 and M >= 58	1.5240	1.2410	1.1547	1.0433	14	13	12	12
2003	Miscellaneous M < 58 and M >= 49	1.7837	1.4525	1.3515	1.2211	16	15	14	14
2004	Miscellaneous M < 49	2.0373	1.6589	1.5436	1.3947	19	17	16	15
2101	Burns	1.9058	1.5390	1.5118	1.3015	22	16	16	14
5001	Short-stay cases, length of stay is 3 days or fewer.				0.1801				3
5101	Expired, orthopedic, length of stay is 13 days or fewer.				0.6240				7
5102	Expired, orthopedic, length of stay is 14 days or more.				1.7071				18
5103	Expired, not orthopedic, length of stay is 15 days or fewer.				0.6795				7
5104	Expired, not orthopedic, length of stay is 16 days or more.				2.1069				21

The following would be 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.

We are proposing to utilize the CMGs based on the data items from the Quality Indicators section of the IRF–PAI to classify IRF patients for purposes of establishing payment under the IRF PPS beginning with FY 2020. We are proposing to implement these revisions in a budget neutral manner. For more information on the specific impacts of this proposal, we refer readers to Table 10. We are also proposing to update the CMG relative weights and average length of stay values associated with the proposed CMGs based on the data items from the Quality Indicators section of the IRF–PAI. We believe it is appropriate to update the CMGs and relative weights for FY 2020 to better align IRF payments with the costs of caring for IRF patients, given the new information that is captured by the data items from the Quality Indicators section of the IRF–PAI. Additionally, 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.

TABLE 10—DISTRIBUTIONAL EFFECTS OF THE PROPOSED CHANGES TO THE CMGS

Facility classification	Number of IRFs	Number of Cases	Percent Change in Mean Payment
(1)	(2)	(3)	(4)
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
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

Table 10 shows how we estimate that the application of the proposed revisions to the case-mix system for FY 2020 would affect particular groups. Table 10 categorizes IRFs by geographic location, including urban or rural location, and location for CMS's 9 Census divisions of the country. In addition, the table divides IRFs into those that are separate rehabilitation hospitals (otherwise called freestanding hospitals in this section), those that are rehabilitation units of a hospital (otherwise called hospital units in this section), rural or urban facilities, ownership (otherwise called for-profit, non-profit, and government), by teaching status, and bed size. The proposed changes to the case-mix classification system are expected to affect the overall distribution of payments across CMGs. Note that, because we propose to implement the revisions to the case-mix classification system in a budget-neutral manner, total estimated aggregate payments to IRFs would not be affected as a result of the proposed revisions to the CMGs. However, these proposed revisions may affect the distribution of payments across CMGs.

We invite public comment on the proposed refinements to the CMGs beginning with FY 2020, that is, for all discharges beginning on or after October 1, 2019.

VIII. Proposed Revisions to Certain IRF Coverage Requirements Beginning With FY 2019

We are committed to transforming the health care delivery system, and the Medicare program, by putting an additional focus on patient-centered care and working with providers and physicians to improve patient outcomes. As an agency, we recognize it is imperative that we develop and implement policies that allow providers and physicians to focus the majority of their time treating patients rather than completing paperwork. Moreover, we believe it is essential for us to reexamine current regulations and administrative requirements, to assure that we are not

placing unnecessary burden on providers.

We believe the agency initiative of treating patients over paperwork will improve patient outcomes, decrease provider costs, and ensure that patients and providers are making the best heath care choices possible. In the FY 2018 IRF PPS proposed rule (82 FR 20743), we included a request for information (RFI) to solicit comments from stakeholders requesting information on CMS flexibilities and efficiencies. The purpose of the RFI was to receive feedback regarding ways in which we could reduce burden for hospitals and physicians, improve quality of care, decrease costs and ensure that patients receive the best care. We received comments from IRF industry associations, state and national hospital associations, industry groups representing hospitals, and individual IRF providers in response to the solicitation. We are appreciative of the feedback. As discussed in more detail in each of the proposals below, we are in some cases using the commenters' specific suggestions to propose changes to regulatory requirements to alleviate provider burden. In other cases, however, we are proposing additional changes to the regulatory requirements that we believe will be responsive to stakeholder feedback and helpful to providers in reducing administrative burden.

In the FY 2010 IRF PPS final rule (74 FR 39788 through 39798), we updated the IRF coverage criteria requirements to reflect changes that had occurred in medical practice since the IRF PPS was first implemented in 2002. IRF care is only considered by Medicare to be reasonable and necessary under section 1862(a)(1) of the Act if the patient meets all of the IRF coverage requirements outlined in § 412.622(a)(3), (4), and (5). Failure to meet the IRF coverage criteria in a particular case will result in denial of the IRF claim. The IRF coverage requirements have not been updated since they became effective on January 1, 2010. To reduce unnecessary burden on IRF providers and physicians, we are proposing to revise the current IRF coverage criteria as suggested by some of the comments received in response to the RFI. Specifically, we are focused on reducing documentation requirements that we believe have become overly burdensome to IRF providers over time.

A. Proposed Changes to the Physician Supervision Requirement Beginning With FY 2019

In response to the RFI, several commenters suggested that we consider decreasing the number of required weekly face-to-face visits that the rehabilitation physician must complete. Commenters suggested that the decrease in visits would not only assist with reducing the documentation burden on rehabilitation physicians, but it would also afford the rehabilitation physician more time to focus on higher-acuity, more complex patients resulting in improved outcomes and lower readmission rates. Additionally, we received comments suggesting that we consider either eliminating the post-admission physician evaluation altogether in an effort to reduce paperwork and duplicative requirements or that we allow the post-admission physician evaluation to count as one of the required face-to-face visits completed by the rehabilitation physician. We agree with the commenters and are proposing to move forward with a combination of these two suggested ideas in order to reduce unnecessary burden on rehabilitation physicians.

Under § 412.622(a)(3)(iv), for an IRF claim to be considered reasonable and necessary under section 1862(a)(1) of the Act, there must be a reasonable expectation at the time of the patient's admission to the IRF that the patient requires physician supervision by a rehabilitation physician, defined as a licensed physician with specialized training and experience in inpatient rehabilitation. 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. Under § 412.622(a)(4)(ii), to document that each patient for whom the IRF seeks payment is reasonably expected to meet all of the requirements in § 412.622(a)(3) at the time of admission, the patient's medical record at the IRF must contain a post-admission physician evaluation that meets all of the requirements specified in the regulation. For more information, we refer readers to the Medicare Benefit Policy Manual, chapter 1, sections 110.1.2 and 110.2.4 (Pub. 100–02), which can be downloaded from the CMS website at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/internet-Only-Manuals-IOMs.html.*

While the purpose of the physician supervision requirement is to ensure that the patient's medical and functional statuses are being continuously monitored as the patient's overall plan of care is being carried out, the purpose of the post-admission physician evaluation is to document the patient's status on admission, identify any relevant changes that may have occurred since the preadmission screening, and provide the rehabilitation physician with the necessary information to begin development of the patient's overall plan of care. When the coverage criteria were initially implemented, we believed that the post-admission physician evaluation should not be used as a way to fulfill one of the face-to-face visits required under § 412.622(a)(3)(iv) because we considered them to be different types of assessments. We also believed it was in the patient's best interest to be seen by a rehabilitation physician at least four times in the first week of the IRF admission when the patient is in the most critical phase of their recovery process.

While we continue to believe that the post-admission physician evaluation and the face-to-face physician visits are two different types of assessments, after reevaluating these coverage criteria, we believe 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 we received in response to the RFI, we believe that it should be the responsibility of the rehabilitation physician to use his or her best clinical judgment to determine whether the patient needs to be seen more than three times in the first week of the IRF admission. Therefore, allowing these two requirements to be met concurrently would reduce redundancy and regulatory burden while still ensuring adequate care to the patient.

Therefore, we are proposing to modify § 412.622(a)(3)(iv) to provide that the post-admission physician evaluation required under § 412.622(a)(4)(ii) may count as one of the face-to-face physician visits required under § 412.622(a)(3)(iv) beginning with FY 2019, that is, for all IRF discharges beginning on or after October 1, 2018. To clarify, we are not proposing to modify § 412.622(a)(4)(ii), including the 24-hour timeframe within which the post-admission physician evaluation requirement must be completed.

We invite public comment on our proposal to modify § 412.622(a)(3)(iv) to provide that the post-admission physician evaluation required under § 412.622(a)(4)(ii) may count as one of the face-to-face physician visits required under § 412.622(a)(3)(iv) beginning with

FY 2019, that is, for all IRF discharges beginning on or after October 1, 2018.

B. Proposed Changes to the Interdisciplinary Team Meeting Requirement Beginning With FY 2019

Under § 412.622(a)(5), for an IRF claim to be considered reasonable and necessary under section 1862(a)(1) of the Act, the patient must require an interdisciplinary team approach to care, as evidenced by documentation in the patient's medical record of weekly interdisciplinary team meetings that meet all of the requirements specified in the regulation. Among those requirements are that the team meetings must be led by a rehabilitation physician and that the results and findings of the team meetings, and the concurrence by the rehabilitation physician with those results and findings, are retained in the patient's medical record. For more information, we refer readers to the Medicare Benefit Policy Manual, chapter 1, section 110.2.5 (Pub. 100–02), which can be downloaded from the CMS website at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/internet-Only-Manuals-IOMs.html.*

We understand that it may occasionally be difficult for the rehabilitation physician to be physically present in the team meetings and for that reason we have always instructed providers that the rehabilitation physician may participate in the interdisciplinary team meetings by telephone as long as it is clearly demonstrated in the documentation of the IRF medical record that the meeting was led by the rehabilitation physician. However, with the advancements in technology since the inception of the IRF coverage criteria in 2010, we believe it is appropriate to allow rehabilitation physicians to lead the meeting remotely via another mode of communication, such as video or telephone conferencing. Therefore, we are proposing to amend § 412.622(a)(5)(A) to expressly provide that the rehabilitation physician may lead the interdisciplinary meeting remotely without any additional documentation requirements. We believe this proposed change will allow time management flexibility and convenience for all rehabilitation physicians, especially those located in rural areas who may need to travel greater distances between facilities. At this time, we are proposing for this change to apply only to the rehabilitation physician and not the other required interdisciplinary team meeting attendees to give IRFs time to adapt to this proposed change. However, we may consider expanding this policy to include other interdisciplinary team meeting attendees in future rulemaking.

Therefore, we are proposing to amend § 412.622(a)(5)(A) to expressly provide that the rehabilitation physician may lead the interdisciplinary meeting remotely without any additional documentation requirements. We believe that other communication modes such as video and telephone conferencing are acceptable ways of leading the interdisciplinary team meeting. Please note that the requirement that the rehabilitation physician must lead the interdisciplinary team meeting will remain the same.

We invite public comment on our proposal to amend § 412.622(a)(5)(A) to expressly provide that the rehabilitation physician may lead the interdisciplinary team meeting remotely without additional documentation requirements.

C. Proposed Changes to the Admission Order Documentation Requirement Beginning With FY 2019

In response to the RFI, several commenters suggest that in general, we should consider eliminating duplicative requirements. Commenters stated that duplicative requirements placed unnecessary administrative burden on facilities trying to make sure they comply with each nuance of each requirement. We agree with the commenters and for that reason we are proposing to remove § 412.606(a) as we believe that IRFs are already required to fulfill this requirement under §§ 482.12(c), 482.24(c), and 412.3.

Under § 412.606(a), at the time that each Medicare Part A FFS patient is admitted, the IRF must have physician orders for the patient's care during the time the patient is hospitalized. For more information, we refer readers to the Medicare Benefit Policy Manual, chapter 1, section 110.1.4 (Pub. 100–02), which can be downloaded from the CMS website at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/internet-Only-Manuals-IOMs.html.*

Additionally, under § 412.3(a) of the hospital payment requirements, for the purposes of payment under Medicare Part A, an individual is considered an inpatient of a hospital, including a critical access hospital, if formally admitted as an inpatient under an order for inpatient admission by a physician or other qualified practitioner in accordance with §§ 412.3, 482.24(c), 482.12(c), and 485.638(a)(4)(iii) for a critical access hospital.

In an effort to reduce duplicative requirements, we believe that if we remove the admission order documentation requirement at § 412.606(a), this requirement would continue to be appropriately addressed through the enforcement of § 482.12(c) and § 482.24(c) of the hospital conditions of participation (CoPs), as well as the hospital admission order payment requirements at § 412.3. IRFs are responsible for meeting all of the inpatient hospital CoPs and the hospital admission order payment requirements at § 412.3, and, therefore, we believe that by removing the admission order documentation requirement at § 412.606(a), we would be reducing both regulatory redundancy as well as administrative burden.

Therefore, we are proposing to amend § 412.606(a) to remove the admission order documentation requirement beginning with FY 2019, that is, for all IRF discharges beginning on or after October 1, 2018. IRFs would continue to meet the requirements at §§ 482.12(c), 482.24(c), and 412.3.

We invite public comment on our proposal to amend § 412.606(a) to remove the admission order documentation requirement beginning with FY 2019, that is, for all IRF discharges beginning on or after October 1, 2018.

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

As discussed in section VIII.A of this proposed rule, under § 412.622(a)(3)(iv), for an IRF claim to be considered reasonable and necessary under section 1862(a)(1) of the Act, there must be a reasonable expectation at the time of the patient's admission to the IRF that the patient requires physician supervision by a rehabilitation physician, defined as a licensed physician with specialized training and experience in inpatient rehabilitation. 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 to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process. For more information, we refer readers to the Medicare Benefit Policy Manual, chapter 1, section 110.2.4 (Pub. 100–02), which can be downloaded from the CMS website at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/internet-Only-Manuals-IOMs.html.*

When the IRF coverage criteria were initially implemented in 2010, we

believed that the rehabilitation physician visits should be completed face-to-face to ensure that the patient receives the most comprehensive in-person care by a rehabilitation physician throughout the IRF stay.

As part of our efforts to assist in reducing unnecessary regulatory burden on IRFs, this is an issue we would like to further explore. We are interested in soliciting public comments on whether the rehabilitation physician should have the flexibility to determine that some of the IRF visits can be appropriately conducted remotely via another mode of communication, such as video or telephone conferencing. Given the level of complexity of IRF patients, we have some concerns about whether this approach would have an impact on the quality of care provided to IRF patients. To maintain the hospital level of care that IRF patients require, we would continue to expect that the majority of IRF physician visits would continue to be performed face-to-face. However, we are interested in feedback from stakeholders on whether we should allow a limited number of visits to be conducted remotely. In order to better assist us in balancing the needs of the patient, as well as retaining the hospital level quality of care provided in an IRF with the goal of reducing the regulatory burden on rehabilitation physicians, we are seeking feedback from stakeholders about potentially amending the face-to-face visit requirement for rehabilitation physicians. Specifically, we would appreciate feedback regarding the following:

- 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?
- 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?

Thus, to assist us in generating ideas and information for analyzing potential refinements in this area, we are seeking feedback from stakeholders on whether the rehabilitation physician should have the flexibility to determine that some of the IRF visits can be appropriately conducted remotely via another mode of communication, such as video or telephone conferencing, while maintaining a hospital level high quality of care for IRF patients.

E. Solicitation of Comments Regarding Changes to the Use of Non-Physician Practitioners in Meeting the Requirements Under § 412.622(a)(3), (4), and (5)

Several of the requirements under § 412.622(a)(3), (4), and (5) require documentation that a rehabilitation physician, defined as a licensed physician with specialized training and experience in inpatient rehabilitation, visited each patient admitted to an IRF and performed an assessment of the patient. For example, under § 412.622(a)(3)(iv), for an IRF claim to be considered reasonable and necessary under section 1862(a)(1) of the Act, there must be a reasonable expectation at the time of the patient's admission to the IRF that the patient requires physician supervision by a rehabilitation physician. 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 to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process. For more information, please refer to the Medicare Benefit Policy Manual, chapter 1, section 110.2.4 (Pub. 100–02), which can be downloaded from the CMS website at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/internet-Only-Manuals-IOMs.html.*

In addition, under § 412.622(a)(4)(ii), to document that each patient for whom the IRF seeks payment is reasonably expected to meet all of the requirements in § 412.622(a)(3) at the time of admission, the patient's medical record at the IRF must contain a post-admission physician evaluation that must, among other requirements, be completed by a rehabilitation physician within 24 hours of the patient's admission to the IRF. For more information, we refer readers to the Medicare Benefit Policy Manual, chapter 1, section 110.1.2 (Pub. 100–02), which can be downloaded from the CMS website at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/internet-Only-Manuals-IOMs.html.*

In the feedback that we received in response to the RFI, it was suggested that we consider amending the requirements in § 412.622(a)(3)(iv) and § 412.622(a)(4)(ii) to enable IRFs to expand their use of non-physician practitioners (physician assistants and nurse practitioners) to fulfill some of the requirements that rehabilitation physicians are currently required to complete. The commenters suggested that expanding the use of non-physician practitioners in meeting some of the IRF requirements would ease the documentation burden on rehabilitation physicians.

In exploring this issue, we have questions about whether non-physician practitioners have the specialized training in inpatient rehabilitation that would enable them to adequately assess the interaction between patients' medical and functional care needs in an IRF. Another concern that has been raised regarding this issue, is whether IRF patients will continue to receive the hospital level and quality of care that is necessary to treat such complex conditions.

To better assist us in balancing the needs of the patient with the desire to reduce the regulatory burden on rehabilitation physicians, we are seeking feedback from stakeholders about potentially allowing IRFs to expand their use of non-physician practitioners to fulfill some of the requirements that rehabilitation physicians are currently required to complete. Specifically, we would appreciate feedback regarding the following:

- 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?

Thus, to assist us in generating ideas and information for analyzing potential refinements in this area, we are seeking feedback from stakeholders on the ways in which 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.

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

A. Background

The Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP) is authorized by section 1886(j)(7) of the Act, and it applies to freestanding IRFs, as well as inpatient rehabilitation units of hospitals or critical access hospitals (CAHs) paid by Medicare under the IRF PPS. Under the IRF QRP, the Secretary reduces the annual increase factor for discharges occurring during such fiscal year by 2 percentage points for any IRF that does not submit data in accordance with the requirements established by the Secretary. For more information on the background and statutory authority for the IRF QRP, we refer readers to the FY 2012 IRF PPS final rule (76 FR 47873 through 47874), the CY 2013 Hospital Outpatient Prospective Payment System/Ambulatory Surgical Center (OPPS/ASC) Payment Systems and Quality Reporting Programs final rule (77 FR 68500 through 68503), the FY 2014 IRF PPS final rule (78 FR 47902), the FY 2015 IRF PPS final rule (79 FR 45908), the FY 2016 IRF PPS final rule (80 FR 47080 through 47083), the FY 2017 IRF PPS final rule (81 FR 52080 through 52081), and the FY 2018 IRF PPS final rule (82 FR 36269 through 36270).

Although we have historically used the preamble to the IRF PPS proposed and final rules each year to remind stakeholders of all previously finalized program requirements, we have concluded that repeating the same discussion each year is not necessary for every requirement, especially if we have codified it in our regulations. Accordingly, the following discussion is limited as much as possible to a discussion of our proposals for future years of the IRF QRP, and represents the approach we intend to use in our rulemakings for this program going forward.

B. General Considerations Used for the Selection of Measures for the IRF QRP

1. Background

For a detailed discussion of the considerations we historically used for the selection of IRF QRP quality, resource use, and others measures, we refer readers to the FY 2016 IRF PPS final rule (80 FR 47083 through 47084).

2. Accounting for Social Risk Factors in the IRF QRP

In the FY 2018 IRF PPS final rule (82 FR 36273 through 36274), we discussed the importance of improving beneficiary outcomes including reducing health disparities. We also discussed our commitment to ensuring that medically complex patients, as well as those with social risk factors, receive excellent care. We discussed how studies show that social risk factors, such as being near or below the poverty level as determined by HHS, belonging to a racial or ethnic minority group, or living with a disability, can be associated with poor health outcomes and how some of this disparity is related to the quality of health care.[3] Among our core objectives, we aim to improve health outcomes, attain health equity for all beneficiaries, and ensure that complex patients as well as those with social risk factors receive excellent care. Within this context, reports by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the National Academy of Medicine have examined the influence of social risk factors in our value-based purchasing programs.[4] As we noted in the FY 2018 IRF PPS final rule (82 FR 36273 through 36274), ASPE's report to Congress, which was required by the IMPACT Act, found that, in the context of value-based purchasing programs, dual eligibility was the most powerful predictor of poor health care outcomes among those social risk factors that they examined and tested. ASPE is continuing to examine this issue in its second report required by the IMPACT Act, which is due to Congress in the fall of 2019. In addition, as we noted in the FY 2018 IPPS/LTCH PPS final rule (82 FR 38428), the National Quality Forum (NQF) undertook a 2-year trial period in which certain new measures and measures undergoing maintenance review have been assessed to determine if risk adjustment for social risk factors is appropriate for these measures.[5] The trial period ended in April 2017 and a final report is available at *http://www.qualityforum.org/SES_Trial_Period.aspx.* The trial concluded that ''measures with a conceptual basis for adjustment generally did not demonstrate an empirical relationship'' between social risk factors and the outcomes measured. This discrepancy may be explained in part by the methods used for adjustment and the limited availability of robust data on social risk factors. NQF has extended the socioeconomic status (SES) trial,[6] allowing further examination of social risk factors in outcome measures.

In the FY/CY 2018 proposed rules for our quality reporting and value-based purchasing programs, we solicited feedback on which social risk factors provide the most valuable information to stakeholders and the methodology for illuminating differences in outcomes rates among patient groups within a provider that would also allow for a comparison of those differences, or disparities, across providers. Feedback we received across our quality reporting programs included encouraging CMS to explore whether factors that could be used to stratify or risk adjust the measures (beyond dual eligibility); to consider the full range of differences in patient backgrounds that might affect outcomes; to explore risk adjustment approaches; and to offer careful consideration of what type of information display would be most useful to the public.

We also sought public comment on confidential reporting and future public reporting of some of our measures stratified by patient dual eligibility. In general, commenters noted that stratified measures could serve as tools for hospitals to identify gaps in outcomes for different groups of patients, improve the quality of health care for all patients, and empower consumers to make informed decisions about health care. Commenters encouraged CMS to stratify measures by other social risk factors such as age, income, and educational attainment. With regard to value-based purchasing programs, commenters also cautioned to balance fair and equitable payment while avoiding payment penalties that mask health disparities or discouraging the provision of care to more medically complex patients. Commenters also noted that value-based payment program measure selection, domain weighting, performance scoring, and payment methodology must account for social risk.

[3] See, for example, United States Department of Health and Human Services. ''Healthy People 2020: Disparities. 2014,'' *http://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities* or National Academies of Sciences, Engineering, and Medicine. Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors. Washington, DC: National Academies of Sciences, Engineering, and Medicine 2016.

[4] Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (ASPE), ''Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs.'' December 2016, *https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicares-value-based-purchasing-programs.*

[5] Available at *http://www.qualityforum.org/SES_Trial_Period.aspx.*

[6] Available at: *http://www.qualityforum.org/SES_Trial_Period.aspx*

As a next step, we are considering options to improve health disparities among patient groups within and across hospitals by increasing the transparency of disparities, as shown by quality measures. We also are considering how this work applies to other CMS quality programs in the future. We refer readers to the FY 2018 IPPS/LTCH PPS final rule (82 FR 38403 through 38409) for more details where we discuss the potential stratification of certain Hospital Inpatient Quality Reporting Program outcome measures. Furthermore, we continue to consider options to address equity and disparities in our value-based purchasing programs.

We plan to continue working with ASPE, the public, and other key stakeholders on this important issue to identify policy solutions that achieve the goals of attaining health equity for all beneficiaries and minimizing unintended consequences.

C. Proposed New Removal Factor for Previously Adopted IRF QRP Measures

As part of our Meaningful Measures Initiative, discussed in section D.1. of the Executive Summary of this proposed rule, we strive to put patients first, ensuring that they, along with their clinicians, are empowered to make decisions about their own healthcare using data-driven information that is increasingly aligned with a parsimonious set of meaningful quality measures. We began reviewing the IRF QRP's measures in accordance with the Meaningful Measures Initiative discussed in section D.1 of the Executive Summary, and we are working to identify how to move the IRF QRP forward in the least burdensome manner possible, while continuing to incentivize improvement in the quality of care provided to patients.

Specifically, we believe the goals of the IRF QRP and the measures used in the program cover most of the Meaningful Measures Initiative priorities, including making care safer, strengthening person and family engagement, promoting coordination of care, promoting effective prevention and treatment, and making care affordable.

We also evaluated the appropriateness and completeness of the IRF QRP's current measure removal factors. We have previously finalized that we would use notice and comment rulemaking to remove measures from the IRF QRP based on the following factors (77 FR 68502 through 68503): [7]

- Factor 1. Measure performance among IRFs is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made.
- Factor 2. Performance or improvement on a measure does not result in better patient outcomes.
- Factor 3. A measure does not align with current clinical guidelines or practice.
- Factor 4. A more broadly applicable measure (across settings, populations, or conditions) for the particular topic is available.
- Factor 5. A measure that is more proximal in time to desired patient outcomes for the particular topic is available.
- Factor 6. A measure that is more strongly associated with desired patient outcomes for the particular topic is available.
- Factor 7. Collection or public reporting of a measure leads to negative unintended consequences other than patient harm.

We continue to believe these measure removal factors are appropriate for use in the IRF QRP. However, even if one or more of the measure removal factors applies, we might nonetheless choose to retain the measure for certain specified reasons. Examples of such instances could include when a particular measure addresses a gap in quality that is so significant that removing the measure could in turn result in poor quality, or in the event that a given measure is statutorily required. We note further that, consistent with other quality reporting programs, we apply these factors on a case-by-case basis.

We are proposing to adopt an additional factor to consider when evaluating measures for removal from the IRF QRP measure set:

Factor 8. The costs associated with a measure outweigh the benefit of its continued use in the program.

As we discussed in section D.1. of the Executive Summary of this proposed rule, to our new Meaningful Measures Initiative, we are engaging in efforts to ensure that the IRF QRP measure set continues to promote improved health outcomes for beneficiaries while minimizing the overall costs associated with the program. We believe these costs are multifaceted and include not only the burden associated with reporting, but also the costs associated with implementing and maintaining the program. We have identified several different types of costs, including, but not limited to: (1) Provider and clinician information collection burden and burden associated with the submitting/reporting of quality measures to CMS; (2) the provider and clinician cost associated with complying with other programmatic requirements; (3) the provider and clinician cost associated with participating in multiple quality programs, and tracking multiple similar or duplicative measures within or across those programs; (4) the cost to CMS associated with the program oversight of the measure including measure maintenance and public display; and (5) the provider and clinician cost associated with compliance to other federal and/or state regulations (if applicable).

For example, it may be needlessly costly and/or of limited benefit to retain or maintain a measure which our analyses show no longer meaningfully supports program objectives (for example, informing beneficiary choice). It may also be costly for health care providers to track confidential feedback, preview reports, and publicly reported information on a measure where we use the measure in more than one program. We may also have to expend unnecessary resources to maintain the specifications for the measure, including the tools needed to collect, validate, analyze, and publicly report the measure data. Furthermore, beneficiaries may find it confusing to see public reporting on the same measure in different programs.

When these costs outweigh the evidence supporting the continued use of a measure in the IRF QRP, we believe it may be appropriate to remove the measure from the program. Although we recognize that one of the main goals of the IRF QRP is to improve beneficiary outcomes by incentivizing health care providers to focus on specific care issues and making public data related to those issues, we also recognize that those goals can have limited utility where, for example, the publicly reported data is of limited use because it cannot be easily interpreted by beneficiaries and used to influence their choice of providers. In these cases, removing the measure from the IRF QRP may better accommodate the costs of program administration and compliance without sacrificing improved health outcomes and beneficiary choice.

We are proposing that we would remove measures based on this factor on a case-by-case basis. We might, for example, decide to retain a measure that is burdensome for health care providers to report if we conclude that the benefit to beneficiaries is so high that it justifies

[7] We refer readers to the FY 2013 CY 2013 Hospital Outpatient Prospective Payment System/Ambulatory Surgical Center (OPPS/ASC) Payment Systems and Quality Reporting Programs final rule (77 FR 68502 through 68503) and FY 2018 IRF PPS final rule (82 FR 36276) for more information on the factors we consider for removing measures and standardized patient assessment data.

the reporting burden. Our 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 improvement in the quality of care provided to patients.

We are inviting public comment on our proposal to adopt an additional measure removal Factor 8, ''the costs associated with a measure outweigh the benefit of its continued use in the program.''

We also are proposing to revise § 412.634(b)(2) of our regulations to codify both the removal factors we have previously finalized for the IRF QRP, as well as the new measure removal factor that we are proposing to adopt in this proposed rule. We are also proposing to remove the reference to the payment impact from the heading of § 412.634(b) and, as discussed more fully in section X.J. of this proposed rule, remove the language in current § 412.634(b)(2) related to the two percentage point payment reduction because that payment reduction is also addressed at § 412.624(c)(4).

We invite public comment on these proposals.

D. Quality Measures Currently Adopted for the FY 2020 IRF QRP

The IRF QRP currently has 18 measures for the FY 2020 program year, which are outlined in Table 11.

TABLE 11—QUALITY MEASURES CURRENTLY ADOPTED FOR THE FY 2020 IRF QRP

Short name	Measure name and 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 Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631).
DRR	Drug Regimen Review Conducted With Follow-Up for Identified Issues-Post Acute Care (PAC) Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP).
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).
NHSN	
CAUTI	National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection Outcome Measure (NQF #0138).
MRSA	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (NQF #1716).
CDI	National Healthcare Safety Network (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)-Post Acute Care (PAC) 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 measure will be replaced with the Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury measure, effective October 1, 2018.

E. Proposed Removal of Two IRF QRP Measures

We are proposing to remove two measures from the IRF QRP measure set. Beginning with the FY 2020 IRF QRP, we are proposing to remove the National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure (NQF #1716). We are also proposing to remove one measure beginning with the FY 2021 IRF QRP: Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680). We discuss these proposals below.

1. Proposed Removal of National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (NQF #1716) Beginning With the FY 2020 IRF QRP

We are proposing to remove the measure, Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (NQF #1716), from the IRF QRP measure set

beginning with the FY 2020 IRF QRP under our proposed measure removal Factor 8, the costs associated with a measure outweigh the benefit of its continued use in the IRF QRP.

We originally adopted this measure in the FY 2015 IRF PPS final rule (79 FR 45911 through 45913). The measure assesses MRSA infections caused by a strain of MRSA bacteria that has become resistant to antibiotics commonly used to treat MRSA infections. The measure is reported as a Standardized Infection Ratio (SIR) of hospital-onset unique blood source MRSA laboratory-identified events among all inpatients in the facility.

The data on this measure is submitted by IRFs via the National Health Safety Network (NHSN), and we adopted it for use in several quality reporting programs because we believe that MRSA is a serious healthcare associated infection. To calculate a measure rate for an individual IRF, we must be able to attribute to the IRF at least one expected MRSA infection during the reporting period. However, we have found that the number of IRFs with expected MRSA infections during a given reporting period is extraordinarily low. For 99.9 percent of IRFs, the expected MRSA infection incident rate is less than one, which is too low to use for purposes of generating a reliable standardized infection ratio. As a result, we are unable to calculate reliable measure rates and publicly report those rates for almost all IRFs because their expected infection rates during a given reporting period are less than one. Therefore, while we still recognize that MRSA is a serious healthcare associated infection, the benefit of this NHSN Facility-wide Inpatient Hospital-onset MRSA Bacteremia Outcome Measure (NQF #1716) is small. For this reason, we believe that the burden required for data collection and submission on this measure and the costs associated with this measure, which include the costs to maintain and publicly report it for the IRF QRP and the costs for a small number of IRFs to track their rates when reliable rates cannot be calculated for most IRFs, outweigh the benefit of its continued use in the program.

Therefore, we are proposing to remove this measure from the IRF QRP, beginning with the FY 2020 IRF QRP.

If finalized as proposed, IRFs would no longer be required to submit data on this measure for the purposes of the IRF QRP beginning with October 1, 2018 admissions and discharges.

We are inviting public comment on this proposal.

2. Proposed Removal of Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680) Beginning With the FY 2021 IRF QRP

We are proposing to remove the measure, Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680), from the IRF QRP beginning with the FY 2021 IRF QRP under measure removal Factor 1, measure performance among IRFs is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made.

In the FY 2014 IRF PPS final rule (78 FR 47910 through 47911), we adopted the Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680) to assess vaccination rates among IRF patients because many patients receiving care in the IRF setting are 65 years and older and considered to be the target population for the influenza vaccination.

This process measure reports the percentage of stays in which the patient was assessed and appropriately given the influenza vaccine for the most recent influenza vaccination season. In our evaluation of this measure, we identified that IRF performance has been high and relatively stable, demonstrating nominal improvements across influenza seasons since data collection began. Our analysis of this particular measure revealed that for the 2015–2016 and the 2016–2017 influenza seasons, nearly every IRF patient was assessed and more than 75 percent of IRFs (n = 836) are vaccinating IRF patients who have not already received a flu vaccination at 90 percent or higher. Further, throughout the last two influenza seasons, the number of IRFs who achieved a perfect score (100 percent) on this measure has grown substantially, increasing by approximately 50 percent from 146 IRFs (12.9 percent) in the 2015–2016 influenza season to 210 IRFs (18.8 percent) in the 2016–2017 influenza season.

The Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680) measure rates are also unvarying. With respect to the 2015–2016 influenza season, the mean performance score was 91.04 percent, and with respect to the 2016–2017 influenza season, the mean performance score on this measure was 93.88 percent. The proximity of these mean rates to the maximum score of 100 percent suggests a potential ceiling effect and a lack of variation that restricts distinction between facilities. Given that performance among IRFs has remained so high and that no meaningful distinction in performance can be made across the majority of IRFs, we are proposing the removal of this measure.

Therefore, we are proposing to remove this measure from the IRF QRP beginning with the FY 2021 IRF QRP under of measure removal Factor 1, measure performance among IRFs is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made.

If finalized as proposed, 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. We plan to remove these data elements from the IRF–PAI version 3.0, effective October 1, 2019. Beginning with October 1, 2018 discharges, IRFs should enter a dash (–) for O0250A, O0250B, and O0250C until the IRF–PAI version 3.0 is released.

We are inviting public comment on this proposal.

F. IMPACT Act Implementation Update

In the FY 2018 IRF PPS final rule (82 FR 36285 through 36286), we stated that we intended to specify two measures that would satisfy the domain of accurately communicating the existence and provision of the transfer of health information and care preferences under section 1899B(c)(1)(E) of the Act no later than October 1, 2018, and intended to propose to adopt them for the FY 2021 IRF QRP with data collection beginning on or about October 1, 2019.

As a result of the input provided during a public comment period between November 10, 2016 and December 11, 2016, input provided by a technical expert panel (TEP) convened by our contractor, and pilot measure testing conducted in 2017, we are engaging in continued development work on these two measures, including supplementary measure testing and providing the public with an opportunity for comment in 2018. Further, we expect to reconvene a TEP for these measures in mid-2018. We now intend to specify the measures under section 1899B(c)(1)(E) of the Act no later than October 1, 2019, and intend to propose to adopt the measures for the FY 2022 IRF QRP, with data collection beginning with patients discharged on or after October 1, 2020. For more information on the pilot testing, we refer readers to: *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.

G. Form, Manner, and Timing of Data Submission Under the IRF QRP

Under our current policy, IRFs report data on IRF QRP assessment-based measures and standardized patient assessment data by completing applicable sections of the IRF–PAI and submitting the IRF–PAI to CMS through the Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. For more information on IRF QRP reporting through the Quality Improvement and Evaluation System Assessment Submission and Processing (QIES ASAP) system, refer to the ''Related Links'' section at the bottom of *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Software.html.* Data on IRF QRP measures that are also collected by the Centers for Disease Control and Prevention (CDC) for other purposes are reported by IRFs to the CDC through the NHSN, and the CDC then transmits the relevant data to CMS. Information regarding the CDC's NHSN is available at: *https://www.cdc.gov/nhsn/index.html.* We refer readers to the FY 2018 IRF PPS final rule (82 FR 36291 through 36292) for the data collection and submission timeframes that we finalized for the IRF QRP.

We previously codified at § 412.634(b)(1) of our regulations the requirement that IRFs submit data on measures specified under sections 1886(j)(7)(D), 1899B(c)(1), and 1899B(d)(1) of the Act in the form and manner, and at a time, specified by CMS. We are proposing in this proposed rule to revise § 412.634(b)(1) to include the policy we previously finalized in the FY 2018 IRF PPS Final Rule (82 FR 36292 through 36293) that IRFs must also submit standardized patient assessment data required under section 1899B(b)(1) of the Act in the form and manner, and at a time, specified by CMS.

We are inviting public comment on this proposal.

H. Proposed Changes to Reconsiderations Requirements Under the IRF QRP

Section 412.634(d)(1) of our regulations states, in part, that IRFs found to be non-compliant with the quality reporting requirements for a particular fiscal year will receive a letter of non-compliance through the Quality Improvement and Evaluation System Assessment Submission and Processing (QIES–ASAP) system, as well as through the United States Postal Service.

We are proposing to revise § 412.634(d)(1) to expand the methods by which we would notify an IRF of non-compliance with the IRF QRP requirements for a program year. Revised § 412.634(d)(1) would state that we would notify IRFs of non-compliance with the IRF QRP requirements via a letter sent through at least one of the following notification methods: The QIES–ASAP system, the United States Postal Service, or via an email from the Medicare Administrative Contractor (MAC). We believe that this change will address the feedback from providers requesting additional methods for notification.

We are also proposing to revise § 412.634(d)(5) to clarify that we will notify IRFs, in writing, of our final decision regarding any reconsideration request using the same notification process.

We are inviting public comments on these proposals.

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

Section 1886(j)(7)(E) of the Act requires the Secretary to establish procedures for making the IRF QRP data available to the public after ensuring that an IRF has the opportunity to review its data prior to public display. Measure data are currently displayed on the *IRF Compare* website, an interactive web tool that assists individuals by providing information on IRF quality of care to those who need to select an IRF. For more information on *IRF Compare,* we refer readers to: *https://www.medicare.gov/inpatientrehabilitationfacilitycompare/.*

We propose to begin publicly displaying data on the following four assessment-based measures in CY 2020, or as soon thereafter as technically feasible: (1) Change in Self-Care (NQF #2633); (2) Change in Mobility Score (NQF #2634); (3) Discharge Self-Care Score (NQF #2635); (4) and Discharge Mobility Score (NQF #2636). Data collection for these four assessment-based measures began with patients discharged on or after October 1, 2016. We are proposing to display data for these assessment-based measures based on four rolling quarters of data, initially using discharges from January 1, 2019 through December 31, 2019 (Quarter 1 2019 through Quarter 4 2019). To ensure the statistical reliability of the data for these four assessment-based measures, we are also proposing that if an IRF has fewer than 20 cases during any four consecutive rolling quarters of data that we are displaying for any of these measures, then we would note in our public display of that measure that with respect to that IRF the number of cases/patient stays is too small to publicly report.

We invite public comment on these proposals

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

As previously noted, section 1886(j)(7)(A)(i) of the Act requires the application of a 2-percentage point reduction of the applicable market basket increase factor for payments for discharges occurring during such fiscal year for IRFs that fail to comply with the quality data submission requirements. We propose to apply a 2-percentage point reduction to the applicable FY 2019 market basket increase factor in calculating a proposed adjusted FY 2019 standard payment conversion factor to apply to payments for only those IRFs that failed to comply with the data submission requirements. As previously noted, application of the 2-percentage point reduction may result in an update that is less than 0.0 for a fiscal year and in payment rates for a fiscal year being less than such payment rates for the preceding fiscal year. Also, reporting-based reductions to the market basket increase factor will not be cumulative; they will only apply for the FY involved.

We invite public comment on the proposed method for applying the reduction to the FY 2019 IRF increase factor for IRFs that fail to meet the quality reporting requirements.

Table 12 shows the calculation of the proposed adjusted FY 2019 standard payment conversion factor that will be used to compute IRF PPS payment rates for any IRF that failed to meet the quality reporting requirements for the applicable reporting period.

TABLE 12—CALCULATIONS TO DETERMINE THE PROPOSED 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 further reduced by 2 percentage points for IRFs that failed to meet the quality reporting requirement	×	0.9935
Budget Neutrality Factor for the Wage Index and Labor-Related Share	×	1.0000
Budget Neutrality Factor for the Revisions to the CMG Relative Weights	×	0.9980
Adjusted FY 2019 Standard Payment Conversion Factor	=	$ 15,704

Our regulations currently address the two percentage point payment reduction for failure to meet requirements under the IRF QRP in two places: § 412.624(c)(4) and § 412.634(b)(2). We believe that these provisions are duplicative and are proposing to revise the regulations so that the payment reduction is addressed only in § 412.624(c)(4). As noted in this proposed rule, we are proposing to remove the language regarding the payment reduction that is currently at § 412.634(b)(2) and to codify that section instead the retention and removal policies for the IRF QRP.

We are also proposing to revise § 412.624(c)(4)(i) to clarify that an IRF's failure to submit data under the IRF QRP in accordance with § 412.634 will result in the 2 percentage point reduction to the applicable increase factor specified in § 412.624(a)(3).

Finally, we are proposing to revise § 412.624(c)(4) for greater consistency with the language of section 1886(j)(7)(A)(i) of the Act. Specifically, we would revise paragraph (i) to clarify that the 2 percentage point reduction is applied ''after application of subparagraphs (C)(iii) and (D) of section 1886(j)(3) of the Act.'' In addition, we would add a new paragraph (iii) that clarifies that the 2 percentage point reduction required under section 1886(j)(7)(A)(i) of the Act may result in an update that is less than 0.0 for a fiscal year.

We invite public comment on these proposals.

X. Request for Information on Promoting Interoperability and Electronic Healthcare Information Exchange Through Possible Revisions to the CMS Patient Health and Safety Requirements for Hospitals and Other Medicare- and Medicaid-Participating Providers and Suppliers

Currently, Medicare- and Medicaid-participating providers and suppliers are at varying stages of adoption of health information technology (health IT). Many hospitals have adopted electronic health records (EHRs), and CMS has provided incentive payments to eligible hospitals, critical access hospitals (CAHs), and eligible professionals who have demonstrated meaningful use of certified EHR technology (CEHRT) under the Medicare EHR Incentive Program. As of 2015, 96 percent of Medicare- and Medicaid-participating non-Federal acute care hospitals had adopted certified EHRs with the capability to electronically export a summary of clinical care.[8] While both adoption of EHRs and electronic exchange of information have grown substantially among hospitals, significant obstacles to exchanging electronic health information across the continuum of care persist. Routine electronic transfer of information post-discharge has not been achieved by providers and suppliers in many localities and regions throughout the nation.

CMS is firmly committed to the use of certified health IT and interoperable EHR systems for electronic healthcare information exchange to effectively help hospitals and other Medicare- and Medicaid-participating providers and suppliers improve internal care delivery practices, support the exchange of important information across care team members during transitions of care, and enable reporting of electronically specified clinical quality measures (eCQMs). The Office of the National Coordinator for Health Information Technology (ONC) acts as the principal federal entity charged with coordination of nationwide efforts to implement and use health information technology and the electronic exchange of health information on behalf of the Department of Health and Human Services.

In 2015, ONC finalized the 2015 Edition health IT certification criteria (2015 Edition), the most recent criteria for health IT to be certified to under the ONC Health IT Certification Program. The 2015 Edition facilitates greater interoperability for several clinical health information purposes and enables health information exchange through new and enhanced certification criteria, standards, and implementation specifications. CMS requires eligible hospitals and CAHs in the Medicare and Medicaid EHR Incentive Programs and eligible clinicians in the Quality Payment Program (QPP) to use EHR technology certified to the 2015 Edition beginning in CY 2019.

In addition, several important initiatives will be implemented over the next several years to provide hospitals and other participating providers and suppliers with access to robust infrastructure that will enable routine electronic exchange of health information. Section 4003 of the 21st Century Cures Act (Pub. L. 114–255), enacted in 2016, and amending section 3000 of the Public Health Service Act (42 U.S.C. 300jj), requires HHS to take steps to advance the electronic exchange of health information and interoperability for participating providers and suppliers in various settings across the care continuum. Specifically, Congress directed that ONC ''. . . for the purpose of ensuring full network-to-network exchange of health information, convene public-private and public-public partnerships to build consensus and develop or support a trusted exchange framework, including a common agreement among health information networks nationally.'' In January 2018, ONC released a draft version of its proposal for the Trusted Exchange Framework and Common Agreement,[9] which outlines principles and minimum terms and conditions for trusted exchange to enable interoperability across disparate health information networks (HINs). The Trusted Exchange Framework (TEF) is focused on achieving the following

[8] These statistics can be accessed at: *https://dashboard.healthit.gov/quickstats/pages/FIG-Hospital-EHR-Adoption.php.*

[9] The draft version of the trusted Exchange Framework may be accessed at *https://beta.healthit.gov/topic/interoperability/trusted-exchange-framework-and-common-agreement.*

four important outcomes in the long-term:

- Professional care providers, who deliver care across the continuum, can access health information about their patients, regardless of where the patient received care.
- Patients can find all of their health information from across the care continuum, even if they do not remember the name of the professional care provider they saw.
- Professional care providers and health systems, as well as public and private health care organizations and public and private payer organizations accountable for managing benefits and the health of populations, can receive necessary and appropriate information on groups of individuals without having to access one record at a time, allowing them to analyze population health trends, outcomes, and costs; identify at-risk populations; and track progress on quality improvement initiatives.
- The health IT community has open and accessible application programming interfaces (APIs) to encourage entrepreneurial, user-focused innovation that will make health information more accessible and improve EHR usability.

ONC will revise the draft TEF based on public comment and ultimately release a final version of the TEF that will subsequently be available for adoption by HINs and their participants seeking to participate in nationwide health information exchange. The goal for stakeholders that participate in, or serve as, a HIN is to ensure that participants will have the ability to seamlessly share and receive a core set of data from other network participants in accordance with a set of permitted purposes and applicable privacy and security requirements. Broad adoption of this framework and its associated exchange standards is intended to both achieve the outcomes described above while creating an environment more conducive to innovation.

In light of the widespread adoption of EHRs along with the increasing availability of health information exchange infrastructure predominantly among hospitals, we are interested in hearing from stakeholders on how we could use the CMS health and safety standards that are required for providers and suppliers participating in the Medicare and Medicaid programs (that is, the Conditions of Participation (CoPs), Conditions for Coverage (CfCs), and Requirements for Participation (RfPs) for Long Term Care Facilities) to further advance electronic exchange of information that supports safe, effective transitions of care between hospitals and community providers. Specifically, CMS might consider revisions to the current CMS CoPs for hospitals such as: Requiring that hospitals transferring medically necessary information to another facility upon a patient transfer or discharge do so electronically; requiring that hospitals electronically send required discharge information to a community provider via electronic means if possible and if a community provider can be identified; and requiring that hospitals make certain information available to patients or a specified third-party application (for example, required discharge instructions) via electronic means if requested.

On November 3, 2015, we published a proposed rule (80 FR 68126) to implement the provisions of the IMPACT Act and to revise the discharge planning CoP requirements that hospitals (including Short-Term Acute-Care Hospitals, Long-Term Care Hospitals (LTCHs), Inpatient Rehabilitation Hospitals (IRFs), Inpatient Psychiatric Hospitals (IPFs), Children's Hospitals, and Cancer Hospitals), critical access hospitals (CAHs), and home health agencies (HHAs) must meet in order to participate in the Medicare and Medicaid programs. This proposed rule has not been finalized yet. However, several of the proposed requirements directly address the issue of communication between providers and between providers and patients, as well as the issue of interoperability:

- Hospitals and CAHs would be required to transfer certain necessary medical information and a copy of the discharge instructions and discharge summary to the patient's practitioner, if the practitioner is known and has been clearly identified;
- Hospitals and CAHs would be required to send certain necessary medical information to the receiving facility/post-acute care providers, at the time of discharge; and
- Hospitals, CAHs and HHAs, would need to comply with the IMPACT Act requirements that would require hospitals, CAHs, and certain post-acute care providers to use data on quality measures and data on resource use measures to assist patients during the discharge planning process, while taking into account the patient's goals of care and treatment preferences.

We published another proposed rule (81 FR 39448), on June 16, 2016, that updated a number of CoP requirements that hospitals and CAH must meet in order to participate in the Medicare and Medicaid programs. This proposed rule has not been finalized yet. One of the proposed hospital CoP revisions in that rule directly addresses the issues of communication between providers and patients, patient access to their medical records, and interoperability. We proposed that patients have the right to access their medical records, upon an oral or written request, in the form and format requested by such patients, if it is readily producible in such form and format (including in an electronic form or format when such medical records are maintained electronically); or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, including current medical records, within a reasonable time frame. The hospital must not frustrate the legitimate efforts of individuals to gain access to their own medical records and must actively seek to meet these requests as quickly as its record keeping system permits.

We also published a final rule (81 FR 68688), on October 4, 2016, that revised the requirements that LTC facilities must meet to participate in the Medicare and Medicaid programs, where we made a number of revisions based on the importance of effective communication between providers during transitions of care, such as transfers and discharges of residents to other facilities or providers, or to home. Among these revisions was a requirement that the transferring LTC facility must provide all necessary information to the resident's receiving provider, whether it is an acute care hospital, a LTC hospital, a psychiatric facility, another LTC facility, a hospice, home health agency, or another community-based provider or practitioner. We specified that necessary information must include the following:

- Contact information of the practitioner responsible for the care of the resident;
- Resident representative information including contact information;
- Advance directive information;
- Special instructions or precautions for ongoing care;
- The resident's comprehensive care plan goals; and
- All other necessary information, including a copy of the resident's discharge or transfer summary and any other documentation to ensure a safe and effective transition of care.

We note that the discharge summary mentioned above must include reconciliation of the resident's medications, as well as a recapitulation of the resident's stay, a final summary of the resident's status, and the post-discharge plan of care. And in the preamble to the rule, we encouraged LTC facilities to electronically exchange

this information if possible and to identify opportunities to streamline the collection and exchange of resident information by using information that the facility is already capturing electronically.

Additionally, we specifically invite stakeholder feedback on the following questions regarding possible new or revised CoPs/CfCs/RfPs for interoperability and electronic exchange of health information:

- 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?
- 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?

We would also like to directly address the issue of communication between hospitals (as well as the other providers and suppliers across the continuum of patient care) and their patients and caregivers. MyHealthEData is a government-wide initiative aimed at breaking down barriers that contribute to preventing patients from being able to access and control their medical records. Privacy and security of patient data will be at the center of all CMS efforts in this area. CMS must protect the confidentiality of patient data, and CMS is completely aligned with the Department of Veterans Affairs (VA), the National Institutes of Health (NIH), ONC, and the rest of the federal government, on this objective.

While some Medicare beneficiaries have had, for quite some time, the ability to download their Medicare claims information, in pdf or Excel formats, through the CMS Blue Button platform, the information was provided without any context or other information that would help beneficiaries understand what the data was really telling them. For beneficiaries, their claims information is useless if it is either too hard to obtain or, as was the case with the information provided through previous versions of Blue Button, hard to understand. In an effort to fully contribute to the federal government's MyHealthEData initiative, CMS developed and launched the new Blue Button 2.0, which represents a major step toward giving patients meaningful control of their health information in an easy-to-access and understandable way. Blue Button 2.0 is a developer-friendly, standards-based API that enables Medicare beneficiaries to connect their claims data to secure applications, services, and research programs they trust. The possibilities for better care through Blue Button 2.0 data are exciting, and might include enabling the creation of health dashboards for Medicare beneficiaries to view their health information in a single portal, or allowing beneficiaries to share complete medication lists with their doctors to prevent dangerous drug interactions.

To fully understand all of these health IT interoperability issues, initiatives, and innovations through the lens of its regulatory authority, CMS invites members of the public to submit their ideas on how best to accomplish the goal of fully interoperable health IT and EHR systems for Medicare- and Medicaid-participating providers and suppliers, as well as how best to further contribute to and advance the MyHealthEData initiative for patients. We are particularly interested in identifying fundamental barriers to interoperability and health information exchange, including those specific barriers that prevent patients from being able to access and control their medical records. We also welcome the public's ideas and innovative thoughts on addressing these barriers and ultimately removing or reducing them in an effective way, specifically through revisions to the current CMS CoPs, CfCs, and RfPs for hospitals and other participating providers and suppliers. We have received stakeholder input through recent CMS Listening Sessions on the need to address health IT adoption and interoperability among providers that were not eligible for the Medicare and Medicaid EHR Incentives program, including long-term and post-acute care providers, behavioral health providers, clinical laboratories and social service providers, and we would also welcome specific input on how to encourage adoption of certified health IT and interoperability among these types of providers and suppliers as well.

We note that this is a Request for Information only. Respondents are encouraged to provide complete but concise and organized responses, including any relevant data and specific examples. However, respondents are not required to address every issue or respond to every question discussed in this Request for Information to have their responses considered. In accordance with the implementing

regulations of the Paperwork Reduction Act at 5 CFR 1320.3(h)(4), all responses will be considered provided they contain information CMS can use to identify and contact the commenter, if needed.

This Request for Information is issued solely for information and planning purposes; it does not constitute a Request for Proposal (RFP), applications, proposal abstracts, or quotations. This Request for Information does not commit the U.S. Government to contract for any supplies or services or make a grant award. Further, CMS is not seeking proposals through this Request for Information and will not accept unsolicited proposals. Responders are advised that the U.S. Government will not pay for any information or administrative costs incurred in response to this Request for Information; all costs associated with responding to this Request for Information will be solely at the interested party's expense.

We note that not responding to this Request for Information does not preclude participation in any future procurement, if conducted. It is the responsibility of the potential responders to monitor this Request for Information announcement for additional information pertaining to this request. In addition, we note that CMS will not respond to questions about the policy issues raised in this Request for Information. CMS will not respond to comment submissions in response to this Request for Information in the FY 2019 IPPS/LTCH PPS final rule. Rather, CMS will actively consider all input as we develop future regulatory proposals or future subregulatory policy guidance. CMS may or may not choose to contact individual responders. Such communications would be for the sole purpose of clarifying statements in the responders' written responses. Contractor support personnel may be used to review responses to this Request for Information. Responses to this notice are not offers and cannot be accepted by the Government to form a binding contract or issue a grant. Information obtained as a result of this Request for Information may be used by the Government for program planning on a nonattribution basis. Respondents should not include any information that might be considered proprietary or confidential.

This Request for Information should not be construed as a commitment or authorization to incur cost for which reimbursement would be required or sought. All submissions become U.S. Government property and will not be returned. CMS may publically post the public comments received, or a summary of those public comments.

XI. Collection of Information Requirements

A. Statutory Requirement for Solicitation of Comments

Under the Paperwork Reduction Act of 1995 (PRA), we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the OMB for review and approval. To fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

This proposed rule makes reference to associated information collections that are not discussed in the regulation text contained in this document.

B. Collection of Information Requirements for Updates Related to the IRF PPS

As discussed in section VIII.A of this proposed rule, we are proposing to modify § 412.622(a)(3)(iv) to provide that the post-admission physician evaluation required under § 412.622(a)(4)(ii) may count as one of the face-to-face physician visits required under § 412.622(a)(3)(iv) beginning with FY 2019, that is, for all IRF discharges beginning on or after October 1, 2018. As discussed in section VIII.B of this proposed rule, we are proposing to modify § 412.622(a)(5) to allow rehabilitation physicians to attend interdisciplinary team meetings remotely beginning with FY 2019, that is, for all IRF discharges beginning on or after October 1, 2018. As discussed in section VIII.C of this proposed rule, we are proposing to modify § 412.606 to remove subsection (a) and eliminate the admission order requirement beginning with FY 2019, that is, for all IRF discharges beginning on or after October 1, 2018.

We estimate the cost savings associated with our proposal to allow the post-admission physician evaluation to count as one of the required face-to-face physician visits, as discussed in section VIII.A of this proposed rule, in the following way. We first estimate that the post-admission physician evaluation takes approximately 60 minutes to complete and the required face-to-face physician visits take, on average, 30 minutes each to complete. Both of these requirements must be fulfilled by a rehabilitation physician. To estimate the burden reduction of this proposal, therefore, we obtained the hourly wage rate for a physician (there was not a specific wage rate for a rehabilitation physician) from the Bureau of Labor Statistics (*http://www.bls.gov/ooh/healthcare/home.htm*) to be $98.83. The hourly wage rate including fringe benefits and overhead is $197.66.

In FY 2017, we estimate that there were approximately 1,124 total IRFs and on average 357 discharges per IRF annually. Therefore, there were an estimated seven patients (357 discharges/52 weeks) at the IRF per week. The rehabilitation physician spends 357 hours (60 minutes × 357 discharges) annually completing the post-admission physician evaluation. If on average each IRF has seven patients per week and each face-to-face visit takes an estimated 30 minutes for the rehabilitation physician to complete, annually the rehabilitation physician spends an estimated 546 hours ((7 patients × 3 visits × 0.5 hours) × 52 weeks) completing the required face-to-face physician visits. On average, a rehabilitation physician currently spends 903 hours (357 hours + 546 hours) annually completing post-admission physician evaluations and the required face-to-face physician visits.

If we allow the post-admission physician evaluation to count as one of the face-to-face required physician visits, we would need to estimate the average time spent on one face-to-face visit ((7 patients × 1 visit × 0.5 hours) × 52 weeks). Removing one of the face-to-face visits required in the first week of the IRF admission will save the rehabilitation physician approximately 182 hours ((7 patients × 1 visit × 0.5 hours) × 52 weeks) annually per IRF. This is a savings of 204,568 hours across all IRFs annually (1,124 IRFs × 182 hours).

To estimate the total cost savings per IRF annually, we multiply 182 hours by $197.66 (average physician's salary doubled to account for fringe and overhead costs). Therefore, we can estimate the total cost savings per IRF will be $36,000 annually. We estimate that the total cost savings for allowing the post-admission physician evaluation to count as one of the required face-to-face physician visits, will be $40.5

million (1,124 IRFs × $36,000) annually across the IRF setting. We would like to note that all of the cost savings reflected in this estimate will occur on the Medicare Part B side, in the form of reduced Part B payments to physicians under the physician fee schedule. Physician services provided in an IRF are billed directly to Part B therefore, IRFs do not pay physicians for their services.

We do not estimate a cost savings in removing the admission order coverage criteria requirements as IRFs are still required to comply with the enforcement of the admission requirements located in §§ 482.24(c), 482.12(c) and 412.3. Any increase in Medicare payments due to the proposed change would be negligible given the anticipated low volume of claims that would be payable under this proposed policy that would not have been paid under the current policy. Therefore, we believe that the reduction of burden in this proposed removal is in reducing the redundancy of requirements only.

As discussed in section VII.A of this proposed rule, we are proposing to remove the FIM™ instrument and associated Function Modifiers from the IRF–PAI beginning with FY 2020, that is, for all IRF discharges beginning on or after October 1, 2019. The proposed removal of the FIM™ instrument and associated Function Modifiers from the IRF PAI would result in the removal of 11 data items. As a result, we estimate the burden and costs associated with the collection of this data will be reduced for IRFs. Specifically, we estimate the proposed removal of the FIM™ instrument and the associated Function Modifiers will save 25 minutes of nursing/clinical staff time used to report data on both admission and discharge which was the estimated time needed to complete these items when the FIM™ instrument was added to the IRF–PAI in the FY 2002 IRF PPS Final Rule (66 FR 41375). We believe that the FIM™ items we are proposing to remove may be completed by social service assistants, Licensed Practical Nurses (LPN), recreational therapists, social workers, dietitians and nutritionists, Registered Nurses (RN), Occupational Therapists (OT), Speech Language Pathologists (SLP) and audiologists, and or Physical Therapists (PT), depending on the item. To estimate the burden associated with the collection of these data items, we obtained mean hourly wages for these staff from the U.S. Bureau of Labor Statistics' May 2016 National Occupational Employment and Wage Estimates (*https://www.bls.gov/oes/2016/may/oes_nat.htm*) and doubled them to account for overhead and fringe benefits. We estimate IRF–PAI preparation and coding costs using a social worker hourly wage rate of $48.76, a social work assistant's hourly wage rate of $32.82, an RN hourly wage rate of $69.40, an LPN hourly wage rate of $43.12, a recreation therapist hourly wage rate of $46.34, a dietitian/nutritionist hourly wage rate of $57.38, a speech-language pathologist hourly wage rate of $75.20, an audiologist hourly wage rate of $76.24, an occupational therapist hourly wage rate of $80.50, and a physical therapist hourly wage rate of $83.86. Using the mean hourly wages (doubled to account for overhead and fringe benefits) for the staffing categories above, we calculate an average rate of $61.36. The $61.36 rate is a blend of all of these categories, and reflects the fact that IRF providers have historically used all of these clinicians for preparation and coding for the IRF–PAI.

To estimate the burden reduction associated with this proposal, we estimate that there are approximately 401,760 discharges from 1,124 IRFs in FY 2017 resulting in an approximate average of 357 discharges per IRF annually. This equates to a reduction of 167,400 hours for all IRFs ((401,760 discharges × 25 minutes)/60 minutes). This is 149 hours (167,400 hours/1,124 IRFs) per IRF annually. We estimate the total cost savings per IRF will be approximately $9,100 (149 hours × $61.36) annually. We estimate that the total cost savings for all IRF providers will be approximately $10.2 million (1,124 IRFs × $9,100) annually.

C. Collection of Information Requirements for Updates Related to the IRF QRP

An IRF that does not meet the requirements of the IRF QRP for a fiscal year will receive a 2 percentage point reduction to its otherwise applicable annual increase factor for that fiscal year. Information is not currently available to determine the precise number of IRFs that will receive less than the full annual increase factor for FY 2019 due to non-compliance with the requirements of the IRF QRP.

We believe that the burden associated with the IRF QRP is the time and effort associated with complying with the requirements of the IRF QRP. As of February 1, 2018, there are approximately 1,124 IRFs reporting quality data to CMS. For the purposes of calculating the costs associated with the collection of information requirements, we obtained mean hourly wages for these staff from the U.S. Bureau of Labor Statistics' May 2016 National Occupational Employment and Wage Estimates (*http://www.bls.gov/oes/current/oes_nat.htm*). To account for overhead and fringe benefits, we have doubled the hourly wage. These amounts are detailed in Table 13.

TABLE 13—U.S. BUREAU OF LABOR STATISTICS' MAY 2016 NATIONAL OCCUPATIONAL EMPLOYMENT AND WAGE ESTIMATES

Occupation title	Occupation code	Mean hourly wage ($/hr)	Overhead and fringe benefit ($/hr)	Adjusted hourly wage ($/hr)
Registered Nurse (RN)	29–1141	$34.70	$34.70	$69.40
Medical Records and Health Information Technician	29–2071	19.93	19.93	39.86

As discussed in section IX.4. of this proposed rule, we are proposing to remove two measures from the IRF QRP.

In section IX.4.2 of this proposed rule, we are proposing to remove the measure, Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680), beginning with the FY 2021 IRF QRP. IRFs will no longer be required to submit data on this measure beginning with patients discharged on October 1, 2018, and the items will be removed from the IRF–PAI V3.0, effective October 1, 2019. As a result, the estimated burden and cost for IRFs for complying with requirements of the FY 2021 IRF QRP will be reduced. Specifically, we believe that there will be a 4.8 minute reduction in clinical staff time to report data per patient stay. We estimate 401,760 discharges from 1,124 IRFs annually. This equates to a decrease of 32,141 hours in burden for all IRFs (0.08 hours per assessment × 401,760 discharges). Given 4.8 minutes

of RN time at $69.40 per hour completing an average of 357 sets of IRF–PAI assessments per provider per year, we estimate that the total cost will be reduced by $1,982 per IRF annually, or $2,227,768 for all IRFs annually. This decrease in burden will be accounted for in the information collection under OMB control number (0938–0842).

In addition, we are proposing to remove one CDC NHSN measure, beginning with the FY 2020 IRF QRP, which will result in a decrease in burden and cost for IRFs. Providers will no longer be required to submit data beginning with October 1, 2018 admissions and discharges. We estimate that the removal of the National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (NQF #1716) measure will result in a 3-hour (15 minutes per MRSA submission × 12 estimated submissions IRF per year) reduction in clinical staff time annually to report data which equates to a decrease of 3,372 hours (3 hours burden per IRF per year × 1,124 total IRFs) in burden for all IRFs. Given 10 minutes of RN time at $69.40 per hour, and 5 minutes of Medical Records or Health Information Technician at $39.86 per hour, for the submission of MRSA data to the NHSN per IRF per year, we estimate that the total cost of complying with requirements of the IRF QRP will be reduced by $178.66 per IRF annually, or $200,813.84 for all IRFs annually.

In summary, the proposed IRF QRP measure removals will result in a burden reduction of $2160.66 per IRF annually, and $2,428,581.84 for all IRFs annually.

XII. Response to Public Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this proposed rule, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

XIV. Regulatory Impact Analysis

A. Statement of Need

This proposed rule updates the IRF prospective payment rates for FY 2019 as required under section 1886(j)(3)(C) of the Act. It responds to section 1886(j)(5) of the Act, which requires the Secretary to publish in the **Federal Register** on or before the August 1 that precedes the start of each fiscal year, the classification and weighting factors for the IRF PPS's case-mix groups, and a description of the methodology and data used in computing the prospective payment rates for that fiscal year.

This proposed rule also implements sections 1886(j)(3)(C) and (D) of the Act. Section 1886(j)(3)(C)(ii)(I) of the Act requires the Secretary to apply a multi-factor productivity adjustment to the market basket increase factor, and to apply other adjustments as defined by the Act. The productivity adjustment applies to FYs from 2012 forward. The other adjustments apply to FYs 2010 through 2019.

Furthermore, this proposed rule also adopts policy changes under the statutory discretion afforded to the Secretary under section 1886(j)(7) of the Act. Specifically, we propose to remove the FIM™ instrument and associated Function Modifiers from the IRF–PAI, revise certain IRF coverage requirements, and remove two measures and codify policies that have been finalized under the IRF QRP.

B. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), the Congressional Review Act (5 U.S.C. 804(2) and Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs (January 30, 2017).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as an action that is likely to result in a rule: (1) Having an annual effect on the economy of $100 million or more in any 1 year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or state, local or tribal governments or communities (also referred to as ''economically significant''); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). We estimate the total impact of the policy updates described in this proposed rule by comparing the estimated payments in FY 2019 with those in FY 2018. This analysis results in an estimated $75 million increase for FY 2019 IRF PPS payments. Additionally we estimate that costs associated with the proposals to revise certain IRF coverage requirements and update the reporting requirements under the IRF quality reporting program result in an estimated $42.9 million reduction in costs in FY 2019 for IRFs. We estimate that this rulemaking is ''economically significant'' as measured by the $100 million threshold, and hence also a major rule under the Congressional Review Act. Also, the rule has been reviewed by OMB. Accordingly, we have prepared a Regulatory Impact Analysis that, to the best of our ability, presents the costs and benefits of the rulemaking.

C. Anticipated Effects

1. Effects on IRFs

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most IRFs and most other providers and suppliers are small entities, either by having revenues of $7.5 million to $38.5 million or less in any 1 year depending on industry classification, or by being nonprofit organizations that are not dominant in their markets. (For details, see the Small Business Administration's final rule that set forth size standards for health care industries, at 65 FR 69432 at *http://www.sba.gov/sites/default/files/files/Size_Standards_Table.pdf,* effective March 26, 2012 and updated on February 26, 2016.) Because we lack data on individual hospital receipts, we cannot determine the number of small proprietary IRFs or the proportion of IRFs' revenue that is derived from

Medicare payments. Therefore, we assume that all IRFs (an approximate total of 1,120 IRFs, of which approximately 55 percent are nonprofit facilities) are considered small entities and that Medicare payment constitutes the majority of their revenues. The HHS generally uses a revenue impact of 3 to 5 percent as a significance threshold under the RFA. As shown in Table 14, we estimate that the net revenue impact of this proposed rule on all IRFs is to increase estimated payments by approximately 0.9 percent. The rates and policies set forth in this proposed rule will not have a significant impact (not greater than 3 percent) on a substantial number of small entities. Medicare Administrative Contractors are not considered to be small entities. Individuals and states are not included in the definition of a small entity. In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. As discussed in detail below in this section, the rates and policies set forth in this proposed rule will not have a significant impact (not greater than 3 percent) on a substantial number of rural hospitals based on the data of the 137 rural units and 11 rural hospitals in our database of 1,124 IRFs for which data were available.

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–04, enacted on March 22, 1995) (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2018, that threshold is approximately $150 million. This proposed rule does not mandate any requirements for State, local, or tribal governments, or for the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has federalism implications. As stated, this proposed rule will not have a substantial effect on state and local governments, preempt state law, or otherwise have a federalism implication.

Executive Order 13771, titled Reducing Regulation and Controlling Regulatory Costs, was issued on January 30, 2017 and requires that the costs associated with significant new regulations ''shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least two prior regulations.'' This proposed rule, if finalized, is considered an E.O. 13771 deregulatory action. We estimate that this rule would generate $46.49 million in annualized cost savings, discounted at 7 percent relative to year 2016, over a perpetual time horizon. Details on the estimated costs savings of this rule can be found in the preceding analyses.

2. Detailed Economic Analysis

This proposed rule proposes updates to the IRF PPS rates contained in the FY 2018 IRF PPS final rule (82 FR 36238). Specifically, this proposed rule would update the CMG relative weights and average length of stay values, the wage index, and the outlier threshold for high-cost cases. This proposed rule would apply a MFP adjustment to the FY 2019 IRF market basket increase factor in accordance with section 1886(j)(3)(C)(ii)(I) of the Act, and a 0.75 percentage point reduction to the FY 2019 IRF market basket increase factor in accordance with sections 1886(j)(3)(C)(ii)(II) and (D)(v) of the Act. Further, this proposed rule contains proposed revisions to remove the FIM™ instrument and associated Function Modifiers from the IRF–PAI beginning in FY 2020, revise certain IRF coverage requirements, and to revise and update the IRF quality reporting requirements that are expected to result in some additional financial effects on IRFs. In addition, section IX.J. of this proposed rule discusses the implementation of the required 2 percentage point reduction of the market basket increase factor for any IRF that fails to meet the IRF quality reporting requirements, in accordance with section 1886(j)(7) of the Act.

We estimate that the impact of the changes and updates described in this proposed rule will be a net estimated increase of $75 million in payments to IRF providers. This estimate does not include the implementation of the required 2 percentage point reduction of the market basket increase factor for any IRF that fails to meet the IRF quality reporting requirements (as discussed in section IX.J. of this proposed rule). The impact analysis in Table 14 of this proposed rule represents the projected effects of the updates to IRF PPS payments for FY 2019 compared with the estimated IRF PPS payments in FY 2018. We determine the effects by estimating payments while holding all other payment variables constant. We use the best data available, but we do not attempt to predict behavioral responses to these changes, and we do not make adjustments for future changes in such variables as number of discharges or case-mix.

We note that certain events may combine to limit the scope or accuracy of our impact analysis, because such an analysis is future-oriented and, thus, susceptible to forecasting errors because of other changes in the forecasted impact time period. Some examples could be legislative changes made by the Congress to the Medicare program that would impact program funding, or changes specifically related to IRFs. Although some of these changes may not necessarily be specific to the IRF PPS, the nature of the Medicare program is such that the changes may interact, and the complexity of the interaction of these changes could make it difficult to predict accurately the full scope of the impact upon IRFs.

In updating the rates for FY 2019, we are proposing standard annual revisions described in this proposed rule (for example, the update to the wage and market basket indexes used to adjust the federal rates). We are also implementing a productivity adjustment to the FY 2019 IRF market basket increase factor in accordance with section 1886(j)(3)(C)(ii)(I) of the Act, and a 0.75 percentage point reduction to the FY 2017 IRF market basket increase factor in accordance with sections 1886(j)(3)(C)(ii)(II) and (D)(v) of the Act. We estimate the total increase in payments to IRFs in FY 2019, relative to FY 2018, will be approximately $75 million.

This estimate is derived from the application of the FY 2019 IRF market basket increase factor, as reduced by a productivity adjustment in accordance with section 1886(j)(3)(C)(ii)(I) of the Act, and a 0.75 percentage point reduction in accordance with sections 1886(j)(3)(C)(ii)(II) and (D)(v) of the Act, which yields an estimated increase in aggregate payments to IRFs of $110 million. Furthermore, there is an additional estimated $35 million decrease in aggregate payments to IRFs due to the proposed update to the outlier threshold amount. Outlier payments are estimated to decrease from approximately 3.4 percent in FY 2018 to 3.0 percent in FY 2019. Therefore, summed together, we estimate that these updates will result in a net increase in estimated payments of $75 million from FY 2018 to FY 2019.

The effects of the proposed updates that impact IRF PPS payment rates are shown in Table 14. The following proposed updates that affect the IRF PPS payment rates are discussed separately below:

- The effects of the proposed update to the outlier threshold amount, from approximately 3.4 percent to 3.0 percent of total estimated payments for FY 2019, consistent with section 1886(j)(4) of the Act.
- The effects of the proposed annual market basket update (using the IRF market basket) to IRF PPS payment rates, as required by section 1886(j)(3)(A)(i) and sections 1886(j)(3)(C) and (D) of the Act, including a productivity adjustment in accordance with section 1886(j)(3)(C)(i)(I) of the Act, and a 0.75 percentage point reduction in accordance with sections 1886(j)(3)(C)(ii)(II) and (D)(v) of the Act.
- The effects of applying the proposed budget-neutral labor-related share and wage index adjustment, as required under section 1886(j)(6) of the Act.
- The effects of the proposed budget-neutral changes to the CMG relative weights and average length of stay values, under the authority of section 1886(j)(2)(C)(i) of the Act.
- The total change in estimated payments based on the proposed FY 2019 payment changes relative to the estimated FY 2018 payments.

3. Description of Table 14

Table 14 categorizes IRFs by geographic location, including urban or rural location, and location for CMS's 9 Census divisions (as defined on the cost report) of the country. In addition, the table divides IRFs into those that are separate rehabilitation hospitals (otherwise called freestanding hospitals in this section), those that are rehabilitation units of a hospital (otherwise called hospital units in this section), rural or urban facilities, ownership (otherwise called for-profit, non-profit, and government), by teaching status, and by disproportionate share patient percentage (DSH PP). The top row of Table 14 shows the overall impact on the 1,124 IRFs included in the analysis.

The next 12 rows of Table 14 contain IRFs categorized according to their geographic location, designation as either a freestanding hospital or a unit of a hospital, and by type of ownership; all urban, which is further divided into urban units of a hospital, urban freestanding hospitals, and by type of ownership; and all rural, which is further divided into rural units of a hospital, rural freestanding hospitals, and by type of ownership. There are 976 IRFs located in urban areas included in our analysis. Among these, there are 707 IRF units of hospitals located in urban areas and 269 freestanding IRF hospitals located in urban areas. There are 148 IRFs located in rural areas included in our analysis. Among these, there are 137 IRF units of hospitals located in rural areas and 11 freestanding IRF hospitals located in rural areas. There are 386 for-profit IRFs. Among these, there are 346 IRFs in urban areas and 40 IRFs in rural areas. There are 621 non-profit IRFs. Among these, there are 534 urban IRFs and 87 rural IRFs. There are 117 government-owned IRFs. Among these, there are 96 urban IRFs and 21 rural IRFs.

The remaining four parts of Table 14 show IRFs grouped by their geographic location within a region, by teaching status, and by DSH PP. First, IRFs located in urban areas are categorized for their location within a particular one of the nine Census geographic regions. Second, IRFs located in rural areas are categorized for their location within a particular one of the nine Census geographic regions. In some cases, especially for rural IRFs located in the New England, Mountain, and Pacific regions, the number of IRFs represented is small. IRFs are then grouped by teaching status, including non-teaching IRFs, IRFs with an intern and resident to average daily census (ADC) ratio less than 10 percent, IRFs with an intern and resident to ADC ratio greater than or equal to 10 percent and less than or equal to 19 percent, and IRFs with an intern and resident to ADC ratio greater than 19 percent. Finally, IRFs are grouped by DSH PP, including IRFs with zero DSH PP, IRFs with a DSH PP less than 5 percent, IRFs with a DSH PP between 5 and less than 10 percent, IRFs with a DSH PP between 10 and 20 percent, and IRFs with a DSH PP greater than 20 percent.

The estimated impacts of each policy described in this proposed rule to the facility categories listed are shown in the columns of Table 14. The description of each column is as follows:

- Column (1) shows the facility classification categories.
- Column (2) shows the number of IRFs in each category in our FY 2019 analysis file.
- Column (3) shows the number of cases in each category in our FY 2019 analysis file.
- Column (4) shows the estimated effect of the proposed adjustment to the outlier threshold amount.
- Column (5) shows the estimated effect of the proposed update to the IRF labor-related share and wage index, in a budget-neutral manner.
- Column (6) shows the estimated effect of the proposed update to the CMG relative weights and average length of stay values, in a budget-neutral manner.
- Column (7) compares our estimates of the payments per discharge, incorporating all of the proposed policies reflected in this proposed rule for FY 2019 to our estimates of payments per discharge in FY 2018.

The average estimated increase for all IRFs is approximately 0.9 percent. This estimated net increase includes the effects of the proposed IRF market basket increase factor for FY 2019 of 2.9 percent, reduced by a productivity adjustment of 0.8 percentage point in accordance with section 1886(j)(3)(C)(ii)(I) of the Act, and further reduced by 0.75 percentage point in accordance with sections 1886(j)(3)(C)(ii)(II) and (D)(v) of the Act. It also includes the approximate 0.4 percent overall decrease in estimated IRF outlier payments from the proposed update to the outlier threshold amount. Since we are making the proposed updates to the IRF wage index and the CMG relative weights in a budget-neutral manner, they will not be expected to affect total estimated IRF payments in the aggregate. However, as described in more detail in each section, they will be expected to affect the estimated distribution of payments among providers.

TABLE 14—IRF IMPACT TABLE FOR FY 2019

[Columns 4 through 7 in percentage]

Facility classification	Number of IRFs	Number of cases	Outlier	FY 2019 CBSA wage index and labor-share	CMG weights	Total percent change [1]
(1)	(2)	(3)	(4)	(5)	(6)	(7)
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
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 less than 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 greater than 19%	12	1,982	−0.5	0.5	0.0	1.4
Disproportionate share patient percentage (DSHPP):						
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

[1] This column includes the impact of the updates in columns (4), (5), and (6) above, and of the IRF 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, and reduced by 0.75 percentage point in accordance with sections 1886(j)(3)(C)(ii)(II) and -(D)(v) of the Act.

4. Impact of the Proposed Update to the Outlier Threshold Amount

The estimated effects of the proposed update to the outlier threshold adjustment are presented in column 4 of Table 14. In the FY 2018 IRF PPS final rule (82 FR 36238), we used FY 2016 IRF claims data (the best, most complete data available at that time) to set the outlier threshold amount for FY 2018 so that estimated outlier payments would equal 3 percent of total estimated payments for FY 2018.

For this proposed rule, we are using preliminary FY 2017 IRF claims data, and, based on that preliminary analysis, we estimate that IRF outlier payments as a percentage of total estimated IRF payments would be 3.4 percent in FY 2018. Thus, we propose to adjust the outlier threshold amount in this proposed rule to set total estimated outlier payments equal to 3 percent of total estimated payments in FY 2019. The estimated change in total IRF payments for FY 2019, therefore, includes an approximate 0.4 percent decrease in payments because the estimated outlier portion of total payments is estimated to decrease from approximately 3.4 percent to 3 percent.

The impact of this proposed outlier adjustment update (as shown in column 4 of Table 14) is to decrease estimated overall payments to IRFs by about 0.4 percent. We estimate the largest decrease in payments from the update to the outlier threshold amount to be 1.9 percent for rural IRFs in the Pacific region.

5. Impact of the Proposed CBSA Wage Index and Labor-Related Share

In column 5 of Table 14, we present the effects of the proposed budget-neutral update of the wage index and labor-related share. The proposed changes to the wage index and the labor-related share are discussed together because the wage index is applied to the labor-related share portion of payments, so the proposed changes in the two have a combined effect on payments to providers. As discussed in section V.C. of this proposed rule, we are proposing to update the labor-related share from 70.7 percent in FY 2018 to 70.6 percent in FY 2019.

6. Impact of the Proposed Update to the CMG Relative Weights and Average Length of Stay Values

In column 6 of Table 14, we present the effects of the proposed budget-neutral update of the CMG relative weights and average length of stay values. In the aggregate, we do not estimate that these proposed updates will affect overall estimated payments of IRFs. However, we do expect these updates to have small distributional effects.

7. Effects of the Proposed Removal of the FIM™ Instrument and Associated Function Modifiers From the IRF–PAI Beginning in FY 2020

As discussed in section VII. of this proposed rule, we are proposing to remove the FIM™ Instrument and Associated Function Modifiers from the IRF–PAI beginning in FY 2020. We estimate that removal of these data items from the IRF–PAI will reduce administrative burden on IRF providers and reduce the costs incurred by IRFs by $10.2 million for FY 2020.

8. Effects of Proposed Revisions to Certain IRF PPS Requirements

As discussed in section VIII. of this proposed rule, in response to the RFI, we are proposing to remove and amend certain IRF coverage criteria requirements that are overly burdensome on IRF providers beginning in FY 2019, that is, all IRF discharges on or after October 1, 2018. We estimate that the removal and updates to these requirements will reduce unnecessary regulatory and administrative burden on IRF providers and reduce the costs incurred by IRFs by 40.5 million for FY 2019.

9. Effects of Proposed Requirements for the IRF QRP for FY 2020

In accordance with section 1886(j)(7) of the Act, we will reduce by 2 percentage points the market basket increase factor otherwise applicable to an IRF for a fiscal year if the IRF does not comply with the requirements of the IRF QRP for that fiscal year. In section VII.K of this proposed rule, we discuss the proposed method for applying the 2 percentage point reduction to IRFs that fail to meet the IRF QRP requirements.

As discussed in section IX.4. of this proposed rule, we are proposing to remove two measures from the IRF QRP: Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680) and National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (NQF #1716).

We describe the estimated burden and cost reductions for both of these measures in section XI.C of this rule. In summary, the proposed IRF QRP measure removals will result in a burden reduction of $2,160.66 per IRF annually, and $2,428,581.84 for all IRFs annually. We intend to continue to closely monitor the effects of the quality reporting program on IRFs and to help perpetuate successful reporting outcomes through ongoing stakeholder education, national trainings, IRF announcements, website postings, CMS Open Door Forums, and general and technical help desks.

D. Alternatives Considered

The following is a discussion of the alternatives considered for the IRF PPS updates contained in this proposed rule.

Section 1886(j)(3)(C) of the Act requires the Secretary to update the IRF PPS payment rates by an increase factor that reflects changes over time in the prices of an appropriate mix of goods and services included in the covered IRF services. Thus, we did not consider alternatives to updating payments using the estimated IRF market basket increase factor for FY 2019. However, as noted previously in this proposed rule, section 1886(j)(3)(C)(ii)(I) of the Act requires the Secretary to apply a productivity adjustment to the market basket increase factor for FY 2019, and sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(v) of the Act require the Secretary to apply a 0.75 percentage point reduction to the market basket increase factor for FY 2019. Thus, in accordance with section 1886(j)(3)(C) of the Act, we propose to update the IRF federal prospective payments in this proposed rule by 1.35 percent (which equals the 2.9 percent estimated IRF market basket increase factor for FY 2019 reduced by a 0.8 percentage point productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act and further reduced by 0.75 percentage point).

We considered maintaining the existing CMG relative weights and average length of stay values for FY 2019. However, in light of recently available data and our desire to ensure that the CMG relative weights and average length of stay values are as reflective as possible of recent changes in IRF utilization and case-mix, we believe that it is appropriate to propose to update the CMG relative weights and average length of stay values at this time to ensure that IRF PPS payments continue to reflect as accurately as possible the current costs of care in IRFs.

We considered updating facility-level adjustment factors for FY 2019. However, as discussed in more detail in the FY 2015 final rule (79 FR 45872), we believe that freezing the facility-level adjustments at FY 2014 levels for FY 2015 and all subsequent years (unless and until the data indicate that they need to be further updated) will allow us an opportunity to monitor the effects of the substantial changes to the adjustment factors for FY 2014, and will allow IRFs time to adjust to the previous changes.

We considered maintaining the existing outlier threshold amount for FY 2019. However, analysis of updated FY 2019 data indicates that estimated outlier payments would be higher than 3 percent of total estimated payments for FY 2019, by approximately 0.4 percent, unless we updated the outlier threshold amount. Consequently, we propose adjusting the outlier threshold amount in this proposed rule to reflect a 0.4 percent decrease thereby setting the total outlier payments equal to 3 percent, instead of 3.4 percent, of aggregate estimated payments in FY 2019.

We considered not proposing to remove the FIM™ instrument and associated Function Modifiers from the IRF–PAI in this proposed rule. However, in light of recently available data located in the Quality Indicators section of the IRF–PAI, we believe that removal of the FIM™ instrument and associated Function Modifiers is appropriate at this time. As the data items located in the Quality Indicators section of the IRF–PAI are now collected for all IRFs, we believe the collection of the FIM data is no longer necessary and creates undue burden on providers. Consequently, we propose removing these data items from the IRF–PAI beginning with FY 2020. Additionally, the proposed removal of

the FIM™ Instrument and associated Function Modifiers would necessitate the incorporation of the data items from the Quality Indicators section of the IRF–PAI into the CMG classification system. To ensure that the CMGs, relative weights, and average length of stay values are as reflective as possible of recent changes in IRF utilization and case-mix, we believe that it is appropriate to incorporate the data items from the Quality Indicators section of the IRF–PAI into the development of the CMGs beginning with FY 2020.

We considered not proposing revisions to certain IRF PPS requirements in order to reduce burden in this proposed rule. However, after the response that we received from providers regarding the RFI solicitation, we believed that there were areas in which we could reduce unnecessary regulatory and administrative burden on IRF providers, while ensuring that IRF patients would continue to receive adequate care.

E. Regulatory Review Costs

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this proposed rule, we should estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review the rule, we assume that the total number of unique commenters on FY 2018 IRF PPS proposed rule will be the number of reviewers of this proposed rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this proposed rule. It is possible that not all commenters reviewed the FY 2018 IRF PPS proposed rule in detail, and it is also possible that some reviewers chose not to comment on the proposed rule. For these reasons we thought that the number of past commenters would be a fair estimate of the number of reviewers of this rule. We welcome any comments on the approach in estimating the number of entities which will review this proposed rule.

We also recognize that different types of entities are in many cases affected by mutually exclusive sections of this proposed rule, and therefore for the purposes of our estimate we assume that each reviewer reads approximately 50 percent of the rule. We seek comments on this assumption.

Using the wage information from the BLS for medical and health service managers (Code 11–9111), we estimate that the cost of reviewing this rule is $105.16 per hour, including overhead and fringe benefits *https://www.bls.gov/oes/current/oes_nat.htm.* Assuming an average reading speed, we estimate that it would take approximately 2 hours for the staff to review half of this proposed rule. For each IRF that reviews the rule, the estimated cost is $210.32 (2 hours × $105.16). Therefore, we estimate that the total cost of reviewing this regulation is $15,984.32 ($210.32 × 76 reviewers).

F. Accounting Statement and Table

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/sites/default/files/omb/assets/omb/circulars/a004/a-4.pdf*), in Table 15, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this proposed rule. Table 15 provides our best estimate of the increase in Medicare payments under the IRF PPS as a result of the proposed updates presented in this proposed rule based on the data for 1,124 IRFs in our database. In addition, Table 15 presents the costs associated with the proposed new IRF quality reporting program requirements for FY 2019.

TABLE 15—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURE

Change in estimated transfers from FY 2018 IRF PPS to FY 2019 IRF PPS	
Category	Transfers
Annualized Monetized Transfers	$75 million.
From Whom to Whom?	Federal Government to IRF Medicare Providers.

Change in Estimated Costs	
Category	Costs
Annualized monetized cost in FY 2019 for IRFs due to the removal of certain IRF coverage requirements.	Reduction of $40.5 million.
Annualized monetized cost in FY 2020 for IRFs due to the removal of FIM™ instrument and associated Function Modifiers from the IRF–PAI.	Reduction of $10.2 million.
Annualized monetized cost in FY 2019 for IRFs due to new quality reporting program requirements.	Reduction of $2.4 million.

G. Conclusion

Overall, the estimated payments per discharge for IRFs in FY 2019 are projected to increase by 0.9 percent, compared with the estimated payments in FY 2018, as reflected in column 7 of Table 15.

IRF payments per discharge are estimated to increase by 1.0 percent in urban areas and 0.7 percent in rural areas, compared with estimated FY 2018 payments. Payments per discharge to rehabilitation units are estimated to increase 0.7 percent in urban areas and 0.6 percent in rural areas. Payments per discharge to freestanding rehabilitation hospitals are estimated to increase 1.2 percent in urban areas and increase 1.5 percent in rural areas.

Overall, IRFs are estimated to experience a net increase in payments as a result of the proposed policies in this proposed rule. The largest payment increase is estimated to be a 2.8 percent increase for rural IRFs located in the New England region. The analysis above, together with the remainder of this preamble, provides a Regulatory Impact Analysis.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects in 42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Department of Health and

Human Services proposes to amend 42 CFR chapter IV as set forth below:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

■ 1. The authority citation for part 412 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh); sec. 124 of Pub. L. 106–113 (113 Stat. 1501A–332); sec. 1206 of Pub. L. 113–67; sec. 112 of Pub. L. 113–93; sec. 231 of Pub. L. 114–113; and secs. 15004, 15006, 15007, 15008, 15009, and 15010 of Pub. L. 114–255.

§ 412.606 [Amended]

■ 2. Section 412.606 is amended by—
■ a. Removing paragraph (a); and
■ b. Redesignating paragraphs (b) and (c) as paragraphs (a) and (b).
■ 3. Section 412.622 is amended by—
■ a. Revising paragraph (a)(3)(iv);
■ b. Redesignating paragraphs (a)(5)(A) through (C) as paragraphs (a)(5)(i) through (iii); and
■ c. Revising newly redesignated paragraph (a)(5)(i).

The revisions read as follows:

§ 412.622 Basis of payment.

(a) * * *

(3) * * *

(iv) Requires physician supervision by a rehabilitation physician, defined as a licensed physician with specialized training and experience in inpatient rehabilitation. 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 to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process. The post-admission physician evaluation described in paragraph (a)(4)(ii) of this section may count as one of the face-to-face visits.

* * * * *

(5) * * *

(i) The team meetings are led by a rehabilitation physician as defined in paragraph (a)(3)(iv) of this section, and further consist of a registered nurse with specialized training or experience in rehabilitation; a social worker or case manager (or both); and a licensed or certified therapist from each therapy discipline involved in treating the patient. All team members must have current knowledge of the patient's medical and functional status. The rehabilitation physician may lead the interdisciplinary team meeting remotely via a mode of communication such as video or telephone conferencing.

* * * * *

■ 4. Section 412.624 is amended by revising paragraph (c)(4)(i) and adding paragraph (c)(4)(iii) to read as follows:

§ 412.624 Methodology for calculating the Federal prospective payment rates.

* * * * *

(c) * * *

(4) * * *

(i) In the case of an IRF that is paid under the prospective payment system specified in § 412.1(a)(3) of this part that does not submit quality data to CMS in accordance with § 412.634, the applicable increase factor specified in paragraph (a)(3) of this section, after application of paragraphs (C)(iii) and (D) of section 1886(j)(3) of the Act, is reduced by 2 percentage points.

* * * * *

(iii) The 2 percentage point reduction described in paragraph (c)(4)(i) of this section may result in the applicable increase factor specified in paragraph (a)(3) of this section being less than 0.0 for a fiscal year, and may result in payment rates under the prospective payment system specified in § 412.1(a)(3) of this part for a fiscal year being less than such payment rates for the preceding fiscal year.

* * * * *

■ 5. Section 412.634 is amended by revising the paragraph (b) subject heading and paragraphs (b)(1) and (2) and (d)(1) and (5) to read as follows:

§ 412.634 Requirements under the Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP).

* * * * *

(b) *Submission requirements.* (1) IRFs must submit to CMS data on measures specified under sections 1886(j)(7)(D), 1899B(c)(1), 1899B(d)(1) of the Act, and standardized patient assessment data required under section 1899B(b)(1) of the Act, as applicable. Such data must be submitted in the form and manner, and at a time, specified by CMS.

(2) CMS may remove a quality measure from the IRF QRP based on one or more of the following factors:

(i) Measure performance among IRFs is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made;

(ii) Performance or improvement on a measure does not result in better patient outcomes;

(iii) The measure does not align with current clinical guidelines or practice;

(iv) A more broadly applicable measure (across settings, populations, or conditions) for the particular topic is available;

(v) A measure that is more proximal in time to desired patient outcomes for the particular topic is available;

(vi) A measure that is more strongly associated with desired patient outcomes for the particular topic is available;

(vii) The collection or public reporting of the measure leads to negative unintended consequences other than patient harm;

(viii) The costs associated with the measure outweigh the benefit of its continued use in the IRF QRP.

* * * * *

(d) * * *

(1) IRFs that do not meet the requirement in paragraph (b) of this section for a program year will receive a written notification of non-compliance through at least one of the following methods: Quality Improvement and Evaluation System Assessment Submission and Processing (QIES ASAP) system, the United States Postal Service, or via an email from the Medicare Administrative Contractor (MAC).

* * * * *

(5) CMS will notify IRFs, in writing, of its final decision regarding any reconsideration request through at least one of the following methods: QIES ASAP system, the United States Postal Service, or via an email from the Medicare Administrative Contractor (MAC).

* * * * *

Dated: April 18, 2018.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

Dated: April 20, 2018.

Alex M. Azar II,

Secretary, Department of Health and Human Services.

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