Medicare Inpatient Rehabilitation Facility Prospective Payment System

Final Payment Rule Brief provided by the Wisconsin Hospital Association
Program Year: FFY 2024

Overview and Resources

On July 27, 2023, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FFY) 2024 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/2023-16050/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 would be effective for discharges on or after October 1, 2023, unless otherwise noted. CMS estimates the overall economic impact of the final payment rate update to be an increase of $355 million (proposed at $335 million) in aggregate payments to IRFs in FFY 2024 over FFY 2023.

Note: Text in italics is extracted from the final rule found in the August 2, 2023 *Federal Register*.

IRF Payment Rate

Federal Register pages 50,982 – 50,984 and 50,990 – 50,993

Incorporating the final updates with the effect of budget neutrality adjustments, the table below shows the final IRF standard payment conversion factor for FFY 2024 compared to the rate currently in effect:

	Final FFY 2023	Final FFY 2024	Percent Change
IRF Standard Payment Conversion Factor	**$17,878**	**$18,541** (proposed at $18,471)	**+3.71%** (proposed at +3.32%)

The table below provides details of the final updates to the IRF payment rate for FFY 2024:

	IRF Final Rate Updates
Marketbasket Update	**+3.6%** (proposed at +3.2%)
Affordable Care Act-Mandated Productivity Adjustment	**-0.2 percentage points (PPT)** (as proposed)
Wage Index/Labor-Related Share Budget Neutrality (BN)	**1.0028** (proposed at 1.0032)
Case-Mix Groups (CMG) and CMG Relative Weight Revisions BN	**1.0002** (proposed at 0.9999)
Overall Rate Change	**+3.71%** (proposed at +3.32%)

Update to the IRF Market Basket Base Year

Federal Register pages 50,966 – 50,982

CMS periodically rebases the market basket to reflect the changes in the goods and services needed to furnish IRF services. CMS is rebasing and revising the IRF market basket to reflect a 2021 base year, beginning with FFY 2024, rather than the current 2016 base year for both freestanding and hospital-based IRFs.

Wage Index, Labor-Related Share, and CBSA Delineations

Federal Register pages 50,984 – 50,990

CMS will continue to use the most recent inpatient hospital wage index, the FFY 2024 pre-floor, pre-reclassified hospital wage index to adjust payments rates under the IRF PPS for FFY 2024. The wage index is applied to the labor-related portion of the IRF standard rate to adjust for differences in area wage levels. Using the adopted 2021-based market basket, CMS is finalizing an increase to the labor-related share of the standard rate from 72.9% for FFY 2023 to 74.1% (as proposed) for FFY 2024.

In the FFY 2023 IRF final rule, CMS finalized a policy to apply a 5% cap on any decrease of the IRF wage index, and all future IRF wage indexes, compared with the previous year's wage index. The cap is 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 will not be less than 95% of the IRF's capped wage index in the prior FFY. Lastly, a new IRF will 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 1.0028 (proposed at 1.0032) for FFY 2024 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 5% cap on IRF wage index decreases.

A complete list of the final wage indexes for payment in FFY 2024 is available on the CMS website at https://www.cms.gov/files/zip/fy-2024-irf-pps-data-files-final.zip.

Case-Mix Group Relative Weight Updates

Federal Register pages 50,961 – 50,966 and 50,991 – 50,992

CMS assigns IRF discharges into case-mix groups that are reflective of the different resources required to provide care to IRF patients. Patients are first categorized into rehabilitation impairment categories 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 adopting updates to these factors for FFY 2024 using FFY 2022 IRF claims data and FFY 2021 IRF cost report data. To compensate for the CMG weights changes, CMS will use a FFY 2024 case-mix budget neutrality factor of 1.0002 (proposed at 0.9999).

CMS is not making any changes to the CMG categories or definitions. Using the claims data, CMS' analysis shows that 99.4% 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 2024 CMG payments weights and ALOS values is provided on *Federal Register* pages 50,962 – 50,965.

Outlier Payments

Federal Register pages 50,993 – 50,994

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 2024, CMS is updating the outlier threshold value to $10,423 (proposed at $9,690), a 16.8% decrease compared to the current threshold of $12,526, based on FFY 2022 claims data.

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

Federal Register page 50,994 – 50,995

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 is adopting a national CCR ceiling of 1.48 (proposed at 1.45) for FFY 2024. If an individual IRF's CCR exceeds this ceiling for FFY 2024, the IRF's CCR will be replaced with the appropriate national average CCR, urban or rural. CMS is adopting a national average CCR of 0.491 (proposed at 0.487) for rural IRFs and 0.402 (proposed at 0.398) for urban IRFs.

Modifications to the Regulation for Excluded IRF Units Paid Under the IRF PPS

Federal Register pages 50,995 – 50,998

Currently, to be paid under IRF PPS, and therefore excluded from the Inpatient PPS, an IRF unit of a hospital must be paid under the IRF PPS for services provided in an excluded unit at the start of a cost reporting period, and may not attain this payment status in the middle of a cost report period.

CMS believes that this requirement is burdensome for hospitals as it is often difficult to predict the exact timing of the end of a construction project for a new unit, and therefore the hospital cannot always guarantee the completion at the start of a cost reporting period. This can lead to significant revenue loss if the hospital is unable to be paid under the IRF PPS until the start of the next cost reporting period.

Separately, the current requirements were established when excluded IRF units were paid at cost-based reimbursement and not PPS, and therefore the restriction that limits an IRF unit to gaining excluded-unit status to the start of a cost reporting period is no longer necessary.

Since advancements in technology have simplified the cost reporting process, and have enhanced communication between providers, CMS is adopting greater flexibility for hospitals to open excluded units. Specifically, CMS is finalizing its proposal to allow a hospital to open a new IRF unit anytime within the cost reporting year, as long as the hospital provides notification in writing of the change to both CMS and their Medicare Administrative Contractor at least 30 days before the date of the change. Additionally, if a unit becomes IPPS-excluded during a cost reporting year, this change would remain in effect for the rest of that cost reporting year.

Updates to the IRF Quality Reporting Program (QRP)

Federal Register pages 50,998 – 51,042

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, as required by law.

The following table lists the previously finalized IRF QRP measures and applicable payment determination years as well as finalized measure removals:

Previously Adopted IRF Measures for FFY 2024 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+ ***(adopted to be removed FFY 2025+)***
IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients	#2633	FFY 2018+ ***(adopted to be removed FFY 2025+)***
IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients	#2634	FFY 2018+ ***(adopted to be removed FFY 2025+)***
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+
COVID-19 Vaccination Coverage among Healthcare Personnel		FFY 2023+

CMS is adopting two new measures:

- Discharge Function Score Measure (beginning with FFY 2025 IRF QRP); and
- COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date (beginning with FFY 2026 IRF QRP).

Separately, CMS is removing three measures beginning with the FFY 2025 IRF QRP:

- Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function;
- IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients; and
- IRF Functional Outcome Measure: Change in Mobility for Medical Rehabilitation Patients.

Beginning with the FFY 2025 IRF QRP, CMS is adopting its proposal to modify the "COVID-19 Vaccination Coverage among Healthcare Personnel" measure to replace the term "complete vaccination course" with the term "up to date" in the healthcare personnel vaccination definition. CMS is also updating the numerator to specify the time frames within which a healthcare personnel is considered up to date with recommended COVID-19 vaccines.

Lastly, CMS will begin public reporting of the "Transfer of Health Information to the Provider-PAC" and "Transfer of Health Information to the Patient-PAC" measures beginning with the September 2024 Care Compare refresh or as soon as possible.

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

Federal Register pages 51,035 – 51,037

In the FFY 2024 IRF proposed rule, CMS solicited comment on the following:

- *"Principles for Selecting and Prioritizing QRP Measures*
    - *To what extent do you agree with the principles for selecting and prioritizing measures?*
    - *Are there principles that you believe CMS should eliminate from the measure selection criteria?*
    - *Are there principles that you believe CMS should add to the measure selection criteria?*
- *IRF QRP Measure Gaps*
    - *CMS requests input on the identified measurement gaps, including in the areas of cognitive function, behavioral and mental health, patient experience and patient satisfaction, and chronic conditions and pain management.*
    - *Are there gaps in the IRF QRP measures that have not been identified in this RFI?*
- *Measures and Measure Concepts Recommended for Use in the IRF QRP*
    - *Are there measures that you believe are either currently available for use, or that could be adapted or developed for use in the IRF QRP program to assess performance in the areas of (1) cognitive functioning, (2) behavioral and mental health, (3) patient experience and patient satisfaction, (4) chronic conditions, (5) pain management, or (6) other areas not mentioned in this RFI?"*

A summary of comments submitted can be found on *Federal Register* pages 51,035 – 51,037, which CMS will use to inform their future measure development.

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