Medicare Inpatient Rehabilitation Facility
Prospective Payment System

Proposed Payment Rule Brief provided by the Wisconsin Hospital Association

Program Year: FFY 2020

Overview and Resources

On April 24, 2019, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FFY) 2020 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. In addition to the regular updates to wage indexes and market basket, this rule includes:

- A change to the IRF market basket base year from 2012 to 2016 Medicare cost report data;
- Elimination of one item from the motor score to assign patients to CMGs beginning FFY 2020;
- Update to the CMGs relative weights and average length of stay;
- Updates to the requirement for the IRF QRP; and
- The determination of a physician's qualifications as a rehabilitation physician.

A copy of the proposed 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 proposed rule is available at https://www.federalregister.gov/documents/2019/04/24/2019-07885/medicare-program-inpatient-rehabilitation-facility-prospective-payment-system-for-federal-fiscal.

A brief of the proposed rule is provided below along with *Federal Register* page references for additional details. Program changes proposed by CMS will be effective for discharges on or after October 1, 2019, unless otherwise noted. CMS estimates the overall economic impact of this proposed payment rate update to be an increase of $195 million in aggregate payments to IRFs in FFY 2020 over FFY 2019.

Comments on the proposed rule are due to CMS by June 17, 2019 and can be submitted electronically at http://www.regulations.gov by using the website's search feature to search for file code "1710-P".

Note: Text in italics is extracted from the April 24, 2019 *Federal Register*.

IRF Payment Rate

Federal Register pages 17261 - 17275, 17280 - 17282

Incorporating the proposed updates with the effect of budget neutrality adjustments, the table below shows the proposed IRF standard payment conversion factor for FFY 2020 compared to the rate currently in effect:

	Final FFY 2019	Proposed FFY 2020	Percent Change
IRF Standard Payment Conversion Factor	**$16,021**	**$16,573**	**+3.45%**

The table below provides details of the proposed updates to the IRF payment rate for FFY 2020:

	IRF Proposed Rate Updates
Marketbasket Update	**+3.0%**
Affordable Care Act (ACA)-Mandated Productivity Reduction	**-0.5 percentage points**
Wage Index/Labor-Related Share Budget Neutrality (BN)	**1.0076**
Case-Mix Group Relative Weight Revisions Budget Neutrality	**1.0016**
Overall Rate Change	**+3.45%**

Update to the Base IRF Market Basket

Federal Register pages 17261 - 17274

CMS periodically rebases the market basket to reflect the changes in the goods and services needed to furnish IRF services. CMS is proposing to rebase and revise the IRF market basket to reflect a 2016 base year rather than the current 2012 base year for both freestanding and hospital-based IRFs.

Wage Index, Labor-Related Share and Rural Adjustments

Federal Register pages 17275 - 17283

CMS is proposing to estimate the labor-related portion of the IRF standard rate using the proposed 2016-based IRF market basket and also adjust for differences in area wage levels using a wage index. In an effort to standardize the wage index data across post-acute care settings, CMS is proposing to use the concurrent fiscal year's pre-rural floor, pre-reclassified IPPS wage index for the IRF PPS wage index beginning FFY 2020 and continuing for all subsequent years. A complete list of the proposed wage indexes for payment in FFY 2020 is available on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Data-Files.html.

CMS is proposing a wage index budget neutrality factor of 1.0076 for FFY 2020 due to adjustments and updates to the IRF wage index.

Based on updates to this year's market basket value, CMS is proposing an increase to the labor-related share of the standard rate from 70.5% for FFY 2019 to 72.6% in FFY 2020. This change will provide a decrease to IRFs with a wage index less than 1.0.

Facility-Level Adjustments

Federal Register pages 17260 - 17261

There are no proposed changes to the facility-level adjustment factors. In FFY 2020, CMS is proposing to 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.

Refinements to the Case-Mix Classification System

Federal Register pages 17250 – 17260

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 (motor score). 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.

CMS is proposing to consolidate CMGs that are only different by their respective communication score within its RICs since patients with higher cognitive deficits inappropriately receive a lower payment. If this proposal is finalized, there would be 92 CMGs with four tiers and another five CMGs that account for very short stays and patients who die in the IRF.

To improve the ability of IRF PPS in predicting patient costs, CMS is proposing to replace the previously finalized unweighted motor score with a weighted motor score to assign patients to CMGs. CMS is also proposing to remove GG0170A1 – Roll left and right from the calculation of the motor score beginning with FFY 2020 because this item was found to be highly correlated with the other items in the motor score. The following lists the proposed weights for each component of the motor score.

Proposed Motor Score Weight Index	
Item	**Weight**
GG0130A1 - Eating	2.7
GG0130B1 – Oral hygiene	0.3
GG0130C1 – Toileting hygiene	2.0
GG0130E1 – Shower bathe self	0.7
GG0130F1 – Upper-body dressing	0.5
GG0130G1 – Lower-body dressing	1.0
GG0130H1 – Putting on/taking off footwear	1.0
GG0170B1 – Sit to lying	0.1
GG0170C1 – Lying to sitting on side of bed	0.1
GG0170D1 – Sit to stand	1.1
GG0170E1 – Chair/bed-to-chair transfer	1.1
GG0170F1 – Toilet transfer	1.6
GG0170I1 – Walk 10 feet	0.8
GG0170J1 – Walk 50 feet with two turns	0.8
GG0170K1 – Walk 150 feet	0.8
GG0170M1 – One-step curb	1.4
H0350 – Bladder Continence	1.3
H0400 – Bowel Continence	0.7

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 2020 using FFYs 2017 and 2018 IRF claims data and FFY 2017 IRF cost report data. To compensate for the CMG weights changes, CMS is proposing to apply a FFY 2020 case-mix budget neutrality factor of 1.0016.

A table that lists the proposed FFY 2020 revised CMG payments weights and ALOS values is provided on the Federal Register pages 17253 - 17259.

Outlier Payments

Federal Register pages 17283 -17284

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 2020, CMS is proposing to update the outlier threshold value to $9,935 for FFY 2020, a 5.7% increase compared to the current threshold of $9,402.

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

Federal Register page 17284

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 is proposing to continue to set the national CCR ceiling at 3 standard deviations above the mean CCR, and therefore CMS is proposing a national CCR ceiling for FY 2020 of 1.31. If an individual IRF's CCR exceeds this ceiling for FY 2020, the IRF's CCR will be replaced with the appropriate national average CCR, urban or rural. CMS is proposing a national average CCR of 0.500 for rural IRFs and 0.406 for urban IRFs.

Amendments to Clarify the Definition of a Rehabilitation Physician

Federal Register pages 17284 - 17285

CMS defines a rehabilitation physician as *"a licensed physician with specialized training and experience in inpatient rehabilitation"* and does not specify the level or type of training and experience required for a licensed physician to be recognized as a rehabilitation physician. CMS is proposing to amend the regulations to clarify that the determination as to whether a physician qualifies as a trained rehabilitation physician is made by the IRF.

Removal of the List of Compliant IRFs

Federal Register pages 17327 - 17328

Due to the minimal benefit of the compliant IRF data, CMS is proposing to no longer publish the list of compliant IRFs on the IRF QRP website beginning FFY 2020.

Updates to the IRF Quality Reporting Program (QRP)

Federal Register pages 17285 – 17327

CMS collects quality data from IRFs on measures 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 market basket update for the applicable year–the reduction factor value is set in law.

CMS is proposing for IRFs to begin submitting QRP data via a new internet Quality Improvement and Evaluation System (iQIES) with real-time upgrades as the data submission system effective October 1, 2019. CMS is also proposing for IRF to begin reporting IRF-PAI data on all patients, regardless of payer in order to meet the quality reporting requirements for FFY 2022 beginning with patient discharges on or after October 1, 2019.

For FFY 2020 payment determinations, CMS plans to use data collected on a total of 15 previously adopted quality measures. The following lists the previously finalized 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+
NHSN Facility-Wide Inpatient Hospital-Onset Clostridium difficile Infection (CDI) Outcome Measure	#1717	FFY 2017+
Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	#0674	FFY 2018+
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+
Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury		FFY 2020+

CMS is proposing to adopt these two process measures that support promoting effective communication and coordination of care with the FFY 2022 QRP, with IRFs reporting data on these measures beginning FFY 2020.

- Transfer of Health Information to the Provider-Post-Acute Care (PAC); and
- Transfer of Health Information to the Patient-PAC.

Additionally, CMS is proposing to exclude baseline nursing facility (NF) residents from the specifications for the Discharge to Community-PAC IRF QRP measure beginning with FFY 2020. Baseline nursing facility residents are

defined as "*IRF patients who had a long-term NF stay in the 180 days preceding their hospitalization and IRF stay, with no intervening community discharge between the NF stay and qualifying hospitalization for measure inclusion".*

CMS is proposing to begin publicly displaying data in CY 2020 on the *Drug Regimen Review Conducted with Follow-Up for Identified Issues-PAC IRF QRP measure*.

For FFY 2019 and each subsequent year, IRFs must report standardized patient assessment data elements (SPADE), as required by the IMPACT Act of 2014. Previously, CMS had adopted SPADEs for two categories:

- Functional Status: Data elements currently reported by IRFs to calculate the measure Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631); and
- Medical conditions and comorbidities: the data elements used to calculate the pressure ulcer measures, Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678) and the replacement measure, Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury.

Beginning with the FFY 2022 IRF QRP, CMS is proposing that IRFs begin reporting the following additional SPADE categories, for admissions and discharges starting October 1, 2020:

- Cognitive Function and Mental Status (*Federal Register pages 17293 - 17297*);
- Special Services, Treatments, and Interventions (*Federal Register pages 17297 - 17314*);
- Impairment Data (*Federal Register pages 17316 - 17326*) and
- Social Determinants of Health (*Federal Register pages 17319 - 17326*) [NEW].

CMS Request for Information (RFI)

Federal Register pages 17291 - 17292

With this proposed rule, CMS is issuing an RFI on "*Quality Measures and Measure Concepts, and Standardized Patient Assessment Data Elements (SPADEs)*" to solicit feedback on the importance, relevance, appropriateness, and applicability of each item under consideration. Submissions will be considered in developing future measures and SPADE. The following lists the Quality Measures and Measure Concepts, and the SPADEs under consideration:

Future Measures, Measure Concepts, and Standardized Patient Assessment Data Elements (SPADEs) Under Consideration for the IRF QRP
Quality Measures and Measure Concepts
Opioid use and frequency
Exchange of Electronic Health Information and Interoperability
Standardized Patient Assessment Data Elements (SPADEs)
Cognitive complexity, such as executive function and memory
Dementia
Bladder and bowel continence including appliance use and episodes of incontinence
Care preferences, advance care directives, and goals of care
Caregiver Status
Veteran Status
Health disparities and risk factors, including education, sex and gender identity, and sexual orientation

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