CHAPTER 1: INTRODUCTION TO THE INPATIENT REHABILITATION FACILITY PATIENT ASSESSMENT INSTRUMENT (IRF-PAI) MANUAL

1.1 Purpose and Content of the IRF-PAI Manual Version 4.2

The purpose of this manual is to guide the user in completing the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI), which is required by the Centers for Medicare & Medicaid Services (CMS) as part of the IRF Prospective Payment System (IRF PPS). The IRF-PAI is used to gather data to determine the payment for each patient admitted to an inpatient rehabilitation unit or hospital.

The IRF-PAI is also the assessment instrument IRF providers use to collect patient assessment data for quality measure calculation in accordance with the IRF Quality Reporting Program (IRF QRP). IRFs are required to report these data with respect to admission and discharge of all patients, regardless of payer, discharged on and after October 1, 2024.[1]

This manual is intended to provide guidance on use of the IRF-PAI. Content contained in this document may be superseded by guidance published by CMS at a later date. Please refer to the following website to obtain the most recent updates: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-PAI-and-IRF-PAI-Manual

1.2 Background of the IRF PPS

- The Medicare statute was originally enacted in 1965, providing for payment for hospital inpatient services based on the reasonable costs incurred in treating Medicare beneficiaries.

- The statute was amended in 1982 by the Tax Equity and Fiscal Responsibility Act (TEFRA), which placed limits on deliverable costs per discharge.

- The Social Security Amendments of 1983 established a Medicare Inpatient Prospective Payment System (IPPS) for the operating costs of an inpatient hospital stay. The following hospitals and hospital units are excluded from the IPPS:
  - o Children's hospitals;
  - o Psychiatric hospitals;
  - o Long-term care hospitals;
  - o Rehabilitation hospitals;

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[1] The fiscal year (FY) 2023 IRF PPS final rule (87 FR 47073) finalized the collection of IRF-PAI assessment data on each patient receiving care in an IRF, regardless of payer.

- o Distinct part psychiatric and rehabilitation units of IPPS hospitals and critical access hospitals (CAHs); and

- o Cancer hospitals.

- • TEFRA payments remained in effect for inpatient rehabilitation hospitals and distinct part rehabilitation units from 1982 to 2001. TEFRA payments are based on costs incurred during a base period, which resulted in inequities in payment between older and newer facilities.

- • The desire to control the rapid growth of rehabilitation facilities and eliminate inequities in Medicare payments led to Congressional action:

  - o Balanced Budget Act (BBA) of 1997.

  - o Balanced Budget Refinement Act (BBRA) of 1999.

    - ▪ Provisions for implementation of an IRF PPS.

    - ▪ IRF PPS was implemented on January 1, 2002.

- • Research began on the development of an IRF PPS:

  - o 1984: The Functional Independence Measure (FIM™) instrument was developed to address functional status measurement.

  - o 1987: RAND and the Medical College of Wisconsin investigated an IRF PPS:

    - ▪ Diagnoses alone explained little of variance in cost.

    - ▪ Functional status explained more of total costs for rehabilitation patients.

  - o 1993: Functional Related Groups (FRGs) concept was developed by N. Harada and colleagues at Veterans Administration (VA) Medical Center in Los Angeles as possible basis for rehabilitation prospective payment.

  - o 1994: FRGs concept was refined and applied by M. Stineman and colleagues from the University of Pennsylvania to large rehabilitation database for use as a patient classification system.

  - o 1994: RAND was commissioned to study the stability of the FRGs and their performance related to cost rather than length of stay.

  - o 1997: RAND found:

    - ▪ FRGs remained stable over time.

    - ▪ FRGs explained 50% of patient costs and 65% of facility costs.

    - ▪ FRGs could be used as a case mix methodology to establish an IRF PPS.

  - o 1997: Prospective Payment Assessment Commission (ProPAC) reported to Congress:

    - ▪ Implement IRF-PPS as soon as possible.

    - ▪ FIM-FRGs could be an appropriate basis for the IRF PPS.

  - o 1997: CMS published the criteria for the IRF PPS.

- • As a result, the Secretary of Health and Human Services:

o   Established Case Mix Groups (CMGs) and the method to classify patients within these groups.

o   Required IRFs to submit data to establish and administer the IRF PPS.

o   Provided a computerized data system to group patients for payment.

o   Provided software for data transmission.

o   Recommended that the Medicare hospital claim form contain appropriate CMG codes to support an IRF PPS.

- 2001: CMS established a patient assessment instrument following a comparison study of two proposed instruments.

- 2001: Final Rule for the IRF PPS was published.

o   In order to be excluded from the IPPS and paid instead under the IRF PPS, an IRF is required to meet all applicable requirements in 42 Code of Federal Regulations 412.25 and 412.29.

o   In order for an IRF claim to be considered reasonable and necessary under section 1862(a)(1) of the Social Security Act (the Act), the IRF claim must meet the requirements in 42 Code of Federal Regulations 412.622(a)(3), (4), and (5).

- 2012: Section 3004(b) of the Affordable Care Act (ACA) directed the Secretary to establish quality reporting requirements for IRFs. Below is a link to text of section 3004 of the ACA.

o   https://www.govinfo.gov/content/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf

o   Section 3004 of the ACA required the Secretary to publish, by no later than October 1, 2012, the selected quality measures that must be reported by IRFs. The ACA requires that CMS use nationally endorsed quality measures, but also allows CMS to specify measures that are not already endorsed if a feasible and practical measure in the area determined appropriate by the Secretary has not been endorsed.

1.3   Background of the IRF QRP

- The IRF QRP was established by section 3004(b) of the ACA.

o   This program applies to freestanding IRFs, as well as IRF units affiliated with either acute care facilities or CAHs.

o   Under the IRF QRP, the Secretary reduces the Annual Increase Factor for discharges occurring during a fiscal year by 2 percentage points for any IRF that does not submit data in accordance with the requirements established by the Secretary.

- The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) (Pub. L. 113–185, enacted on Oct. 6, 2014), amended title XVIII of the Social Security Act by adding section 1899B of the Act, titled Standardized Post-Acute Care (PAC) Assessment Data for Quality, Payment, and Discharge Planning.

- Section 1899B(c)(1) of the Act requires that the Secretary specify not later than the applicable specified application date, quality measures in the following quality domains:

  - Functional status, cognitive function, and changes in function and cognitive function;

  - Skin integrity and changes in skin integrity;

  - Medication reconciliation;

  - Incidence of major falls; and

  - Accurately communicating the existence of and providing for the transfer of health information and care preferences of an individual to the individual, family, caregiver of the individual, and providers of services furnishing items and services to the individual when the individual transitions (1) from a hospital or CAH to another applicable setting, including a PAC provider or the home of the individual, or (2) from a PAC provider to another applicable setting, including a different PAC provider, hospital, CAH, or the home of the individual.

- The resource use and other measures specified under section 1899B(d)(1) of the Act must address at least the following domains:

  - Resource use measures, including total estimated Medicare spending per beneficiary;

  - Discharge to community; and

  - Measures to reflect all-condition risk-adjusted potentially preventable hospital readmissions rates.

- Section 1886(j)(7)(F)(ii) of the Act requires that for fiscal year 2019 and each subsequent year, IRFs report standardized patient assessment data required under section 1899B(b)(1) of the Act for the following categories:

  - Functional status, such as mobility and self-care at admission to a PAC provider and before discharge from a PAC provider;

  - Cognitive function, such as ability to express ideas and to understand, and mental status, such as depression and dementia;

  - Special services, treatments, and interventions such as the need for ventilator use, dialysis, chemotherapy, central line placement, and total parenteral nutrition (TPN);

  - Medical conditions and co-morbidities such as diabetes, congestive heart failure, and pressure ulcers;

  - Impairments, such as incontinence or an impaired ability to hear, see, or swallow; and

  - Other categories deemed necessary and appropriate.

- As required under section 1899B(b)(1)(A) of the Act, the standardized patient assessment data must be reported at least for IRF admissions and discharges, but the Secretary may require the data to be reported more frequently.

- For more information on the IMPACT Act requirements, please see:
  https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-

Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-of-2014-Data-Standardization-and-Cross-Setting-Measures.html

- In October 2017, CMS launched the Meaningful Measures Initiative, which is one component of the agency-wide Patients Over Paperwork Initiative, aimed at evaluating and streamlining regulations with a goal to reduce unnecessary cost and burden, increase efficiencies, and improve beneficiary experience. When first introduced, the objective was to reduce the number of Medicare quality measures and ease the burden on measured entities. The launch of the Meaningful Measures Initiative made considerable progress in reducing the number of Medicare quality measures by 18 percent.

- The initiative has evolved into a new phase referred to as Meaningful Measures 2.0 and the Cascade of Meaningful Measures framework in the context of the CMS National Quality Strategy.

  o The CMS National Quality Strategy provides an overarching, strategic plan that brings together initiatives and frameworks across the agency to ensure harmony and alignment across CMS quality efforts.

  o Meaningful Measures 2.0 is a key initiative that addresses several of the Strategy's priority areas and goals, including:

    ▪ Person-centered care

    ▪ Safety

    ▪ Chronic conditions

    ▪ Seamless care coordination

    ▪ Equity

    ▪ Affordability and efficiency

    ▪ Wellness and prevention

    ▪ Behavioral health

  o The Cascade of Meaningful Measures describes in increased detail the components of the health care system that are being measured. It moves from the eight Meaningful Measures health care priorities to goals and objectives.

- For more information, please see: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/MMF/General-info-Sub-Page.html