Medicare Inpatient Rehabilitation Facility Prospective Payment System

Payment Rule Brief — Proposed Rule

Program Year: FFY 2014

Overview, Resources, and Comment Submission

On May 8, 2013, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FFY) 2014 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 based on regulatory changes put forward by CMS and legislative changes previously adopted by Congress.

A copy of the proposed rule *Federal Register* (FR) and other resources related to the IRF PPS are available on the CMS Web site at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/index.html.

An online version of the proposed rule is available at https://federalregister.gov/a/2013-10755.

A brief of the proposed rule is provided below along with FR page references for additional details. Program changes adopted by CMS would be effective for discharges on or after October 1, 2013 unless otherwise noted. Comments on the proposed rule are due to CMS by Tuesday, July 1 and can be submitted electronically at http://www.regulations.gov by using the Web site's search feature to search for file code "1448-P."

IRF Payment Rate for FFY 2014

FR pages 26,890-26,891 and 26,892-26,895

Incorporating the proposed updates with the effect of budget neutrality adjustments, the table below shows the IRF standard payment conversion factor for FFY 2014 compared to the rate currently in effect:

	Final FFY 2013	Proposed FFY 2014	Percent Change
IRF Standard Payment Conversion Factor	**$14,343**	**$14,865**	**+3.6%**

CMS is proposing changes to the IRF PPS' facility-level adjustments for FFY 2014. As a result of these proposed changes, CMS is proposing to adjust the rates upward and downward to maintain program budget neutrality. The table below provides detail on the updates and budget neutrality factors proposed for FFY 2014:

	Proposed IRF Rate Updates and Budget Neutrality Adjustments

Marketbasket (MB) Update Full MB update of 2.5% minus Affordable Care Act (ACA)-mandated 0.4% productivity reduction and 0.3% pre-determined reduction	**+1.8%**
Wage Index/Labor-Related Share Budget Neutrality (BN)	**+0.11%**
Low-Income Percentage (LIP) Adjustment BN	**+1.74%**
Teaching Adjustment BN	**-0.34%**
Rural Adjustment BN	**+0.3%**
Overall Rate Change	***+3.6%***

Effect of Sequestration for FFY 2014

FR page reference not available

While the proposed rule does not specifically address the 2.0% sequester reductions to all lines of Medicare payments authorized by the Budget Control Act (BCA) of 2011 and currently in effect through FFY 2021, sequester will continue unless Congress intervenes. Sequester is not applied to the payment rate; instead, it is applied to Medicare claims after determining co-insurance, any applicable deductibles, and any applicable Medicare secondary payment adjustments.

Wage Index and Labor-Related Share for FFY 2014

FR pages 26,891-26,892

The labor-related portion of the IRF standard rate is adjusted for differences in area wage levels using a wage index. CMS is not proposing any major changes to the calculation of Medicare IRF wage indexes. As has been the case in previous years, CMS would use the prior year's inpatient hospital wage index, the FFY 2013 pre-rural floor and pre-reclassified hospital wage index, to adjust payment rates under the IRF PPS for FFY 2014. A complete list of the proposed wage indexes for payment in FFY 2014 is available on the CMS Web site at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Data-Files.html. These values would not be updated for the final rule.

Based on updates to this year's proposed marketbasket value, CMS is proposing to reduce the labor-related share of the standard rate from 69.981% for FFY 2013 to 69.658% for FFY 2014. This change would provide slight increases in payments to IRFs with a wage index less than 1.0.

LIP, Teaching, and Rural Adjustments for FFY 2014

FR pages 26,888-26,890

CMS adjusts the IRF standard payment conversion factor for differences at the facility level, including adjustments to account for an IRF's percentage of low income patients, teaching status and intensity, and rural location.

CMS is proposing to update the facility-level adjustments for FFY 2014. The updates result from the use of more recent data and a slight methodology change to account for differences between hospital-based and freestanding IRFs. CMS has not modified these factors since FFY 2010. The following describes the adjustments and proposed changes:

- LIP Adjustment: CMS is proposing to reduce the LIP adjustment factor from 0.4613 for FFY 2013 to 0.3158 for FFY 2014. With the newly proposed adjustment factor, CMS would maintain the following formula to calculate the LIP adjustment: (1 + Disproportionate Share Hospital (DSH) patient percentage) ^ 0.3158. The DSH patient percentage for each IRF is calculated using the following formula: (Medicare SSI days / total Medicare days) + (Medicaid, non-Medicare days / total days).

- Teaching Adjustment: CMS is proposing to increase the teaching adjustment factor from 0.6876 for FFY 2013 to 0.9859 for FFY 2014. This payment adjustment is based on the number of full-time equivalent (FTE) interns and residents training in the IRF and the IRF's average daily census (ADC). With the newly proposed adjustment factor, CMS would maintain the following formula to calculate the teaching payment adjustment: (1 + IRF's FTE resident to ADC ratio) ^ 0.9859.
- Rural Adjustment: CMS is proposing to reduce the rural adjustment from 18.4% for FFY 2013 to 14.28% for FFY 2014.

The proposed changes to these factors require CMS to apply adjustments to the IRF payment rate in order to maintain program budget neutrality. The proposed budget neutrality adjustments are described in the rate update section above.

CMG Updates for FFY 2014

FR pages 26,885-26,888

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. Within each of the CMGs there are four tiers, each with a different relative weight that is determined based on comorbidities. Currently, there are 87 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 is proposing to update these factors for FFY 2014 using the most current full federal fiscal year of claims data (FFY 2012) and the most recently available IRF cost reports. CMS is not making any changes to the CMG categories/definitions. Using FFY 2012 claims data, CMS analysis shows that 99% of IRF cases are in CMGs and tiers that would experience less than a +/-5% change in the CMG relative weight as a result of the updates. A table that lists the proposed FFY 2014 CMG payments weights and ALOS values is provided on FR pages 26,886-26,888.

Outlier Payments for FFY 2014

FR page 26,895

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 2014, CMS is proposing to update the outlier threshold value to $10,111 for FFY 2014, a 3.4% decrease compared to the current threshold of $10,466.

Updates to the 60% Compliance Threshold Criteria for FFY 2014

FR pages 26,895-26905

Under current law, at least 60% of a hospital's total inpatient population must be diagnosed with one of 13 medical conditions for that hospital to be classified as a rehabilitation facility and paid under the IRF PPS. Prior to 2006, this compliance threshold was set at 75%. Compliance with the 60% threshold is evaluated using certain CMS-defined International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis codes that correspond with the 13 specified medical conditions.

CMS uses two methodologies to calculate an IRF's compliance percentage. The first method is referred to as the "presumptive methodology." Under this method, the compliance threshold is met if a facility's Medicare Part A fee-for-service and Medicare Advantage population for the 13 specified compliance threshold conditions is at least 50% or more of the facility's total inpatient population. If a facility does not meet the compliance threshold under the presumptive methodology, then the second methodology known as the "medical review methodology," is used. This method uses a sample of medical records from the facility's total inpatient population to estimate compliance with the threshold percentage.

For FFY 2014, CMS is proposing to reduce the number of ICD-9-CM diagnosis codes used to determine compliance with the 60% threshold. Under the proposal, CMS would remove any "unspecified" codes when more specific codes for a compliance threshold condition are available; diagnoses codes associated with three arthritis conditions; codes for congenital anomaly and unilateral upper extremity amputations; and several other diagnoses that CMS has deemed not intensive enough to require rehabilitation care. In total, CMS would remove over 300 diagnosis codes from the current compliance threshold list. The list of codes CMS is proposing to remove as available on FR pages 26,901-26-905.

Appendix C, available on the CMS Web site at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Data-Files.html lists the 972 diagnosis codes CMS is proposing to use for determining compliance with the 60% rule for compliance review periods that begin on or after October 1, 2013 (FFY 2014).

Updates to the IRF QRP

FR pages 26,909-26,922

The ACA required CMS to implement a quality data pay-for-reporting program for providers paid under the IRF PPS. CMS first adopted measures and policies in the FFY 2012 rulemaking cycle to implement the Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP) and rehabilitation providers are currently collecting and submitting data on measures specified by CMS. IRFs that fail to successfully participate in the IRF QRP receive reduced payments through a reduction of 2.0 percentage points to the marketbasket update. CMS will make these payment determinations each year beginning with FFY 2014.

For FFYs 2014 and 2015 payment determinations, CMS is collecting data on 2 measures:

- Catheter-Associated Urinary Tract Infections (CAUTI) outcome measure (National Quality Forum (NQF) #0138); and
- Percent of Residents with Pressure Ulcers that are New or Have Worsened (NQF #0678)

Details on the previously adopted IRF QRP measures and rules for FFYs 2014 and 2015 payment determinations are available in FR pages 47,874-47,883 of FFY 2012 IRF PPS final rule at https://federalregister.gov/a/2011-19516 and FR pages 68,500-68,508 of the calendar year 2013 outpatient PPS final rule at https://federalregister.gov/a/2012-26902.

CMS is using the FFY 2014 rulemaking process to propose new measures for FFYs 2016 and 2017 payment determinations along with updated and/or new data submission timelines for the previously adopted and newly proposed measures.

For FFY 2016 payment determinations, CMS is proposing to collect data on a total of 3 measures. CMS would retain 2 measures currently in place and add the following measure:

- Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431)

For FFY 2017 payment determinations, CMS is proposing to collect data on a total of 5 measures. CMS would retain 3 measures currently in place/proposed and add the following 2 measures:

- All-cause Unplanned Readmission Measure for 30 Days Post Discharge From Inpatient Rehabilitation Facilities; and

- Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay) (NQF #0680)

CMS is proposing to release an updated version of the IRF-patient assessment instrument (PAI) on October 1, 2014 (FFY 2015). Along with other updates, the tool would allow for more detailed data collection and risk adjustment of the IRF QRP measure in place for FFY 2014 payment determinations and beyond: Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened. Data on this measure using the modified tool would be evaluated for FFY 2017 payment determinations. The updated tool would also allow for data collection on the newly proposed IRF QRP measure for FFY 2017 payment determinations and beyond: Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine.

CMS is proposing both mandatory and voluntary additions to the IRF-PAI. CMS plans to post a detailed matrix on its Web site that identifies which data elements would be required, and which would be voluntary. That matrix will be available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/.

Complete detail on the proposed IRF QRP data submission methods and timeframes for FFYs 2016 and 2017 payment determinations are provided in the FR pages referenced above.

CMS is also proposing a waiver process to recognize the effect that natural disasters might have on an IRF's ability to collect and submit quality data. Under the proposal, an IRF would be required to submit a waiver request within 30 days of the date that the extraordinary circumstance occurred.

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