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Update on Medicare and Medicaid Payment Issues

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Editors: Leslie Demaree Goldsmith and Carel T. Hedlund

CMS Finalizes Quality Reporting Rules for IRFs and More Lenient Rules on Size and Square Footage for IRFs and IPFs

By: Carel T. Hedlund

Like many other Medicare providers, inpatient rehabilitation facilities (IRFs) will soon be subject to quality reporting requirements. In addition to the usual annual updates of the IRF rates addressed in the final rule for Federal Fiscal Year 2012 [PDF] published in the August 5, 2011 Federal Register, CMS is taking steps to implement a quality reporting program for IRFs, as mandated by the Affordable Care Act. CMS also is easing rules for qualifying as a new IRF and for changes in size and square footage for both IRFs and inpatient psychiatric facilities (IPFs).

IRF Annual Update

The final rule includes:

- A projected 1.8 percent increase in IRF rates (up from 1.5 percent in the proposed rule).
- A temporary increase in the FTE intern and resident cap when an IRF accepts displaced interns and residents because another IRF closes or closes a medical residency training program.
- A reduction in the labor-related share from 75.271 percent in FY 2011 to 70.199 percent in FY 2012 (down from 70.334 percent in the proposed rule).
- An increase in the standard payment conversion factor from $13,869 in FY 2011 to $14,076 in FY 2012 (down from $14,528 in the proposed rule).
- An outlier threshold of $10,660 for FY 2012 (down from $11,822 in the proposed rule) to maintain estimated outlier payments at 3 percent of total estimated IRF payments.

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CMS did not adopt, however, a proposed revision to the method used to calculate the three-year moving average for the rural, low-income percentage (LIP) and teaching status adjustments, by replacing the weighting factor in the regression analysis used for each adjustment with an equal weighting of all facilities. Instead, CMS is holding these facility-level adjustments at FY 2011 levels while they conduct further research on the reasons for fluctuations.

IRF Quality Reporting

CMS adopted the following two quality measures for FY 2014:

- "Urinary Catheter-Associated Urinary Tract Infection [CAUTI] for Intensive Care Unit Patients" (NQF #0138). This data would be reported through the Center for Disease Control/National Healthcare Safety Network.
- "Percent of Residents with Pressure Ulcers that Are New or Worsened" (NQF #0678 (formerly # NH-012-10)). This was originally endorsed by the National Quality Forum for short-stay nursing homes.

IRFs that do not report data on these measures will have their annual increase factor reduced by two percentage points.

In addition, CMS put IRFs on notice that it intends to propose the following third quality measure, which it is currently developing and expects to be completed in late 2011:

- 30-day Comprehensive All-Cause Risk-Standardized Readmission Measure. This addresses readmissions within 30 days to another inpatient stay, whether in an acute care hospital, IRF or other setting. CMS anticipates using claims data otherwise submitted by IRFs as the data for this measure.

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Changes in IRF Rules

CMS adopted a number of changes in longstanding regulations governing IRFs, in recognition that many of them are no longer necessary now that these facilities, whether a freestanding hospital or a hospital unit, are paid under a prospective payment system instead of the former method, which was based on their cost reports subject to certain facility-specific limits. The changes include:

- Consolidating most of the requirements for classification as a rehabilitation hospital and rehabilitation unit, currently at 42 C.F.R. §§ 412.23(b), 412.29 and 412.30, into one regulation at 42 C.F.R. § 412.29.
- Revising the requirement for an IRF to be considered "new" to indicate that an IRF can be considered "new" if it has not been paid under the IRF PPS system for at least 5 calendar years.
- Clarifying rules regarding changes of ownership/mergers of IRFs:
  - Where the new owner accepts assignment of the previous owner's provider agreement, IRFs would retain excluded status and continue to be paid under IRF PPS as long as all the requirements of the regulatory section at 42 C.F.R. § 412.29 are met.
  - Where the new owner does not accept assignment, it is considered a voluntary termination and the new owner must apply as an initial applicant to operate an IRF and would not be required to wait for 5 years to reapply
- Eliminating the requirement that a hospital seeking to increase its hospital bed capacity by more than 50 percent of the number of beds it seeks to add to its IRF unit must obtain approval under State licensure and Medicare certification. Instead, IRF beds would be considered "new" if they meet all applicable state certificate of need and licensure laws and if they get written approval from the CMS Regional Office.

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- Revising when new beds can be added. New IRF beds can be added one time at any point during a cost reporting period, instead of only at the start of a cost reporting period. However, a full 12-month cost reporting period must elapse before an IRF that has had beds delicensed or decertified can add new beds.
- Aligning the IRF payment rules with the IRF coverage rules, by including in the IRF classification criteria the requirements that the IRF have processes under which (1) admissions must be reviewed and approved by a rehabilitation physician prior to each patient's admission to an IRF; and (2) the patient must receive close medical supervision as evidenced by at least 3 face-to-face visits per week by an appropriate physician to assess patient medically and functionally.

Changes in Rules on Size and Square Footage for IRF and IPF Units

CMS adopted its proposal to ease the restrictions on bed size and square footage changes for both IRF units and IPF units, by permitting increases or decreases in bed size or square footage one time at any point in a given cost reporting period, as long as it notifies the CMS regional office at least 30 days before the proposed change and maintains required documentation to determine cost of excluded unit. Any increase in beds would be considered new only through the end of that cost reporting period.

Ober|Kaler's Comments

Now that IRFs have notice of the quality measures that CMS will require, they should be evaluating this data to determine how to improve their performance in these areas. In addition, the increased flexibility in adjusting the bed size and square footage of IRFs and IPFs at any one time during the year will eliminate the need to calibrate the timing of construction projects and mergers or acquisitions so that they are completed and operational only at the start of a cost reporting period.

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