Medicare Inpatient Rehabilitation Facility Prospective Payment System

Final Payment Rule Brief provided by the Wisconsin Hospital Association

Program Year: FFY 2019

Overview and Resources

On July 31, 2018, the Centers for Medicare and Medicaid Services (CMS) released the display copy of the federal fiscal year (FFY) 2019 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* (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/Spotlight.html

On August 6, 2018, an online version of the display copy of the final rule will be available at https://www.federalregister.gov/d/2018-16517.

A brief of the final rule is provided below along with display copy page references for additional details. Program changes finalized by CMS are effective for discharges on or after October 1, 2018, unless otherwise noted.

IRF Payment Rate

DISPLAY pages 40 – 45 and 55 – 58

Incorporating the adopted updates with the effect of budget neutrality adjustments, the table below shows the final IRF standard payment conversion factor for FFY 2019 compared to the rate currently in effect:

	Final FFY 2018	Final FFY 2019	Percent Change
IRF Standard Payment Conversion Factor	**$15,838**	**$16,021**	**+1.16%**

The table below provides details of the adopted updates to the IRF payment rate for FFY 2019:

	IRF Final Rate Updates
Marketbasket Update	**+2.9%** (as proposed)
Affordable Care Act (ACA)-Mandated Productivity Reduction	**-0.8 percentage points** (as proposed)
ACA Pre-Determined Reduction	**-0.75 percentage points**
Wage Index/Labor-Related Share Budget Neutrality (BN)	**1.0000**
Case-Mix Group Relative Weight Revisions Budget Neutrality	**0.9981**
Overall Rate Change	**+1.16%**

Wage Index, Labor-Related Share and Rural Adjustments

DISPLAY pages 45 – 55

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 2018 pre-rural floor and pre-reclassified hospital wage index, to adjust payment rates under the IRF PPS for FFY 2019. A complete list of the final wage indexes for payment in FFY 2019 is available on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Data-Files.html.

CMS is adopting a wage index budget neutrality factor of 1.0000 for FFY 2019 due to adjustments and updates to the IRF wage index.

As the Social Security Administration (SSA) county codes are no longer being updated, CMS will transition to the use of the Federal Information Processing Standard (FIPS) county codes for crosswalking to CBSAs beginning FFY 2019 for IRFs.

Based on updates to this year's marketbasket value, CMS is adopting a small decrease to the labor-related share of the standard rate from 70.7% for FFY 2018 to 70.5% in FFY 2019. This change will provide a small increase to IRFs with a wage index less than 1.0.

Facility-Level Adjustments

DISPLAY pages 38 - 39

There are no changes to the facility-level adjustment factors. In FFY 2019, CMS will continue to hold the facility-level adjustment factors - low-income percentage (LIP), teaching, and rural - at the FFY 2014 levels as they continue to evaluate IRF claims data.

Case-Mix Group Relative Weight Updates

DISPLAY pages 26 – 38, 72 – 127

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 will update these factors for FFY 2019 using FFY 2017 claims data and FFY 2016 IRF cost reports. To compensate for the CMG weights changes, CMS will apply a FFY 2019 case-mix budget neutrality factor of 0.9981.

CMS is not making any changes to the CMG categories/definitions. Using FFY 2017 claims data, CMS' analysis shows that 99.3% 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 FFY 2019 CMG payments weights and ALOS values is provided on pages 29 - 36.

The changes in the ALOS values for FFY 2019, compared with FFY 2018, are small and do not show any particular trends in IRF length of stay patterns.

As CMS finalized the removal of the FIM™ instrument and associated Function Modifiers from the IRF-PAI beginning FFY 2020, CMS will replace the use of the FIM™ items in assigning CMGs with use of data items located in the Quality Indicators section of the IRF-PAI in FFY 2020. In addition, CMS will update the functional status scores used in the case-mix system. However, due to comments received, CMS did not finalize the revised CMG definitions and plan on incorporating two years of data (FFYs 2017-2018), instead of one, and will update the relative weights and average length of stay values associated with the revised CMGs prior to implementation in FFY 2020. CMS will implement these revisions in a budget neutral manner. CMS is not finalizing any changes the methodology used to determine CMG relative weights.

A list of the revised CMG payments weights and ALOS values that will be updated for FFY 2020 is provided in Table 9 on the pages 83 - 91.

Outlier Payments

DISPLAY pages 60 – 66

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 2019, CMS has adopted an update the outlier threshold value of $9,402 for FFY 2019, an 8.3% increase compared to the current threshold of $8,679.

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

DISPLAY pages 66 – 68

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;
- 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 is adopting a national CCR ceiling for FY 2019 of 1.32. If an individual IRF's CCR exceeds this ceiling for FY 2019, the IRF's CCR will be replaced with the appropriate national average CCR, urban or rural. CMS is also adopting a national average CCR of 0.515 for rural IRFs and 0.412 for urban IRFs.

Removal of the FIM™ Instrument and Associated Function Modifiers from the IRF-PAI

DISPLAY pages 68 – 72, 81 – 127

The IRF-PAI is a data collection instrument through which IRFs are required to collect and electronically submit patient data for all Medicare Part-A FFS patients. Currently, to encourage timely filling of data, the failure to submit the data within the required deadline results in a 25% payment penalty.

The IRF-PAI currently in use was originally developed based on a modified version of the Uniform Data System for medical rehabilitation patient assessment instrument, commonly referred to as the FIM™. The FIM™

instrument and associated Function Modifiers are currently used to assign a patient into a CMG for payment purposes under the IRF PPS based on the patient's ability to perform specific activities of daily living and the patient's cognitive ability.

Since many of the Function Modifiers overlap with data items collected in the Quality Indicators section of the IRF-PAI under the IRF QRP, CMS has adopted its proposal to remove the FIM™ instrument and associated Function Modifiers from the IRF-PAI beginning FFY 2020 to reduce administrative burden on IRFs.

Revisions to Certain IRF Coverage Requirements

DISPLAY pages 127 – 146

IRF care is only considered by Medicare to be reasonable and necessary if the patient meets all of the IRF coverage requirements. Failure to meet the IRF coverage criteria in a particular case will result in denial of the IRF claim.

In the FFY 2018 IRF PPS Proposed Rule, CMS included a Request for Information to receive feedback on ways CMS could reduce burden for hospitals and physicians, improve quality of care, decrease costs, and ensure that patients receive the best care.

Currently, two of the IRF coverage requirements include:

- The rehabilitation physician must conduct face-to-face visits with the patient at least 3 days per week throughout the patient's stay in the IRF; and
- Separately, the patient must have an additional post-admission physician evaluation that meets all of the requirements specified, including the 24-hour timeframe within which it must be completed.

In order to reduce unnecessary burden on IRF providers and physicians, CMS finalized that, beginning FFY 2019, the post-admission physician evaluation may count as one of the face-to-face physician visits.

Another requirement in order for an IRF claim to be considered reasonable and necessary is that the patient must require an interdisciplinary team approach to care led by a rehabilitation physician. In the past, CMS has allowed rehabilitation physicians to participate in the team meetings by telephone as long as it is clearly demonstrated in the documentation of the IRF medical record. CMS is adopting its proposal that, beginning FFY 2019, rehabilitation physicians may lead the team meetings remotely without any additional documentation requirements. CMS has only made this change for the rehabilitation physician and not for the other required team meeting attendees, but may consider expanding this policy in future rulemaking. CMS also notes that this policy does not preclude IRFs from using their own discretion in determining how to best organize their medical staff or implementing a protocol for determining when the rehabilitation physician should lead the team meeting in person or remotely.

One final coverage requirement is that IRFs must have physician admission orders for a patient's care during the time the patient is hospitalized. Separately, an individual is considered an inpatient of a hospital, including a critical access hospital, if formally admitted as an inpatient under an order for inpatient admission by a physician or other qualified practitioner. In an effort to reduce duplicative requirements, CMS has removed the requirement for IRFs to have admission order documentation for a patient's care beginning FFY 2019.

Updates to the IRF Quality Reporting Program (QRP)

DISPLAY pages 146 – 179

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.

For FFY 2020 payment determinations, CMS plans to use data collected on a total of 18 previously adopted quality measures. The following table lists the previously adopted IRF QRP measures and applicable payment determination years:

Previously Adopted IRF Measures for FFY 2020 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+
Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay)	#0680	FFY 2017+
NHSN Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure	#1716	FFY 2017+
NHSN Facility-Wide Inpatient Hospital-Onset Clostridium difficile Infection (CDI) Outcome Measure	#1717	FFY 2017+
All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from IRFs	#2502	FFY 2017+ ***refined for FFY 2018+**
Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay)	#0678	FFY 2014+ ***refined for FFY 2018+**
An application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	#0674	FFY 2018+
An 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 Rehabilitation Patients	#2635	FFY 2018+
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+

CMS is adopting an additional factor to consider when evaluating measures for removal from the IRF QRP Program measure set: the costs associated with a measure outweigh the benefit of its continued use in the program.

Additionally, CMS will remove the NHSN Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (NQF #1716) from the IRF QRP beginning FFY 2020. Beginning FFY 2021, CMS will also remove Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680) from the IRF QRP; as the data elements for this measure will not be removed from the IRF-PAI until version 3.0 (effective October 1, 2019), IRFs should enter a dash (-) for O0250A, O0250B, and O0250C beginning with October 1, 2018 discharges until IRF-PAI version 3.0 is released.

Currently, CMS notifies an IRF of noncompliance with the IRF QRP requirements using the QIES ASAP system and via letter sent through the United States Post Service. CMS has adopted its proposal to notify IRFs of noncompliance with the IRF QRP requirements via a letter sent through at least once of the following methods: the QIES ASAP system, the United States Postal Service, or via an email from the Medicare Administrative Contractor (MAC).

CMS is considering options to improve health disparities among patient groups within and across hospitals by increasing transparency of disparities through quality measures and quality programs. To this end, CMS will also begin publicly displaying data in CY 2020 on the following four assessment-based measures, based on four rolling quarters of data:

- Change in Self-Care Score (NQF #2633);
- Change in Mobility Score (NQF #2634);
- Discharge Self-Care Score (NQF #2635); and
- Discharge Mobility Score (NQF #2636).

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