Illinois Health and Hospital Association

MEDICARE PAYMENT FACT SHEET

APRIL 2022

FFY 2023 INPATIENT REHABILITATION FACILITY PROSPECTIVE PAYMENT SYSTEM PROPOSED RULE (CMS-1767-P)

On April 6, the Centers for Medicare & Medicaid Services (CMS) published in the Federal Register the federal fiscal year (FFY) 2023 Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) proposed rule effective Oct. 1, 2022 through Sept. 30, 2023. After accounting for all payment and budget neutrality factors, CMS proposed a 2.8% update to IRF PPS payments.

Comments on this proposed rule are due May 31.

Rate Update (*pp. 20222-20234)*: CMS proposed a 3.2% IRF market basket update and a multifactor productivity (MFP) reduction of 0.4 percentage points, resulting in a 2.8% proposed update. The payment rate for IRFs that fail to submit required quality data will decrease by two percentage points.

CMS proposed updated Case-Mix Group (CMG) relative weights and average length of stay (ALOS) values for FFY 2023 using FFY 2021 IRF claims and FFY 2020 IRF cost report data. Table 2 (*pp. 20224-20227*) lists relative weight and ALOS changes by CMG. CMS stated 99.3% of all IRF cases are in CMGs and tiers that would experience less than a 5% change (either increase or decrease) in the CMG relative weight value as a result of proposed revisions. Proposed ALOS changes do not show any particular trends in IRF length of stay patterns.

The FFY 2023 proposed standard payment conversion factor is $17,698, up from $17,240 in FFY 2022. Table 6 (*pp. 20233-20234*) displays the FFY 2023 payment rates after application of Case-Mix Group (CMG) relative weights.

Wage Index (*pp. 20228-20232*): In the FFY 2021 IRF final rule, CMS implemented a 5% cap on any decrease in an IRF's wage index to mitigate any negative effects of wage index changes compared to FFY 2020. This year, CMS proposed making the 5% cap permanent. This means an IRF's wage index would not be less than 95% of its wage index from the previous year, regardless of the circumstances causing a wage index decline. This policy as proposed will be budget neutral. New IRFs will receive the wage index applicable in its geographic location for its first full or partial fiscal year with no cap applied. CMS stated this proposal will maintain the IRF PPS wage index as a relative measure of the value of labor in a given labor market area, increase the predictability of IRF PPS payments, and mitigate instability and significant negative impacts to providers resulting from significant changes to wage index.

CMS has not yet posted the proposed wage index values for FFY 2023. When the file is ready, it will be here.

CMS proposed increasing the IRF labor-related share from 72.9% in FFY 2022 to 73.2% in FFY 2023.

Outlier Payments and Cost-to-Charge Ratios (*pp. 20235-20236*): CMS proposed an outlier threshold amount of $13,038 for FFY 2023, a significant increase from $9,491 in FFY 2022. CMS stated it is exploring the underlying reasons for the large change in the proposed outlier threshold amount.

CMS proposed a FFY 2023 cost-to-charge ratio (CCR) ceiling of 1.40, a rural average CCR of 0.463 and an urban average CCR of 0.393.

IRF Quality Reporting Program (QRP) (*pp. 20243-20256*): Table 11 (*p.*) displays the 18 measures currently adopted for the FFY 2023 IRF QRP program year. There are no proposals for new IRF QRP measures.

However, CMS does request information on measure concepts under consideration for future years, including cross-setting function measure that would incorporate the domains of self-care and mobility, health equity measures, and a post-acute care COVID-19 vaccination coverage among patients measure.

Specific to health equity, CMS continues to explore ways it can leverage the IRF QRP and other Medicare quality programs to address health equity. CMS noted "measuring healthcare disparities in quality measures is a cornerstone of our approach to advancing healthcare equity." In this proposed rule, CMS requests feedback on a general framework it may use across CMS quality programs to assess disparities in healthcare quality; approaches that could be used in the IRF QRP program to assess drivers of healthcare quality disparities in IRFs; and two measures related to health equity.

Specifically, CMS solicits comments on the use of a Health Equity Summary Score (HESS) across Medicare quality programs, similar to the HESS score used with Medicare Advantage plans. Additionally, CMS developed a structural measure for use in acute care hospitals: Hospital Commitment to Health Equity (MUC2021-106). This measure assesses hospital leader engagement in the collection of health equity performance data.

CMS noted that it will not respond to specific comments in the FFY 2023 IRF PPS final rule, but will actively consider all input as it develops future regulatory proposals or sub-regulatory policy guidance.

Finally, CMS proposed requiring quality data reporting on all IRF patients, beginning with the FFY 2025 IRF QRP. If finalized, this policy would require IRFs to report IRF-Patient Assessment Instrument (PAI) for each patient, regardless of payer, beginning with discharges between Oct. 1, 2023 and Dec. 31, 2023.

IRF Teaching Status Adjustment Policy (*pp. 20236-20239*): CMS proposed codifying two longstanding teaching status adjustment policies:

1. The definition of "factor" and explanation of how it is computed (FFY 2006 IRF PPS final rule); and
2. Temporary FTE cap adjustments reflecting additional residents in an IRF's teaching program because another IRF or residency program closed (FFY 2012 IRF PPS final rule).

Additionally, CMS proposed updating the IRF teaching policy to better align with inpatient prospective payment system (IPPS) policies, including:

1. Linking the status of displaced residents to the day that an IRF or residency program closure is publicly announced;
2. Removing the link between the status of displaced residents and their presence at the closing IRF or residency program on the day prior to or the day of the closure;
3. Changes to letters that receiving IRFs must submit to their Medicare Administrative Contractor (MAC) in order to request a temporary increase in their FTE resident cap; and
4. If there are more displaced IRF residents than available FTE cap slots, the slots may be apportioned according to the closing IRF's discretion.

Request for Information – Facility-Level Adjustment Factor Methodology (*pp. 20239-20242*): CMS discussed the changes in teaching status and rural adjustments from their 2014 levels, and the potential payment impacts associated with those adjustments. CMS is soliciting comments from stakeholders on possible updates and refinements to its facility-level adjustment methodology.

Request for Information – IRF Transfer Payment Policy (*pp. 20242-20243*): The current IRF transfer payment policy applies to IRF stays that are less than the average length of stay for the applicable CMG and tier and when that stay is transferred directly to another institutional site. However, the policy has not applied when the patient is transferred to home health care. Recently, the Office of Inspector General issued a report suggesting CMS expand its IRF transfer payment policy to include home health transfers, estimating such a policy could have realized significant savings of approximately $993 million over the 2-year period studied.

CMS plans to study this recommendation, and solicits comments on the impact such a policy might have on patient access to appropriate post-acute care services, among other issues.

Contact:

Cassie Yarbrough, Senior Director, Medicare Policy
630-276-5516 | cyarbrough@team-iha.org

Sources:
Centers for Medicare & Medicaid Services. Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2022 and Updates to the IRF Quality Reporting Program. April 6, 2022. Available from: https://www.federalregister.gov/documents/2022/04/06/2022-07019/medicare-program-inpatient-rehabilitation-facility-prospective-payment-system-for-federal-fiscal. Accessed April 8, 2022.