Medicare Inpatient Rehabilitation Facility Prospective Payment System

Payment Rule Brief — PROPOSED RULE

Program Year: FFY 2018

Overview and Resources

On May 3, 2017, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FFY) 2018 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/Spotlight.html

An online version of the proposed rule is available at https://federalregister.gov/a/2017-08428.

A brief of the proposed rule is provided below along with FR page references for additional details. Program changes proposed by CMS would be effective for discharges on or after October 1, 2017, unless otherwise noted. Comments on the proposed rule are due to CMS by June 26 and can be submitted electronically at http://www.regulations.gov by using the website's search feature to search for file code "1671-P".

IRF Payment Rate

FR pages 20700, 20703 - 20705

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

	Final FFY 2017	Proposed FFY 2018	Percent Change
IRF Standard Payment Conversion Factor	**$15,708**	**$15,835**	**+0.81%**

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

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

	IRF Proposed Rate Updates
Marketbasket Update	**2.7%**
Affordable Care Act (ACA)-Mandated Productivity Reduction	**-0.4 percentage points**
ACA Pre-Determined Reduction	**-0.75 percentage points**
Mandated 1.0% Marketbasket Update Due to MACRA	**-0.54%**
Wage Index/Labor-Related Share Budget Neutrality (BN)	**1.0007**
Case-Mix Group Relative Weight Revisions Budget Neutrality	**0.9974**
Overall Rate Change	**+0.81%**

Wage Index, Labor-Related Share and Rural Adjustments

FR pages 20700-20703

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 is proposing to 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 proposed 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 proposing a wage index budget neutrality factor of 1.0007 for FFY 2018 due to adjustments and updates to the IRF wage index.

Based on updates to this year's marketbasket value, CMS is proposing a small decrease to the labor-related share of the standard rate from 70.9% for FFY 2017 to 70.7% 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

FR page 20699 - 20700

There are no proposed changes to the facility-level adjustments. In FFY 2018, CMS is proposing to continue to hold the facility-level adjustments at the FFY 2014 levels as they continue to evaluate IRF claims data.

Case-Mix Group Relative Weight Updates

FR pages 20697-20700

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 proposing to update these factors for FFY 2018 using FFY 2016 claims data and FFY 2015 IRF cost reports. To compensate for the proposed CMG weights changes, CMS is proposing a FFY 2018 case-mix budget neutrality factor of 0.9974.

CMS is not proposing 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 proposed FFY 2018 CMG payments weights and ALOS values is provided on Federal Register pages 20697-20699.

The proposed 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

FR pages 20705 - 20706

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 proposing to update the outlier threshold value to $8,656 for FFY 2018, an 8.42% increase compared to the current threshold of $7,984.

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

FR page 20706

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 2018 of 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 proposing a national average CCR of 0.516 for rural IRFs and 0.416 for urban IRFs.

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

FR pages 20706-20707

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 proposing to remove 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

FR pages 20707-20714

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 proposing a new list of ICD-10-CM diagnosis codes that should count towards the rule. The complete revised lists 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 proposing to have 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 that would be made only through the proposed and final rule making process.

Updates to the IRF Quality Reporting Program (QRP)

FR pages 20714-20742

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.

CMS used the FFY 2017 rulemaking process to adopt new NQF-endorsed measures for FFY 2018 payment determinations along with updated and/or new data submission timelines for the previously adopted and newly adopted measures.

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 2017/2018 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 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 proposing to remove the All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from IRFs from the IRF QRP beginning FFY 2019. CMS is also proposing to remove the current Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678) measure and replace 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 also 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 is seeking comment on how to incorporate social risk factors and which social risk factors should be incorporated.

To comply with the IMPACT Act, in order to enable access to longitudinal information and to facilitate coordinated care, CMS is proposing 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

Request for Information on CMS Flexibilities and Efficiencies

FR pages 20720-20721

CMS is issuing a Request for Information on how Medicare can contribute to making the healthcare delivery system less bureaucratic and complex, and how they can reduce burden to clinicians, providers, and patients in a way that increases the quality of care and decreases costs.

####