Illinois Health and Hospital Association

RULE SUMMARY

APRIL 2024

MEDICARE INPATIENT REHABILITATION FACILITY PROSPECTIVE PAYMENT SYSTEM

Overview and Resources

On March 27, 2024, the Centers for Medicare & Medicaid Services (CMS) released the federal fiscal year (FFY) 2025 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 and other resources related to the IRF PPS are available here.

An online version of the proposed rule is here.

A brief of the proposed 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, 2024, unless otherwise noted. CMS estimates the overall economic impact of the proposed payment rate update to be an increase of $255 million in aggregate payments to IRFs in FFY 2025 over FFY 2024.

Comments on the proposed rule are due to CMS by May 28, 2024 and can be submitted electronically at http://www.regulations.gov by using the website's search feature to search for file code "CMS-1804-P."

IRF Payment Rate

Incorporating the proposed updates with the effect of budget neutrality adjustments, the table below shows the proposed IRF standard payment conversion factor for FFY 2025 compared to the rate currently in effect:

	Final FFY 2024	**Proposed FFY 2025**	**Percent Change**
IRF Standard Payment Conversion Factor	$18,541	$18,872	+1.79%

The table below provides details of the proposed updates to the IRF payment rate for FFY 2025:

	IRF Proposed Rate Updates
Market-basket Update	+3.2%
Affordable Care Act-Mandated Productivity Adjustment	-0.4 percentage points (PPT)
Wage Index/Labor-Related Share Budget Neutrality (BN)	0.9928
Case-Mix Groups (CMG) and CMG Relative Weight Revisions BN	0.9973
Overall Rate Change	**+1.79%**

Wage Index, Labor-Related Share, and CBSA Delineations

CMS proposed to continue to use the most recent inpatient hospital wage index, the FFY 2025 pre-floor, pre-reclassified hospital wage index to adjust payments rates under the IRF PPS for FFY 2025. 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 2021-based market-basket, CMS proposed an increase to the labor-related share of the standard rate from 74.1% for FFY 2024 to 74.2% for FFY 2025.

CMS applies a 5% cap on any decrease to the IRF wage index, 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. A new IRF is 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.

On July 21, 2023, the Office of Management and Budget (OMB) issued OMB Bulletin No. 23-01, here that made a number of significant changes related Core Based Statistical Area (CBSA) delineations. To align with these changes, CMS proposed to adopt the newest OMB delineations for the FFY 2025 IRF PPS wage index. If CMS adopts this proposal, 54 counties that are currently part of an urban CBSA would be considered located in a rural area, listed in Table 5 of *Federal Register* pages 22259 – 22260, and 54 counties that are currently located in rural areas would be considered located in urban areas, listed in Table 6 on *Federal Register* pages 22261 – 22262. Since CMS already applies a 5% cap on wage index loses from year to year (described above), CMS does not believe any additional transition for IRFs is necessary.

CMS states that 8 facilities designated at rural in FFY 2024 would become urban in FFY 2025 if this proposal is adopted, resulting in a loss of the 14.9% rural adjustment. To mitigate the impacts of this loss, CMS proposed that these eight IRF providers would be provided with a gradual phase out of their rural adjustment over a three-year period. Specifically, these providers would receive two-thirds of the rural adjustment in FFY 2025, one-third of the rural adjustment in FFY 2026, and no rural adjustment in FFY 2027. For the IRF providers changing from urban to rural status, there will be no phase-in; they would receive the full rural adjustment in FFY 2025.

CMS proposed a wage index and labor-related share budget neutrality factor of 0.9928 for FFY 2025 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 proposed wage indexes for payment in FFY 2025 is available here.

Case-Mix Group Relative Weight Updates

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 proposed updates to these factors for FFY 2025 using FFY 2023 IRF claims data

and FFY 2022 IRF cost report data. To compensate for the CMG weights changes, CMS proposed to use a FFY 2025 case-mix budget neutrality factor of 0.9973.

CMS is not proposing any changes to the CMG categories or definitions. Using the claims data, CMS' analysis shows that 99.2% 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 2025 CMG payments weights and ALOS values is provided on *Federal Register* pages 22251 – 22255.

Outlier Payments

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% of total IRF PPS payments to be set aside for high-cost outliers. To meet this target for FFY 2025, CMS proposed an outlier threshold value of $12,158, a 16.6% increase compared to the current threshold of $10,423, based on FFY 2023 claims data.

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

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 proposed to continue to set the national CCR ceiling at three standard deviations above the mean CCR, and therefore CMS proposed a national CCR ceiling of 1.52 for FFY 2025. If an individual IRF's CCR exceeds this ceiling for FFY 2025, the IRF's CCR will be replaced with the appropriate national average CCR, urban or rural. CMS proposed a national average CCR of 0.492 for rural IRFs and 0.406 for urban IRFs.

Updates to the IRF Quality Reporting Program (QRP)

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:

Previously Adopted IRF Measures		
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+
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+
Discharge Function Score Measure		FFY 2025+
COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date		FFY 2026+

CMS is not proposing any new measures for the IRF QRP.

Separately, CMS proposed to require IRFs to report four new items to the IRF-Patient Assessment Instrument (PAI) social determinants of health category beginning with the FFY 2028 IRF QRP:

- Living Situation: “What is your living situation today?”
- Food: “Within the past 12 months, you worried that your food would run out before you got money to buy more.”
- Food: “Within the past 12 months, the food you bought just didn’t last and you didn’t have money to get more.”
- Utilities: “In the past 12 months, has the electric, gas, oil, or water company threatened to shut off services in your home?”

Additionally, CMS proposed to modify the transportation item of the IRF-PAI beginning with the FFY 2028 QRP from "Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?" to "In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?" in order to distinguish the look back period and to simplify response options. In addition, the revised assessment item will be collected at admission only, which will decrease provider burden since the current assessment item is collected at both admission and discharge.

IRFs would be required to report these items beginning with patients admitted on October 1, 2026. CMS is also proposing to remove the Admission Class Item from the IRF-PAI beginning October 1, 2026.

Request for Information – IRF QRP Quality Measure Concepts under consideration for future years

CMS seeks input on three measure concepts under consideration for the IRF QRP: vaccination composite, pain management, and depression.

Request for Information – Future IRF Star Rating System

CMS seeks feedback on the development of a five-star methodology for IRFs that can distinguish between quality of care provided. Specifically, CMS is asking for comment on:

- Are there specific criteria CMS should use to select measures for an IRF star rating system?
- How should CMS present IRF star ratings information in a way that it is most useful to consumers?

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