Medicare Inpatient Rehabilitation Facility Prospective Payment System

Proposed Payment Rule Brief provided by the Wisconsin Hospital Association

Program Year: FFY 2021

Overview and Resources

On April 17, 2020, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FFY) 2021 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* (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/2020/04/21/2020-08359/medicare-program-inpatient-rehabilitation-facility-prospective-payment-system-for-federal-fiscal.

A brief of the proposed rule along with *Federal Register* page references for additional details are provided below. Program changes proposed by CMS will be effective for discharges on or after October 1, 2020, unless otherwise noted. CMS estimates the overall economic impact of this proposed payment rate update to be an increase of $270 million in aggregate payments to IRFs in FFY 2021 over FFY 2020.

Comments on the proposed rule are due to CMS by June 15, 2020 and can be submitted electronically at http://www.regulations.gov by using the website's search feature to search for file code "1729-P".

Note: Text in italics is extracted from the *Federal Register*.

IRF Payment Rate

Federal Register pages 22073 – 22074, 22080 - 22084

Incorporating the proposed updates with the effect of budget neutrality adjustments, the table below shows the proposed IRF standard payment conversion factor for FFY 2021 compared to the rate currently in effect:

	Final FFY 2020	Proposed FFY 2021	Percent Change
IRF Standard Payment Conversion Factor	**$16,489**	**$16,847**	**+2.17%**

The table below provides details of the proposed updates to the IRF payment rate for FFY 2021:

	IRF Proposed Rate Updates
Marketbasket Update	**+2.9%**
Affordable Care Act (ACA)-Mandated Productivity Reduction	**-0.4 percentage points**
Wage Index/Labor-Related Share/CBSA Delineations Budget Neutrality (BN)	**0.9999**
Case-Mix Groups (CMGs) and CMG Relative Weight Revisions BN	**0.9969**
Overall Rate Change	**+2.17%**

Wage Index, Labor-Related Share, and CBSA Delineations

Federal Register pages 22074 – 22080

CMS is proposing to estimate the labor-related portion of the IRF standard rate and also adjust for differences in area wage levels using a wage index. CMS is proposing an increase to the labor-related share of the standard rate from 72.7% for FFY 2020 to 72.9% in FFY 2021.

For FFY 2021, CMS is proposing to update the Core-Based Statistical Areas (CBSA) for all providers based on the delineations published in the Office of Budget and Management (OMB) Bulletin No. 18-04 released on September 14, 2018. Included in this bulletin are new CBSAs, urban counties that become rural, rural counties that become urban, and existing CBSAs which are split apart or otherwise changed. CMS believes that these delineations better represent current rural and urban areas. As a result, provider wage indexes change depending on which CBSA they are assigned to. In order to alleviate significant losses in revenue, CMS is proposing a 2-year transition period. Adopted delineations would be effective beginning October 1, 2020 and include a 5% cap on the reduction of a provider's wage index for FFY 2021 compared to its wage index for FFY 2020, with the full reduction of a provider's wage index for FFY 2022.

CMS is proposing a wage index and labor-related share budget neutrality factor of 0.9999 for FFY 2021 to ensure that aggregate payments made under the IRF PPS are not greater or less than would otherwise be made if wage adjustments had not changed.

A complete list of the proposed wage indexes for payment in FFY 2021 is available on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Data-Files.html. OMB Bulletin 18-04 can be found at https://www.whitehouse.gov/wp-content/uploads/2018/09/Bulletin-18-04.pdf.

The March 6, 2020 OMB Bulletin 20-01 was not issued in time for integration into the rule. This bulletin can be found at https://www.whitehouse.gov/wp-content/uploads/2020/03/Bulletin-20-01.pdf. For FFY 2022, CMS intends to propose any updates from this OMB bulletin to further update CBSA delineation.

Case-Mix Group Relative Weight Updates

Federal Register pages 22069 – 22073

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 95 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 2021 using FFY 2019 IRF claims data and FFY 2018 IRF cost report data. To compensate for the CMG weights changes, CMS is proposing to apply a FFY 2021 case-mix budget neutrality factor of 0.9969.

CMS is not proposing to make any changes to the CMG categories/definitions. Using FFY 2019 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 proposed FFY 2021 CMG payments weights and ALOS values is provided on the Federal Register pages 22070 - 22073.

Outlier Payments

Federal Register pages 22084 – 22085

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 2021, CMS is proposing to update the outlier threshold value to $8,102 for FFY 2021, a 12.9% decrease compared to the current threshold of $9,300.

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

Federal Register page 422085– 22086

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 2021 of 1.33. If an individual IRF's CCR exceeds this ceiling for FY 2021, the IRF's CCR will be replaced with the appropriate national average CCR, urban or rural. CMS is proposing a national average CCR of 0.490 for rural IRFs and 0.400 for urban IRFs.

Revisions to Certain IRF Coverage Requirements

Federal Register pages 22086 – 22090

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.

Based on the responses to CMS' request for information in the FFY 2018 IRF PPS Proposed Rule on ways to reduce burden for hospitals and physicians, improve quality of care, decrease costs, and ensure that patients receive the best care, CMS is proposing that a non-physician practitioner that the IRF determines has the specialized training and experience in inpatient rehabilitation may perform any of the IRF coverage

requirement duties that are currently required to be performed by a rehabilitation physician, as long as the duties are within the non-physician practitioner's scope of practice under applicable state law.

In the April 6, 2020 Interim Final Rule, CMS finalized the removal of the post-admission physician evaluation requirement in order to address the public health emergency for the COVID-19 pandemic only for the duration of the pandemic. In order to reduce unnecessary burden on IRF providers and physicians, CMS is proposing to permanently remove the post-admission physician evaluation documentation requirement from the list of IRF coverage requirements for all IRFs beginning with FFY 2021.

Additionally, a comprehensive pre-admission screening must meet several requirements, including but not limited to:

- It includes a detailed and comprehensive review of each patient's condition and medical history; and
- It is used to inform a rehabilitation who reviews and comments his or her occurrence with the findings and results of the preadmission screening.

In order to reduce administrative burden and for ease of reference, CMS is proposing the following amendments to the above comprehensive preadmission screening beginning FFY 2021:

- The comprehensive pre-admission screening must include a detailed and comprehensive review of each patient's condition and medical history, including:
  - The patient's level of function prior to the event or condition that led to the patient's need for intensive rehabilitation therapy, expected level of improvement, and the expected length of time necessary to achieve that level of improvement;
  - An evaluation of the patient's risk for clinical complications;
  - The condition that caused the need for rehabilitation;
  - The treatments needed;
  - Expected frequency and duration of treatment in the IRF;
  - Anticipated discharge destination; and
  - Anticipated post-discharge treatments.
- The comprehensive preadmission screening must be used to inform a rehabilitation physician who must document that he/she has reviewed and concurs with the findings and results of the preadmission screening prior to the IRF admission as these were not previously finalized in the preadmission screening documentation.

Lastly, CMS is proposing to define a "week" as *a period of 7 consecutive calendar days beginning with the date of admission to the IRF* in order to reduce administrative burden and provide clarity regarding several of the IRF coverage requirements.

With this proposed rule, CMS is requesting feedback and reasoning regarding aspects of the preadmission screening that stakeholders believe are most or least critical and useful for supporting the appropriateness of an IRF admission.

Updates to the IRF Quality Reporting Program (QRP)

Federal Register pages 22066, 22090

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.

The following lists the previously finalized IRF QRP measures and applicable payment determination years:

Previously Adopted IRF Measures for FFY 2021 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 not proposing any changes to the IRF QRP program.

####