Medicare Inpatient Rehabilitation Facility Prospective Payment System

Payment Rule Brief — PROPOSED RULE
Program Year: FFY 2016

Overview, Resources, and Comment Submission

On April 23, 2015, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FFY) 2016 proposed payment rule for the Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS). The proposed rule reflects the annual update to the Medicare fee-for-service (FFS) IRF payment rates and policies.

A copy of the proposed 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 proposed rule is available at https://federalregister.gov/a/2015-09617.

A brief of the proposed 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. Comments on the proposed rule are due to CMS by June 22 and can be submitted electronically at http://www.regulations.gov by using the website’s search feature to search for file code “1624-P.”

**IRF Payment Rate**
*FR pages 23,355-23,364*

Incorporating the proposed 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:

<table>
<thead>
<tr>
<th>IRF Standard Payment Conversion Factor</th>
<th>Final FFY 2015</th>
<th>Proposed FFY 2016</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>IRF Standard Payment Conversion Factor</td>
<td>$15,198</td>
<td>$15,529</td>
<td>+2.17%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>IRF Rate Updates and Budget Neutrality Adjustment</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Marketbasket (MB) Update</td>
<td>1.9%</td>
</tr>
<tr>
<td>Full MB update of 2.7% minus Affordable Care Act (ACA)-mandated 0.6% productivity reduction, 0.2% pre-determined reduction</td>
<td></td>
</tr>
<tr>
<td>Wage Index/Labor-Related Share Budget Neutrality (BN)</td>
<td>+0.27%</td>
</tr>
<tr>
<td><strong>Overall Rate Change</strong></td>
<td>+2.17%</td>
</tr>
</tbody>
</table>
IRF-Specific Market Basket

Beginning in FY 2016, CMS is proposing a new IRF-specific market basket to replace the Rehabilitation, Psychiatric and Long-Term Care market basket that would be based only on FY2012 Medicare cost report data from both freestanding and hospital-based IRFs. The market basket under the proposed methodology is 2.7%; the market basket under the previous RPL methodology would be 2.8%.

Effect of Sequestration

While the proposed 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

The labor-related portion of the IRF standard rate is adjusted for differences in area wage levels using a wage index. CMS is not proposing any major changes to the calculation of Medicare IRF wage indexes. Also, CMS is not proposing to adopt the new labor-market areas proposed for use under the Inpatient PPS and other Medicare payment systems for FFY 2016 and beyond. As has been the case in previous years, CMS would 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 proposed 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. These values would not be updated for the final rule.

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 is proposing to adopt the newest OMB delineations for the FY 2016 IRF PPS wage index. CMS also is proposing to 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 would consist of a blend of fifty percent of the FY 2016 wage index using the current OMB delineations and fifty percent of the FY 2016 wage index using the revised OMB delineations.

Rural Adjustments: The proposed adoption of revised OMB delineations for the FY 2016 IRF PPS wage index would result in 19 IRF providers having their status changed from rural to urban, resulting in a loss of a 14.9 percent rural adjustment. CMS is proposing that these 19 IRF providers be provided with a gradual phase out of their rural adjustment over a three-year period. Specifically, CMS recommends that these providers 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 4 IRF providers changing from urban to rural status, no phase-in is proposed; they will receive the full rural adjustment in FY 2016.

Based on updates to this year’s proposed market basket value, CMS is proposing a small increase the labor-related share of the standard rate from 69.3% for FFY 2015 to 69.6% for FFY 2016. This change would slightly reduce 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.
CMG Updates
FR pages 23,336-23,341

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 proposing to update these factors for FFY 2016 using the most current full federal fiscal year of claims data (FFY 2014) and the most recently available IRF cost reports. CMS is not proposing 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 would experience less than a +/-5% change in the CMG relative weight as a result of the updates. A table that lists the proposed FFY 2016 CMG payments weights and ALOS values is provided on pages 23,338-23,340.

Outlier Payments
FR page 23,367

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 proposing to update the outlier threshold value to $9,689 for FFY 2016, a 9.5% increase compared to the current threshold of $8,848.

Updates to the 60% Compliance Threshold Criteria
There are no updates in the proposed rule.

ICD-10-CM
PR page 23,368

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 QRP
FR pages 23,368-23,389

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

For FFY 2018 payment determinations, CMS is proposing to collect data on a total of 9 quality measures (up from 7 measures for FFY 2017 determinations). CMS is proposing to retain the 7 measures currently in place for FFY 2017 determinations and add 2 National Healthcare Safety Network (NHSN) outcome measures. The following lists the IRF QRP measures and applicable payment determination years:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Payment Determination Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>NQF #0138: NHSN Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure</td>
<td>FFY 2015 and beyond</td>
</tr>
<tr>
<td>NQF #0431: Influenza Vaccination Coverage among Healthcare Personnel</td>
<td>FFY 2015 and beyond</td>
</tr>
<tr>
<td>NQF #2502: All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from IRFs</td>
<td>FFY 2016 and beyond</td>
</tr>
<tr>
<td>NQF #0680: Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine</td>
<td>FFY 2016 and beyond</td>
</tr>
<tr>
<td>NQF #0678: Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened</td>
<td>FFY 2016 and beyond</td>
</tr>
<tr>
<td>NQF #1716: NHSN Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure</td>
<td>FFY 2017 and beyond</td>
</tr>
<tr>
<td>NQF #1717: NHSN Facility-Wide Inpatient Hospital-Onset Clostridium difficile Infection (CDI) Outcome Measure</td>
<td>FFY 2017 and beyond</td>
</tr>
<tr>
<td>NQF #2502: All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from IRFs</td>
<td>FFY 2018 and beyond</td>
</tr>
<tr>
<td>NQF #0678: Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened</td>
<td>FFY 2018 and beyond</td>
</tr>
</tbody>
</table>

As it does each year, CMS is using the proposed rule to update the IRF QRP data submission deadlines and procedures, data validation requirements and methods, and other program details. CMS is also seeking 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 23,383-23,384.

CMS is also proposing to adopt six new quality measures. The six proposed quality measures are: (1) an application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674); (2) an application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631; under review); (3) IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633; under review); (4) IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634; under review); (5) IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635; under review); and (6) IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636; under review).

Additionally, CMS proposes that data for these six measures will be collected and reported using the IRF-PAI (version 1.4).
CMS proposes to begin publicly reporting certain IRF QRP data in Fall FY 2016. Each IRF is given the opportunity to review the data and information that is to be made public and to submit corrections prior to the publication or posting of this data.

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

####