Medicare Inpatient Rehabilitation Facility Prospective Payment System

Proposed Payment Rule Brief provided by the Wisconsin Hospital Association

Program Year: FFY 2022

Overview and Resources

On April 7, 2021, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FFY) 2022 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://federalregister.gov/d/2021-07343.

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, 2021, unless otherwise noted. CMS estimates the overall economic impact of this proposed payment rate update to be an increase of $160 million in aggregate payments to IRFs in FFY 2022 over FFY 2021.

Comments on the proposed rule are due to CMS by June 7, 2021 and can be submitted electronically at http://www.regulations.gov by using the website's search feature to search for file code "1748-P".

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

IRF Payment Rate

Federal Register pages 19,095 – 19,096, 19,098 – 19,102

Incorporating the proposed updates with the effect of budget neutrality adjustments, the table below shows the proposed IRF standard payment conversion factor for FFY 2022 compared to the rate currently in effect:

	Final FFY 2021	Proposed FFY 2022	Percent Change
IRF Standard Payment Conversion Factor	**$16,856**	**$17,273**	**+2.47%**

The table below provides details of the proposed updates to the IRF payment rate for FFY 2022:

	IRF Proposed Rate Updates
Marketbasket Update	**+2.4%**
Affordable Care Act (ACA)-Mandated Productivity Reduction	**-0.2 percentage points**
Wage Index/Labor-Related Share/CBSA Delineations Budget Neutrality (BN)	**1.0027**
Case-Mix Groups (CMGs) and CMG Relative Weight Revisions BN	**1.0000**
Overall Rate Change	**+2.47%**

In the past, CMS has used the Moody's AAA Corporate Bond Yield index as the price proxy for the For-profit Interest cost category of the 2016-based IRF marketbasket. Instead, CMS is proposing to use the iBoxx AAA Corporate Bond Yield index, which closely resembles the Moody's AAA Corporate Bond Yield index, as the Moody's AAA Corporate Bond series is no longer available for use under license to IHS Global Inc. (IGI) and therefore IGI discontinued the publication of the associated historical data and forecasts of this series.

Wage Index, Labor-Related Share, and CBSA Delineations

Federal Register pages 19,096 – 19,098

CMS proposes to estimate the labor-related portion of the IRF standard rate and adjust for differences in area wage levels using a wage index. CMS is proposing to decrease the labor-related share of the standard rate from 73.0% for FFY 2021 to 72.9% in FFY 2022.

CMS proposes to use the FFY 2022 pre-rural floor, pre-reclassified IPPS wage index for the IRF PPS wage index. A complete list of the proposed wage indexes for payment in FFY 2022 is available on the CMS website at https://www.cms.gov/httpswwwcmsgovmedicaremedicare-fee-service-paymentinpatientrehabfacppsirf-rules-and-related-files/cms-1748-p.

CMS proposes a wage index and labor-related share budget neutrality factor of 1.0027 for FFY 2022 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.

Case-Mix Group Relative Weight Updates

Federal Register pages 19,090 – 19,095

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 2022 using FFY 2020 IRF claims data and FFY 2019 IRF cost report data. To compensate for the CMG weights changes, CMS is proposing to apply a FFY 2022 case-mix budget neutrality factor of 1.0000.

CMS is not proposing to make any changes to the CMG categories/definitions. Using FFY 2020 claims data, CMS' analysis shows that 97.3% 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 2022 CMG payments weights and ALOS values is provided on *Federal Register* pages 19,092 – 19,095.

Outlier Payments

Federal Register pages 19,102 – 19,103

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 2022, CMS is proposing to update the outlier threshold value to $9,192, a 16.3% increase compared to the current threshold of $7,906.

> IRF uses FFY 2020 claims, which differs from Inpatient Psychiatric Facility (IPF) proposed rule which uses FFY 2019 claims due to effect of COVID-19. This resulted in a lower IPF outlier threshold than if FFY 2020 claims were used.

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

Federal Register pages 19,103

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 2022 of 1.34. If an individual IRF's CCR exceeds this ceiling for FY 2022, the IRF's CCR will be replaced with the appropriate national average CCR, urban or rural. CMS is proposing a national average CCR of 0.478 for rural IRFs and 0.393 for urban IRFs.

Updates to the IRF Quality Reporting Program (QRP)

Federal Register pages 19,103 – 19,117

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 2022 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	#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+
Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury		FFY 2020+
Transfer of Health Information to the Provider-Post-Acute Care (PAC)		FFY 2022+
Transfer of Health Information to the Patient-PAC		FFY 2022+

In response to the public health emergency (PHE) for the COVID-19, CMS released an interim final rule which delayed the compliance date for the collection and reporting of the Transfer of Health Information measures for at least 1 full fiscal year after the end of the PHE.

CMS is proposing to adopt one new measure for the FFY 2023 IRF QRP that supports the Meaningful Measures domain of Promote Effective Prevention and Treatment of Chronic Disease:

- COVID-19 Vaccination Coverage among Healthcare Personnel (HCP).

CMS is also proposing to begin reporting the COVID-19 Vaccination measure on Care Compare with the September 2022 refresh.

Separately, CMS is proposing to update the denominator of the Transfer of Health Information to the Patient-PAC to exclude patients discharged home under the care of an organized home health service or hospice in order to align the measure with other quality reporting programs and to avoid counting the patient in both of the Transfer of Health measures in the IRF QRP.

CMS is seeking input on the following measures/concepts for future IRF QRP program years:

- Frailty;
- Opioid use and frequency;
- Patient reported outcomes;
- Shared decision making process;
- Appropriate pain assessment and pain management processes; and
- Health equity.

Due to the COVID-19 pandemic public health emergency, CMS did not use IRF-PAI assessments or IRF claims from Q1 or Q2 2020 for public reporting. Therefore CMS froze the data displayed on Care Compare with the December 2020 refresh values. However, to avoid posting increasingly out-of-date data, CMS is proposing to use fewer quarters of data for future refreshes. The table below lists the proposed refresh schedule and the associated data periods.

Quarter Refresh	IRF-PAI Assessment Quarters for Care Compare (number of quarters)	Claims-based Quarters for Care Compare (number of quarters)	CDI and CAUTI Quarters for Care Compare (number of quarters)	HCP Influenza Quarters for Care Compare (number of quarters)
December 2020	Q1 2019 – Q4 2019 (4)	Q4 2017 – Q3 2019 (8)	Q4 2018 – Q3 2019 (4)	Q4 2017 – Q1 2018 (2)
March 2021	Q1 2019 – Q4 2019 (4)	Q4 2017 – Q3 2019 (8)	Q4 2018 – Q3 2019 (4)	Q4 2017 – Q1 2018 (2)
June 2021	Q1 2019 – Q4 2019 (4)	Q4 2017 – Q3 2019 (8)	Q4 2018 – Q3 2019 (4)	Q4 2017 – Q1 2018 (2)
September 2021	Q1 2019 – Q4 2019 (4)	Q4 2017 – Q3 2019 (8)	Q4 2018 – Q3 2019 (4)	Q4 2017 – Q1 2018 (2)
December 2021	Q3 2020 – Q4 2021 (3)	Q4 2018 – Q4 2019, Q3 2020 (6)	Q1 2019 – Q4 2019 (4)	Q4 2018 – Q1 2019 (2)
March 2022	Q3 2020 – Q2 2021 (4) *Normal reporting resumes with 4 quarters of data	Q4 2018 – Q4 2019, Q3 2020 (6)	Q2 2019 – Q4 2019, Q3 2020 (4)	Q4 2018 – Q1 2019 (2)
June 2022	*Normal reporting resumes with 4 quarters of data	Q4 2018 – Q4 2019, Q3 2020 (6)	Q3 2020 – Q2 2021 (4) *Normal reporting resumes with 4 quarters of data	Q4 2018 – Q1 2019 (2)
September 2022		Q4 2019, Q3 2020 – Q3 2021 (6)	*Normal reporting resumes with 4 quarters of data	Q4 2018 – Q1 2019 (2)
December 2022		Q4 2019, Q3 2020 – Q3 2021 (6)		Q4 2018 – Q1 2019 (2) *Normal reporting resumes
March 2023		Q4 2019, Q3 2020 – Q3 2021 (6)		*Normal reporting resumes
June 2023		Q4 2019, Q3 2020 – Q3 2021 (6)		
September 2023		Q4 2020 – Q3 2022 (8) *Normal reporting resumes with 8 quarters of data		

Note: The shaded cells represent data held constant.

Request for Information – Fast Healthcare Interoperability Resources (FHIR) in support of Digital Quality Measurement in Quality Programs

Federal Register pages 19,109 – 19,110

CMS is looking for feedback on its potential use of FHIR, a free and open source standards framework, to define digital quality measures (dQMs) within the IRF QRP. FHIR is a common language and process for health information technology that allows for exchange of clinical information through application programming interfaces so that clinicians can digitally submit quality information one time and it can then be used in many ways to enable collaboration and information sharing.

CMS is also requesting feedback on the following definition of dQMs: "*Digital Quality Measures (dQMs) are quality measures that use one or more sources of health information that are captured and can be transmitted electronically via interoperable systems.* "

In order to transition to full digital quality measurement, CMS is considering a cohesive portfolio of dQMs across quality programs, agencies, and private payors. This would be a staged implementation and include the alignment of "*measure concepts and specifications including narrative statements, measure logic, and value sets and the individual data elements used to build these measure specifications and calculate the measures."*

Lastly, CMS is seeking input on the following to help guide the transition to fully digital quality reporting:

- *"What EHR/IT systems do you use and do you participate in a health information exchange (HIE)?*
- *How do you currently share information with other providers?*
- *In what ways could we incentivize or reward innovative uses of health information technology (IT) that could reduce burden for post-acute care settings, including but not limited to IRFs?*
- *What additional resources or tools would post-acute care settings, including but not limited to IRFs, and health IT vendors find helpful to support the testing, implementation, collection, and reporting of all measures using FHIR standards via secure APIs to reinforce the sharing of patient health information between care settings?*
- *Would vendors, including those that service post-acute care settings, such as IRFs, be interested in or willing to participate in pilots or models of alternative approaches to quality measurement that would align standards for quality measure data collection across care settings to improve care coordination, such as sharing patient data via secure FHIR API as the basis for calculating and reporting digital measures?"*

Request for Information – Closing the Health Equity Gap in Post-Acute Care Quality Reporting Programs

Federal Register pages 19,110 – 19,112

CMS is requesting public comment on potential revisions to the IRF QRP to make reporting of health disparities based on social risk factors and race/ethnicity more comprehensive and actionable for providers and patients. CMS states it is committed to achieving equity in health care outcomes and supporting providers in quality improvement activities to reduce health inequities.

Specifically, CMS is seeking comment on:

- *"Recommendations for quality measures or measurement domains that address health equity, for use in the IRF QRP;*
- *IRFs must report certain standardized patient assessment data (SPADEs) on SDOH, including race, ethnicity, preferred language, interpreter services, health literacy, transportation and social isolation. CMS is seeking guidance on any additional items, including SPADEs that could be used to assess health equity in the care of IRF patients, for use in the IRF QRP;*
- *Recommendations for how CMS can promote health equity in outcomes among IRF patients;*
- *Methods that commenters or their organizations use in employing data to reduce disparities and improve patient outcomes, including the source(s) of data used, as appropriate; and*
- *. . .. the existing challenges providers encounter for effective capture, use, and exchange of health information, such as data on race, ethnicity, and other social determinants of health, to support care delivery and decision making."*

####