



WISCONSIN HOSPITAL
ASSOCIATION

Summary of Final Rule

for

Medicare Prospective Payment System

for

Inpatient Rehabilitation Facilities

Federal Fiscal Year 2004

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OVERVIEW OF FINAL RULE—IRF PROSPECTIVE PAYMENT SYSTEM

On August 1, the Centers for Medicare and Medicaid Services (CMS) issued the final rule updating the Medicare payment rates under the Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) for federal fiscal year (FFY) 2004. The rate update in this proposed rule is effective for services beginning on October 1, 2003. CMS estimates the impact resulting from the provisions in the notice to be a 3.2% increase in payments across the nation.

PPS RATE PAYMENT CALCULATION

Marketbasket Update

CMS uses the excluded hospital marketbasket in determining an annual rate update for the IRF PPS. CMS revised the inpatient rehabilitation marketbasket and rebased it from 1992 to 1997. The final marketbasket increase for FFY 2004 is 3.2%.

IRF Wage Index

The IRF PPS wage index, which is based on acute care hospital wage data, has been updated based on 1999 data as opposed to the 1997 data that is currently used. A budget neutrality factor of .9954 will be applied to maintain budget neutrality as required by law. In addition, the update to the wage index results in a labor-related portion of the rate of 72.526%.

National IRF PPS Rate

The national IRF PPS rate for FFY 2003 was \$12,193. After applying the marketbasket increase of 3.2% and the budget neutrality factor of .9954, the resulting FFY 2004 national rate is \$12,525. This rate is applied to the appropriate Case Mix Group (CMG) weight based on a CMG classification resulting from a clinical assessment of the patient.

Rate Adjustments

In addition to the wage index adjustment, the final rule contains two other facility level adjustments:

- Low-income patient adjustment (LIP)
- Rural facility adjustment (RF)

The methodology for calculating the LIP remains unchanged from the prior year and the RF adjustment of 19.14% remains unchanged.

The final rule includes three case-level adjustments:

- transfer adjustment methodology,
- interrupted stay methodology, and
(The above methodologies remain unchanged from the prior year)
- cost outlier adjustment.

The cost outlier threshold of \$11,211 continues as well as the payment of 80% of the difference between the estimated cost of the case and the outlier threshold. The changes to the cost outlier adjustment

computation methodology mainly involve the derivation of the estimated cost. The changes as detailed in the proposed rule will be implemented per this final rule.

The facility cost-to-charge ratio is used to estimate the cost of a particular case. Currently, CMS uses the cost-to-charge ratio from the most recent final **settled** IRF Medicare cost report. CMS will use the cost-to-charge ratio from the latter of the most recently settled Medicare IRF cost report or the most recently **tentatively settled** IRF Medicare cost report.

In addition, CMS will apply a ceiling in determining a facility's cost-to-charge ratio. There will be two national ceilings: one for urban hospitals and one for rural hospitals. In determining the ceilings, CMS will compute the standard deviation of both the urban and rural IRF cost-to-charge ratios and multiply each of these amounts by three. These amounts are then added to the respective national cost-to-charge ratio for both urban and rural IRFs and would represent the ceiling. CMS will update the ceilings on a yearly basis and publish them in future program memoranda. There will be no floor for lower than normal cost-to-charge ratios.

CMS will implement a retroactive settlement process for outlier payments. Under this policy, outlier payments will be subject to reconciliation when hospitals' cost reports are settled. Outlier payments will continue to be processed during the year using facility cost-to-charge ratios based on the best information available at that time. When the cost report is settled, any reconciliation of outlier payments by fiscal intermediaries will be based on facility cost-to-charge ratios calculated using the cost and charge data determined in the cost report.

OTHER IRF PPS CHANGES

Eliminate IRF Bed Size Limits

The limits imposed on the bed size of a satellite IRF, whether it is freestanding or a unit of a hospital will be eliminated. CMS feels this provision is no longer necessary now that the IRF PPS is fully implemented.

Empower Fiscal Intermediaries as Regulatory Enforcers

IRFs must meet several regulatory requirements and conditions of payment under the IRF PPS. CMS will add language that empowers Medicare fiscal intermediaries to determine a facility's compliance with these conditions and to withhold or reduce their Medicare payments or reclassify the IRF as an inpatient hospital.

Case Mix Refinements and Quality Indicators

The relative weights for the CMGs will remain the same as in the previous year. CMS has contracted with the RAND Corporation to lead efforts to refine the case mix classification system and to improve the accuracy of PPS payments.

In addition to case mix refinements, the RAND contract includes tasks that will identify quality indicators that are pertinent to inpatient rehabilitation. RAND will convene a technical expert panel to assist in this work.

Patient Privacy Rights Notification

CMS will require that IRF clinicians give patients two written notifications about their privacy rights before performing an IRF PAI. These forms both contain the same information. One form, titled, *Data Collection Information Summary for Patients in Inpatient Rehabilitation Facilities*, is written in plain

language and the other, *Privacy Act Statement—Health Care Records*, is written in technical language. In addition, CMS will post these documents on its Web site in English and Spanish.

PAI Completion Date

CMS will add language that clarifies for clinical staff that PAIs should be completed by the day after the assessment reference date (ARD), not specifically on the day after the ARD.

Optional Transmission of PAI Data for Some Part A Stays

CMS wishes to decrease the burden of PAI data transmission for IRFs, therefore CMS will add a provision granting IRFs the option to not transmit PAI data when Medicare is not paying for a beneficiary's Part A stay. WHA urges providers to be cautious when considering this option as it may put providers at financial risk.

There are instances when providers have an initial expectation of third party coverage for a Medicare Part A stay, but sometimes subsequently receive a denial of that coverage after the stay is complete. If a provider chose not to complete a PAI within the required CMS timeframe based on that expectation, but finds a need to now bill Medicare, Medicare will not pay the provider for that stay. The reason is that lack of a PAI and resulting CMG for the stay, means Medicare is unable to determine an appropriate payment for services. To protect against this, WHA suggests providers complete and submit a PAI on all patients admitted who meet Medicare eligibility requirements, regardless of the initial anticipated payment source.

IRF Discharge Definition

CMS will define an IRF discharge after October 1 simply as one where the patient is formally released from the IRF or dies in the IRF.

Waiver of Penalty for Late PAI Data Transmissions

CMS has added provisions in this rule for waiving the current penalty for late transmissions, if the IRF proves to CMS that there were extraordinary circumstances beyond an IRF's control that caused the PAI transmission to be late. In granting a waiver, CMS requires certain documentation to be established and maintained by the provider. Currently, the penalty for late transmission of PAI data is a 25% deduction in the CMG payment associated with each late PAI transmitted.

NEXT STEPS

WHA welcomes CMS' rate updates and regulatory changes that are clarifications to confusing language and reductions to providers' burden with unnecessary regulations. We await CMS' release of a proposed rule on changes to the "75% Rule" and will work closely with members in developing comments in response to that document.