Medicare Inpatient Rehabilitation Facility Prospective Payment System

Final Payment Rule Brief provided by the Wisconsin Hospital Association
Program Year: FFY 2023

Overview and Resources

On July 27, 2022, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FFY) 2023 final payment rule for the Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS). The final rule reflects the annual update to the Medicare fee-for-service (FFS) IRF payment rates and policies.

A copy of the final rule 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 final rule is available at https://www.federalregister.gov/public-inspection/2022-16225/medicare-program-inpatient-rehabilitation-facility-prospective-payment-system-for-federal-fiscal.

A brief of the final rule along with page references for additional details is provided below. Program changes adopted by CMS will be effective for discharges on or after October 1, 2022, unless otherwise noted. CMS estimates the overall economic impact of the adopted payment rate update to be an increase of $275 million in aggregate payments to IRFs in FFY 2023 over FFY 2022.

Note: Text in italics is extracted from either the April 6, 2022 or the July 27, 2022 *Federal Register*.

IRF Payment Rate

Federal Register pages 47,048 – 47,051 and 47,056 – 47,060

Incorporating the adopted updates with the effect of budget neutrality adjustments, the table below shows the final IRF standard payment conversion factor for FFY 2023 compared to the rate currently in effect:

	Final FFY 2022	Final FFY 2023	Percent Change
IRF Standard Payment Conversion Factor	**$17,240**	**$17,878** (proposed at $17,698)	**+3.7%** (proposed at +2.66%)

The table below provides details of the final updates to the IRF payment rate for FFY 2023:

	IRF Final Rate Updates
Marketbasket Update	**+4.2%** (proposed at +3.2%)
Affordable Care Act (ACA)-Mandated Productivity Adjustment	**-0.3 percentage points (PPT)** (proposed at -0.4 PPT)
Wage Index/Labor-Related Share Budget Neutrality (BN)	**1.0002** (proposed at 1.0007)
Case-Mix Groups (CMGs) and CMG Relative Weight Revisions BN	**0.9979** (as proposed)
Overall Rate Change	**+3.7%** (proposed at +2.66)

Wage Index, Labor-Related Share, and CBSA Delineations

Federal Register pages 47,051 – 47,056

CMS will continue to use the most recent inpatient hospital wage index, the FFY 2023 pre-floor, pre-reclassified hospital wage index to adjust payments rates under the IRF PPS for FFY 2023. The wage index is applied to the labor-related portion of the IRF standard rate to adjust for differences in area wage levels. CMS will continue to hold the labor-related share of the standard rate at 72.9% for FFY 2023 (proposed at 73.2%).

In the past, CMS implemented wage index transition policies with limited duration in order to phase in significant changes to labor market areas with the intent to mitigate short-term negative impact to affected providers. Additionally, CMS recognizes that there are also year-to-year fluctuations in wage indexes that can occur due to external factors beyond a provider's control. In order to reduce large swings in year-to-year wage index changes and increase the predictability of IRF payments, CMS is adopting a 5% cap on any decrease of the FFY 2023 IRF wage index, and all future IRF wage indexes, compared with the previous year's wage index. The cap will be applied regardless of the reason for the decrease and implemented in a budget neutral manner. This also means that if an IRF's prior FFY wage index is calculated with the application of the 5% cap, the following year's wage index would not be less than 95% of the IRF's capped wage index in the prior FFY. Lastly, CMS finalized its proposal that a new IRF be paid the wage index for the area in which it is geographically located for its first full or partial FFY with no cap applied, because a new IRF would not have a wage index in the prior FFY.

CMS is adopting a wage index and labor-related share budget neutrality factor of 1.0002 (proposed at 1.0007) for FFY 2023 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. This budget neutrality factor also includes the impact of the adopted 5% cap on IRF wage index decreases.

A complete list of the finalized wage indexes for payment in FFY 2023 is available on the CMS website at https://www.cms.gov/medicaremedicare-fee-service-paymentinpatientrehabfacppsirf-rules-and-related-files/cms-1767-f.

Case-Mix Group Relative Weight Updates

Federal Register pages 47,042 – 47,048

CMS assigns IRF discharges into case-mix groups (CMG) that are reflective of the different resources required to provide care to IRF patients. Patients are first categorized into rehabilitation impairment categories (RIC) 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 five other 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 finalizing updates to these factors for FFY 2023 using FFY 2021 IRF claims data and FFY 2020 IRF cost report data. To compensate for the CMG weights changes, CMS will use a FFY 2023 case-mix budget neutrality factor of 0.9979 (as proposed).

CMS is not adopting any changes to the CMG categories/definitions. Using the claims data, CMS' analysis shows that 98.9% 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 final FFY 2023 CMG payments weights and ALOS values is provided on *Federal Register* pages 47,044 – 47,047.

Outlier Payments

Federal Register pages 47,060 – 47,062

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 2023, CMS will update the outlier threshold value to $12,526 (proposed at $13,038), a 31.98% increase compared to the current threshold of $9,491, based on FFY 2021 claims data.

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

Federal Register page 47,062

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; and/or
- 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, CMS adopted a national CCR ceiling of 1.41 (proposed at 1.40) for FFY 2023. If an individual IRF's CCR exceeds this ceiling for FFY 2023, the IRF's CCR will be replaced with the appropriate final national average CCR, urban or rural. CMS finalized a national average CCR of 0.466 (proposed at 0.463) for rural IRFs and 0.392 (proposed at 0.393) for urban IRFs.

Codification and Clarifications of IRF Teaching Status Adjustment Policy

Federal Register pages 47,062 – 47,065

CMS is codifying two policies adopted in previous final rules so that IRF providers can more easily locate the policies and so the policies can be aligned with the IPPS IME and IPF teaching adjustment policy regulations. These two policies are

- how CMS adjusts prospective payment on a facility basis by a factor to account for direct teaching costs (FFY 2006 IRF PPS final rule); and
- allowing an IRF to receive a temporary adjustment to its FTE cap to reflect residents added to its teaching program because of another IRF's closure or the closure of an IRF's medical residency training program (FFY 2012 IRF PPS final rule).

CMS will update the policy pertaining to displaced residents to align with the policy changes finalized in the FFY 2021 IPPS final rule and the FFY 2022 IPF PPS final rule, with any future deviations from the IPPS IME policy only occurring when it is necessary and appropriate for the IRF PPS.

CMS finalized its proposal that the key day for linking temporary Medicare funding would be the day that the IRF/residency program closure was publicly announced, allowing residents time to find a new facility at which to complete their training while the residency program of the originating IRF winds down. This will replace the current method of linking Medicare temporary funding for the affected residents to the day prior to or the day of program or hospital closure.

CMS also adopted the proposal to allow funding to be transferred temporarily for the second and third group of residents who are not physically present at the closing IRF program, but had intended to train at (or return to training at, in the case of residents on rotation) the closing IRF program.

To apply for the temporary Medicare resident cap increase, CMS finalized that the receiving IRF will have to submit a letter to its Medicare Administrative Contractor (MAC) within 60 days of beginning the training of the displaced residents (residents added by a receiving IRF due to an IRF or program closure). This letter must include the name of each displaced resident; the last four digits of each resident's social security number; the IRF and program in which the resident was previously training; and the amount of cap increase needed for each resident.

Lastly, CMS adopted the proposal that if there are more displaced IRF residents than available cap slots, the slots may be apportioned according to the displaced residents, with the amount determined by the originating IRF.

Updates to the IRF Quality Reporting Program (QRP)

Federal Register pages 47,069 – 47,082

CMS collects quality data from IRFs on measures that relate to 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 2023 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+
Transfer of Health Information to the Provider-Post-Acute Care (PAC)		FFY 2022+
Transfer of Health Information to the Patient-PAC		FFY 2022+

CMS did not adopt any new measures for the IRF QRP.

Beginning with the FFY 2026 IRF QRP, CMS will require that the IRF-PAI assessment be collected on each patient receiving care in an IRF, regardless of payer, in order to ensure high quality care is delivered to all patients. This data would be reported for all patients discharged from October 1, 2024 – December 31, 2024. This was originally proposed for implementation with the FFY 2025 IRF QRP, however CMS chose to delay the policy until FFY 2026 to provide IRFs with more time to prepare for the new data collection.

Request for Information – IRF QRP Quality Measure Concepts under Consideration for Future Years

Federal Register pages 47,070 – 47,071

In the proposed rule, CMS had sought input on the importance, relevance, and applicability of each of the following concepts for new measures in future years in the IRF QRP

- Cross-setting functional measures which would incorporate domains of self-care and mobility;
- Health equity measures such as structural measures that assess an organization's leadership in advancing equity goals or assess progress towards achieving equity priorities; and
- PAC – COVID-19 Vaccination Coverage among Patients that would assess whether IRF patients are up to date on their COVID-19 vaccine.

CMS did not respond to comments received in the final rule, but will take them into account in future measure development.

Request for Information – Inclusion of the National Healthcare Safety Network (NHSN) Healthcare-associated Clostridioides difficile Infection Outcome Measure in the IRF QRP

Federal Register pages 47,071 – 47,072

In the proposed rule, CMS had sought input on the potential future inclusion of the NHSN Healthcare-Associated *Clostridioides difficile* Infection Outcome measure (HA-CDI) (MUC2021–098) as a digital quality measure via their Electronic Health Records (EHR) under the IRF QRP. Specifically, CMS sought information on the following:

- *"Would you support utilizing IRF EHRs as the mechanism of data collection and submission for IRF QRP measures?*
- *Would your EHR support exposing data via HL7 FHIR to a locally installed MCT? For IRFs using certified health IT systems, how can existing certification criteria under the Office of the National Coordinator (ONC) Health Information Technology (IT) Certification Program support reporting of this data? What updates, if any, to the Certification Program would be needed to better support capture and submission of this data?*
- *Is a transition period between the current method of data submission and an electronic submission method necessary? If so, how long of a transition would be necessary and what specific factors are relevant in determining the length of any transition?*
- *Would vendors, including those that service IRFs, be interested in or willing to participate in pilots or voluntary electronic submission of quality data?*
- *Do IRFs anticipate challenges, other than the adoption of EHR to adopting the HACDI, and if so, what are potential solutions for those challenges?"*

Some of the comments received are available on the pages listed above, however CMS did not respond to these comments in the final rule, but will take them into account in future measure development.

Request for Information - Overarching Principles for Measuring Equity and Healthcare Quality Disparities across CMS Quality Programs

Federal Register pages 47,072 – 47,073

CMS is working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people served by our programs, eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing care and support.

In the proposed rule, CMS requested comment on the following topics having to do with health equity:

- *"Identification of Goals and Approaches for Measuring Healthcare Disparities and Using Measure Stratification Across CMS Quality Reporting Programs*
    - *The use of the within- and between-provider disparity methods in IRFs to present stratified measure results.*
    - *The use of decomposition approaches to explain possible causes of measure performance disparities*
    - *Alternative methods to identify disparities and the drivers of disparities*
- *Guiding Principles for Selecting and Prioritizing Measures for Disparity Reporting*
    - *Principles to consider for prioritization of health equity measures and measures for disparity reporting, including prioritizing stratification for validated clinical quality measures, those measures with established disparities in care, measures that have adequate sample size and representation among healthcare providers and outcomes, and measures of appropriate access and care.*
- *Principles for Social Risk Factor and Demographic Data Selection and Use*
    - *Principles to be considered for the selection of social risk factors and demographic data for use in collecting disparity data including the importance of expanding variables used in measure stratification to consider a wide range of social risk factors, demographic variables and other markers of historic disadvantage. In the absence of patient -reported data we will consider use of administrative data, area-based indicators and imputed variables as appropriate.*
- *Identification of Meaningful Performance Differences*
    - *Ways that meaningful difference in disparity results should be considered.*
- *Guiding Principles for Reporting Disparity Measures*
    - *Guiding principles for the use and application of the results of disparity measurement.*
- *Measures Related to Health Equity*
    - *The usefulness of a HESS score for IRFs, both in terms of provider actionability to improve health equity, and in terms of whether this information would support Care Compare website users in making informed healthcare decisions.*
    - *The potential for a structural measure assessing an IRF's commitment to health equity, the specific domains that should be captured, and options for reporting this data in a manner that would minimize burden.*
    - *Options to collect facility-level information that could be used to support the calculation of a structural measure of health equity.*
    - *Other options for measures that address health equity."*

Some of the comments received are available on the pages listed above, however CMS did not respond to these comments in the final rule, but will take them into account in future development of health equity policies for the IRF QRP.

Request for Comment – Facility-Level Adjustment Factor Methodology

Federal Register page 47,065

CMS currently adjusts IRF payments associated with a CMG to account for facility-level characteristics such as the percentage of low-income patients (LIP), teaching status, and location in a rural area, where applicable and in a

budget-neutral manner. These factors are intended to account for differences in costs for the different types of IRF providers and to better align payments with associated costs. In the FFY 2015 IRF PPS final rule, CMS froze these adjustment factors at the FFY 2014 levels for FFY 2015 and onwards, while also monitoring how these adjustments would change over time. Table 9 on *Federal Register* page 47,066 shows what these factors would have been if not frozen for FFYs 2014 - 2023.

An analysis by CMS shows that since FFY 2014 there has been a large increase in the potential teaching status adjustment which CMS does not believe to be a true reflection of the higher costs of teaching IRFs. Additionally, if these teaching adjustments were to be implemented (replacing the frozen FFY 2014 values), there could be negative effects to IRFs that do not receive this adjustment due to budget neutrality. Paired with the reduction of the rural adjustment factor since FFY 2014, CMS believe that rural hospitals specifically could see a large impact to their reimbursement if these factors were implemented.

Given the aforementioned changes to the teaching status and rural adjustments from their 2014 levels, in the proposed rule, CMS had solicited comments on the methodology used to determine facility-level adjustment factors as well as any refinement or updates to this methodology to be used in future rulemaking. CMS did not respond to comments received in the final rule, but will take them into account in the development of future payment policies.

Request for Comment – IRF Transfer Payment Policy

Federal Register pages 47,065 – 47,069

In the August 7, 2001 Federal Register, CMS finalized an IRF transfer payment policy which was aimed to minimize incentives associated with early transfer of a patients to other settings, as well as admit patients now able to endure inpatient therapy services. This policy applies to IRF stays that are less than the average length of stay for the applicable CMG and tier and are transferred directly to another IRF, inpatient hospital, nursing home, or long-term care hospital. However, this policy does not cover early discharges to home health (HH) care due to analytical challenges with the implementation of the HH PPS.

A recent Office of the Inspector General report "Early Discharges from Inpatient Rehabilitation Facilities to Home Health Services" recommends that CMS expand the IRF transfer policy to include early discharges to home health. This report used CY 2017 and CY 2018 claim data to determine that an expanded IRF transfer policy would have saved the Medicare program $993 million over the two years. Given these findings, CMS plans to analyze home health claims data to determine if it is appropriate to include home health in the IRF transfer policy.

In the proposed rule, CMS requested comments on the following questions to be used with any future analysis for potential rulemaking:

- *"Beyond the existing Medicare claims data, under what circumstances, and for what types of patients (in terms of clinical, demographic, and geographic characteristics) do IRFs currently transfer patients to home health?*
- *Should we consider a policy similar to the IPPS transfer payment policy… – such as including as part of the IRF transfer payment policy a discharge from an IRF to home health under a written plan for the provision of home health services from a home health agency and those services to begin within 48 hours of referral, or within 48 hours of the patient's return home (see § 484.55(a)(1)), or on the provider's start of care date?*
- *What impact, if any, do stakeholders believe this proposed policy change could have on patient access to appropriate post-acute care services?"*

CMS did not respond to comments received in the final rule, but will take them into account in future potential rulemaking.

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