



WISCONSIN HOSPITAL
ASSOCIATION

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

May 2006

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SUBMISSION OF COMMENTS

This document provides an overview of the Medicare proposed 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>.

CMS must receive comments on the proposal by 5 p.m. on July 7. CMS requests that comments reference the file code CMS-1540-P and the specific “issue identifier” that precedes the section on which you choose to comment. Each section of this summary provides the “issue identifier” that CMS requests you reference in your comments.

Comments on the proposed rule can be:

Submitted electronically at:

<http://www.cms.hhs.gov/eRulemaking>.

Click on the “Submit electronic comments on CMS regulations with an open comment period” link. (Attachments should be in Microsoft® Word, WordPerfect®, or Excel format.)

-OR-

Regular Mail (an original and two copies):
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1540-P
P.O. Box 8012
Baltimore, MD 21244-8012

Express/Overnight Mail (an original and two copies):
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1540-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

-OR-

Hand-deliver to (an original and three copies):
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

I. OVERVIEW

The Centers for Medicare and Medicaid Services (CMS) published the proposed Medicare Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) rule for federal fiscal year (FFY) 2007 in the May 15 *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

Refer to “Proposed FY 2007 Federal Prospective Payment Rates” if you submit a comment on this issue. (*Federal Register* page 28125)

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.”*

Reduction to the Standard Payment Rate

Refer to “Proposed FY 2007 Federal Prospective Payment Rates” if you submit a comment on this issue. (*Federal Register* pages 28122 - 28125)

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 presents 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.”*

Calculation of the FFY 2007 Proposed Standard Payment Rate

Refer to “Proposed FY 2007 Federal Prospective Payment Rates” if you submit a comment on this issue.
(*Federal Register* pages 28127 - 28128)

FFY 2006 standard payment rate: \$12,762

FFY 2007 adjustments:

- RPL marketbasket: 3.4%

- Across-the-board reduction: -2.9%

- Budget-neutrality factors:

- Wage index and
labor-related share: 0.17%

- Hold-harmless policy
and patient classification
system: 0.91%

Proposed FFY 2007
standard payment rate: \$12,952

Although the proposed rule provides a full marketbasket update of 3.4%, the actual standard payment rate for IRFs will increase by approximately 1.5% from FFY 2006 to FFY 2007 due to two things discussed in this summary: a CMS proposal to apply a one-time 2.9% reduction to the standard payment rate, and upward budget-neutrality adjustments of about 1.0% 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

Refer to “Refinements to the Patient Classification System” if you submit a comment on this issue.
(*Federal Register* pages 28110 - 28122)

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 effect among IRFs.

CMS Proposal: For FFY 2007, CMS is proposing further refinements to the patient classification system.

Although these changes will not have as great a redistributive effect 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 proposed CMGs (FFY 2007).

IV. 75% RULE

Compliance Threshold Change

Refer to “Revisions to the Classification Criteria Percentage for IRFs” if you submit a comment on this issue. (*Federal Register* pages 28135 - 28136)

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 is currently 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 Proposal: The proposed 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 (two common reporting periods).

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

Refer to “Proposed FY 2007 Federal Prospective Payment Rates” if you submit a comment on this issue. (*Federal Register* pages 28125 - 28126)

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.” This is the same wage index that will be used for skilled nursing facilities and home health agencies.

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.”*

Therefore, for FFY 2007, CMS is proposing to 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 proposed a slight decrease to the labor-related share from 75.865% in FFY 2006 to 75.720%.

Hold-Harmless Policy for IRFs Redesignated from Rural to Urban

Refer to “Proposed FY 2007 Federal Prospective Payment Rates” if you submit a comment on this issue.
(*Federal Register* pages 28125 - 28126)

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 has 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

Refer to “Proposed FY 2007 Federal Prospective Payment Rates” if you submit a comment on this issue.
(*Federal Register* page 28127)

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

Rural Location Adjustment

Refer to “Proposed FY 2007 Federal Prospective Payment Rates” if you submit a comment on this issue.
(*Federal Register* page 28127)

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

Teaching Status Adjustment

Refer to “Proposed FY 2007 Federal Prospective Payment Rates” if you submit a comment on this issue.
(*Federal Register* page 28127)

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 Proposal: CMS has 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

Refer to “High-Cost Outliers Under the IRF PPS” if you submit a comment on this issue.
(*Federal Register* pages 28133 - 28134)

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 will continue to hold individual facilities’ cost-to-charge ratios (CCRs) to a ceiling; the ceiling for FFY 2007 is 1.57, 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 0.488 and 0.613, respectively.

Transfers

Refer to “Background” if you submit a comment on this issue.
(*Federal Register* pages 28107 - 28110)

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 Proposal: CMS has proposed no changes to this policy.

Interrupted Stays

Refer to “Background” if you submit a comment on this issue.
(*Federal Register* pages 28107 - 28110)

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 Proposal: CMS has proposed no changes to this policy.

Attachment I
Inpatient Rehabilitation Facility Prospective Payment System
Current Versus Proposed Federal Fiscal Year (FFY) 2007 Case-Mix Group (CMG) Relative Weights

CMG	CMG Description (M=motor, C=cognitive, A=age)	FFY 2006 - Final Rule CMGs								FFY 2007 - Proposed Rule CMGs							
		Relative Weights				Average Length of Stay				Relative Weights				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
0101	Stroke M>51.05	0.7691	0.7299	0.6484	0.6350	8	11	9	9	0.7707	0.7303	0.6572	0.6347	8	11	9	9
0102	Stroke M>44.45 and M<51.05 and C>18.5	0.9471	0.8989	0.7985	0.7820	11	15	11	10	0.9493	0.8995	0.8095	0.7818	11	15	11	10
0103	Stroke M>44.45 and M<51.05 and C<18.5	1.1162	1.0594	0.9411	0.9217	14	13	12	12	1.1192	1.0605	0.9544	0.9218	14	13	12	12
0104	Stroke M>38.85 and M<44.45	1.1859	1.1255	0.9999	0.9792	13	14	13	13	1.1885	1.1260	1.0134	0.9787	13	14	13	13
0105	Stroke M>34.25 and M<38.85	1.4233	1.3509	1.2001	1.1753	16	17	15	15	1.4261	1.3512	1.2161	1.1745	16	17	16	15
0106	Stroke M>30.05 and M<34.25	1.6567	1.5724	1.3969	1.3680	18	20	18	18	1.6594	1.5722	1.4150	1.3666	18	20	18	18
0107	Stroke M>26.15 and M<30.05	1.9121	1.8148	1.6122	1.5790	21	23	20	21	1.9150	1.8145	1.6330	1.5771	21	23	21	20
0108	Stroke M<26.15 and A>84.5	2.2106	2.0981	1.8639	1.8254	27	29	24	24	2.2160	2.0997	1.8897	1.8250	28	29	25	24
0109	Stroke M>22.35 and M<26.15 and A<84.5	2.1976	2.0858	1.8529	1.8147	23	26	24	23	2.1998	2.0843	1.8758	1.8116	23	26	24	23
0110	Stroke M<22.35 and A<84.5	2.6262	2.4926	2.2143	2.1686	30	33	28	28	2.6287	2.4907	2.2416	2.1649	30	33	28	27
0201	Traumatic brain injury M>53.35 and C>23.5	0.8140	0.6826	0.6021	0.5648	10	9	9	8	0.8143	0.6806	0.6080	0.5647	10	9	9	8
0202	Traumatic brain injury M>44.25 and M<53.35 and C>23.5	1.0437	0.8753	0.7720	0.7241	12	10	11	9	1.0460	0.8743	0.7810	0.7254	12	10	11	9
0203	Traumatic brain injury M>44.25 and C<23.5	1.2487	1.0472	0.9236	0.8664	15	15	12	12	1.2503	1.0450	0.9335	0.8671	15	15	12	12
0204	Traumatic brain injury M>40.65 and M<44.25	1.3356	1.1201	0.9879	0.9267	15	16	13	13	1.3390	1.1192	0.9998	0.9287	15	16	13	13
0205	Traumatic brain injury M>28.75 and M<40.65	1.6381	1.3738	1.2116	1.1365	17	18	16	15	1.6412	1.3718	1.2254	1.1382	17	18	16	15
0206	Traumatic brain injury M>22.05 and M<28.75	2.1379	1.7930	1.5814	1.4833	23	22	21	20	2.1445	1.7924	1.6011	1.4873	23	22	21	20
0207	Traumatic brain injury M<22.05	2.7657	2.3194	2.0457	1.9188	35	29	26	25	2.7664	2.3122	2.0655	1.9185	35	29	26	25
0301	Non-traumatic brain injury M>41.05	1.1293	0.9536	0.8440	0.7764	12	12	11	10	1.1394	0.9533	0.8552	0.7772	12	12	11	10
0302	Non-traumatic brain injury M>35.05 and M<41.05	1.4729	1.2438	1.1008	1.0126	14	16	14	13	1.4875	1.2446	1.1164	1.0147	14	16	14	13
0303	Non-traumatic brain injury M>26.15 and M<35.05	1.7575	1.4841	1.3136	1.2083	20	19	17	16	1.7701	1.4810	1.3285	1.2074	20	19	17	16
0304	Non-traumatic brain injury M<26.15	2.4221	2.0453	1.8103	1.6651	31	25	23	21	2.4395	2.0410	1.8309	1.6640	32	25	23	21
0401	Traumatic spinal cord injury M>48.45	0.9891	0.8517	0.7656	0.6837	12	12	10	10	0.9587	0.8456	0.7722	0.6858	12	12	11	10
0402	Traumatic spinal cord injury M>30.35 and M<48.45	1.3640	1.1746	1.0558	0.9428	19	16	14	12	1.3256	1.1691	1.0676	0.9482	18	16	14	13
0403	Traumatic spinal cord injury M>16.05 and M<30.35	2.3743	2.0446	1.8379	1.6412	22	24	23	22	2.3069	2.0347	1.8580	1.6502	22	24	24	22
0404	Traumatic spinal cord injury M<16.05 and A>63.5	4.2567	3.6656	3.2950	2.9424	51	46	39	37	4.1542	3.6639	3.3458	2.9717	51	46	41	37
0405	Traumatic spinal cord injury M<16.05 and A<63.5	3.2477	2.7967	2.5139	2.2449	32	38	33	28	3.1371	2.7668	2.5266	2.2441	33	37	33	28
0501	Non-traumatic spinal cord injury M>51.35	0.7705	0.6449	0.5641	0.5059	9	8	8	7	0.7648	0.6455	0.5687	0.5071	9	8	8	7
0502	Non-traumatic spinal cord injury M>40.15 and M<51.35	1.0316	0.8634	0.7553	0.6774	13	12	10	9	1.0262	0.8661	0.7630	0.6804	13	12	11	9
0503	Non-traumatic spinal cord injury M>31.25 and M<40.15	1.3676	1.1446	1.0013	0.8979	15	15	13	12	1.3596	1.1476	1.0109	0.9014	15	15	13	12
0504	Non-traumatic spinal cord injury M>29.25 and M<31.25	1.7120	1.4328	1.2534	1.1240	20	19	16	15	1.6984	1.4335	1.2628	1.1260	21	19	16	15
0505	Non-traumatic spinal cord injury M>23.75 and M<29.25	2.0289	1.6981	1.4855	1.3321	23	22	19	18	2.0171	1.7025	1.4997	1.3373	23	22	19	18
0506	Non-traumatic spinal cord injury M<23.75	2.7607	2.3106	2.0212	1.8126	29	28	25	23	2.7402	2.3128	2.0374	1.8167	29	28	26	23
0601	Neurological M>47.75	0.8965	0.7331	0.6966	0.6493	11	10	9	9	0.8991	0.7330	0.7019	0.6522	11	10	9	9
0602	Neurological M>37.35 and M<47.75	1.1925	0.9752	0.9267	0.8636	13	13	12	12	1.1968	0.9757	0.9342	0.8682	13	13	13	12

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Current Versus Proposed Federal Fiscal Year (FFY) 2007 Case-Mix Group (CMG) Relative Weights

CMG	CMG Description (M=motor, C=cognitive, A=age)	FFY 2006 - Final Rule CMGs								FFY 2007 - Proposed Rule CMGs							
		Relative Weights				Average Length of Stay				Relative Weights				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
0603	Neurological M>25.85 and M<37.35	1.5266	1.2484	1.1863	1.1056	16	17	15	15	1.5326	1.2495	1.1965	1.1118	17	17	15	15
0604	Neurological M<25.85	1.9539	1.5979	1.5183	1.4151	22	20	20	19	1.9592	1.5973	1.5295	1.4213	22	20	21	19
0701	Fracture of lower extremity M>42.15	0.9055	0.7736	0.7265	0.6585	12	11	10	9	0.9028	0.7717	0.7338	0.6617	12	11	10	9
0702	Fracture of lower extremity M>34.15 and M<42.15	1.1757	1.0044	0.9432	0.8549	13	14	13	12	1.1736	1.0033	0.9539	0.8602	13	14	13	12
0703	Fracture of lower extremity M>28.15 and M<34.15	1.4636	1.2504	1.1742	1.0643	16	17	15	14	1.4629	1.2506	1.1890	1.0722	16	17	16	14
0704	Fracture of lower extremity M<28.15	1.7962	1.5345	1.4410	1.3062	20	20	19	18	1.7969	1.5361	1.4605	1.3170	20	20	19	18
0801	Replacement of lower extremity joint M>49.55	0.6561	0.5511	0.5109	0.4596	7	7	7	6	0.6537	0.5504	0.5131	0.4607	7	7	7	6
0802	Replacement of lower extremity joint M>37.05 and M<49.55	0.8570	0.7198	0.6673	0.6004	10	10	9	8	0.8542	0.7193	0.6704	0.6020	10	10	9	8
0803	Replacement of lower extremity joint M>28.65 and M<37.05 and A>83.5	1.2707	1.0672	0.9894	0.8901	15	15	13	12	1.2707	1.0700	0.9974	0.8956	15	15	13	12
0804	Replacement of lower extremity joint M>28.65 and M<37.05 and A<83.5	1.1069	0.9296	0.8618	0.7754	13	12	11	10	1.1040	0.9296	0.8665	0.7781	13	12	12	10
0805	Replacement of lower extremity joint M>22.05 and M<28.65	1.3937	1.1705	1.0852	0.9763	17	16	14	13	1.3927	1.1727	1.0931	0.9816	17	16	14	13
0806	Replacement of lower extremity joint M<22.05	1.6726	1.4047	1.3023	1.1716	18	19	17	15	1.6723	1.4082	1.3126	1.1787	18	19	17	15
0901	Other orthopedic M>44.75	0.8412	0.7658	0.6805	0.6090	10	11	10	9	0.8425	0.7641	0.6868	0.6120	10	11	10	9
0902	Other orthopedic M>34.35 and M<44.75	1.1054	1.0063	0.8942	0.8002	13	13	12	11	1.1088	1.0057	0.9039	0.8056	13	13	12	11
0903	Other orthopedic M>24.15 and M<34.35	1.4583	1.3276	1.1797	1.0557	18	19	16	15	1.4638	1.3277	1.1934	1.0635	18	19	16	15
0904	Other orthopedic M<24.15	1.8281	1.6643	1.4788	1.3234	25	23	20	19	1.8341	1.6636	1.4952	1.3325	25	23	21	19
1001	Amputation, lower extremity M>47.65	0.9638	0.8888	0.7931	0.7312	11	11	11	10	0.9625	0.8879	0.7957	0.7361	11	11	11	10
1002	Amputation, lower extremity M>36.25 and M<47.65	1.2709	1.1719	1.0457	0.9641	14	15	14	13	1.2709	1.1724	1.0507	0.9719	14	15	14	13
1003	Amputation, lower extremity M<36.25	1.7876	1.6483	1.4709	1.3561	19	22	19	18	1.7876	1.6491	1.4779	1.3671	19	22	19	18
1101	Amputation, non-lower extremity M>36.35	1.2544	1.0496	0.9189	0.8462	14	15	12	11	1.2554	1.0482	0.9225	0.8496	14	15	12	11
1102	Amputation, non-lower extremity M<36.35	1.8780	1.5713	1.3756	1.2668	19	19	18	17	1.8824	1.5717	1.3832	1.2739	19	19	18	17
1201	Osteoarthritis M>37.65	1.0184	0.8794	0.8106	0.7317	11	12	11	10	1.0177	0.8785	0.8182	0.7405	11	12	11	10
1202	Osteoarthritis M>30.75 and M<37.65	1.3181	1.1383	1.0492	0.9470	15	16	14	13	1.3168	1.1367	1.0586	0.9581	15	16	14	13
1203	Osteoarthritis M<30.75	1.6238	1.4022	1.2925	1.1666	21	19	17	16	1.6241	1.4020	1.3057	1.1817	21	19	17	16
1301	Rheumatoid, other arthritis M>36.35	1.0338	0.9617	0.8325	0.7358	12	13	11	10	1.0354	0.9636	0.8511	0.7429	12	13	11	10
1302	Rheumatoid, other arthritis M>26.15 and M<36.35	1.4324	1.3325	1.1534	1.0195	15	18	15	14	1.4321	1.3327	1.1772	1.0275	15	18	15	14
1303	Rheumatoid, other arthritis M<26.15	1.8308	1.7032	1.4743	1.3032	22	21	20	18	1.8250	1.6984	1.5002	1.3094	22	21	20	18
1401	Cardiac M>48.85	0.8172	0.7352	0.6396	0.5806	10	9	9	8	0.8160	0.7351	0.6534	0.5861	10	9	9	8
1402	Cardiac M>38.55 and M<48.85	1.1034	0.9926	0.8636	0.7839	12	13	12	11	1.1038	0.9944	0.8839	0.7928	12	13	12	11
1403	Cardiac M>31.15 and M<38.55	1.3735	1.2356	1.0750	0.9759	16	16	14	13	1.3705	1.2347	1.0975	0.9844	16	16	14	13
1404	Cardiac M<31.15	1.7419	1.5671	1.3633	1.2376	21	20	18	16	1.7370	1.5649	1.3910	1.2477	21	20	18	16
1501	Pulmonary M>49.25	0.9222	0.8995	0.7687	0.7397	11	12	10	10	0.9986	0.8870	0.7793	0.7399	11	13	10	10
1502	Pulmonary M>39.05 and M<49.25	1.1659	1.1371	0.9718	0.9352	12	15	12	12	1.2661	1.1246	0.9880	0.9381	13	15	12	12
1503	Pulmonary M>29.15 and M<39.05	1.4269	1.3917	1.1894	1.1445	12	17	15	15	1.5457	1.3730	1.2062	1.1453	16	16	15	15

Attachment I
Inpatient Rehabilitation Facility Prospective Payment System
Current Versus Proposed Federal Fiscal Year (FFY) 2007 Case-Mix Group (CMG) Relative Weights

CMG	CMG Description (M=motor, C=cognitive, A=age)	FFY 2006 - Final Rule CMGs								FFY 2007 - Proposed Rule CMGs							
		Relative Weights				Average Length of Stay				Relative Weights				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
1504	Pulmonary M<29.15	1.8812	1.8348	1.5681	1.5089	21	22	20	18	2.0216	1.7957	1.5775	1.4979	26	21	20	18
1601	Pain syndrome M>37.15	1.0065	0.8544	0.7731	0.6904	12	11	10	9	1.0070	0.8550	0.7774	0.6957	12	11	10	10
1602	Pain syndrome M>26.75 and M<37.15	1.3810	1.1724	1.0607	0.9473	15	17	14	13	1.3826	1.1739	1.0673	0.9552	15	17	14	13
1603	Pain syndrome M<26.75	1.6988	1.4421	1.3048	1.1653	19	19	17	16	1.7025	1.4455	1.3143	1.1762	19	19	18	16
1701	Major multiple trauma without brain or spinal cord injury M>39.25	1.0102	0.9634	0.8323	0.7321	12	12	11	10	0.9818	0.9641	0.8479	0.7368	12	12	11	10
1702	Major multiple trauma without brain or spinal cord injury M>31.05 and M<39.25	1.3305	1.2688	1.0962	0.9643	14	16	15	13	1.2921	1.2688	1.1158	0.9696	14	16	15	13
1703	Major multiple trauma without brain or spinal cord injury M>25.55 and M<31.05	1.5832	1.5098	1.3043	1.1474	17	20	17	16	1.5356	1.5080	1.3262	1.1524	17	20	18	16
1704	Major multiple trauma without brain or spinal cord injury M<25.55	1.9808	1.8889	1.6319	1.4355	26	26	21	20	1.9246	1.8899	1.6620	1.4443	26	26	22	19
1801	Major multiple trauma with brain or spinal cord injury M>40.85	1.2118	0.9832	0.8245	0.7282	15	13	12	10	1.1920	0.9866	0.8243	0.7342	15	13	13	10
1802	Major multiple trauma with brain or spinal cord injury M>23.05 and M<40.85	1.9385	1.5728	1.3190	1.1649	20	21	18	16	1.9058	1.5774	1.3179	1.1738	19	21	18	16
1803	Major multiple trauma with brain or spinal cord injury M<23.05	3.4784	2.8222	2.3668	2.0903	43	33	30	27	3.4302	2.8391	2.3721	2.1127	43	33	30	27
1901	Guillian Barre M>35.95	1.2362	1.0981	1.0677	0.9349	14	13	14	12	1.2399	1.0986	1.0965	0.9350	14	13	14	12
1902	Guillian Barre M>18.05 and M<35.95	2.3162	2.0574	2.0004	1.7515	27	25	24	23	2.3194	2.0552	2.0512	1.7491	27	25	25	23
1903	Guillian Barre M<18.05	3.3439	2.9703	2.8881	2.5287	37	39	31	33	3.3464	2.9651	2.9593	2.5235	37	39	31	33
2001	Miscellaneous M>49.15	0.8743	0.7387	0.6623	0.6047	10	10	9	8	0.8734	0.7381	0.6735	0.6084	10	10	9	8
2002	Miscellaneous M>38.75 and M<49.15	1.1448	0.9672	0.8671	0.7917	12	13	11	11	1.1447	0.9674	0.8827	0.7975	12	13	12	11
2003	Miscellaneous M>27.85 and M<38.75	1.4789	1.2495	1.1202	1.0227	16	16	15	14	1.4777	1.2488	1.1395	1.0294	16	16	15	14
2004	Miscellaneous M<27.85	1.9756	1.6692	1.4964	1.3663	25	22	20	18	1.9716	1.6662	1.5204	1.3735	25	22	20	18
2101	Burns M>0	2.1858	2.1858	1.5910	1.4762	29	24	19	17	2.1842	2.1842	1.6606	1.4587	27	24	20	17
5001	Short-stay cases, length of stay is 3 days or fewer				0.2201				2	0.0000	0.0000	0.0000	0.2201	0	0	0	2
5101	Expired, orthopedic, length of stay is 13 days or fewer				0.6351				8	0.0000	0.0000	0.0000	0.6351	0	0	0	8
5102	Expired, orthopedic, length of stay is 14 days or more				1.6002				22	0.0000	0.0000	0.0000	1.5985	0	0	0	22
5103	Expired, not orthopedic, length of stay is 15 days or fewer				0.7204				8	0.0000	0.0000	0.0000	0.7203	0	0	0	8
5104	Expired, not orthopedic, length of stay is 16 days or more				1.8771				24	0.0000	0.0000	0.0000	1.8784	0	0	0	24

Notes:

Final FFY 2006 CMGs are from the August 15, *Federal Register*

Proposed FFY 2007 CMGs are from the May 15, *Federal Register*