Medicare Inpatient Rehabilitation Facility Prospective Payment System

Payment Rule Brief — PROPOSED RULE
Program Year: FFY 2017

Overview and Resources

On April 25, 2016, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FFY) 2017 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* 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/2016-09397.

A brief of the proposed rule is provided below along with FR page references for additional details. Program changes adopted by CMS would be effective for discharges on or after October 1, 2016, unless otherwise noted. Comments on the proposed rule are due to CMS by June 20 and can be submitted electronically at http://www.regulations.gov by using the website's search feature to search for file code "1647-P".

IRF Payment Rate

FR pages 24,187-24,188, 24,190-24,193

Incorporating the proposed updates with the effect of a budget neutrality adjustment, the table below shows the IRF standard payment conversion factor for FFY 2017 compared to the rate currently in effect:

	Final FFY 2016	Proposed FFY 2017	Percent Change
IRF Standard Payment Conversion Factor	**$15,478**	**$15,674**	**+1.27%**

The table below provides details of the proposed updates to the IRF payment rate for FFY 2017:

	IRF Rate Updates and Budget Neutrality Adjustment
IRF-Specific Marketbasket (MB) Update	**2.7%**
Affordable Care Act (ACA)-Mandated Productivity Reduction	**-0.5 percentage points**
ACA Pre-Determined Reduction	**-0.75 percentage points**
Wage Index/Labor-Related Share Budget Neutrality (BN)	**-0.1%**
Case-Mix Group Relative Weight Revisions Budget Neutrality	**-0.1%**
Overall Rate Change	***+1.27%***

Effect of Sequestration

FR page reference not available

While the proposed rule does not specifically address the 2.0% sequester reductions to all lines of Medicare payments authorized by Congress and currently in effect through FFY 2025, sequester will continue unless Congress intervenes. Sequester is not applied to the payment rate; instead, it is applied to Medicare claims after determining co-insurance, any applicable deductibles, and any applicable Medicare secondary payment adjustments.

Wage Index and Labor-Related Share and Rural Adjustments

FR pages 24,188-24,190

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 2016 pre-rural floor and pre-reclassified hospital wage index, to adjust payment rates under the IRF PPS for FFY 2017. A complete list of the wage indexes for payment in FFY 2017 is available on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Data-Files.html.

In 2013, the Office of Management and Budget (OMB) made a number of significant changes related to the delineation of Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas. To align with these changes, CMS adopted the newest Office of Management and Budget delineations for the FFY 2016 IRF PPS wage index. For FFY 2017, CMS proposes to use the CBSA labor market definitions and the FFY 2016 pre-reclassification and pre-floor hospital wage index.

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 are being provided with a gradual phase out of their rural adjustment over a three-year period. In FFY 2016, IRFs that were designated as rural in FFY 2015 and became designated as urban in FFY 2016 received two-thirds of the 2015 rural adjustment

of 14.9 percent. FFY 2017 is the second year of the 3-year phase out of the rural adjustment, in which these same IRFs will receive one-third of the 2015 rural adjustment.

CMS is proposing the labor-related share to remain unchanged at 71.0 from FFY 2016 to FFY 2017.

There are no changes to the facility-level adjustments, i.e. low income percentage (LIP) and teaching status. In FFY 2017, 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 24,184-24,187

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 2017 using FFY 2015 claims data and FFY 2014 IRF cost reports. To compensate for the proposed CMG weights changes, CMS is proposing a FFY 2017 case-mix budget neutrality factor of 0.9990.

CMS is not making any changes to the CMG categories/definitions. Using FFY 2015 claims data, CMS' analysis shows that 99.5% of IRF cases are in CMGs and tiers that will experience less than a +/-5% change in its CMG relative weight as a result of the updates. A table that lists the FFY 2017 CMG payments weights and ALOS values is provided on Federal Register pages 24,185 -24,187.

The changes in the ALOS values for FFY 2017, compared with FFY 2016 are small and do not show any particular trends in IRF length of stay patterns.

Outlier Payments

FR page 24,193

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 2017, CMS is proposing the outlier threshold value to be $8,301, a 4.1% decrease compared to the current threshold of $8,658.

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

FR pages 24,193-24,194

CMS applies a ceiling to IRF's CCRs. If an individual IRF's CCR exceeds this ceiling, the IRF's CCR is replaced with the appropriate national average CCR for that year, 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 FY;
- 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 the proposed national CCR ceiling for FFY 2017 is 1.36. If an individual IRF's CCR exceeds this ceiling its CCR will be replaced with the appropriate national urban or rural average CCR. CMS is proposing a national average CCR of 0.562 for rural IRFs and 0.435 for urban IRFs.

Updates to the IRF Quality Reporting Program (QRP)

FR pages 24,194-24,220

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 is using 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 collect data 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 2016/2017/2018 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 and beyond
Influenza Vaccination Coverage among Healthcare Personnel	#0431	FFY 2016 and beyond
Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine	#0680	FFY 2017 and beyond
NHSN Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure	#1716	FFY 2017 and beyond
NHSN Facility-Wide Inpatient Hospital-Onset Clostridium difficile Infection (CDI) Outcome Measure	#1717	FFY 2017 and beyond

All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from IRFs	#2502	FFY 2017 and beyond ***refined for FFY 2018 and beyond**
Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened	#0678	FFY 2015 and beyond ***refined for FFY 2018 and beyond**
An application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	#0674	FFY 2018 and beyond
An application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function	#2631	FFY 2018 and beyond
IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients	#2633	FFY 2018 and beyond
IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients	#2634	FFY 2018 and beyond
IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients	#2635	FFY 2018 and beyond
IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients	#2636	FFY 2018 and beyond

To address the IRP QRP changes mandated in the IMPACT Act, CMS is proposing four claims-based measures for inclusion in the IRF QRP for FFY 2018 payment determination and subsequent years.

- Discharge to community – Post Acute Care IRF
- Medicare Spending Per Beneficiary - Post Acute Care IFR
- Potentially Preventable 30 Day Post-Discharge Readmission Measure for IRFs; and
- Potentially Preventable Within Stay Readmission Measure for IRFs.

CMS is proposing one new assessment-based quality measure for inclusion in the IRF QRP for FFY 2020 and subsequent years

- Drug Regimen Review Conducted with Follow-Up for Identified Issues (assessment-based)

CMS is also considering these IRF QRP Quality Measures for Future Years:

- Transition of health information and care preferences when an individual transitions;
- Patient Experience of Care;
- Percent of Patients with Moderate to Severe Pain; and
- Venous Thromboembolism Prophylaxis.

As it does each year, CMS updated the IRF QRP data submission deadlines and procedures, data validation requirements and methods, and other program details.

CMS is proposing to add the four new measures to IRF QRP public reporting on a CMS website, such as Hospital Compare by fall 2017. CMS is also proposing to extend the timeline for submission of exception and extension requests for extraordinary circumstances from 30 days to 90 days from the date of the qualifying event.