INPATIENT REHABILITATION FACILITY PPS:
PROPOSED RULE FOR FY 2014

At a Glance

The Issue:
In the May 8 Federal Register, the Centers for Medicare & Medicaid Services (CMS) published its fiscal year (FY) 2014 proposed rule for the inpatient rehabilitation facility (IRF) prospective payment system (PPS). Under the proposed rule, IRFs would receive a 2.5 percent market-basket update, which is offset by 0.3 percent productivity cut and 0.4 percent additional cut required by the Patient Protection and Affordable Care Act (ACA), and a 0.2 percentage point increase for payment changes for outlier cases. CMS estimates that collectively, these payment changes would produce a net increase of 2.0 percent ($150 million) over FY 2013 payment levels. In addition, the rule proposes narrowing the codes that count toward compliance with the “60% Rule,” which requires that at least 60 percent of an IRF’s cases for a prior 12-month period fall within 13 qualifying conditions.

Our Take:
We are pleased that CMS proposed a positive net update for IRFs. However, the AHA has concerns about the proposal to implement more specific 60% Rule coding guidelines. We are closely examining the details of this proposed change to identify any inappropriate narrowing of the 60% rule’s compliance criteria. The AHA also is concerned that several proposed quality measures for FY 2017 are not endorsed by the National Quality Forum.

What You Can Do:
✓ Share this summary with your senior management team to examine the impact of these payment changes on your organization for FY 2014.
✓ Prepare and submit by July 1 a comment letter to CMS to voice your concerns related to the regulation.

Further Questions:
Please contact Rochelle Archuleta, senior associate director of policy, at (202) 626-2320 or rarchuleta@aha.org.

A 9-page analysis of this issue follows.
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BACKGROUND

In the May 8 Federal Register, the Centers for Medicare & Medicaid Services (CMS) published its fiscal year (FY) 2014 proposed rule for the inpatient rehabilitation facility (IRF) prospective payment system (PPS). In the proposed rule, CMS estimates that IRFs would receive an overall update of 2.0 percent, a $150 million increase over FY 2013 payment levels. As detailed below, this net increase takes into account a market-basket update, reductions mandated by the Patient Protection and Affordable Care Act (ACA) and payment increases for high-cost outliers. In addition, the rule proposes narrowing the codes that count toward compliance with the “60% Rule,” a requirement that at least 60 percent of an IRF’s cases for a prior 12-month period fall within 13 qualifying conditions. The proposed rule also includes changes to the IRF quality reporting program.

Comments are due to CMS by July 1 and can be submitted following the instructions found at the end of this advisory.

FY 2014 Proposed Payment Update

Market-basket Update
The IRF PPS standard rate is annually updated using the rehabilitation, psychiatric and long-term care (RPL) market basket, which is calculated using data from only freestanding facilities. For FY 2014, the rule proposes a market-basket update of 2.5 percent, which is offset by a 0.4 percentage cut for productivity and an additional 0.3 percentage point cut, both required by the ACA. The standard rate is further adjusted by budget neutrality adjustments for changes to the wage index, labor-related share, relative weights of the case-mix groups, and the three facility adjustments, which yields the proposed FY 2014 IRF standard payment conversion factor of $14,865, a 3.6 percent increase over the FY 2013 standard rate.

Case-mix Group Relative Weights
Each case is assigned to an IRF PPS case-mix group (CMG) based on the primary diagnosis and clinical severity of the patient. Each CMG is assigned a relative weight based on estimated resource use and has four tiers that reflect the number of comorbidities that are estimated to materially impact resource use. For FY 2014, the
CMG relative weights were updated in a budget-neutral manner using FYs 2011 and 2012 cost report data. Table 1 in the rule lists the proposed FY 2014 relative weights and average stays for each CMG and its comorbidity tiers.

**Labor-related Share**

The labor-related share is the national average proportion of total costs that are related to, influenced by, or vary with the local labor market, such as wages, salaries and benefits. The proposed labor-related share for FY 2014 is 69.658 – a decrease from the current labor-related share of 69.881. While the change in labor-related share is implemented in an overall budget-neutral manner, there is a redistributional effect at the facility level.

**Area Wage Index**

The IRF PPS wage index is computed using the FY 2011 area wage indices from the inpatient acute-care hospital PPS without adjustments for geographic reclassification. The proposed FY 2014 wage index values for urban and rural IRFs are found in Tables A and B of the Addendum to this proposed rule.

**Adjustment for High-cost Outliers**

As required by law, CMS must allocate 3 percent of total IRF payments for high-cost outlier payments. CMS estimates that this pool will not be fully paid out in FY 2013. Therefore, CMS proposes to reduce the current high-cost outlier threshold of $10,466 to $10,111 in FY 2014, to enable a greater proportion of IRF claims to receive outlier payments. This change is estimated to increase total IRF payments by $15 million over FY 2013 levels.

**Facility-level Payment Adjustments**

CMS continues to be concerned about the reliability of the IRF PPS’s current facility adjustments for rural, low-income percentage (LIP) and teaching IRFs. Specifically, the agency is concerned that variation in costs between freestanding IRFs and IRF units in general acute hospitals and critical access hospitals (CAH) is reducing the accuracy of the facility adjustment factor estimates. To enhance the precision of these facility adjustments, CMS proposes adding a new control variable to identify the IRF as a freestanding hospital or a hospital unit in the regression analysis CMS uses each year to update these adjustments. With this change, CMS would be able to control for cost structure differences and remove their influence from the calculation of average cost per case for rural and urban, high-LIP and low-LIP, and teaching and non-teaching IRFs.

Consistent with the existing methodology, the proposed FY 2014 adjustments are based on a three-year moving average of claims data (FYs 2010, 2011 and 2012), with the addition of the new control variable discussed above. Based on this approach, CMS proposes the following FY 2014 facility adjustments:

- Rural Adjustment: 14.28 percent (compared to 18.4 percent for FY 2013);
- LIP Adjustment Factor: 0.3158 (compared to 0.4613 for FY 2013); and
- Teaching Adjustment Factor: 0.9859 (compared to 0.6876 for FY 2013).

CMS proposes to make these changes budget-neutral by using the following budget neutrality adjustment factors: 1.0030 for the rural adjustment; 1.0174 for the LIP...
adjustment; and 0.9966 for the teaching adjustment. These adjustments would be applied after the budget neutrality factors for the wage adjustment and the CMG relative weights are applied. CMS is seeking input on whether to use these proposed FY 2014 update factors or maintain the FY 2013 levels for another year.

**Proposed Changes to 60% Rule Compliance Criteria**

There are two approaches for assessing IRF compliance with the 60% Rule. Most IRFs use the presumptive methodology, which is a software analysis by a CMS contractor that assesses ICD-9-CM diagnosis codes submitted for each patient. IRFs that fail to demonstrate 60% Rule compliance using the presumptive test may elect a comprehensive assessment in which the contractor audits a sample of the facility’s medical records to assess compliance with this policy.

The proposed rule notes that CMS has studied the codes that currently count toward 60% Rule compliance, which may be found at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Criteria.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Criteria.html). Through this examination, CMS found changes and variation over the years in hospital coding, clinical practice, condition frequencies and 60% Rule enforcement by CMS contractors. The agency states that these proposed changes – the first material narrowing of the codes that qualify toward the 60% Rule compliance – necessitate the updating of the qualifying diagnosis codes, and is proposing various changes, including deleting 331 codes from the list. The specific proposed deletions are provided in Table 7 in the proposed rule and fall within these categories:

- Non-specific diagnosis codes;
- Arthritis codes, which do not indicate whether the patient meets the 60% Rule’s severity and prior treatment criteria;
- Selected congenital anomaly diagnosis codes, since CMS believes that patients with these conditions would be unlikely to meet the IRF admissions criterion for intensive therapy;
- Unilateral upper extremity amputations diagnosis codes, which CMS believes do not indicate whether a patient meets IRF admissions criteria; and
- Miscellaneous diagnosis codes for conditions that CMS believes do not require intensive rehabilitation.

CMS is not proposing to add any new codes to the list. The rule notes that patients with a code proposed for deletion may still be counted toward a facility’s 60% Rule compliance percentage based on an audit of the medical record by a Medicare contractor.

Based on our preliminary review, the AHA is concerned that the proposed new 60% Rule coding guidelines appear to inappropriately narrow some of the 60% Rule compliance criteria.

**Proposed Changes to the IRF-PAI**
For each beneficiary treated in an IRF, the facility must complete and submit an assessment using the IRF patient assessment instrument (IRF-PAI). For the first time since FY 2002, CMS is proposing changes to the PAI to improve alignment with the agency’s current data needs. The proposed revisions to the instrument would take effect Oct. 1, 2013. The proposed IRF-PAI changes summarized below do not alter the quality program for IRFs, which is discussed in the next section of this advisory.

- Change the IRF-PAI status codes to mirror those in the CMS-1450 (UB-04) claim form. The revised codes would be:
  - 01 Home (private home/apt., board/care, assisted living, group home);
  - 02 Short-term General Hospital;
  - 03 Skilled Nursing Facility (SNF);
  - 50 Hospice;
  - 62 Another Inpatient Rehabilitation Facility;
  - 63 Long-term Care Hospital (LTCH);
  - 64 Medicaid Nursing Facility;
  - 65 Inpatient Psychiatric Facility;
  - 66 Critical Access Hospital; and
  - 99 Not Listed.

- Update the options for responding to item 20B: Secondary Source to the following:
  - 02 Medicare-Fee for Service;
  - 51 Medicare-Medicare Advantage; and
  - 99 Not Listed.

- Add the following items:
  - 25A, Height;
  - 26A, Weight;
  - 44C, Was the patient discharged alive?; and
  - Signature of Persons Completing the IRF-PAI.

- For Item 24, expand the current 10 spaces by 15 additional spaces for comorbid conditions;

- Delete these items:
  - 18 Pre-Hospital Vocational Category;
  - 19 Pre-Hospital Vocational Effort;
  - 25 Is patient comatose at admission?;
  - 26 Is patient delirious at admission?; and
  - 28 Clinical signs of dehydration.

- Replace all references to the ICD-9-CM code(s) in the IRF-PAI with references to ICD code(s), in recognition of the planned movement to ICD-10.

- Amend the response codes on selected items.

A draft of the proposed revised IRF-PAI is available on CMS’s website.
IRF Quality Reporting Program

The ACA mandates the establishment of a quality reporting program (QRP) for IRFs paid under the IRF PPS. Failure to meet the data submission requirements and deadlines of the program subjects IRFs to a 2 percent reduction to their annual market-basket update, beginning in FY 2014. CMS proposes no new measures for the FY 2014 or FY 2015 program, but does make proposals for FY 2016 and FY 2017.

FY 2016 Proposed Measure
CMS proposes to add the same influenza vaccination coverage among health care personnel measure that is currently reported in other federal programs. The measure is endorsed by the National Quality Forum (NQF), and was supported for inclusion in the IRF QRP by the Measure Applications Partnership (MAP). The MAP is a multi-stakeholder board charged with making annual recommendations to the Secretary of Health and Human Services (HHS) regarding which measures should be included in national quality reporting programs. MAP’s creation was mandated by the ACA and it functions under appropriated dollars from HHS. CMS proposes to collect this measure using the Centers for Disease Control and Prevention National Health Safety Network (NHSN), the same mechanism used to collect the measure in other programs.

FY 2017 Proposed Measures
The agency proposes two new measures and updates one existing measure for the FY 2017 IRF QRP.

Unplanned all-cause, all condition readmissions. The proposed claims-based measure assesses readmissions to short-stay acute care hospitals and long-term care hospitals for within 30 days of a discharge from an IRF. The measure uses the same basic approach as the Hospital Wide All-Cause Unplanned readmission measure currently in the hospital inpatient quality reporting program (IQR). The measure also employs a risk-adjustment methodology to adjust for patient factors such as demographic characteristics (e.g., age, gender), principal diagnosis, and co-morbid conditions.

The AHA is very concerned that this measure is not NQF-endorsed. We will urge CMS to seek NQF endorsement before finalizing the measure in the program. Moreover, given that the basic measurement approach is similar to the IQR measure, we believe this measure fails to exclude readmissions unrelated to the initial reason for admission. Because of this, IRFs' performance on the measure may suffer for factors beyond their control.

Percent of residents or patients who were assessed and appropriately given the seasonal influenza vaccine (short-stay). CMS proposes to collect the data for this measure through the addition of data items to the Quality Indicator section of the IRF-PAI, which will be used beginning on Oct. 1, 2014.

The AHA is concerned that this measure may not be appropriate for the IRF setting. While the measure is NQF-endorsed and received support from the MAP, short-stay post-acute patients have access to influenza vaccination in multiple settings prior to arrival at an IRF. Moreover, it can be difficult for IRFs to obtain an accurate vaccination history, which could lead to patients receiving unnecessary vaccinations.
Update to percent of residents with new or worsened pressure ulcers. CMS previously finalized this measure for the FY 2014 IRF QRP as a non-risk adjusted measure. With the updates to the Quality Indicator section of the IRF-PAI, CMS proposes to use a risk-adjusted version of the measure for FY 2017 payment determination. CMS also notes that the measure received expanded NQF endorsement that now includes IRFs.

**FY 2016 and FY 2017 Data Submission Proposals**

The agency proposes several notable changes to the data reporting and submission timeframes for the IRF QRP.

Measures Reported through the IRF-PAI. With the implementation of the revised IRF-PAI planned for Oct. 1, 2014, CMS proposes to collect only three quarters of data for the FY 2016 program (Jan. 1, 2014 – Sep. 30, 2014). CMS would then use the new IRF-PAI for the entire FY 2017 program, collecting data beginning Oct. 1, 2014. CMS’s data collection proposals for the measures reported through the IRF-PAI for FYs 2016 and 2017 are summarized in the table below.

**Proposed Data Collection and Submission Timeframes for Measures Collected through the IRF-PAI (Pressure Ulcers and Patient Influenza Vaccination)**

<table>
<thead>
<tr>
<th>FY 2016 Data Collection</th>
<th>FY 2016 Data Submission Deadline</th>
<th>FY 2017 Data Collection</th>
<th>FY 2017 Submission Deadline</th>
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</table>

Infection Measures Reported through NHSN. For FYs 2016 and 2017, CMS proposes to use the quarterly submission deadlines for the catheter-associated urinary tract infection (CAUTI) measures that are aligned with those for the hospital IQR program, as well as the long-term care hospital quality reporting (LTCHQR) program. Similarly, the agency proposes to collect the health care provider influenza vaccination measure using the same timeframe as the IQR and LTCHQR. CMS’s data submission proposals for IRF QRP infection measures are outlined below.
Proposed Data Collection and Submission Timeframes for IRF QRP Measures Reported through NHSN

<table>
<thead>
<tr>
<th>Measure</th>
<th>FY 2016 Data Collection</th>
<th>FY 2016 Data Submission Deadline</th>
<th>FY 2017 Data Collection</th>
<th>FY 2017 Submission Deadline</th>
</tr>
</thead>
</table>

Public reporting of IRF QRP Measures. CMS makes no formal proposals for publicly reporting the measures in the IRF QRP, but does invite public comment on what issues the agency should consider in developing processes for public reporting. CMS intends to propose a formal process in future rulemaking.

Disaster/Extenuating Circumstances Waiver. Recognizing the impact of natural disasters and other extenuating circumstances on the ability of IRFs to collect and report quality data, CMS proposes a waiver process for IRFs participating in the IRF QRP. IRFs seeking a temporary pause in quality reporting would submit a waiver request to CMS within 30 days of the occurrence of the extraordinary circumstance, providing evidence of the impact of the extraordinary circumstance, and an estimated date when reporting would be able to resume. CMS also states it has the authority to grant waivers or extensions to a region or locale without IRFs specifically requesting them.

Reconsiderations and Appeals Process. IRFs must report mandatory measures and meet data submission deadlines or receive a 2 percent reduction to their annual payment update for a given fiscal year. Given these payment implications, CMS proposes to institute a reconsideration and appeals process for IRFs beginning with FY 2014 payments.

Each year, the agency would notify in advance any IRFs found to be non-compliant with IRF QRP requirements that they are potentially subject to a reduction in their annual payment update. These IRFs would be given an opportunity to file a reconsideration request with CMS. CMS could reverse its finding of non-compliance if the IRF provides sufficient evidence that the facility complied with the requirements, or has a justifiable reason why it could not comply. CMS has posted additional details about the reconsideration process on its website.
Other Proposed Changes

Proposed Change to Criteria for IRF Units. CMS proposes to make more specific one of the current regulatory requirements a hospital unit must meet to qualify for payment under the IRF PPS. Currently, the host hospital must have “enough beds that are not excluded from the prospective payment systems to permit the provision of adequate cost information.” In the rule, CMS proposes to require that the host hospital have a minimum of at least 10 staffed and maintained hospital beds that are not excluded from the inpatient PPS, or at least one staffed and maintained general acute hospital bed for every 10 certified IRF beds, whichever is greater. If the institution is unable to meet this requirement, the IRF unit should instead be classified as an IRF freestanding hospital. CMS notes that CAHs with IRF units would be excluded from this requirement since they have separate bed-size criteria.

Proposed Clarification of Administrative & Judicial Review. The regulations establishing the IRF PPS prohibit administrative or judicial review of the methodologies used to establish the CMGs, patient classifications within CMGs, CMG weighting, PPS rates, outlier and special payments, and area wage adjustments. CMS believes this prohibition has been improperly interpreted by some IRFs. To expand this prohibition to cover all elements of the IRF PPS, which CMS believes was the original intent of this provision, the rule would delete the word “unadjusted” from “unadjusted federal per discharge payment rates” in 42 CFR 412.630.

Proposed Clarification to Preadmission Screening Process. CMS proposes to clarify that the IRF’s preadmission screening procedure requiring that the results of a preadmission screening procedure be reviewed and approved by a rehabilitation physician prior to the IRF admission applies only to beneficiaries seeking Medicare coverage for the IRF stay. However, CMS would still require a standardized preadmission screen for every prospective patient – not just Medicare beneficiaries – to assess medical condition and history to determine whether the patient is likely to significantly benefit from IRF services.

Next Steps

The AHA hosted a member call on May 31 on the proposed rule, which is available for playback at www.aha.org/postacute.

Please contact Rochelle Archuleta, senior associate director of policy, at (202) 626-2320 or rarchuleta@aha.org with any feedback or questions on the proposed rule.

The AHA urges all IRFs to submit comments to CMS. Comments are due to CMS by July 1 and may be submitted electronically at www.regulations.gov. Follow the instructions for “Comment or Submission” and enter the file code “CMS-1448-P” to submit comments on this proposed rule.
You also may mail written comments (an original and two copies) to CMS.

**Via regular mail**
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P.O. Box 8011  
Baltimore, MD 21244-1850

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