Medicare Inpatient Rehabilitation Facility Prospective Payment System

Payment Rule Brief — FINAL RULE

Program Year: FFY 2015

Overview and Resources

On August 6, 2014, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FFY) 2015 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 based on regulatory changes put forward by CMS and legislative changes previously adopted by Congress.

A copy of the final rule *Federal Register* (FR) 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://federalregister.gov/a/2014-18447.

A brief of the final rule is provided below along with FR page references for additional details. Program changes adopted by CMS will be effective for discharges on or after October 1, 2014, unless otherwise noted.

IRF Payment Rate

FR pages 45,883-45,890

Incorporating the adopted updates with the effect of a budget neutrality adjustment, the table below shows the IRF standard payment conversion factor for FFY 2015 compared to the rate currently in effect:

	Final FFY 2014	Final FFY 2015	Percent Change
IRF Standard Payment Conversion Factor	**$14,846**	**$15,198**	**+2.37%** ***(proposed at +2.28%)***

The table below provides details of the adopted updates to the IRF payment rate for FFY 2015:

	IRF Rate Updates and Budget Neutrality Adjustment
Marketbasket (MB) Update Full MB update of 2.9% (proposed at 2.7%) minus Affordable Care Act (ACA)-mandated 0.5% productivity reduction (proposed at 0.4%) and 0.2% pre-determined reduction (no change from proposed)	**+2.2%** ***(proposed at +2.1%)***
Wage Index/Labor-Related Share Budget Neutrality (BN)	**+0.17%** ***(proposed at +0.18%)***
Overall Rate Change	***+2.37%*** ***(proposed at +2.28%)***

Effect of Sequestration

FR page reference not available

While the final rule does not specifically address the 2.0% sequester reductions to all lines of Medicare payments authorized by Congress and currently in effect through FFY 2024, sequester will continue unless Congress intervenes. Sequester is not applied to the payment rate; instead, it is applied to Medicare claims after determining co-insurance, any applicable deductibles, and any applicable Medicare secondary payment adjustments.

Wage Index and Labor-Related Share

FR pages 45,886-45,887

The labor-related portion of the IRF standard rate is adjusted for differences in area wage levels using a wage index. CMS did not propose and is not adopting any major changes to the calculation of Medicare IRF wage indexes. Also, CMS did not propose or adopt the new labor-market areas adopted for use, beginning FFY 2015, under the Inpatient PPS and other Medicare payment systems. CMS plans to put forward these changes next year. As has been the case in previous years, CMS will use the prior year's inpatient hospital wage index, the FFY 2014 pre-rural floor and pre-reclassified hospital wage index, to adjust payment rates under the IRF PPS for FFY 2015. A complete list of the wage indexes for payment in FFY 2015 is available on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Data-Files.html.

Based on updates to this year's marketbasket value, CMS will reduce the labor-related share of the standard rate from 69.494% for FFY 2014 to 69.294% for FFY 2015 (CMS had proposed to increase the labor-share to 69.538%). This change will provide a small increase in payments to IRFs with a wage index less than 1.0.

LIP, Teaching, and Rural Adjustments

FR pages 45,882-45,883

CMS adjusts the IRF standard payment conversion factor for differences at the facility level, including adjustments to account for an IRF's percentage of low income patients (LIP), teaching status and intensity, and rural location.

CMS made significant changes to these adjustment factors for FFY 2014, reducing the LIP and rural adjustments, while increasing the teaching adjustment. For FFY 2015, CMS is adopting its proposal to hold the facility-level adjustments at the values adopted for FFY 2014. CMS will propose future changes to these factors based on the evaluation of claims data. The following describes the facility-level adjustments that will apply for FFY 2015:

- **LIP Adjustment:** CMS will maintain the LIP adjustment factor at 0.3177 for FFY 2015. CMS will maintain the following formula to calculate the LIP adjustment: (1 + Disproportionate Share Hospital (DSH) patient percentage) ^ 0.3177. The DSH patient percentage for each IRF is calculated using the following formula: (Medicare SSI days / total Medicare days) + (Medicaid, non-Medicare days / total days).
- **Teaching Adjustment:** CMS will maintain the teaching adjustment factor at 1.0163 for FFY 2015. This payment adjustment is based on the number of full-time equivalent (FTE) interns and residents training in the IRF and the IRF's average daily census (ADC). CMS will maintain the following formula to calculate the teaching payment adjustment: (1 + IRF's FTE resident to ADC ratio) ^ 1.0163.
- **Rural Adjustment:** CMS will maintain the rural adjustment at 14.9% for FFY 2015.

CMG Updates

FR pages 45,878-45,882

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. Within each of the CMGs there are four tiers, each with a different relative weight that is determined based on comorbidities. Currently, there are 87 CMGs with four tiers and another five 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 adopting its proposal to update these factors for FFY 2015 using the most current full federal fiscal year of claims data (FFY 2013 claims experience) and the most recently available IRF cost reports. CMS did not propose any changes to the CMG categories/definitions. Using FFY 2013 claims data, CMS analysis shows that 99% of IRF cases are in CMGs and tiers that will experience less than a +/-5% change in the CMG relative weight as a result of the updates.

The current and newly adopted CMG payment weights and ALOS values are available on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Data-Files.html.

Outlier Payments

FR pages 45,890-45,891

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 2015, CMS is adopting an outlier threshold of $8,848 for FFY 2015 (proposed at $9,149), a 4.6% decrease compared to the current threshold of $9,272.

Updates to the 60% Compliance Threshold Criteria

FR pages 45,891-45,900

Last year, CMS adopted a policy to reduce, beginning FFY 2015, the number of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis codes used to determine compliance with the IRF PPS's 60% threshold. CMS deemed the selected diagnoses as not intensive enough to require rehabilitation care.

CMS plans to move forward with this policy. However, in light of newly adopted changes related to this policy (see below) and to allow both CMS and providers more time to adapt to the changes, CMS will delay implementation until FFY 2016 (October 1, 2015). Under this policy, CMS will remove over 260 diagnosis codes from the current compliance threshold list (list of codes is available on FR pages 47,891-47-895 of the FFY 2014 IRF final rule at https://www.federalregister.gov/a/2013-18770).

As it relates to the policy changes put forward in this year's rule, CMS is adopting its proposal to remove 10 additional diagnoses codes for "status post-amputation" (ICD-9 codes listed on FR page 45,893). CMS is also adopting its proposal, with some modification, to make conforming changes to the newly modified

presumptive compliance policy by aligning the comorbidities, impairment group codes (IGCs), and Etiological Diagnosis used to determine 60% threshold compliance.

A file made available with the final rule called *"ICD-9 Presumptive Diagnosis Codes_FY 2015 final rule.xlsx"* available on CMS' website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Data-Files.html lists the 1,029 diagnosis codes CMS will use for determining compliance with the 60% rule for compliance review periods that begin on or after October 1, 2015 (FFY 2016). A file on the same website called *"IGCs_meet presumptive compliance criteria_ICD9_FY 2015 final rule.xlsx"* lists the IGC codes that will be used for compliance reviews.

Under current law, at least 60% of a hospital's total inpatient population must be diagnosed with one of 13 medical conditions for that hospital to be classified as a rehabilitation facility and paid under the IRF PPS. Prior to 2006, this compliance threshold was set at 75%. Compliance with the 60% threshold is evaluated using certain CMS-defined ICD-9-CM diagnosis codes that correspond with the 13 specified medical conditions.

CMS uses two methodologies to calculate an IRF's compliance percentage. The first method is referred to as the "presumptive methodology." Under this method, the compliance threshold is met if a facility's Medicare Part A FFS and Medicare Advantage population for the 13 specified compliance threshold conditions is at least 50% or more of the facility's total inpatient population. If a facility does not meet the compliance threshold under the presumptive methodology, then the second methodology known as the "medical review methodology," is used. This method uses a sample of medical records from the facility's total inpatient population to estimate compliance with the threshold percentage.

Updates to the IRF QRP

FR pages 45,908-45,926

As previously adopted, for FFY 2015 payment determinations under the Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP), hospitals were required to report on a total of 2 quality measures. IRFs that do not successfully participate in the IRF QRP are subject to a 2.0 percentage point reduction to the marketbasket update for the applicable year–the reduction factor value is set in law.

CMS used the FFY 2015 rulemaking process to adopt new measures for FFY 2017 payment determinations along with updated and/or new data submission timelines for the previously adopted and newly adopted measures.

For FFY 2017 payment determinations, CMS is adopting its proposal to collect data on a total of 7 quality measures (up from 5 measures for FFY 2016 determinations). CMS will retain the 5 measures currently in place for FFY 2016 determinations and add 2 National Healthcare Safety Network (NHSN) outcome measures. The following lists the IRF QRP measures and applicable payment determination years:

Measure	**Payment Determination Year**
NQF #0138: NHSN Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure	FFY 2015 and beyond
NQF #0431: Influenza Vaccination Coverage among Healthcare Personnel	FFY 2015 and beyond
NQF #2502: All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from IRFs	FFY 2016 and beyond
NQF #0680: Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine	FFY 2016 and beyond

NQF #0678: Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened	FFY 2016 and beyond
NQF #1716: NHSN Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant Staphylococcusaureus (MRSA) Bacteremia Outcome Measure	FFY 2017 and beyond
NQF #1717: NHSN Facility-Wide Inpatient Hospital-Onset Clostridium difficile Infection (CDI) Outcome Measure	FFY 2017 and beyond

As it does each year, CMS used the rulemaking process to update the IRF QRP data submission deadlines and procedures, data validation requirements and methods, and other program details. CMS also collected industry comment on future measure topics and the future use of electronic health records (EHRs) to collect IRF quality data. Complete detail on these items is available on FR pages 45,914-45,926.

Additions to the IRF-PAI

FR pages 45,900-45,905

CMS is adopting the following additions to the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI):

- Therapy Data Collection: Beginning October 1, 2015 (FFY 2016), CMS has added a new Therapy Information Section to the IRF-PAI. This section will record the amount and mode of therapy (Individual, Concurrent, Group, Co-Treatment) patients receive in each therapy discipline (physical, occupational, and speech-language pathology). CMS does not currently collect detailed data on the mode and type of therapy provided by IRFs. CMS modified its proposal slightly to separate out Concurrent Therapy from the Group Therapy definition and to collect the total number of minutes by mode and discipline for weeks 1 and 2 only (CMS had proposed to collect this data beyond week 2).

  CMS plans to use the therapy data collected to analyze the amount and type of therapy services currently paid for under the IRF PPS. Specifically, CMS is considering a policy to limit Group Therapy to 25% of total therapy treatment time (similar to a Skilled Nursing Facility PPS therapy policy).

- Data Item for Arthritis Conditions: Beginning October 1, 2015 (FFY 2016), CMS has added a new "Yes/No" item for IRFs to identify if specific arthritis diagnoses codes that meet the prior treatment and severity regulatory requirements were reported on earlier items in the IRF-PAI (CMS had proposed that the new item require IRFs to duplicate the recording of the arthritis diagnoses codes).

  The addition of this item is directly related to the policy change adopted last year by CMS to reduce the number of diagnosis codes used to determine compliance with the 60% threshold (described above). The arthritic condition data will provide CMS with the additional severity and prior treatment information necessary to identify the arthritis diagnoses that are appropriate to count toward an IRF's compliance percentage under the presumptive compliance method. CMS, through this addition, is seeking to limit the potential increase and corresponding burden of full medical reviews to determine future compliance with the 60% threshold.

The final IRF-PAI for FFY 2016 that includes the new Therapy Information Section and arthritis condition item is available on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRFPAI.html.

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