Medicare Inpatient Rehabilitation Facility Prospective Payment System

Final Payment Rule Brief provided by the Wisconsin Hospital Association

Program Year: FFY 2021

Overview and Resources

On August 4, 2020, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FFY) 2021 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 *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 final rule is available at https://www.federalregister.gov/documents/2020/08/10/2020-17209/medicare-program-inpatient-rehabilitation-facility-prospective-payment-system-for-federal-fiscal.

A brief of the final rule along with *Federal Register* page references for additional details are provided below.

CMS is waiving the 60-day requirement and determines that the IRF PPS final rule will be effective for discharges on or after October 1, 2020, unless otherwise noted due to CMS efforts in prioritizing and supporting efforts in containing and combating the COVID-19 pandemic. CMS estimates the overall economic impact of this final payment rate update to be an increase of $260 million in aggregate payments to IRFs in FFY 2021 over FFY 2020.

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

IRF Payment Rate

Federal Register pages 48431 - 48433, 48441 - 48443

Incorporating the adopted updates with the effect of budget neutrality adjustments, the table below shows the adopted IRF standard payment conversion factor for FFY 2021 compared to the rate currently in effect:

	Final FFY 2020	Final FFY 2021	Percent Change
IRF Standard Payment Conversion Factor	**$16,489**	**$16,856** **(proposed at $16,847)**	**+2.23%**

The table below provides details of the adopted updates to the IRF payment rate for FFY 2021:

	IRF Final Rate Updates
Marketbasket Update	**+2.4%** **(proposed at +2.9%)**
Affordable Care Act (ACA)-Mandated Productivity Reduction	**0.0 percentage points** **(proposed at -0.4)**
Wage Index/Labor-Related Share/CBSA Delineations Budget Neutrality (BN)	**1.0013** **(proposed at 0.9999)**
Case-Mix Groups (CMGs) and CMG Relative Weight Revisions BN	**0.9970** **(proposed at 0.9969)**
Overall Rate Change	**+2.23%** **(proposed at +2.17%)**

Wage Index, Labor-Related Share, and CBSA Delineations

Federal Register pages 48433 – 48441

CMS will estimate the labor-related portion of the IRF standard rate and also adjust for differences in area wage levels using a wage index. CMS will increase the labor-related share of the standard rate from 72.7% for FFY 2020 to 73.0% (proposed at 72.9%) in FFY 2021.

For FFY 2021, CMS will update the Core-Based Statistical Areas (CBSA) for all providers based on the delineations published in the Office of Budget and Management (OMB) Bulletin No. 18-04 released on September 14, 2018. Included in this bulletin are new CBSAs, urban counties that become rural, rural counties that become urban, and existing CBSAs which are split apart or otherwise changed. CMS believes that these delineations better represent current rural and urban areas. As a result, provider wage indexes will change depending on which CBSA they are assigned to. In order to alleviate significant losses in revenue, CMS is adopting a 2-year transition period. Adopted delineations will be effective beginning October 1, 2020 and include a 5% cap on the reduction of a provider's wage index for FFY 2021 compared to its wage index for FFY 2020 and a full reduction of a provider's wage index for FFY 2022. OMB Bulletin 18-04 can be found at https://www.whitehouse.gov/wp-content/uploads/2018/09/Bulletin-18-04.pdf.

CMS adopted a wage index and labor-related share budget neutrality factor of 1.0013 (proposed at 0.9999) for FFY 2021 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.

A complete list of the final wage indexes for payment in FFY 2021 is available on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Data-Files.html.

The March 6, 2020 OMB Bulletin 20-01 was not issued in time for integration into the rule. This bulletin can be found at https://www.whitehouse.gov/wp-content/uploads/2020/03/Bulletin-20-01.pdf. For FFY 2022, CMS intends to propose any updates from this OMB bulletin to further update CBSA delineation.

Case-Mix Group Relative Weight Updates

Federal Register pages 48428 – 48431

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 will update these factors for FFY 2021 using FFY 2019 IRF claims data and FFY 2018 IRF cost report data. To compensate for the CMG weights changes, CMS will apply a FFY 2021 case-mix budget neutrality factor of 0.9970 (proposed at 0.9969).

CMS will not make any changes to the CMG categories/definitions. Using FFY 2019 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 final FFY 2021 CMG payments weights and ALOS values is provided on *Federal Register* pages 48428 – 48430.

Outlier Payments

Federal Register page 48444

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 2021, CMS will update the outlier threshold value to $7,906 (proposed at $8,102) for FFY 2021, a 15.0% decrease compared to the current threshold of $9,300.

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

Federal Register pages 48444 – 48445

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 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 for FY 2021 of 1.34 (proposed at 1.33). If an individual IRF's CCR exceeds this ceiling for FY 2021, the IRF's CCR will be replaced with the appropriate national average CCR, urban or rural. CMS is adopting a national average CCR of 0.493 (proposed at 0.490) for rural IRFs and 0.398 (proposed at 0.400) for urban IRFs.

Revisions to Certain IRF Coverage Requirements

Federal Register pages 48445 – 48453

IRF care is only considered by Medicare to be reasonable and necessary if the patient meets all of the IRF coverage requirements. Failure to meet the IRF coverage criteria in a particular case will result in denial of the IRF claim.

Based on the responses to CMS' request for information in the FFY 2018 IRF PPS Proposed Rule on ways to reduce burden for hospitals and physicians, improve quality of care, decrease costs, and ensure that patients

receive the best care, CMS is finalizing part of its proposal to allow a non-physician practitioner that the IRF determines has the specialized training and experience in inpatient rehabilitation to perform 1 of the 3 face-to-face IRF coverage requirement duties with the patient per week that are currently required to be performed by a rehabilitation physician, as long as the duties are within the non-physician practitioner's scope of practice under applicable state law.

In the April 6, 2020 Interim Final Rule, CMS finalized the removal of the post-admission physician evaluation requirement in order to address the public health emergency for the COVID-19 pandemic only for the duration of the pandemic. In order to reduce unnecessary burden on IRF providers and physicians, CMS will permanently remove the post-admission physician evaluation documentation requirement from the list of IRF coverage requirements for all IRFs beginning with FFY 2021.

Additionally, a comprehensive pre-admission screening must meet several requirements, including but not limited to:

- It includes a detailed and comprehensive review of each patient's condition and medical history; and
- It is used to inform a rehabilitation who reviews and comments his or her occurrence with the findings and results of the preadmission screening.

In order to reduce administrative burden and for ease of reference, CMS will adopt the following amendments to the above comprehensive preadmission screening beginning FFY 2021:

- The comprehensive pre-admission screening must include a detailed and comprehensive review of each patient's condition and medical history, including:
    - The patient's level of function prior to the event or condition that led to the patient's need for intensive rehabilitation therapy;
    - Expected level of improvement;
    - Expected length of time necessary to achieve that level of improvement;
    - An evaluation of the patient's risk for clinical complications;
    - The conditions that caused the need for rehabilitation;
    - The combinations of treatments needed; and
    - Anticipated discharge destination.
- Based on the responses to CMS' request for comments in the FFY 2021 Proposed Rule regarding what elements of the pre-admission screening should be removed in order to reduce burden on rehabilitation physicians, CMS is finalizing to remove the following elements from the pre-admission screening:
    - Expected frequency and duration of treatment in the IRF;
    - Any anticipated post-discharge treatments; and
    - Other information relevant to the patient's care needs.
- The comprehensive preadmission screening must be used to inform a rehabilitation physician who must document that he/she has reviewed and concurs with the findings and results of the preadmission screening prior to the IRF admission as these were not previously finalized in the preadmission screening documentation.

Lastly, CMS is finalizing to define a "week" as *a period of 7 consecutive calendar days beginning with the date of admission to the IRF* in order to reduce administrative burden and provide clarity regarding several of the IRF coverage requirements.

Updates to the IRF Quality Reporting Program (QRP)

Federal Register pages 48424, 48453 – 48454

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 2021 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+

CMS is not making any changes to the IRF QRP program in this final rule.

####