



WISCONSIN HOSPITAL  
ASSOCIATION

*A Valued Voice*

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**SUMMARY OF THE FINAL FFY  
2006 MEDICARE INPATIENT  
REHABILITATION FACILITY  
RULE**

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**August 2005**

# TABLE OF CONTENTS

<b>I.</b>	<b>Overview .....</b>	<b>1</b>
<b>II.</b>	<b>Standard Payment Rate .....</b>	<b>1</b>
	-Marketbasket Update .....	1
	-Reduction to the Standard Payment Rate .....	1
	-Budget Neutrality Factors .....	2
	-Calculation of the Standard Payment Rate.....	2
<b>III.</b>	<b>Patient Classification System.....</b>	<b>2</b>
	-Changes to the Existing List of Tier Comorbidities.....	3
	-Moving Dialysis to Tier One.....	3
	-Moving Comorbidity Codes Based on Their Marginal Cost .....	3
	-Updating the CMGs .....	3
	-Updating the Relative Weights .....	3
	-Use of a Weighted Motor Score Index .....	3
<b>IV.</b>	<b>Facility-Level Adjustments.....</b>	<b>4</b>
	-Wage Index... ..	4
	-Labor-Related Share.....	5
	-Low-Income Patient Adjustment .....	5
	-Rural Location Adjustment .....	5
	-Teaching Status Adjustment .....	6
<b>V.</b>	<b>Case-Level Adjustments .....</b>	<b>6</b>
	-Transfers.....	6
	-Interrupted Stays .....	7
	-Cost Outliers.....	7
<b>VI.</b>	<b>Other.....</b>	<b>7</b>
	-Quality Monitoring.....	7

**Attachment I:** IRF PPS Current Versus Proposed FFY 2006 Case-Mix Group Relative Weights

**Attachment II:** 2006 MSA, CBSA, and Transition Wage Indexes by County

## I. OVERVIEW

The Centers for Medicare and Medicaid Services (CMS) published the final Medicare Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) rule for federal fiscal year (FFY) 2006 in the August 15 *Federal Register*. Changes are effective October 1, 2005, unless otherwise noted. Where applicable, *Federal Register* page numbers are provided as a reference throughout this document. A copy of the final rule is available at the WHA website: [http://www.wha.org/financeAndData/pps\\_rehab.aspx](http://www.wha.org/financeAndData/pps_rehab.aspx).

The current Medicare inpatient rehabilitation patient classification and payment system was adopted in the August 7, 2001 IRF PPS final rule. CMS has noted that the original IRF PPS utilized as its database, sample data on Medicare rehabilitation patients from 1999, prior to the implementation of the IRF PPS. The data that has been generated and submitted by IRFs since the implementation of the IRF PPS are now available for data analysis. The refinements that CMS is adopting in this final IRF PPS rule are based on analyses of this newer data set and subsequent recommendations from the RAND Corporation. In addition, RAND sought advice from a technical expert panel (TEP), which reviewed RAND's methodology and findings. As a result of these analyses, CMS is adopting major revisions to the IRF PPS. **Except where otherwise noted, the changes adopted in the final FFY 2006 rule are the same as those proposed in the May 25 proposed rule.**

## II. STANDARD PAYMENT RATE

### **Marketbasket Update** (*Federal Register* pages 47908 - 47915):

CMS states that, due to lack of data, it is unable to create an IRF-specific marketbasket. In prior years, the marketbasket index for IRFs was the same as that used for Long Term Care Hospitals (LTCHs), Inpatient Psychiatric Facilities (IPFs), cancer hospitals, and children's hospitals. Under the 2006 final rule, CMS is adopting a separate marketbasket index for the facilities on this list that are paid on a PPS system (i.e. cancer and children's hospitals will not be included). CMS has rebased and revised the marketbasket index to reflect the operating and capital cost structures for IRFs, LTCHs, and IPFs and will refer to this index as the RPL (for rehabilitation, psychiatric, long-term care) marketbasket. CMS has also rebased the RPL marketbasket to 2002 Medicare cost report data.

The RPL marketbasket update to the standard payment rate for FFY 2006 is 3.6%; this is 0.5% higher than the update percentage originally proposed. CMS states that this is based on a revised forecast; however, it should be noted that the projection methodology was also revised to be in keeping with the inpatient marketbasket. WHA has been urging CMS to revise its marketbasket calculation to more appropriately reflect the rate of cost increases. Earlier this year, WHA, the AHA and other state associations developed an analysis to demonstrate the annual Medicare marketbasket shortfall and make the case for correction.

### **Reduction to the Standard Payment Rate** (*Federal Register* pages 47904 - 47908):

According to CMS, the implementation of the IRF PPS has caused case-mix increases for a number of reasons, including the payment system's incentives for facilities to take patients with greater impairment, lower function, or comorbidities. Although CMS states that the IRF PPS likely improved the accuracy and consistency of coding, the Agency is concerned that some payment increases may be due to facilities' changes in coding practices that do not represent real changes in case-mix. The RAND analysis estimated that case-mix changes due to coding improvement increased IRF PPS payments by somewhere in the range of 1.9% to 5.8%. Therefore, CMS will apply a 1.9% across-the-board reduction to the standard payment to adjust for coding changes between 1999 and 2002 that did not reflect real changes in case-mix.

CMS references the 75% rule in justifying its choice to reduce the standard payment amount by the lowest possible amount by stating: “. . . we chose to propose a 1.9 percent reduction in the standard payment amount to recognize that IRFs’ current cost structures may be changing as they strive to comply with other recent Medicare policy changes, such as the criteria for IRF classification commonly known as the ‘75 percent rule’.”

**Budget Neutrality Factors** (*Federal Register* pages 47937 - 47938):

With this final rule, CMS is adopting a change to its IRF PPS budget neutrality methodology to include adjustments that will reflect changes to the tiers and CMGs, the rural adjustment, the LIP adjustment, and the teaching adjustment. These types of changes were not previously addressed in the budget neutrality calculation. CMS has revised their proposed 2006 budget neutrality factors to reflect additional data that had been left out of the original impact analysis. The budget neutrality factors will be applied to the standard payment amount as follows:

**Calculation of the FFY 2006 Standard Payment Amount:**

FFY 2005 standard payment amount = \$12,958

FFY 2006 adjustments:

- RPL marketbasket: 3.6%
- Across-the-board reduction: 1.9%
- Budget neutrality factors:
  - Wage index changes: .9995
  - Tier and CMG changes: .9995
  - Teaching adjustment proposal: .9889
  - Rural adjustment change .9961
  - Low Income Patient (LIP) adjustment change: .9851

FFY 2006 standard payment amount = \$12,767

Because each of the adjustments to IRF PPS payments has the net effect of increasing payments, each of these budget neutrality factors reduces the standard amount. Coupled with the 1.9% across-the-board payment reduction, the result is that the FFY 2006 standard payment amount is lower than the FFY 2005 amount.

### **III. PATIENT CLASSIFICATION SYSTEM**

IRF PPS payments are based on 100 distinct Case Mix Groups (CMGs). Patients are first categorized into one of 21 Rehabilitation Impairment Categories (RICs) based on the primary reason for rehabilitative care. From there, patients are further categorized into CMGs within the RICs based upon their ability to perform activities of daily living and sometimes also based on cognitive ability and/or age. There are currently 95 CMGs that have been derived using this categorization and another five CMGs to account for very short stays and patients who expire in the IRF. Within each of the 95 CMGs, there are four Tiers, each with a different relative weight, which are determined based on comorbidities. The combination of 95 CMGs, each with four Tiers results in 290 CMG payment classifications – the five special CMGs do not have separate Tiers.

The final 2006 rule makes the following refinements to the patient classification system, which will be implemented in a budget-neutral manner by reducing the standard payment rate by .9995:

### **Tier Updates:**

#### **Changes to the Existing List of Tier Comorbidities** (*Federal Register* pages 47888 - 47891):

The RAND analysis indicated to CMS that 1.6% of cases in FFY 2003 received a Tier payment that was not justified by any higher cost for the case. Based on this analysis, CMS is removing 17 diagnosis codes from the Tier list because they are no longer considered to be related to treatment cost. CMS is also removing two other diagnoses that are either too unspecific to be differentiated from other related codes or unrealistically represented in the data. Finally, CMS is adding 14 new diagnosis codes that the RAND analysis found to have a positive impact on costs. A table that provides a list of the diagnosis codes to be removed from the Tier list can be found on pages 47888 and 47889 of the *Federal Register*.

#### **Changes to Move Dialysis to Tier One** (*Federal Register* page 47891):

Based on data from the RAND analysis, which indicates that a patient on dialysis costs 31% more than a non-dialysis patient (when all other factors are held constant), CMS is moving dialysis to a higher comorbidity Tier. Dialysis is currently in Tier two and will be moved to Tier one, which is the highest payment Tier.

#### **Changes to Move Comorbidity Codes Based on Their Marginal Cost** (*Federal Register* page 47892):

CMS believes that the IRF PPS led to substantial changes in coding practices between 1999 (pre-implementation of the IRF PPS) and 2003 (post-implementation of the IRF PPS). According to CMS, the incidence rate of cases with one or more comorbidities increased by 52%; the recording of a Tier one comorbidity, the highest paid of the tiers, almost quadrupled during this same period. CMS notes that although coding likely improved, the presence of “up-coding” for a higher payment may also be a factor. For this reason, and with the availability of more complete, 2003 data, comorbidity codes will be assigned to Tiers based on marginal as opposed to relative costs.

### **CMG Updates:**

#### **Changes to the List of CMGs** (*Federal Register* pages 47892 - 47896):

The current list of CMGs was developed using 1999 data. In an attempt to better align Medicare payments and actual IRF costs, CMS has used a new algorithm and FFY 2003 data to construct a list of refined CMGs.

The following are the most substantial differences between the existing CMGs and the FFY 2006 CMGs:

- fewer CMGs than before (87 compared with 95 in the current system);
- the number of CMGs under the RIC for stroke patients (RIC 1) would decrease from 14 to 10;
- the cognitive index score would affect patient classification in two of the RICs (RICs 1 and 2), whereas it currently affects RICs 1, 2, 5, 8, 12, and 18; and
- a patient's age would now affect assignment for CMGs in RICs 1, 4 and 8, whereas it currently affects assignment for CMGs in RICs 1 and 4.

#### **Changes to the Relative Weights** (*Federal Register* pages 47900 - 47904):

CMS is has recalculated the relative weights for each CMG using FFY 2003 Medicare billing data. CMS has not made any changes to the methodology for calculating the relative weights. A list of the refined CMGs and their relative weights can be found in Table 4 on pages 47902 through 47904 of the *Federal Register*.

#### **Use of a Weighted Motor Score Index** (*Federal Register* pages 47896 - 47900)

Currently, to classify a patient into a CMG, IRFs use the admission assessment data from the IRF Patient Assessment Instrument (PAI) to score a patient’s functional independence. The functional independence

measures consist of motor items and cognitive items. The IRF PPS currently uses standard motor and cognitive scores, and sums the items with equal weighting to assign patients to CMGs.

In an attempt to improve the classification of patients into CMGs, and subsequently improve the accuracy of payments to IRFs, CMS is adopting its proposed weighting methodology for the motor score index. The motor activity weights (average optimal weights) are based on a regression analysis of Functional Independent Measure's (FIM) relative ability to predict treatment costs. CMS is not making any changes to the cognitive score index. The FIM-based motor score weights are shown in Table 3 on page 47898 of the *Federal Register*.

The motor score index will be calculated as follows:

Motor score index = 1.4\*dressing lower + 1.2\*toilet + 0.9\*bathing + 0.6\*eating + 0.2\*dressing upper + 0.2\*grooming + 0.5\*bladder + 0.2\*bowel + 2.2\*transfer to bed + 1.4\*transfer to toilet + 1.6\*walking + 1.6\*stairs.

CMS is also changing how it will handle a code of 0 (which indicates no activity) for the transfer to toilet item on the IRF PAI. CMS will assign a code of 2 to patients for whom a 0 is recorded on the IRF PAI for this item. Prior to this, the automatic assignment had been to code 1. According to CMS, based on calendar year 2002 and FFY 2003 data, patients for whom a 0 is recorded have more similar costs and characteristics to patients with a recorded score of 2 than to patients with a recorded score of 1.

Attachment I compares the CMGs, relative weights, and average lengths of stay (LOS) between the existing CMGs and the final CMGs. The RICs and their related CMGs are listed in Table 2 of the *Federal Register*, pages 47895 and 47896.

## IV. FACILITY-LEVEL ADJUSTMENTS

**Wage Index** (*Federal Register* pages 47917 - 47928):

The labor-related portion of the standard payment amount is adjusted for differences in area wage levels using a wage index. The 2006 wage index for IRFs is calculated using FFY 2001 acute inpatient PPS wage data, without geographic reclassifications and without applying the "rural floor." This is the same wage index as will be used for Skilled Nursing Facilities and Home Health Agencies.

Currently the IRF wage index is based on Metropolitan Statistical Areas (MSAs) from the 1990 Census. In FFY 2005, CMS adopted revised labor market area definitions, based on the 2000 Census, called Core-based Statistical Areas (CBSAs), for its inpatient PPS wage indexes. CMS provided a one-year transition to hospitals that were harmed by the area redefinitions, allowing inpatient hospitals that experienced a decrease due to the new definitions to receive a blend of 50% of the wage index based on the new definitions and 50% based on the old MSAs. Last year's IRF PPS update discussed, but did not adopt the inpatient PPS redefined labor market areas for the IRF wage index.

CMS is now implementing the revised CBSA labor market area definitions for IRFs. Based on comments to its proposed rule, CMS will provide a one-year transitional blend for all IRFs in FFY 2006. This means that, for FY 2006, the IRF transitional wage index will equal 50% of the wage index calculated based on MSAs and 50% of the wage index calculated based on CBSAs for all IRFs regardless of whether the new area definitions are beneficial or detrimental. The change to the wage index will be implemented in a budget-neutral manner by reducing the standard payment rate by .9995.

Attachment II shows the MSA, CBSA, and transition wage indexes for 2006 by county.

**Hold Harmless Policy for IRFs Redesignated from Rural to Urban** (*Federal Register* pages 47923 – 47926):

In this final rule, CMS responds to commenters concerns regarding IRFs that go from a rural designation under the MSA-defined wage indexes to an urban designation under CBSA-defined wage indexes. The concern is that some of these facilities will be financially harmed by this redesignation because the increase in their wage index will be more than offset by the loss of their rural facility adjustment (which is currently 19.14%). CMS is implementing a three-year transition for those IRFs that will be harmed by this redesignation. CMS will adjust these facilities' payments with two-thirds of the 2005 rural adjustment factor in FFY 2006 (12.76%) and with one-third of the 2005 rural adjustment factor in FFY 2007 (6.38%). Since this is a hold harmless policy, CMS will reduce the adjustment if it would result in payments that would be higher than they would have been under the old, MSA-defined wage indexes. The Hold Harmless policy will be implemented in a budget neutral manner; the impact is included in the wage index budget neutrality factor.

**Labor-Related Share** (*Federal Register* pages 47915 - 47917):

The labor-related share is based on an estimate of the national average proportion of IRF operating costs that are attributable to wages or are wage-related. In prior years, CMS has used the inpatient marketbasket as its source for determining the relative importance of the various labor-related cost factors. The FFY 2005 labor-related share is 72.359%. For FFY 2006, CMS is revising its calculation of the labor-related share to reflect the RPL marketbasket costs. The final FFY 2006 labor-related share of 75.865% is lower than the percentage in the proposed rule because it reflects updated marketbasket projections.

**Low-Income Patient Adjustment** (*Federal Register* pages 47933 - 47934):

Currently, IRFs receive an adjustment to their standard payment amount to account for the cost differences associated with the treatment of low-income or disproportionate share (DSH) patients. Using data from the RAND regression analysis, augmented by additional data, CMS has revised its proposal and is updating the formula used to calculate the LIP adjustment from:

(1 + DSH patient percentage) raised to the power of .4838 to:

(1 + DSH patient percentage) raised to the power of .6229

where the DSH patient percentage =

$$\frac{\text{Medicare SSI Days}}{\text{Total Medicare Days}} + \frac{\text{Medicaid, non-Medicare Days}}{\text{Total Days}}$$

This revised formula has the impact of increasing LIP payments. According to CMS, this will better distribute current payments among IRFs. The changes to the LIP adjustment will be implemented in a budget-neutral manner by reducing the standard payment rate by .9851.

**Adjustment for Rural Location** (*Federal Register* pages 47932 - 47933):

Currently, IRFs located in rural areas receive a 19.14% add-on to their federal standard payment amount. Using data from the RAND regression analysis, CMS found that rural IRFs continue to have higher costs associated with caring for Medicare patients than their urban counterparts and that the current adjustment is insufficient. Therefore, CMS is finalizing its proposal to increase the add-on for IRFs located in rural areas, but the adjustment percentage has been reduced to 21.3% based on the availability of additional data. The change to the rural adjustment will be implemented in a budget-neutral manner by reducing the standard payment rate by .9961.

**Teaching Status Adjustment** (*Federal Register* pages 47928 - 47932):

In the past, CMS had considered, but had not adopted, a teaching adjustment for IRFs. The argument had been that CMS' regression analyses did not support an adjustment to account for higher indirect operating costs experienced by IRFs that participate in Graduate Medical Education programs.

The more recent RAND analyses show that teaching facilities do experience higher costs for caring for Medicare patients than non-teaching facilities. Therefore, CMS is adopting its proposal to establish a teaching adjustment for IRFs that are, or are part of, teaching institutions. The adjustment is calculated using the ratio of interns and residents assigned to the IRF to the average daily census (ADC) for the IRF. The IRF PPS teaching payment adjustment would be equal to the  $(1 + (\text{Interns} + \text{Residents}/\text{ADC}))$  raised to the power of 0.9012. The adjustment variable has been reduced from the proposed amount based on additional data availability. The teaching status adjustment will be implemented in a budget-neutral manner by reducing the standard payment amount by .9889.

An example of the calculation of the teaching adjustment is shown below. In this case, the IRF would receive a 16.31% increase in its per discharge payments:

IRF ADC :	$4,000 \text{ (total IRF patient days)} / 365 = 10.96$
IRF Interns and Residents per ADC:	$2.0 \text{ (residents)} / 10.96 = 0.1825$
IRF Teaching Adjustment:	$(1 + 0.1825) ^ 0.9012 = 1.1631$

CMS will establish a cap on the number of IRF residents that is similar to the cap that limits increases in residents under inpatient and IPF PPS. CMS has revised its proposed base period for determining the IRF resident cap to the final settlement of the IRF's most recent cost reporting period ending on or before November 15, 2004; making the policy consistent with the IPF PPS. Residents with less than full-time status and residents rotating through the IRF for less than a full year will be counted in proportion to the time they spend in their assignment with the IRF. CMS will not allow IRFs to aggregate the full-time equivalent resident caps used to compute the IRF PPS teaching status adjustment through affiliation agreements. For purposes of determining the teaching adjustment under the IRF PPS, the number of residents cannot exceed the number of residents in the facility's base year.

Currently, Direct Graduate Medical Education (DGME) payments are provided to teaching hospitals for residents training in the acute hospital and residents training in exempt rehabilitation or psychiatric units. These DGME payments will continue.

## **V. CASE-LEVEL ADJUSTMENTS**

**Transfers:**

A patient discharged from an IRF is considered an early transfer when two conditions are met:

- 1) the length of stay is less than the average length of stay for non-transfer cases in the specific CMG; and
- 2) the patient is discharged to another institutional care setting such as another IRF, an inpatient hospital, long-term care hospital, or a nursing home that accepts Medicare and/or Medicaid payments.

Discharges to home health care, outpatient rehabilitation, or day treatment services are not counted as a transfer for payment purposes, but are treated as part of the normal progression of care and paid a full discharge payment.

Transfer cases are paid a per diem rate that is calculated by dividing the normal case payment for the CMG by the average length of stay for the CMG. The transfer payment amount includes an additional half-day payment for the first day.

There have been no changes to the transfer policy.

**Interrupted Stays:**

An interrupted stay is defined as one in which the beneficiary is discharged, then returns to the facility by midnight of the third day following the discharge. These cases receive only one discharge payment based on the admission assessment from the initial stay.

There have been no changes to the interrupted stay policy.

**Cost Outliers** (*Federal Register* pages 47934 - 47937):

The IRF outlier methodology is designed to result in outlier payments that are 3% of total IRF payments. Outlier payments are made for any discharge where the estimated cost of a case (measured by applying a facility's cost to charge ratio to the charges for the discharge) exceeds a fixed-loss threshold (which equals the CMG payment for the case plus the outlier threshold multiplied by the facility's adjustments). The IRF outlier payment is 80% of the amount over the fixed-loss threshold.

The FFY 2005 outlier fixed loss threshold is set at \$11,211 above the standard payment amount. Based on the RAND analysis, augmented by additional data, CMS is has revised its proposed FFY 2006 fixed loss threshold to \$5,132, which would maintain total outlier payments at 3% of total IRF PPS payments.

CMS will continue to hold individual facilities' CCRs to a ceiling; the ceiling for FFY 2006 is 1.52, as proposed. The national average urban and rural CCRs (which are used in cases where a facility CCR cannot be determined) are being updated to 0.518 and 0.631 respectively.

## **VI. OTHER**

**Quality Monitoring** (*Federal Register* pages 47941 - 47943):

Currently, the IRF-PAI contains quality and medical needs questions (collected on a voluntary basis). CMS has contracted with the Research Triangle Institute (RTI) to identify quality indicators pertinent to the IRF setting and determine what information is necessary to calculate those quality indicators. Once RTI has issued a final report, CMS will determine which quality-related items should be listed on the IRF PAI. The revised IRF PAI will need to be approved by the Office of Management and Budget before it is used in IRFs. CMS indicates that any new quality-related data collected from the IRF PAI would have to be analyzed to determine the feasibility of developing a payment method that accounts for the performance of the IRF.