



**SUMMARY OF THE FINAL FFY  
2008 MEDICARE INPATIENT  
REHABILITATION FACILITY  
RULE**

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**August 2007**

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## 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) 2008 in the August 7, 2007 *Federal Register*. Changes are effective October 1, 2007, unless otherwise noted.

Note: Text in italics is extracted from the May 8 and the August 7, 2007 *Federal Registers*.

## II. STANDARD PAYMENT CONVERSION FACTOR

### Marketbasket Update for FFY 2008

*Federal Register* pages 44297 - 44298

**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 rebased the RPL marketbasket to reflect 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 2008 IRF market basket increase factor and labor-related share. For this proposed rule, the FY 2008 IRF market basket increase factor is 3.3 percent. This is based on Global Insight, Inc. for the first quarter of 2007 (2007q1) with historical data through the fourth quarter of 2006 (2006q4). 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 2008 IRF market basket increase factor is 3.2 percent. This is based on Global Insight, Inc.’s (GII) forecast of price proxies for the second quarter of 2007 (2007Q2) with historical data through the first quarter of 2007 (2007Q1).”*

Even though CMS in the final rule provides a full marketbasket increase of 3.2% in FFY 2008, The Children’s Health and Medicare Protection Act (CHAMP Act) of 2007, which was passed by the U.S. House of Representatives, would reduce the IRF marketbasket update to 1.0% for the period January 1, 2008 through September 30, 2008.

It is uncertain whether this proposal will be included in any final legislative package that passes both chambers and is signed by the President.

Based on the relative weights from the RPL marketbasket, CMS will provide a slight increase to the labor-related share, from 75.720% in FFY 2007 to 75.818% in FFY 2008.

### Behavioral Offset

*Federal Register* pages 44285 - 44286

**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 FFY 2007, after further analysis was performed on changes in coding behavior, an additional reduction of 2.6% was applied to the standard payment conversion factor.

**CMS Final Rule:** For FFY 2008, CMS has determined that a behavioral offset to the standard payment conversion factor is not needed.

## **Calculation of the FFY 2008 Final Standard Conversion Factor**

*Federal Register* pages 44300 - 44301

Final FFY 2007 Standard Payment Conversion Factor:	\$12,981
Final FFY 2008 Adjustments:	
- RPL Marketbasket:	3.2%
- Budget-Neutrality Factors:	
- Wage Index and Labor-Related Share:	1.0028
- Expiration of Rural Hold-Harmless Policy:	1.0013
Final FFY 2008 Standard Payment Conversion Factor:	\$13,451

Although the final rule provides a full marketbasket update of 3.2%, upward budget neutrality adjustments will cause the actual standard payment conversion factor for IRFs to increase by approximately 3.6% from FFY 2007 to FFY 2008.

## **III. PATIENT CLASSIFICATION SYSTEM**

### **IRF Patient Classification System**

*Federal Register* pages 44292 - 44297

**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, or age factor and cognitive ability. 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.

In FFY 2007, CMS further refined the patient classification system, changing the existing list of tier comorbidities and changing the CMG relative weights and average lengths of stay (LOS). For more details regarding these changes, refer to the FFY 2007 IRF PPS final rule.

**CMS Proposal:** “For the FY 2008 IRF PPS, we will use the same case-mix classification system that we used for FY 2007. . .”

**CMS Final Rule:** For FFY 2008, CMS will continue to use the case-mix classification system used in the FFY 2007 final rule. A complete listing of the final comorbidity tiers, relative weights, and average length of stay for each CMG is available on the *Federal Register* pages referenced above.

## IV. 75% RULE

*Federal Register* pages 44287 - 44292

**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.”

Before FFY 2005, the 75% rule applied to ten medical conditions. However, in FFY 2005, CMS revised the 75% rule, increasing the number of medical conditions to 13, as well as temporarily lowering the compliance threshold, creating a transition period to the full compliance threshold of 75%. In addition, CMS temporarily allowed patients with certain comorbid conditions to be included in the inpatient population that counts toward the required compliance threshold if certain requirements are met.

During 2006, CMS implemented a provision of the Deficit Reduction Act of 2005 that revised the 75% rule compliance thresholds. The provision essentially extended the 60% compliance threshold for an additional 12 months, requiring an IRF with a cost reporting period starting on or after July 1, 2008 (instead of July 1, 2007) to meet the full compliance threshold of 75%. CMS also permitted an extension of cases with certain comorbidities to be used in determining the compliance threshold for this same time period. *“For cost reporting periods beginning on or after July 1, 2008, comorbidities will not be eligible for inclusion in the calculations used to determine if the provider meets the 75 percent compliance threshold . . .”*

The following tables detail the compliance thresholds and compliance determination dates for hospitals with cost report periods beginning in January or July (the most common for New York State).

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, 2007	September 2006 - August 2007	12	60%	January 1, 2008
January 1, 2008	September 2007 - December 2007	4	60%	January 1, 2009
	January 2008 - August 2008	8	65%	
January 1, 2009	September 2008 - December 2008	4	65%	January 1, 2010
	January 2009 - August 2009	8	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, 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%	
July 1, 2009	March 2009 - February 2010	12	75%	July 1, 2010

Additional information regarding the 75% rule, including compliance thresholds and compliance determinations, is available on the CMS Web site at <http://www.cms.hhs.gov/transmittals/downloads/R1135CP.pdf>.

**CMS Proposal:** *“As the 75 percent rule is only partially phased in at this time and there are limitations to the policy conclusions that can be drawn from currently available claim and patient assessment data, this rule maintains existing policy.”*

**CMS Final Rule:** *“After carefully considering the comments, we are maintaining the comorbidity policy specified in §412.23(b)(2). Therefore, for cost reporting periods beginning on or after July 1, 2007, and before July 1, 2008, the compliance threshold remains 65 percent and we will continue to include comorbidities when calculating the compliance percentage. However, for cost reporting periods beginning on or after July 1, 2008, the compliance threshold will increase to 75 percent, but the comorbidities will not be used to determine whether a provider met the 75 percent the compliance threshold.”*

The IRF PPS final rule has been published at the same time Congress is debating legislative proposals related to IRF payments. The Children’s Health and Medicare Protection Act (CHAMP Act) of 2007, which was passed by the U.S. House of Representatives, would establish a permanent compliance threshold at 60% and continue the use of comorbidities in the “75 percent rule” test.

In addition, The CHAMP Act of 2007, would also reduce payment rates to IRFs for treating patients for unilateral hip replacement, unilateral hip fracture, and unilateral knee replacements.

It is uncertain whether these proposals will be included in any final legislative package that passes both chambers and is signed by the President.

## V. FACILITY-LEVEL ADJUSTMENTS

### Wage Index

*Federal Register* pages 44298 - 44300

**Background:** The labor-related portion of the standard payment conversion factor 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 is 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 values calculated under the Metropolitan Statistical Areas (MSAs) and 50% of the wage index values

calculated under the CBSAs for all IRFs regardless of whether the new area definitions were beneficial or detrimental.

In FFY 2007, CMS based the wage index solely on the CBSA labor-market definitions, eliminating the transitional blend provided in FFY 2006.

**CMS Proposal:** *“For FY 2008, we propose to maintain the policies and methodologies described in the FY 2007 IRF PPS final rule relating to the labor market area definitions, the wage index methodology for areas with wage data, and hold harmless policy consistent with the rationale outlined in the FY 2006 IRF PPS final rule. . . . Therefore, this proposed rule continues to use the Core-Based Statistical Area (CBSA) labor market area definitions and the prereclassification and pre-floor hospital wage index based on 2003 cost report data.”*

**CMS Final Rule:** For FFY 2008, CMS has adopted the above proposal with no modifications.

## **Hold-Harmless Policy for IRFs Redesignated from Rural to Urban**

*Federal Register* pages 44298 - 44300

**Background:** Under the CBSA-defined labor-market areas implemented in FFY 2006, IRFs that were designated rural under the MSA-defined labor market areas may now be designated urban under the CBSA-defined labor market areas. Due to the redesignations, IRFs that moved from a rural to urban status were no longer eligible for the 21.3% rural adjustment, which would cause financial hardship to their overall reimbursement under the IRF PPS. Therefore, in FFY 2006, CMS implemented a three-year transition for those IRFs that will be harmed by this redesignation, adjusting those facilities’ payments with two-thirds of the 2005 rural adjustment factor in FFY 2006 and with one-third of the 2005 rural adjustment factor in FFY 2007. Since the hold-harmless policy is budget-neutral, CMS would reduce the adjustment if it resulted in payments that would be higher than they would have been under the old, MSA-defined wage indexes.

**CMS Proposal:** *“For FY 2008, the third and final year of the 3-year phase-out of the budget-neutral hold harmless policy, we will no longer apply an adjustment for IRFs that meet the criteria described in the FY 2006 final rule. . . . In addition, the budget neutral hold harmless policy established in the FY 2006 final rule will expire for discharges occurring on or after October 1, 2007.”*

**CMS Final Rule:** For FFY 2008, CMS has adopted the above proposal with no modifications.

## **Geographic Areas with No Hospitals**

*Federal Register* pages 44298 - 44300

**Background:** When adopting the Office of Management and Budget’s (OMB) new labor market designations, CMS identified some geographic areas where there were no hospitals, and thus, no hospital wage index data on which to base the calculation of the IRF PPS wage index.

**CMS Proposal:** *“. . . in cases where there is a rural area without rural hospital wage data, we propose using the average wage index from all contiguous CBSAs to represent a reasonable proxy for the rural area within a State. . . . In determining an imputed rural wage index, we interpret the term “contiguous” to mean sharing a border.”*

**CMS Final Rule:** For FFY 2008, CMS has adopted the above proposal with no modifications.

## Low-Income Patient Adjustment

*Federal Register* pages 44302 - 44303

**Background:** Currently, IRFs receive an adjustment to their standard payment conversion factor 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 + DSH patient percentage) raised to the power of 0.6229 where the DSH patient percentage is defined as:

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

**CMS Final Rule:** For FFY 2008, CMS will continue to calculate the LIP adjustment using the exponential factor of 0.6229.

## Rural Location Adjustment

*Federal Register* pages 44302 - 44303

**Background:** Currently, IRFs receive an adjustment to their standard payment conversion factor to account for the cost differences associated with the treatment of patients in rural areas. Based on an 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:** For FFY 2008, CMS will continue to apply the 21.3% rural adjustment to designated rural IRFs.

## Teaching Status Adjustment

No *Federal Register* pages were identified for this topic.

**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:

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

**CMS Final Rule:** For FFY 2008, CMS 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* page 44303

**Background:** Outlier payments are made for any IRF 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).

CMS has established an outlier threshold amount for the IRF PPS so that estimated outlier payments equal 3.0% of total estimated IRF PPS payments. For FFY 2007, CMS based its estimated outlier threshold of \$5,534 on FY 2004 claims data and IRF-PAI data.

**CMS Proposal:** “. . . we propose to update the outlier threshold amount to \$7,522 to decrease estimated outlier payments from approximately 3.8 to 3 percent of total estimated aggregate IRF payments for FY 2008. The outlier threshold amount for FY 2008 is subject to change in the final rule based on analysis of updated data.”

**CMS Final Rule:** “Based on the updated analysis using FY 2006 data. . . we are updating the outlier threshold amount to \$7,362 to decrease estimated outlier payments from approximately 3.7 to 3 percent of total estimated aggregate IRF payments for FY 2008.”

Using FY 2006 claims and IRF-PAI data, CMS' current analysis indicates that in FFY 2007 CMS paid out an estimated 3.7% in outlier payments. Therefore, in order to maintain outlier payments in FFY 2008 at a level of 3.0%, CMS has updated the outlier threshold to \$7,362.

In addition, based on rules from the FFY 2004 final rule, IRF outlier payments are subject to retroactive reconciliation. To this point, CMS has not begun reconciling outlier payments. However, in the final rule, CMS indicated their intent to soon begin retroactively reconciling IRF outlier payments.

### IRF Cost-to-Charge Ratio Ceilings

*Federal Register* page 44303

**Background:** CMS has established national cost-to-charge ratio (CCR) ceilings for urban and rural IRFs to ensure that outlier payments are equitably distributed and continue to reduce incentives for IRFs to underserve patients who require more costly care.

CMS applies the national urban and rural CCRs in the following situations:

- new IRFs that have not yet submitted their first Medicare cost report;
- IRFs whose overall CCR is in excess of three standard deviations above the corresponding national geometric mean, which they proposed to set at 1.55 (based on the current estimate) for FY 2008; and

- other IRFs for whom accurate data with which to calculate an overall CCR are not available.

**CMS Proposal:** “Specifically, for FY 2008, we estimate a proposed national CCR of 0.589 for rural IRFs and 0.475 for urban IRFs.”

**CMS Final Rule:** “. . . for FY 2008, we estimate a national CCR of 0.596 for rural IRFs and 0.476 for urban IRFs.”

Additionally, the estimate of three standard deviations above the national geometric mean is now finalized at 1.56.

## **Transfers**

*Federal Register* pages 44305 - 44306

**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 proposed no changes to this policy. However, CMS did make a clarification to the transfer policy by proposing changes to regulation text clarifying that outlier payments are provided to both transfer cases and full CMG cases when applicable.

**CMS Final Rule:** For FFY 2008, CMS has adopted the above proposal.

## **Interrupted Stays**

No *Federal Register* pages were identified for this topic.

**Background:** An interrupted stay is defined as one in which the beneficiary is discharged, and 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:** For FFY 2008, CMS will maintain its current practices with no modifications.