Medicare Inpatient Rehabilitation Facility Prospective Payment System

Payment Rule Brief — FINAL RULE

Program Year: FFY 2016

Overview and Resources

On August 6, 2015, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FFY) 2016 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 *Federal Register* 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/2015-18973.

A brief of the final rule is provided below along with FR page references for additional details. Program changes adopted by CMS would be effective for discharges on or after October 1, 2015, unless otherwise noted.

IRF Payment Rate

FR pages 47,064-47,066; 47,075-47,078

Incorporating the final updates with the effect of a budget neutrality adjustment, the table below shows the IRF standard payment conversion factor for FFY 2016 compared to the rate currently in effect:

	Final FFY 2015	Final FFY 2016	Percent Change
IRF Standard Payment Conversion Factor	**$15,198**	**$15,478**	**+1.84%**

The table below provides details of the final updates to the IRF payment rate for FFY 2016:

	IRF Rate Updates and Budget Neutrality Adjustment
IRF-Specific Marketbasket (MB) Update	**2.4%** (proposed at 2.7%)
Affordable Care Act (ACA)-Mandated Productivity Reduction	**-0.5 percentage points** (proposed at 0.6 percentage points)
ACA Pre-Determined Reduction	**-0.2 percentage points**
Wage Index/Labor-Related Share Budget Neutrality (BN)	**+0.33 percentage points** (proposed at 0.27 percentage points)
Case-Mix Group Relative Weight Revisions Budget Neutrality	**-0.19 percentage points**
Overall Rate Change	***+1.84%*** (proposed at +2.17%)

IRF-Specific Market Basket

FR pages 47,046-47,064

Beginning in FFY 2016, CMS is implementing a new IRF-specific market basket to replace the 2008 Rehabilitation, Psychiatric and Long-Term Care (RPL) market basket that would be based on FFY 2012 Medicare cost report data from both freestanding and hospital-based IRFs. This new IRF-specific market basket does not include costs from either IPF or LTCH providers, as the 2008 RPL market basket did. The proposed rule methodology to calculate the IRF-specific market basket only calculated overhead wages and salaries attributable to the routine inpatient hospital-based IRF unit, not the ancillary departments of hospital-based IRFs. In the final rule the methodology has been corrected.

The market basket under the final rule methodology is 2.4% (proposed at 2.7%); the market basket under the previous RPL methodology would be 2.4% as well.

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 and Rural Adjustments

FR pages 47,066-47,076

The labor-related portion of the IRF standard rate is adjusted for differences in area wage levels using a wage index. CMS is not making any major changes to the calculation of Medicare IRF wage indexes. As has been the case in previous years, CMS will use the prior year's inpatient hospital wage index, the FFY 2015 pre-rural floor and pre-reclassified hospital wage index, to adjust payment rates under the IRF PPS for FFY 2016. A complete list of the wage indexes for payment in FFY 2016 is available on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Data-Files.html.

In 2013, the Office of Management and Budget (OMB) made a number of significant changes related to the delineation of Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas. To align with these changes, CMS will adopt the newest OMB delineations for the FY 2016 IRF PPS wage index. CMS will implement these changes using a 1-year transition with a 50/50 blended wage index for all providers. The FY 2016 wage index for each provider will consist of a blend of fifty percent of the FY 2016 wage index using the current OMB delineations that were used in FY 2015 and fifty percent of the FY 2016 wage index using the revised OMB delineations.

Rural Adjustments: The adoption of revised OMB delineations for the FY 2016 IRF PPS wage index results in 19 IRF providers having their status changed from rural to urban, resulting in a loss of a 14.9 percent rural adjustment. These 19 IRF providers will be provided with a gradual phase out of their rural adjustment over a three-year period. Specifically, these providers will receive two-thirds of the rural adjustment in FY 2016, one-third of the rural adjustment in FY 2017, and no rural adjustment in FY 2018. For the IRF providers changing from urban to rural status, there will be no phase-in; they will receive the full rural adjustment in FFY 2016.

For FFY 2016, CMS will begin to report and apply the IRF PPS labor-related rounded to a tenth of a percentage point, rather than a thousandth of a percent. This adjustment will bring reporting of the IRF PPS labor share in line with other payment systems. Based on updates to this year's marketbasket value, there will also be a small increase to the labor-related share of the standard rate, resulting in a change in labor-related share from 69.294% for FFY 2015 to 71.0% (proposed at 69.6%) for FFY 2016. This change slightly reduces payments to IRFs with a wage index less than 1.0.

There are no changes to the facility-level adjustments. In FFY 2016, CMS will continue to hold the facility-level adjustments at the FFY 2014 levels as they continue to evaluate IRF claims data.

Case-Mix Group Relative Weight Updates

FR pages 47,041-47,046

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 updating these factors for FFY 2016 using FFY 2014 claims data and the most recently available IRF cost reports. To calculate the FY 2016 CMG relative weights, CMS used a budget neutrality factor for the revisions to the CMG relative weights of .9981 (proposed at 1.000). CMS is not making any changes to the CMG categories/definitions. Using FFY 2014 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. A table that lists the FFY 2016 CMG payments weights and ALOS values is provided on pages 47,042-47,045.

The changes in the ALOS values for FY 2016, compared with FY 2015 are small and do not show any particular trends in IRF length of stay patterns.

Outlier Payments

FR page 47,079

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 2016, CMS is updating the outlier threshold value to $8,658 (proposed at $9,689) for FFY 2016, a 2.15% decrease compared to the current threshold of $8,848.

Updates to the 60% Compliance Threshold Criteria

There are no updates in the final rule.

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

FR pages 47,079-47,080

CMS applies a ceiling to IRF's CCRs. If an individual IRF's CCR exceeds this ceiling, the IRF's CCR is replaced with the appropriate national average CCR for that FY, 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 FY;
- 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 the national CCR ceiling for FY 2016 is 1.36. If an individual IRF's CCR exceeds this ceiling for FY 2016, the IRF's CCR will be replaced with the appropriate national average CCR, urban or rural. CMS is finalizing a national average CCR of 0.562 for rural IRFs

and 0.435 for urban IRFs.

ICD-10-CM

FR page 47,080

International Classification of Diseases, 10th Revision, ICD-10-CM, will become the required medical data code set for use on Medicare claims and for IRF patient assessment instrument submissions, with an implementation date for ICD-10 of October 1, 2015.

Updates to the IRF Quality Reporting Program (QRP)

FR pages 47,080-47,219

CMS collects quality data from IRFs on measurers that relate to five stated quality domains and 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 marketbasket update for the applicable year–the reduction factor value is set in law.

CMS is using the FFY 2016 rulemaking process to adopt new NQF-endorsed measures for FFY 2018 payment determinations along with updated and/or new data submission timelines for the previously adopted and newly adopted measures.

For FFY 2018 payment determinations, CMS will collect data on a total of 7 previously adopted quality measures. The following lists the IRF QRP measures and applicable payment determination years:

Previously Adopted IRF Measures for FFY 2016/2017 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 and beyond
Influenza Vaccination Coverage among Healthcare Personnel	#0431	FFY 2016 and beyond
Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine	#0680	FFY 2017 and beyond
NHSN Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant Staphylococcusaureus (MRSA) Bacteremia Outcome Measure	#1716	FFY 2017 and beyond
NHSN Facility-Wide Inpatient Hospital-Onset Clostridium difficile Infection (CDI) Outcome Measure	#1717	FFY 2017 and beyond
All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from IRFs	#2502	FFY 2017 and beyond ***refined for FFY 2018 and beyond**
Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened	#0678	FFY 2015 and beyond ***refined for FFY 2018 and beyond**

CMS is considering a future update to the numerator of NQF #0678: Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened which would hold providers accountable for the development of unstageable pressure ulcers, including suspected deep tissue injuries (sDTIs).

To address the IRP QRP changes mandated in the IMPACT Act, CMS finalizes six new measures measuring functional status and falls with injury as well as refining two previously adopted measures for FFY 2018 payment determination and subsequent years. The six quality measures are:

Newly/Previously Adopted IRF Measures for FFY 2018 Payment Determination	
IRF QRP Measures	**NQF #**
All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from IRFs – **refined for FFY 2018**	#2502
Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened – **refined for FFY 2018**	#0678
An application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) – **newly adopted**	#0674
An application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function – **newly adopted**	#2631; endorsed on July 23, 2015
IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients – **newly adopted**	#2633; under review
IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients – **newly adopted**	#2634; under review
IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients – **newly adopted**	#2635; endorsed on July 23, 2015
IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients – **newly adopted**	#2636; endorsed on July 23, 2015

As it does each year, CMS updated the IRF QRP data submission deadlines and procedures, data validation requirements and methods, and other program details.

Submission Timeline for IRF-PAI Data for Discharges	Payment Adjustment Year
October 1, 2016 – December 31, 2016 (first quarter)	FFY 2018 and beyond
January 1, 2017 – December 31, 2017 (one year collected every quarter)	FFY 2019 and beyond

Additionally, data for these six measures will be collected and reported using the IRF-PAI (version 1.4).

CMS will begin publicly reporting certain IRF QRP data in Fall FY 2016. CMS is temporarily suspending their previously finalized data validation policy in order to allow time to develop a more comprehensive policy that potentially decreases the burned on IRF providers, allows CMS to establish an estimation of accuracy related to quality data submitted, and facilitates the alignment of the IRF validation policy with that of other CMS quality reporting program policies.

Additions to the IRF-PAI

There are no additions to the IRF- Patient Assessment Instrument (IRF-PAI) in the final rule.

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