Inpatient Rehabilitation Facility (IRF) Listening Session Summary: Revising the Transmission Schedule for the IRF Patient Assessment Instrument (IRF-PAI)

Prepared for

Centers for Medicare & Medicaid Services
Contract No. 75FCMC18D0012
Development, Maintenance, and Support for Quality Reporting and Value Based Purchasing Programs and NHQI

Prepared by

RTI International
3040 Cornwallis Road
Research Triangle Park, NC 27709

Current as of December 10, 2024

Inpatient Rehabilitation Facility (IRF) Listening Session Summary: Revising the Transmission Schedule for the IRF-PAI

Table of Contents

Chapter 1:
Introduction

The Centers for Medicare & Medicaid Services (CMS) contracted RTI International (RTI) to develop and maintain measures for the Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP). RTI operates under the Development, Maintenance, and Support for Quality Reporting and Value Based Purchasing Programs and Nursing Home Care Compare contract (75FCMC18D0012/Task Order 75FCMC24F0121).

On October 22, 2024, RTI hosted an IRF Patient Assessment Instrument (PAI) listening session to hear interested parties' feedback on possible revisions of the transmission schedule for the IRF-PAI assessments. Registration was open to the IRF community through CMS's IRF QRP webpage. Of the 339 participants who registered for the listening session, 245 attended.

This report provides a summary of the participants' feedback during the listening session. The rest of the introduction will give the rationale for revising the IRF-PAI assessment data transmission schedule. **Sections 2 through 4** present a summary of the presentation for each discussion topic, feedback from interested parties for each topic, and the key takeaways found. Specifically, **Section 2** addressed the data collection and submission considerations of revising the transmission schedule. **Section 3** summarizes the potential for a subset of IRF-PAI for when there is a change in payer during an IRF stay. **Section 4** covers other issues CMS should consider and provides some specific examples to get participants' feedback.

For the 30 days following the listening session, CMS invited additional feedback from participants on these topics via email using a dedicated email inbox, IRFQRPfeedback@rti.org. In total, six emailed comments were received. Feedback received via email is summarized and addressed in the applicable discussion topic sections of this report. Only comments related to the topics asked in the listening session were included in this report.

Section 1.1: Background and rationale

The listening session began with background on the collection of IRF-PAI data. The IRF-PAI is required by the CMS as part of the IRF Prospective Payment System (IRF PPS). It is used to gather data to determine payment for each patient admitted to an IRF, as well as to collect patient assessment data for quality measure calculation in accordance with the 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. For each patient, an IRF must submit both the admission patient assessment and the discharge patient assessment at the same time to CMS.

The session continued with a summary of the rationale for revising the transmission schedule for the IRF-PAI. CMS believes that revising the schedule could streamline the data submission process for IRFs in the following ways:

- Creating separate admission and discharge assessments would improve clarity about the items required at each assessment time point, i.e., which items should be completed for an unplanned discharge.

1. It could reduce the burden on IRF providers by specifying which items should be used for which assessment and by removing certain items for patients with unplanned discharges or

who expire in the IRF. For example, several items (including items requiring a patient interview such as the BIMS and the patient mood interview, health literacy, and social isolation) are required on the IRF-PAI at discharge but are not required on the Long-term Care Facilities (LTCH) Care Data Set Unplanned Discharge Assessment.

- Creating a subset of the IRF-PAI could also reduce data collection burden for patients who have a change in payer during their IRF stay.

2. Revisions to the transmission schedule will help align the IRF-PAI with other post-acute care providers. The IRF setting is unique from other post-acute care settings, such as LTCHs and skilled nursing facilities (SNFs), because of its single-patient assessment data transmission requirements.

Chapter 2: Data Collection and Submission Considerations

This section summarizes participants' feedback on the Listening Session's first discussion topic and is organized into three subsections **Section 2.1** introduces the questions asked on this topic and summarize participants' comments in response to the questions during the October 22, 2024 meeting. Finally, **Section 2.2** presents the key takeaways extracted from that discussion.

Section 2.1: Questions

Question 1. To facilitate this change in the IRF-PAI submission schedule, CMS would add an item to identify which assessment content is needed. Types of assessment include: admission, planned discharge, unplanned discharge, and expired. Are these types of assessments appropriate for IRFs? Are there other types that are missing?

In general, commenters did not believe that creating separate assessment types was appropriate for the IRF setting. Several commenters recommended maintaining a single assessment, submitted at discharge, and better utilizing skip patterns to reduce burden for providers.

Two commenters expressed concerns about potential impact on payment. Specifically, one commenter had concerns about creating separate admission and discharge assessments because of the risk that tiered comorbidities may not be captured appropriately. The commenter noted that these tiered comorbidities can increase the payment for certain patients if they are not captured in the appropriate assessment or discharge assessment window. This commenter was concerned that splitting IRF-PAI assessments will make it difficult for providers to capture information required for both payment and the IRF QRP.

One commenter suggested a "short stay" assessment, in the case where a patient was discharged almost immediately from the IRF and the full admission assessment could not be completed.

Another commenter felt that the current QRP Manual gives definitions and instructions for the correct way to code for incomplete stays. However, this commenter believed that confusion occurs due to the criteria for an incomplete stay being based on responses to other items (Items 14, 41, 44C, and 44D).

Question 2. Would having separate item sets for admission and discharge provide more clarity about what items are necessary to collect when patients are discharged unexpectedly?

Commenters did not believe that adding an unplanned discharge assessment would provide clarity for patients who are discharged unexpectedly. A few commenters asked for additional clarification about the terminology used to describe unplanned discharges and what items would be required.

One commenter noted there are currently items with indicated skip patterns for a patient with an "incomplete stay," the definition of which currently includes unplanned discharges but can also include other situations. The commenter recommended updating the current IRF-PAI skip patterns to clarify whether an item can be skipped for an unplanned discharge and/or any incomplete stay. This participant was also concerned that if there are skip patterns on items for incomplete stays, yet the IRF-PAI requires the completion of this information for the QRP, this could lead to unwarranted 2% payment penalties.

Question 3. How would submitting assessments separately, i.e., at admission and discharge timepoints, impact your workflows? Would this type of change require updates to your systems? How much time do you anticipate needing to make changes to your systems to accommodate these changes?

Multiple commenters expressed that submitting assessments separately would put an unnecessary strain on facilities and would not provide improvement to current workflows. Multiple commenters stated that having assessments at different timepoints would create an additional administrative burden on PPS coordinators. Via email, two commenters noted that collecting and submitting the IRF-PAI records at multiple times will create additional costs to providers as they will need to update existing technologies to meet new data submission requirements as well as train and educate clinical staff on these changes. These commenters were concerned that additional costs related to these changes would take time away from patient care, negatively impacting the quality of care provided by IRFs. Another commenter agreed that changing data submission timeframes for even a subset of items would continue to pull clinicians away from direct patient care and may even result in unintended consequences whereby clinicians would feel pressured to complete the admission assessments to meet an arbitrary deadline, instead of focusing on the accuracy of the assessments.

One commenter agreed that submitting all or a subset of IRF-PAI data prior to discharge would constitute a significant change for how data is captured in electronic health records systems and submitted to CMS at patient discharge. This commenter stated that IRF electronic health record systems are complex, and the functionality of any changes takes significant time and cost to develop, test, and verify. Additional time and resources would be required to educate the IRF clinical and administrative workforce on the changes. This commenter did not believe that this potential change would reduce confusion on what items are necessary at admission and discharge, since IRF EHR systems are designed and built to accommodate the current IRF-PAI manual and technical specifications.

Another participant noted, referring to alignment with the transmission schedule in other PAC settings, that IRFs have a shorter stay length compared to SNFs and LTCHs. This commenter stated that SNFs and LTCHs lend themselves to a bifurcated submission schedule due to the

longer stays of the patients. Via email, this commenter noted that IRFs have the first three days of a patient's stay to assess patients upon admission and have until day 10 of a stay to encode patients' data. Adding a new submission timeframe would alter this established assessment period and a data submission requirement at day 10 would come close to the average LOS discharge timeframe. This commenter also stated that clinicians may learn of additional patient comorbidities after the initial 3 days which may impact Case Mix Group (CMG) assignment and, under the IRF-PAI manual, may be added until the day prior to discharge. This commenter stated that technical changes require a lot of work for many IRF employees, and they do not see how this change would have a clear benefit on patient care. A few additional commenters agreed with these statements.

Several commenters mentioned feeling overwhelmed from adjusting to the most recent IRF-PAI changes, including the collection of data from all patients regardless of payer, and felt that the timeframe would be difficult to meet, especially for smaller units with fewer staff. One commenter added that if the PPS coordinator takes time off work, it would be much more difficult to find support to submit IRF-PAIs at two timepoints than it is under the current workflow. Via email, a PPS coordinator added that transmitting data twice for each patient would be a significant increase in work hours, noting that there is typically one PPS coordinator per facility.

Section 2.2: Key takeaways

1. Commenters had concerns about changing the IRF-PAI submission schedule, citing the additional burden of submitting separate admission and discharge assessments and the shorter length of stay of IRF patients.
2. Commenters requested clarification of the terms "unplanned discharge" and "incomplete stay," and recommended better utilization of skip patterns to indicate which items are not required for those situations.
3. Commenters shared concerns about payment implications of changes to the IRF-PAI assessment schedule.

Chapter 3:
Subset of IRF-PAI to be Used when a Patient Changes Payers

This section summarizes participants' feedback on the Listening Session's second discussion topic and is organized into five subsections. **Section 3.1** provides background information on current guidelines for when there is a change in payer, and **Section 3.2** introduces the questions asked on this topic and summarize the information received from participant's feedback during the October 22, 2024, meeting. **Section 3.3** presents the key takeaways extracted from that discussion.

Section 3.1: Background

With the implementation of the IRF all-payer data collection, CMS recognizes an opportunity to streamline the assessment process when a patient's payer changes during an IRF stay. Currently,

those who become eligible for Medicare during IRF stay are required to fill out another IRF-PAI admission assessment beginning on day 1 of the Medicare stay to obtain a CMG to be paid under the IRF PPS. CMS could potentially create a subset of the IRF-PAI, comprised of the minimum information necessary to calculate an IRF CMG, that would not impact assessment-based quality measure calculation in the IRF QRP.

Section 3.2: Questions

Question 1. How frequently do patients change payers during an IRF stay at your facility?

Participants did not address this specific question during the discussion but did cite multiple examples of patients changing payers in their comments. Via email, three commenters cited that, in their experience, patients in IRFs rarely change payers during their stay.

Question 2. Would it be feasible to complete an IRF-PAI consisting of a subset of items for CMG calculation when a patient changes payers? If not feasible, what are the problems you would encounter?

A few commenters pointed out that there is often a delay in finding out that patient's insurance has changed. One commenter mentioned that their team may not find out about a change in payer until up to 6 weeks later. Therefore, having to fill out a new IRF-PAI subset based on the date of that insurance change is problematic. Via email, a commenter noted that the identification of a change in payer source often occurs at the time when the patient is discharged. This suggests that any opportunity for the completion of an interim CMG-only assessment may be lost by the time the need for such an assignment is identified.

One commenter questioned how this would impact public reporting of quality measures, given that IRF QRP assessment-based measures are currently reported on Care Compare only for Medicare fee-for-service (FFS) and Medicare Advantage beneficiaries. The commenter wanted additional information about how quality measures would be calculated if not all the data elements related to QRP are being captured in this subset of items collected at the time of a change in payer. Via email, a commenter expressed concerns about that quality measures publicly reported for Medicare patients will be based upon either inconsistent information or IRF-PAI data that was collected when the patient was not a Medicare beneficiary.

Two commenters were concerned about how data, such as the function data from Section GG, might be skewed if a new assessment was started at the time of a change in payer. One of these commenters did not believe this new assessment would accurately capture length of stay, how long it takes to treat a patient within a given diagnostic category or CMG, and the outcomes of these patients. Another commenter expressed concerns about Section GG items that record a patient's function prior to the benefit of service, and whether a new assessment when a patient changes payers would skew the prior and admission function scores. A clarification was made at this time that this subset of items would not be used to calculate assessment-based quality measures in the IRF QRP. The intention behind a potential IRF-PAI subset for a change in payer would be to obtain the minimum information for a CMG related to the IRF PPS payment.

Question 3. How much time do you anticipate needing to make changes to your systems to accommodate this subset of the IRF-PAI that would be required when a patient changes payers?

Two commenters discussed the complexity of making changes to accommodate a subset of the IRF-PAI for change in payer and estimated needing between 8 months and more than a year. Both commented on the slow nature of updates to their electronic medical record systems. Another commenter stated that even if these became regulatory changes, which would make them a high priority, this could still take a very long time, potentially several years, to implement.

Section 3.3: Key takeaways

1. Commenters felt that the implementation of a subset of the IRF-PAI could be complicated by a delay in finding out about the change in payer.
2. Commenters agreed that it would take a long time, potentially several years, to make these changes in their system to incorporate an IRF-PAI subset for a change in payer.
3. Commenters were concerned about the potential impact of this policy on quality measure calculation and the public reporting of IRF QRP data.

Chapter 4:
Other Issues CMS Should Consider

For the Listening Session's third topic area, CMS presented some issues and asked for feedback on any other issues CMS should consider when revising the IRF-PAI transmission schedule. This section summarizes participants' input on each discussion topic and is organized into four subsections. **Section 4.1** introduces the question asked on this topic and summarizes the information received during the October 22, 2024, meeting, and provides the responses given for general issues that should be considered. **Section 4.2** presents the key takeaways extracted from the discussions.

Section 4.1: Questions

Question 1. Should CMS consider a pediatric IRF-PAI assessment to reduce burden, streamline the assessment process, and focus on age-appropriate assessment items for the pediatric population?

Two commenters agreed that there is a need for more age-appropriate assessment items for young patients, given the all-payer IRF-PAI requirements. One of the commenters felt it would be inappropriate to enter pediatric data on IRF-PAI assessment tools that have not been validated in the pediatric population.

Via email, a commenter supported making the IRF-PAI more appropriate for pediatric, adolescent, and all other patients under the age of 18. The commenter cited ongoing concerns about the ability to complete certain IRF-PAI assessments when the items have not been tested on the younger population and do not measure age-appropriate clinical domains. The commenter included examples of assessments that are not appropriate for pediatric populations, such as health literacy, transportation, living situation, food insecurity, and utilities insecurity. While the commenter noted that there are response options such as "Patient Unable to Respond" for younger patients, the administrative burden to collect and report this information is inappropriate

and unnecessary. In addition, this commenter had concerns with the cognitive and functional assessment items, especially for pediatric and adolescent patients who should not be measured against tools designed to evaluate the normative performance of fully developed adults. This commenter recommended that CMS reconsider the requirement to complete and submit IRF-PAI information for pediatric, adolescent, and all other patients under the age of 18, and exclude these patients from the IRF QRP compliance determination until such a time as fully tested age-appropriate assessment items are available for use on the IRF-PAI.

Question 2. Are there any potential negative or unintended consequences of modifying the IRF-PAI Assessment schedule?

A commenter brought up the fact that having to transmit data closer to the time of admission limits the time PPS has to clarify questions with physicians who may be away from the IRF for multiple days. Two commenters agreed, and one added that the tightening of deadlines would make it more difficult on smaller units who may only have one PPS coordinator to complete additional assessments. One person noted that modifying the assessment schedule and thereby reducing the timeline PPS coordinators have to complete the assessments, could lead to missing information on the IRF-PAI impacting their potential for receiving a penalty.

Question 3. Are there other considerations we should be aware of?

Numerous commenters advised CMS to take a closer look at the IRF-PAI assessment items and remove those that are not being used for payment or QRP purposes to help reduce the burden. An example given was the requirement to collect week 1 and 2 therapy information, originally intended to assess the 3-hour guidelines. Another example given, and echoed by multiple people, are certain social determinants of health (SDOH) elements, like race and ethnicity, which do not impact payments, or the type of care received. One commenter went on further to address the fact that their facility has moved away from raced-based care and shifted to looking at race as a social construct. Another person emphasized the inaccurate classification of race/ethnicity that can sometimes occur with self-reporting and recommended the CMS collect their own demographic data if they feel it is needed. One person recommended CMS should continue in their efforts to align the PAC assessments before adjusting the transmission schedule.

A few commenters noted that with the implementation of all-payer IRF-PAI data collection, the submission requirements for the IRF-PAI impact Medicare and non-Medicare payers differently. One example was related to the interrupted stay policy for IRF patients. The Medicare policy is that if a patient has an interrupted stay that is 3 days or less, the IRF-PAI effectively continues, and the patient is treated as having one continual assessment. However, non-Medicare payers often do not follow this same policy. One commenter mentioned that with other payers, any disruption in the stay requires discharge; other payers may have a different limit on the number of days allowed for an interrupted stay. As CMS approaches the IRF-PAI from an all-payer lens, commenters asked for more consideration for those patients who come from non-FFS payer sources, so providers do not have conflicting requirements from CMS and from non-Medicare payers.

Section 4.2: Key takeaways

1. Commenters believed that the revisions to the IRF-PAI submission schedule would be an additional burden on IRFs, especially smaller units. Various commenters recommended

alleviating this burden by removing any items from the IRF-PAI that are not being used for payment or QRP measures.

2. There is some support for age-appropriate assessment items for pediatric patients.