Medicare Inpatient Rehabilitation Facility Prospective Payment System

Final Payment Rule Brief provided by the Wisconsin Hospital Association

Program Year: FFY 2018

Overview and Resources

On August 3, 2017, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FFY) 2018 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

An online version of the final rule is available at https://federalregister.gov/a/2017-16291.

A brief of the final rule is provided below along with FR page references for additional details. Program changes finalized by CMS would be effective for discharges on or after October 1, 2017, unless otherwise noted.

IRF Payment Rate

Federal Register pages 36247 – 36248, 36251 - 36254

Incorporating the final updates with the effect of budget neutrality adjustments, the table below shows the final IRF standard payment conversion factor for FFY 2018 compared to the rate currently in effect:

	Final FFY 2017	Final FFY 2018	Percent Change
IRF Standard Payment Conversion Factor	**$15,708**	**$15,838** (proposed at $15,835)	**+0.83%** (proposed at +0.81%)

The Medicare Access and CHIP Reauthorization Act (MACRA) mandated the annual marketbasket update factor for FFY 2018, after all ACA productivity adjustments, will be 1 percent.

The table below provides details of the final updates to the IRF payment rate for FFY 2018:

	IRF Final Rate Updates
Marketbasket Update	**+2.6%** (proposed at +2.7%)
Affordable Care Act (ACA)-Mandated Productivity Reduction	**-0.6 percentage points** (proposed at -0.4 percentage points)
ACA Pre-Determined Reduction	**-0.75 percentage points** (proposed at -0.75 percentage points)
Mandated 1.0% Marketbasket Update Due to MACRA	**-0.25%** (proposed at -0.54%)
Wage Index/Labor-Related Share Budget Neutrality (BN)	**1.0007** (as proposed)

Case-Mix Group Relative Weight Revisions Budget Neutrality	**0.9976** (proposed at 0.9974)
Overall Rate Change	**+0.83%** (proposed at +0.81%)

Wage Index, Labor-Related Share and Rural Adjustments

Federal Register pages 36248- 36251

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 2017 pre-rural floor and pre-reclassified hospital wage index, to adjust payment rates under the IRF PPS for FFY 2018. A complete list of the final wage indexes for payment in FFY 2018 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 1.0007 (as proposed) for FFY 2018 due to adjustments and updates to the IRF wage index.

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 70.9% for FFY 2017 to 70.7% (as proposed) in FFY 2018. This change will provide a small increase to IRFs with a wage index less than 1.0.

Rural Adjustments: The adoption of revised OMB delineations for the FFY 2016 IRF PPS wage index resulted 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 were provided a gradual phase out of their rural adjustment over a three-year period. FFY 2018 is the last year of the three-year phase out of the rural adjustment and these IRFs will receive the full FFY 2018 wage index with no rural adjustment.

Facility-Level Adjustments

Federal Register page 36247

There are no changes to the facility-level adjustment factors. In FFY 2018, 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

Federal Register pages 36244 - 36247

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 2018 using FFY 2016 claims data and FFY 2015 IRF cost reports. To compensate for the CMG weights changes, CMS is applying a FFY 2018 case-mix budget neutrality factor of 0.9976 (proposed at 0.9974).

CMS is not making any changes to the CMG categories/definitions. Using FFY 2016 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 final FFY 2018 CMG payments weights and ALOS values is provided on *Federal Register* pages 36245 - 36246.

The changes in the ALOS values for FFY 2018, compared with FFY 2017, are small and do not show any particular trends in IRF length of stay patterns.

Outlier Payments

Federal Register pages 36254 - 36255

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 2018, CMS is updating the outlier threshold value to $8,679 (proposed at $8,656) for FFY 2018, an 8.7% increase compared to the current threshold of $7,984.

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

Federal Register pages 36255 - 36256

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 2018 of 1.31 (proposed at 1.28). If an individual IRF's CCR exceeds this ceiling for FY 2018, the IRF's CCR will be replaced with the appropriate national average CCR, urban or rural. CMS is adopting a national average CCR of 0.518 (proposed at 0.516) for rural IRFs and 0.416 (as proposed) for urban IRFs.

Removal of the 25 Percent Payment Penalty for IRF-PAI Late Submissions

Federal Register pages 36256 - 36257

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.

In 2012 CMS issued an edit within the Fiscal Intermediary Shared System (FISS) in which if an IRF attempts to submit a Medicare Part-A FFS claim for a patient and there is not a corresponding IRF-PAI on file for the patient to match with the claim, the FISS will return an error to the IRF provider advising that an IRF-PAI needs to be submitted. Therefore, IRFs can only receive payment from Medicare for a Medicare Part-A FFS patient when both an IRF claim and IRF-PAI are submitted. CMS believes this is an incentive to file patients IRF-PAIs in a timely manner and therefore the 25% payment penalty is no longer needed. CMS is removing the 25% payment penalty for IRF-PAI late submissions beginning FFY 2018.

Refinements to the List of ICD-10-CM Diagnosis Codes for the 60 Percent Rule

Federal Register pages 36257 - 36269

The compliance percentage has been part of the criteria for defining IRFs since 1983. In FFY 2015, CMS developed the 60% rule, which consists of two different methods to test if an IRF complies. To align with the presumptive method CMS is adopting a new list of ICD-10-CM diagnosis codes that should count towards the rule for all IRF discharges occurring on or after October 1, 2017. The final revised lists (with changes from the proposed) are posted on the IRF PPS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Downloads/ICD-10-CM-DataFiles.zip

CMS is also adopting a formal process to distinguish between non-substantive updates to the ICD-10-CM codes on the list of codes that should count towards the 60% rule that would be made through sub-regulatory updates and substantive revisions made only through the proposed and final rule making process.

Updates to the IRF Quality Reporting Program (QRP)

Federal Register pages 36269 - 36299

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 2018 payment determinations, CMS will use data collected on a total of 13 previously adopted quality measures. The following lists the IRF QRP measures and applicable payment determination years:

Previously Adopted IRF Measures for FFY 2018 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	#2633	FFY 2018+

Rehabilitation Patients		
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 removing the All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from IRFs from the IRF QRP beginning FFY 2019. CMS is also removing the current Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678) measure and replacing it with a modified version of the measure, Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury for the FFY 2020 IRF QRP.

CMS is considering the following measures for the IRF QRP Quality Measures for Future Years:

- Experience of Care;
- Application of Percent of Residents Who Self-Report Moderate to Severe Pain; and
- Modification of the Discharge to Community-Post Acute Care.

CMS is considering methods to account for social risk factors in the IRF QRP such as income, education, race and ethnicity, employment, disability, community resources, and social support. CMS sought comment in the proposed rule on how to incorporate social risk factors and which social risk factors should be incorporated. A discussion of these comments is on *Federal Register* pages 36273 – 36274.

To comply with the IMPACT Act, in order to enable access to longitudinal information and to facilitate coordinated care, CMS is requiring that IRFs begin reporting standardized patient assessment data with respect to five specified patient assessment categories required by law for the FFY 2020 IRF QRP, including:

- Functional status
- Cognitive function
- Special services, treatments, and interventions
- Medical conditions and comorbidities
- Impairments

CMS is not finalizing the standardized patient assessment data elements that were proposed for the FFY 2020 IRF QRP for cognitive function, special services, treatments and interventions, and impairments due to the newly imposed reporting burden they would cause on IRFs. However, CMS is finalizing the standardized resident assessment data elements for the other two patient assessment categories, functional status and medical conditions and comorbidities.

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