Medicare Inpatient Rehabilitation Facility Prospective Payment System

Final Payment Rule Brief provided by the Wisconsin Hospital Association
Program Year: FFY 2022

Overview and Resources

On July 29, 2021, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FFY) 2022 final payment rule for the Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS). The final rule reflects the annual update to the Medicare fee-for-service (FFS) IRF payment rates and policies.

A copy of the final rule and other resources related to the IRF PPS are available on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/index.html.

An online version of the final rule is available at https://www.federalregister.gov/public-inspection/2021-16310/medicare-program-inpatient-rehabilitation-facility-prospective-payment-system-for-federal-fiscal.

A brief of the final rule along with Federal Register page references for additional details is provided below. Program changes adopted by CMS will be effective for discharges on or after October 1, 2021, unless otherwise noted. CMS estimates the overall economic impact of the finalized payment rate update to be an increase of $130 million in aggregate payments to IRFs in FFY 2022 over FFY 2021.

Note: Text in italics is extracted from the August 4, 2021 Federal Register.

IRF Payment Rate

FR pages 42,373 – 42,376 and 42,379 – 42,382

Incorporating the finalized updates with the effect of budget neutrality adjustments, the table below shows the final IRF standard payment conversion factor for FFY 2022 compared to the rate currently in effect:

	Final FFY 2021	Final FFY 2022	Percent Change
IRF Standard Payment Conversion Factor	**$16,856**	**$17,240** (proposed at $17,273)	**+2.28%** (proposed at 2.47%)

The table below provides details of the finalized updates to the IRF payment rate for FFY 2022:

	IRF Finalized Rate Updates
Marketbasket Update	**+2.6%** (proposed at $2.4%)
Affordable Care Act (ACA)-Mandated Productivity Adjustment	**-0.7 percentage points (PPT)** (proposed at -0.2 PPT)
Wage Index/Labor-Related Share Budget Neutrality (BN)	**1.0032 (**proposed at 1.0027)
Case-Mix Groups (CMGs) and CMG Relative Weight Revisions BN	**1.0005** (proposed at 1.0000)
Overall Rate Change	**+2.28%** (proposed at 2.47%)

In the past, CMS had used the Moody's AAA Corporate Bond Yield index as the price proxy for the For-profit Interest cost category of the 2016-based IRF marketbasket. Instead, CMS is adopting the use of the iBoxx AAA

Corporate Bond Yield index, which closely resembles the Moody's AAA Corporate Bond Yield index, as the Moody's AAA Corporate Bond series is no longer available for use under license to IHS Global Inc. (IGI), and therefore, IGI discontinued the publication of the associated historical data and forecasts of this series.

Wage Index, Labor-Related Share, and CBSA Delineations

FR pages 42,376 – 42,379

CMS will continue to estimate the labor-related portion of the IRF standard rate and adjust for differences in area wage levels using a wage index. CMS is finalizing the decrease to the labor-related share of the standard rate from 73.0% for FFY 2021 to 72.9% (as proposed) for FFY 2022.

CMS finalized the use of the FFY 2022 pre-floor, pre-reclassified IPPS wage index for the IRF PPS wage index. A complete list of the final wage indexes for payment in FFY 2022 is available on the CMS website at https://www.cms.gov/medicaremedicare-fee-service-paymentinpatientrehabfacppsirf-rules-and-related-files/cms-1748-f.

CMS adopted a wage index and labor-related share budget neutrality factor of 1.0032 (proposed at 1.0027) for FFY 2022 to ensure that aggregate payments made under the IRF PPS are not greater or less than would otherwise be made if wage adjustments had not changed.

Case-Mix Group Relative Weight Updates

FR pages 42,367 – 42,373

CMS assigns IRF discharges into case-mix groups (CMGs) that are reflective of the different resources required to provide care to IRF patients. Patients are first categorized into rehabilitation impairment categories (RICs) based on the primary reason for rehabilitative care. Patients are further categorized into CMGs based upon their ability to perform activities of daily living or based on age and cognitive ability (motor score). Within each of the CMGs there are four tiers, each with a different relative weight that is determined based on comorbidities. Currently, there are 95 CMGs with four tiers and five other CMGs that account for very short stays and patients who die in the IRF.

Each year, CMS updates the CMG relative weights and average lengths of stays (ALOS) with the most recent available data. CMS is finalizing their updates with these factors for FFY 2022 using FFY 2020 IRF claims data and FFY 2019 IRF cost report data. To compensate for the CMG weights changes, CMS will apply a FFY 2022 case-mix budget neutrality factor of 1.0005 (proposed at 1.0000).

CMS is not making any changes to the CMG categories/definitions. Using FFY 2020 claims data, CMS' analysis shows that 97.2% of IRF cases are in CMGs and tiers that would experience less than a +/-5% change in its CMG relative weight as a result of the updates. A table that lists the adopted FFY 2022 CMG payments weights and ALOS values is provided on *FR* pages 42,369 – 42,372.

Outlier Payments

FR pages 42,382 – 42,383

Outlier payments were established under the IRF PPS to provide additional payments for extremely costly cases. Outlier payments are made if the estimated cost of the case exceeds the payment for the case plus an outlier threshold. Costs are determined by multiplying the facility's overall cost-to-charge ratio (CCR) by the allowable charges for the case. When a case qualifies for an outlier payment, CMS pays 80% of the difference between the estimated cost of the case and the outlier threshold.

CMS has established a target of 3.0% of total IRF PPS payments to be set aside for high cost outliers. To meet this target for FFY 2022, CMS will update the outlier threshold value to $9,491 (proposed at $9,192), a 20.0% increase compared to the current threshold of $7,906, based on FFY 2020 claims data.

Updates to the IRF Cost-to-Charge Ratio (CCR) Ceiling

FR pages 42,383 – 42,384

CMS applies a ceiling to IRF's CCRs. If an individual IRF's CCR exceeds this ceiling, that CCR is replaced with the appropriate national average CCR for that FFY, either urban or rural. The national urban and rural CCRs and the national CCR ceiling for IRFs are updated annually based on analysis of the most recent data that is available. The national urban and rural CCRs are applied when:

- New IRFs have not yet submitted their first Medicare cost report;
- IRFs overall CCR is in excess of the national CCR ceiling for the current FFY; and/or
- Accurate data to calculate an overall CCR are not available for IRFs.

CMS will continue to set the national CCR ceiling at 3 standard deviations above the mean CCR, and therefore, CMS finalized a national CCR ceiling of 1.35 (proposed at 1.34) for FFY 2022. If an individual IRF's CCR exceeds this ceiling for FFY 2022, the IRF's CCR will be replaced with the appropriate national average CCR, urban or rural. CMS finalized a national average CCR of 0.478 (as proposed) for rural IRFs and 0.394 (proposed at 0.393) for urban IRFs.

Updates to the IRF Quality Reporting Program (QRP)

FR pages 42,384 – 42,408

CMS collects quality data from IRFs on measures that relate to three stated resource domains. IRFs that do not successfully participate in the IRF QRP are subject to a 2.0 percentage point reduction to the market basket update for the applicable year – the reduction factor value is set in law.

The following lists the previously finalized IRF QRP measures and applicable payment determination years:

Previously Adopted IRF Measures for FFY 2022 Payment Determinations		
IRF QRP Measures	**NQF #**	**Payment Determination Year**
National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure	#0138	FFY 2015+
Influenza Vaccination Coverage among Healthcare Personnel	#0431	FFY 2016+
NHSN Facility-Wide Inpatient Hospital-Onset Clostridium Difficile Infection (CDI) Outcome Measure	#1717	FFY 2017+
Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	#0674	FFY 2018+
Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function	#2631	FFY 2018+
IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients	#2633	FFY 2018+
IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients	#2634	FFY 2018+
IRF Functional Outcome Measure: Discharge Self-Care Score for Medical		FFY 2018+

Rehabilitation Patients	#2635	
IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients	#2636	FFY 2018+
Discharge to community – Post Acute Care IRF, with the added exclusion of patients with a hospice benefit in the 31-day post-discharge observation window		FFY 2020+
Medicare Spending Per Beneficiary - Post Acute Care IRF		FFY 2020+
Potentially Preventable 30 Day Post-Discharge Readmission Measure for IRFs		FFY 2020+
Potentially Preventable Within Stay Readmission Measure for IRFs		FFY 2020+
Drug Regimen Review Conducted with Follow-Up for Identified Issues (assessment-based)		FFY 2020+
Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury		FFY 2020+
Transfer of Health Information to the Provider-Post-Acute Care (PAC)		FFY 2022+
Transfer of Health Information to the Patient-PAC		FFY 2022+

In response to the public health emergency (PHE) for the COVID-19, CMS released an interim final rule which delayed the compliance date for the collection and reporting of the Transfer of Health Information measures for, at least, 1 full fiscal year after the end of the PHE.

CMS is adopting its proposal to add one new measure for the FFY 2023 IRF QRP that supports the Meaningful Measures domain of Promote Effective Prevention and Treatment of Chronic Disease:

- COVID-19 Vaccination Coverage among Healthcare Personnel (HCP).

CMS also finalized, with modification, to begin reporting the COVID-19 Vaccination measure on Care Compare with the September 2022 refresh, or as soon as feasible. Instead of adding one additional quarter of data during each advancing refresh as proposed, CMS will only report the most recent quarter of data.

Separately, CMS is adopting its update to the denominator of the Transfer of Health Information to the Patient-PAC to exclude patients discharged home under the care of an organized home health service or hospice in order to align the measure with other quality reporting programs and to avoid counting the patient in both of the Transfer of Health measures in the IRF QRP.

CMS sought input in the proposed rule on measures/concepts for future IRF QRP program years. Comments are summarized on *FR* pages 42,397 – 42,398.

Due to the COVID-19 pandemic public health emergency, CMS did not use IRF-PAI assessments or IRF claims from Q1 or Q2 2020 for public reporting. Therefore, CMS froze the data displayed on Care Compare with the December 2020 refresh values. However, to avoid posting increasingly out-of-date data, CMS finalized the use of fewer quarters of data for future refreshes. The table below lists the finalized refresh schedule and the associated data periods.

Quarter Refresh	IRF-PAI Assessment Quarters for Care Compare (number of quarters)	Claims-based Quarters for Care Compare (number of quarters)	CDI and CAUTI Quarters for Care Compare (number of quarters)	HCP Influenza Quarters for Care Compare (number of quarters)
December 2020	Q1 2019 – Q4 2019 (4)	Q4 2017 – Q3 2019 (8)	Q4 2018 – Q3 2019 (4)	Q4 2017 – Q1 2018 (2)
March 2021	Q1 2019 – Q4 2019 (4)	Q4 2017 – Q3 2019 (8)	Q4 2018 – Q3 2019 (4)	Q4 2017 – Q1 2018 (2)
June 2021	Q1 2019 – Q4 2019 (4)	Q4 2017 – Q3 2019 (8)	Q4 2018 – Q3 2019 (4)	Q4 2017 – Q1 2018 (2)
September 2021	Q1 2019 – Q4 2019 (4)	Q4 2017 – Q3 2019 (8)	Q4 2018 – Q3 2019 (4)	Q4 2017 – Q1 2018 (2)
December 2021	Q3 2020 – Q4 2021 (3)	Q4 2018 – Q4 2019, Q3 2020 (6)	Q1 2019 – Q4 2019 (4)	Q4 2018 – Q1 2019 (2)

March 2022	Q3 2020 – Q2 2021 (4) *Normal reporting resumes with 4 quarters of data	Q4 2018 – Q4 2019, Q3 2020 (6)	Q2 2019 – Q4 2019, Q3 2020 (4)	Q4 2018 – Q1 2019 (2)
June 2022	*Normal reporting resumes with 4 quarters of data	Q4 2018 – Q4 2019, Q3 2020 (6)	Q3 2020 – Q2 2021 (4) *Normal reporting resumes with 4 quarters of data	Q4 2018 – Q1 2019 (2)
September 2022		Q4 2019, Q3 2020 – Q3 2021 (6)	*Normal reporting resumes with 4 quarters of data	Q4 2018 – Q1 2019 (2)
December 2022		Q4 2019, Q3 2020 – Q3 2021 (6)		Q4 2018 – Q1 2019 (2) *Normal reporting resumes
March 2023		Q4 2019, Q3 2020 – Q3 2021 (6)		*Normal reporting resumes
June 2023		Q4 2019, Q3 2020 – Q3 2021 (6)		
September 2023		Q4 2020 – Q3 2022 (8) *Normal reporting resumes with 8 quarters of data		

Note: The shaded cells represent data held constant.

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

FR pages 42,408 – 42,412

In the May 11, 2018 Federal Register, CMS published an interim final rule with comment period (IFC) entitled *"Medicare Program; Durable Medical Equipment Fee Schedule Adjustments to Resume the Transitional 50/50 Blended Rates to Provide Relief in Rural Areas and Non-Contiguous Areas,"* which finalized to exempt accessories and seat and back cushions furnished in connection with Group 3 or higher complex rehabilitative power wheelchairs from the fee schedule adjustments, using prices for these items when furnished with:

- standard power wheelchairs; or
- Group 2 complex rehabilitative power wheelchairs under the DMEPOS Competitive Bidding Program (CBP).

Based on comments received in the IFC, in this final rule, CMS also extends this policy to exempt *"accessories (including seating systems) and seat and back cushions furnished in connection with complex rehabilitative manual wheelchairs and other complex manual wheelchairs described by HCPCS codes E1235, E1236, E1237, E1238, and K0008"* from the fee schedule adjustments, based on information from the CBP.

Further, in November 2020, CMS released a proposed rule entitled *"Medicare Program; Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Policy Issues and Level II of the Healthcare Common Procedure Coding System (HCPCS)",* in which CMS proposed to edit the definition of "item" under § 414.402 to exclude complex rehabilitative manual wheel chairs, manual wheel chairs described by HCPCS codes E1235, E1236, E1237, E1238, and K0008, and related accessories from the DMEPOS CBP. In this final rule, CMS is finalizing this proposal.

Request for Information – Advancing to Digital Quality Measurement and the Use of Fast Healthcare Interoperability Resources (FHIR) in Hospital Quality Programs

Federal Register page 42,398

CMS aims to move to fully digital quality measurement in quality reporting and value-based purchasing programs by 2025. CMS has heard from stakeholders about the technological challenges and burden of reporting eCQM data and therefore is currently working to convert current eCQMs to FHIR. CMS specifically asked for feedback on its potential use of FHIR, a free and open source standards framework, to define digital quality measures (dQMs) within hospital quality programs.

Request for Information – Closing the Health Equity Gap in CMS Hospital Quality Programs

Federal Register pages 42,398 – 42,399

CMS requested public comment on potential expansion of current disparity methods in hospital quality programs. CMS states it is committed to achieving equity in health care outcomes and supporting providers in quality improvement activities to reduce health inequities.

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