



**SUMMARY OF THE PROPOSED
FFY 2009 MEDICARE
INPATIENT REHABILITATION
FACILITY RULE**

May 2008

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) 2009. 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 June 20. CMS requests that comments reference the file code CMS-1554-P.

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-1554-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-1554-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-8012

-OR-

Hand-deliver to (an original and two copies):
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
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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) 2009 in the April 25, 2008 *Federal Register*. Changes are effective October 1, 2008, unless otherwise noted.

Note: Text in italics is extracted from the April 25, 2008 *Federal Register*.

Major provisions of the proposed rule include:

- **Marketbasket Update:** A zero percent marketbasket update will be applied for FFY 2009.
- **Standard Amount Conversion Factor:** The standard amount conversion factor will decrease from \$13,034 in FFY 2008 to \$12,999 in FFY 2009.
- **Outlier Threshold:** The outlier threshold would increase from \$7,522 in FFY 2008 to \$9,191 in FFY 2009.
- **Compliance Threshold:** For FFY 2009 the compliance threshold will be 60 percent and will include consideration of patient comorbidities as qualifying conditions.
- **Patient Classification System:** CMS is proposing to update the Case-Mix Group (CMG) weights using FFY 2006 claims data. In addition, CMS is proposing to update the CMG relative weights and ALOS methodology by using more detailed cost-to-charge (CCR) ratios from IRF sub-provider units of primary acute care hospitals, rather than the associated primary acute care hospital. This proposed change to the methodology would not affect freestanding IRF's.

II. LEGISLATIVE MANDATES

This proposed rule implements a series of payment policy that are mandated in the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA). Most important, the MMSEA rolled back the phase-in of the "75 percent rule" compliance threshold, which would have required that at least 75 percent of admissions to an IRF be diagnosed with one of 13 specified conditions. Prior to passage of the MMSEA, CMS was in the process of reinstating the IRF compliance threshold. The MMSEA lowers the threshold to 60 percent and allows for comorbid conditions to count toward that threshold.

The proposed FFY 2009 IRF PPS rule includes the following MMSEA-based provisions:

- a zero percent marketbasket update beginning April 1, 2008 through September 30, 2009;
- a 60 percent compliance threshold (60 percent of patients must need treatment for specified conditions) for cost reporting periods beginning on or after July 1, 2006; and
- inclusion of patient comorbidities as qualifying conditions toward the compliance threshold for cost reporting periods beginning on or after July 1, 2007.

III. STANDARD PAYMENT CONVERSION FACTOR

Marketbasket Update for FFY 2009

Federal Register pages 22680-22681

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.

Section 115 of MMSEA requires CMS to apply a zero percent marketbasket update factor for IRF PPS in FFY 2008 (beginning with discharges occurring on or after April 1, 2008) and FFY 2009. After application of budget neutrality factors, the final standard payment conversion factor for the April 1, 2008 through September 30, 2008 portion of FFY 2008 is \$13,034.

CMS Proposals: Per the legislative mandate for FFY 2009, CMS is “...applying an increase factor of zero percent to update the proposed IRF Federal prospective payment rates for FY 2009 in this proposed rule.”

Based on the relative weights from the RPL marketbasket, CMS proposes a decrease to the labor-related share, from 75.818 percent in FFY 2008 to 75.691 percent in FFY 2009.

Calculation of the FFY 2009 Standard Conversion Factor

Federal Register pages 22683-22685

Final FFY 2008 Standard Payment Conversion Factor (effective for discharges after April 1, 2008)	\$13,034
Proposed FFY 2009 Adjustments:	
- RPL Marketbasket	1.0000
- Budget-Neutrality Factors	
- Wage Index and Labor-Related Share	1.0004
- Revisions to the CMG Relative Weights	0.9969
Proposed FFY 2009 Standard Payment Conversion Factor:	\$12,999

The decrease in the standard payment conversion factor of 0.3% from FFY 2008 to FFY 2009 is due to the budget neutrality adjustments.

IV. PATIENT CLASSIFICATION SYSTEM

IRF Patient Classification System

Federal Register pages 22676 - 22680

Background: Before FFY 2006, IRF PPS payments were based on 100 distinct case-mix groups (CMGs). Patients were first categorized into one of 21 Rehabilitation Impairment Categories (RICs) based on the primary reason for rehabilitative care. From there, patients were further categorized into CMGs within the RICs based upon their ability to perform activities of daily living or based on age 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 were four tiers, each with a different relative weight, which was determined based on comorbidities.

In the FFY 2006 final rule, CMS adopted major revisions to the IRF PPS based on analyses by RAND using data provided 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.

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). As of FFY 2008, there were 87 CMGs with four tiers and another five CMGs to account for very short stays and patients who expire in the IRF. Currently, CMS calculates CMG weights and average lengths-of-stay using FFY 2003 claims data.

CMS Proposal: For FFY 2009, CMS is proposing to update the CMG weights and average lengths-of-stay using claims FFY 2006 data. In addition, CMS proposes a change in the calculation of CMG weights to use cost-to-charge ratios (CCRs) specific to the IRF sub-provider rather than using the CCRs from the whole primary care hospital.

According to CMS, *“When we analyzed the CMG relative weights for FY 2009, using both the primary acute care hospital CCRs and the IRF sub-provider unit CCRs, we found that the CCRs we used made very little difference in the CMG relative weights. Since the data needed to calculate the IRF subprovider units’ CCRs are now available in enough detail, and since conceptually it is more appropriate to use the cost report data from the IRF sub-provider units. . .we are proposing this change to the methodology.” “...we propose to continue using CCR data from the freestanding IRF’s (that is, the primary hospital’s) cost report.”*

V. 75 PERCENT RULE

Federal Register pages 22687-22689

Background: CMS uses the 75 percent rule to determine whether a hospital or unit of a hospital qualifies as an IRF. This criterion sets a minimum percentage of a facility’s total inpatient population that must be diagnosed with one of 13 medical conditions in order for the facility to be classified as an IRF. This minimum percentage is known as the “compliance threshold.”

Before FFY 2005, the 75 percent rule was applied to ten medical conditions. In FFY 2005, CMS revised the 75 percent rule, increasing the number of medical conditions to 13 as well as temporarily lowering the compliance threshold, creating a transition period for a full compliance threshold of 75 percent. At that time, CMS temporarily allowed patients with certain comorbid conditions to be included in the inpatient population that counted towards the required compliance threshold, if certain requirements are met.

During 2006, CMS implemented a provision of the Deficit Reduction Act of 2005 (DRA) that revised the 75 percent rule compliance thresholds. The provision essentially extended the 60 percent 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 percent. CMS also provided an extension for 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 as a qualifying condition towards the 75 percent compliance threshold.

However, recent legislation enacted under section 115 of the MMSEA revises the 75 percent rule requirements by; establishing a permanent compliance threshold no greater than 60 percent for cost reporting periods beginning July 1, 2006, with the continued use of comorbidities as qualifying conditions.

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

CMS Proposal: For FFY 2009, CMS believes that “... setting the compliance rate at 60 percent, the highest level possible within current statutory authority, will help to ensure that IRFs predominantly treat patients who benefit most from this level of care.”

VI. FACILITY-LEVEL ADJUSTMENTS

Wage Index

Federal Register pages 22681 - 22683

Background: The labor-related portion of the standard payment conversion factor is adjusted for differences in area wage levels using a wage index. The wage index for IRFs is calculated using 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.

CMS Proposal: For FFY 2009, CMS is proposing to continue the use of Core-Based Statistical Area labor market definitions based on the pre-reclassification and pre-rural floor hospital wage index data based on 2004 cost report data.

Low-Income Patient Adjustment

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

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 patients. The formula used to calculate the low-income patient 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 Proposal: For FFY 2009, 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

Federal Register pages 22681 - 22682

Background: Currently, rural 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 performed 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 percent to 21.3 percent.

CMS Clarification: There has been some confusion over the treatment of the two “New England deemed counties” still considered rural under CBSA definitions (Litchfield, CT and Merrimack, NH). These counties are no longer considered urban under the IPPS, effective for discharges occurring on or after October 1, 2007. However, the IPPS does treat hospitals in these counties as reclassified to their deemed urban area for

discharges on or after October 1, 2007. Since the IRF PPS does not recognize reclassifications, IRFs in these counties are NOT considered urban for IRF PPS and, therefore, should receive the rural payment add-on.

CMS Proposal: For FFY 2009, CMS has proposed no changes to this policy and 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 area.

Background: In FFY 2006, CMS adopted an adjustment to account for the 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 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:

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

An example of the calculation of the teaching adjustment is shown below. In this case, the IRF would receive a 16.31 percent 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 inpatient psychiatric facility (IPF) PPSs. 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.

CMS Proposal: For FFY 2009, CMS has proposed no changes to this policy and will continue to calculate the teaching adjustment using the exponential factor of .9012.

VII. CASE-LEVEL ADJUSTMENTS

Cost Outliers

Federal Register pages 22686 - 22687

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 establishes an outlier threshold amount for the IRF PPS so that estimated outlier payments equal 3 percent of total estimated IRF PPS payments. For FFY 2008, CMS based its outlier threshold of \$7,362 on

FFY 2006 claims data and IRF Patient Assessment Instrument (PAI) data, which would yield 3 percent of total IRF payments.

However, due to the marketbasket freeze for discharges after April 1, 2008, total FFY 2008 IRF payments are expected to be reduced from the amount originally projected. As a result, this will cause outlier payments to exceed 3 percent of total IRF payments for FFY 2008.

CMS Proposal: For FFY 2009, CMS is proposing to “... to update the outlier threshold amount to \$9,191 to maintain estimated outlier payments at 3 percent of total estimated aggregate IRF payments for FY 2009.”

“The outlier threshold amount for FY 2009 is subject to change in the final rule based on analysis of updated data.”

IRF Cost-to-Charge Ratio Ceilings

Federal Register page 22687

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 under-serve 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 was set at 1.56 for FY 2008; and
- other IRFs for whom accurate data with which to calculate an overall CCR are not available.

For FFY 2008, the national CCR average was 0.596 for rural IRFs and 0.476 for urban IRFs.

CMS Proposal: For FFY 2009, CMS has proposed a national CCR of 0.486 for urban IRFs and 0.616 for rural IRFs.

Transfers

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

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: FFY 2009, CMS has proposed no changes for the transfer methodology.

Interrupted Stays

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

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 Proposal: For FFY 2009, CMS has proposed no changes for the interrupted stay methodology.

VIII. Post Acute Care Payment Reform Demonstration (PAC PRD)

Federal Register pages 22688 - 22689

The DRA requires CMS to establish a demonstration program to look at how the same type of post-acute care is provided across different sites. The PAC PRD was developed to meet this requirement and will investigate differences in costs and outcomes for similar services provided in different settings. The Continuity Assessment Record and Evaluation (CARE) tool is a universal assessment tool under development. CMS is seeking comments on this tool, which is available for viewing/download at <http://www.cms.hhs.gov/paperworkreductionactof1995/pral/list.asp>.

CMS is also seeking comments on the applicability of Value-Based Purchasing strategies to post-acute care settings such as IRFs, SNFs, Home Health Agencies (HHAs), etc. Specifically, CMS seeks comments on the applicability of its present-on-admission rules for settings other than hospital acute inpatient.