



**SUMMARY OF THE FINAL FFY
2007 MEDICARE INPATIENT
REHABILITATION FACILITY
RULE**

September 2006

TABLE OF CONTENTS

I.	Overview	2
II.	Standard Payment Rate	2
	- Marketbasket Update for FFY 2007.....	2
	- Reduction to the Standard Payment Rate.....	2
	- Calculation of the FFY 2007 Proposed Standard Payment Rate.....	3
III.	Patient Classification System	3
	- Refinements to the Patient Classification System.....	3
IV.	75% Rule	4
	- Compliance Threshold Change.....	4
V.	Facility-Level Adjustments	5
	- Wage Index... ..	5
	- Hold-Harmless Policy for IRFs Redesignated from Rural to Urban.....	6
	- Low-Income Patient Adjustment	6
	- Rural Location Adjustment	6
	- Teaching Status Adjustment	7
VI.	Case-Level Adjustments	7
	- Cost Outliers.....	7
	- Transfers.....	8
	- Interrupted Stays	8

Attachment I: IRF PPS Current (FFY 2006) Versus Proposed FFY 2007 Case-Mix Group Relative Weights

I. OVERVIEW

This document provides an overview of the Medicare final rule for the Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) for federal fiscal year (FFY) 2007. Additional information regarding the IRF PPS is available on the Centers for Medicare and Medicaid Services (CMS) Web site at <http://www.cms.hhs.gov/InpatientRehabFacPPS>.

The final rule was published the August 18 *Federal Register*. Changes are effective October 1, 2006, unless otherwise noted.

Note: Text in italics is extracted from the *Federal Register*.

II. STANDARD PAYMENT RATE

Marketbasket Update for FFY 2007

(Federal Register pages 48375 –48376)

Background: In FFY 2006, CMS adopted the rehabilitation, psychiatric, and long-term care (RPL) hospital marketbasket. This revised methodology was developed to reflect the operating and capital cost structures for IRFs, Long-term Care Hospitals (LTCHs), and Inpatient Psychiatric Facilities (IPFs). This methodology is now used to update all three of these payment systems. In FFY 2006, CMS also rebased the RPL marketbasket to 2002 Medicare cost report data.

CMS Proposal: *“We will use the same methodology described in the FY 2006 IRF PPS final rule to compute the FY 2007 IRF market basket increase factor and labor-related share. For this proposed rule, the FY 2007 IRF market basket increase factor is 3.4 percent. This is based on Global Insight, Inc. for the first quarter of 2006 (2006q1) forecast with historical data through the fourth quarter of 2005 (2005q4). We propose to update the market basket with more recent data for the final rule to the extent it is available.”*

CMS Final Rule: *“For this final rule, the FY 2007 IRF market basket increase factor is 3.3 percent. This is based on the Global Insight, Inc. (GII) forecast for the second quarter of 2006 (2006q2) with historical data through the first quarter of 2006 (2006q1).”*

The final marketbasket increase of 3.3% is 0.1 percentage point lower than the increase provided in the proposed rule.

Reduction to the Standard Payment Rate

(Federal Register pages 48370 – 48375)

Background: In FFY 2006, CMS applied a “one-time” 1.9% reduction to the standard payment rate for what were determined to be coding changes between 1999 and 2002 that did not reflect real changes in case mix. 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. This reduction was based on an analysis by the RAND Corporation that estimated case-mix changes due to coding improvement had increased IRF PPS payments by a range of 1.9% to 5.8%. In the FFY 2006 final rule, CMS stated that it would continue to review the need for any further reduction in the standard payment rate to account for the impact of coding changes on payments to IRFs.

In the proposed rule, CMS presented more evidence from continuing research to support the need for another across-the-board reduction to the standard payment rate. In its March 2006 report to Congress available at http://www.medpac.gov/publications/congressional_reports/Mar06_EntireReport.pdf, the Medicare Payment Advisory Commission (MedPAC) reported that IRF profit margins increased from 1.5% in 2001, the year before the introduction of the IRF PPS, to 11.1% in 2002, 17.7% in 2003, and 16.3% in 2004. Additional analysis by CMS to determine if coding practices are artificially inflating changes in case mix, reviewed IRF Patient Assessment Instrument data from 2002 and 2005 and found that the proportion of patients shifted each year from the lowest to the higher-paying tiers.

CMS Proposal: “. . . for FY 2007, we propose to reduce the IRF standard payment amount by 2.9 percent, which would result in a total adjustment (when combined with the 1.9 percent adjustment for FY 2006) of 4.8 percent (1.9 + 2.9 = 4.8). In this way, we can adjust the IRF PPS to reflect more fully the impact of coding changes on payments. Because 4.8 percent is well within the range of RAND’s estimates of the effects of coding changes on IRF PPS payments, we continue to believe that we are still providing flexibility to account for the possibility that some of the observed changes may be attributable to factors other than coding changes.”

CMS Final Rule: “For FY 2007, . . . we are continuing our incremental approach to adjusting payments for coding changes that occurred when we first began implementing the IRF PPS in 2002. Together with the 1.9 percent reduction that we implemented for FY 2006, the 2.6 percent reduction for FY 2007 will result in a total adjustment of 4.5 percent (1.9 + 2.6 = 4.5).”

“Because 4.5 percent is still well within the range of RAND’s estimates of the effects of coding changes that do not reflect real changes in case mix on IRF PPS payments that occurred between 1999 and 2002, we continue to believe that we are still providing flexibility to account for the possibility that some of the observed changes may be attributable to factors other than coding changes.”

Calculation of the FFY 2007 Final Standard Payment Rate

(Federal Register pages 48377 – 48378)

FFY 2006 standard payment rate:	\$12,762
FFY 2007 adjustments:	
- RPL marketbasket:	3.3%
- Across-the-board reduction:	-2.6%
- Budget-neutrality factors:	
- Wage index and labor-related share:	0.16%
- Hold-harmless policy and patient classification system:	0.93%
Proposed FFY 2007 Standard payment rate:	\$12,981

Although the final rule provides a full marketbasket update of 3.3%, the actual standard payment rate for IRFs will increase by approximately 1.7% from FFY 2006 to FFY 2007 due to two things discussed in this summary: application of a one-time 2.6% reduction to the standard payment rate, and upward budget-neutrality adjustments of about 1.1% for wage index and changes to the patient classification system. It should be noted that in FFY 2006, budget-neutrality adjustments coupled with a 1.9% across-the-board reduction to the standard payment rate resulted in the FFY 2006 standard payment rate being lower than the FFY 2005 rate.

III. PATIENT CLASSIFICATION SYSTEM

Refinements to the Patient Classification System

(Federal Register pages 48360 – 48370)

Background: Before FFY 2006, IRF PPS payments were 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 were 95 CMGs 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.

In the FFY 2006 final rule, CMS adopted major revisions to the IRF PPS based on analyses by RAND using data generated by IRFs after the implementation of the IRF PPS. Although CMS kept the same basic structure to the payment system as described above, substantial modifications were made to the CMGs, tier comorbidities, and relative weights causing a significant redistributive affect among IRFs.

CMS Final Rule: For FFY 2007, CMS is proposing further refinements to the patient classification system. Although these changes will not have as great a redistributive affect as the FFY 2006 changes, individual CMGs will be impacted. Proposed changes include changes to the existing list of tier comorbidities and changes to the CMG relative weights and average lengths of stay (LOS). A complete discussion of these changes can be found on the *Federal Register* pages referenced above.

Attachment I compares the CMGs, relative weights, and average LOS between the existing CMGs (FFY 2006) and the finalized CMGs (FFY 2007).

IV. 75% RULE

Compliance Threshold Change

(Federal Register pages 48383 - 48384)

Background: CMS uses the “75% rule” to classify a hospital or unit of a hospital as an IRF. This criterion sets a minimum percentage of a facility’s total inpatient population that must meet one of 13 medical conditions for the facility to be classified as an IRF. This minimum percentage is known as the “compliance threshold.”

The compliance threshold was formerly being phased to the 75% level over several cost reporting periods, as follows:

- 50% for cost reporting periods beginning on or after July 1, 2004, and before July 1, 2005;
- 60% for cost reporting periods beginning on or after July 1, 2005, and before July 1, 2006;
- 65% for cost reporting periods beginning on or after July 1, 2006 and before July 1, 2007; and
- 75% for cost reporting periods beginning on or after July 1, 2007.

CMS Final Rule: The final rule implements a provision of the Deficit Reduction Act of 2005 that revises the 75% rule compliance thresholds. The provision essentially extends the current 60% compliance threshold for an additional 12 months. The revised 75% rule compliance threshold transition is:

- 50% for cost reporting periods beginning on or after July 1, 2004, and before July 1, 2005;
- 60% for cost reporting periods beginning on or after July 1, 2005 and before July 1, 2007;
- 65% for cost reporting periods beginning on or after July 1, 2007 and before July 1, 2008; and
- 75% for cost reporting periods beginning on or after July 1, 2008.

The following tables detail the revised compliance thresholds and compliance determination dates for hospitals with cost report periods beginning in January or July.

January cost reports:

Cost Report Begin Date:	Review Period	Number of Months Reviewed	Compliance Threshold Percent Test	Compliance Determination Applies to Cost Report Beginning On:
January 1, 2006	September 2005 - August 2006	12	60%	January 1, 2007
January 1, 2007	September 2006 - June 2007	10	60%	January 1, 2008
	July 2007 - August 2007	2	65%	
January 1, 2008	September 2007 - June 2008	10	65%	January 1, 2009
	July 2008 - August 2008	2	75%	

July cost reports:

Cost Report Begin Date:	Review Period	Number of Months Reviewed	Compliance Threshold Percent Test	Compliance Determination Applies to Cost Report Beginning On:
July 1, 2006	March 2006 - February 2007	12	60%	July 1, 2007
July 1, 2007	March 2007 - June 2007	4	60%	July 1, 2008
	July 2007 - February 2008	8	65%	
July 1, 2008	March 2008 - June 2008	4	65%	July 1, 2009
	July 2008 - February 2009	8	75%	

V. FACILITY-LEVEL ADJUSTMENTS

Wage Index

(Federal Register pages 48376 – 48377)

Background: The labor-related portion of the standard payment rate is adjusted for differences in area wage levels using a wage index. The 2007 wage index for IRFs is calculated using FFY 2002 acute Inpatient PPS wage data, without geographic reclassifications and without applying the “rural floor.”

In FFY 2006, CMS adopted the revised Core-based Statistical Area (CBSAs) labor market area definitions for IRFs. CMS also provided a one-year transitional blend for all IRFs; which was based on 50% of the wage index calculated based on old Metropolitan Statistical Areas (MSAs) and 50% of the wage index calculated based on new CBSAs for all IRFs regardless of whether the new area definitions were beneficial or detrimental.

CMS Proposal: *“We propose to continue to use the most recent final pre-reclassified and pre-floor hospital wage data available (FY 2002 hospital wage data) based on the CBSA labor market area definitions consistent with the rational outlined in the FY 2006 IRF PPS final rule.”*

CMS Final Rule: CMS has adopted the above proposal as final with no revisions.

Therefore, for FFY 2007, CMS will base the wage index solely on the CBSA labor-market definitions, eliminating the transition blend provided in FFY 2006.

In addition, based on the relative weights from the RPL marketbasket, CMS has finalized a slight decrease to the labor-related share from 75.865% in FFY 2006 to 75.612%.

The final wage indexes for FFY 2007 by CBSA are available on [Federal Register pages 48412 – 48434](#).

Hold-Harmless Policy for IRFs Redesignated from Rural to Urban

[\(Federal Register pages 48376 – 48377\)](#)

Background: Under the CBSA-defined labor-market areas implemented in FFY 2006, IRFs that were designated rural under the Metropolitan Statistical Area (MSA)-defined labor market areas and are now designated urban under the CBSA-defined labor market areas may be financially harmed because the increase in their wage index will be offset by the loss of the 2005 19.14% rural facility adjustment. Therefore, in FFY 2006, CMS implemented a three-year transition for those IRFs that will be harmed by this redesignation, adjusting 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 is budget-neutral.

CMS Proposal: CMS had proposed no changes to this policy, and, as determined in FFY 2006, will apply one-third of the 2005 rural adjustment factor to these facilities in FFY 2007 (6.38%). As was the case in FFY 2006, 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.

Low-Income Patient Adjustment

[\(Federal Register pages 48381 – 48382\)](#)

Background: Currently, IRFs receive an adjustment to their standard payment rate to account for the cost differences associated with the treatment of low income or Disproportionate Share Hospital (DSH) patients. The formula used to calculate the low-income adjustment (LIP) adjustment is:

- $(1 + \text{DSH patient percentage})$ raised to the power of .6229 where the DSH patient percentage equal:

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

CMS Final Rule: CMS had proposed no changes to this policy and will continue to calculate the LIP adjustment using the exponential factor of 0.6229.

Rural Location Adjustment

[\(Federal Register pages 48381 – 48382\)](#)

Background: Currently, IRFs receive an adjustment to their standard payment rate to account for the cost differences associated with the treatment of patients in rural areas. Based on analysis by RAND, in FFY 2006, CMS determined that rural IRFs continue to have higher costs associated with caring for Medicare patients than their urban counterparts and increased the rural adjustment from 19.14% to 21.3%.

CMS Final Rule: CMS had proposed no changes to this policy and will continue to provide a 21.3% add-on for rural IRFs.

Teaching Status Adjustment

(Federal Register pages 48381 – 48382)

Background: In FFY 2006, CMS adopted an adjustment to account for higher *indirect* operating costs experienced by IRFs that participate in Graduate Medical Education (GME) programs. Before FFY 2006, only payments for Direct GME were provided to IRFs. The adjustment adopted in FFY 2006 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 is:

- $1 + [\text{Interns} + \text{Residents}/\text{ADC}]$ raised to the power of 0.9012

CMS Final Rule: CMS had proposed no changes to this policy and will continue to calculate the teaching adjustment using the exponential factor of 0.9012.

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

CMS will continue to cap the number of IRF residents, similar to the cap that limits increases in residents under the Inpatient and IPF PPS. An IRF's full-time equivalent resident cap is determined based on the final settlement of the IRF's most recent cost report period ending on or before November 15, 2004; this policy is 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.

VI. CASE-LEVEL ADJUSTMENTS

Cost Outliers

(Federal Register pages 48382 – 48383)

Background: 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 2006 outlier threshold is set at \$5,129 above the standard payment rate.

CMS Proposal: “. . . we propose to update the outlier threshold amount to \$5,609 to set estimated outlier payments equal to 3 percent of total estimated aggregate IRF payments for FY 2007.”

CMS Final Rule: “. . . we are finalizing our decision to update the outlier threshold amount for FY 2007 to \$5,534. . . we . . . will maintain estimated outlier payments at 3 percent of total estimated payments.”

This outlier threshold amount is slightly lower than the \$5,609 proposed, due to the reduction of the coding adjustment from the 2.9 percent adjustment that we had proposed to the 2.6 percent coding adjustment that has been finalized by CMS.

CMS will continue to hold individual facilities' cost-to-charge ratios (CCRs) to a ceiling; the ceiling for FFY 2007 is 1.56. The national average urban and rural CCRs (which are used in cases where a facility CCR cannot be determined) are being updated to 0.484 and 0.600, respectively.

Transfers

(Federal Register pages 48355 – 48357)

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

- the LOS is less than the average LOS for non-transfer cases in the specific CMG; and
- 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 LOS for the CMG. The transfer payment amount includes an additional half-day payment for the first day.

CMS Final Rule: CMS had proposed no changes to this policy.

Interrupted Stays

(Federal Register pages 48355 – 48357)

Background: 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.

CMS Final Rule: CMS had proposed no changes to this policy.