



**WISCONSIN HOSPITAL  
ASSOCIATION**

**SUMMARY OF THE  
FFY 2011 MEDICARE  
INPATIENT REHABILITATION  
FACILITY  
FINAL RULE UPDATE NOTICE**

**August 2010**

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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) 2011 as an Update Notice in the July 22 *Federal Register*. Changes are effective October 1, 2010, unless otherwise noted.

**Note:** Text in italics is extracted from the July 22 *Federal Register*.

### Major Provisions of the Final Rule Update Notice

- **Marketbasket Update:** For FFY 2011, CMS will provide a marketbasket update factor of 2.25 percent which reflects a full marketbasket update of 2.5 percent reduced by 0.25 percentage points as mandated by the Affordable Care Act (ACA) of 2010.
- **Labor Share:** CMS decreased the labor-related portion of the IRF PPS rate from 75.779 percent for FFY 2010 to 75.271 percent for FFY 2011.
- **Outlier Threshold Amount:** For FFY 2011, the outlier threshold amount will be \$11,140 so that the estimated outlier payments are maintained at 3 percent of total estimated payments.

## II. LEGISLATIVE MANDATES

The rule includes payment policy changes mandated by the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 (MMSEA) mandates. Importantly, the MMSEA rolled back the phase-in of the "75% rule," a requirement that at least 75% of admissions to an IRF meet one of 13 specified conditions. MMSEA lowered the threshold permanently to 60% and allows comorbid conditions to count toward that threshold. The rule also incorporates changes mandated by ACA of 2010. Where appropriate, legislative references are provided in the text below.

## III. STANDARD PAYMENT CONVERSION FACTOR

### Marketbasket Update

*Federal Register* pages 42848 - 42849

**Background:** In FFY 2006, CMS adopted the rehabilitation, psychiatric, and long-term care (RPL) hospital marketbasket 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 those payment systems.

The ACA mandated a 0.25 percentage point reduction to the marketbasket increase factor for FFYs 2010 (April, 1, 2010 through September 30, 2010) and 2011.

**CMS' Final Rule:** For FFY 2011, ". . . a reduction of 0.25 percentage point is . . . applied to the . . . RPL market basket increase factor of 2.5 percent. Thus, the adjusted RPL market basket increase factor is 2.25 percent for FY 2011." This is based on ". . . IHS Global Insight, Inc. forecast for the second quarter of 2010 of the 2002-based RPL marketbasket."

## Calculation of the FFY 2011 Standard Payment Conversion Factor

*Federal Register* page 42850

Final FFY 2010 Standard Payment Conversion Factor	\$13,627
Final FFY 2011 Adjustments:	
- RPL Marketbasket less 0.25 percentage point reduction per ACA	1.0225
- Budget-Neutrality Factors:	
- Wage Index and Labor-related Share	1.0005
- Revisions to the CMG Relative Weights	0.9942
<b>Final FFY 2011 Standard Payment Conversion Factor:</b>	<b>\$13,860</b>

## IV. PATIENT CLASSIFICATION SYSTEM

### IRF Patient Classification System

*Federal Register* pages 42839 - 42848

**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. Ninety-five CMGs were derived using this categorization and another five CMGs to account for short stays and patients who died 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 Corporation, using data provided by IRFs after 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.

Currently, there are 87 CMGs with four tiers, and another five CMGs to account for short stays and patients who died in the IRF. CMS calculates CMG weights and average length of stay (ALOS) using IRF PPS claims data. In FFY 2009, CMS began using cost-to-charge ratios (CCRs) specific to IRF sub-providers in calculating CMG weights. However, for freestanding IRFs, CMS continues to use CCR data from the freestanding IRF's cost reports.

**CMS' Final Rule:** For FFY 2011, CMS is updating the CMG relative weights and ALOS values using FFY 2009 IRF claims and FFY 2008 IRF cost report data. CMS is not changing the CMG definitions.

## V. COMPLIANCE THRESHOLD REQUIREMENTS

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

**Background:** Before enactment of MMSEA, CMS required hospitals to meet the "75% rule," which determined whether a hospital or unit of a hospital qualified as an IRF. According to the rule, at least 75% of a facility's total inpatient population must be diagnosed with one of 13 pre-established medical conditions for that facility to be classified as an IRF. This minimum percentage is known as the "compliance threshold."

When MMSEA was enacted, it revised the “75% rule” requirements and established that the compliance threshold could be no greater than 60%, with continued use of comorbidities as qualifying conditions.

CMS provided two methodologies to calculate an IRF’s compliance percentage. The first method is referred to as the “presumptive methodology.” If a facility’s Medicare Part A fee-for-service inpatient population is at least 50% or more of the facility’s total inpatient population, the compliance percentage can be calculated by dividing the total number of IRF-PAIs for patients diagnosed with at least one of the 13 medical conditions by the total number of IRF-PAIs submitted by the facility.

If a facility does not meet the criteria under this “presumptive methodology,” then the second methodology known as the “medical review methodology,” is applied. This method uses a sample of medical records from the facility’s total inpatient population to estimate its compliance percentage. The “medical review methodology” is time-consuming and labor-intensive.

Since 2004, there has been an increased enrollment of Medicare beneficiaries into Medicare Advantage (MA) plans, which decreased Medicare Part A fee-for-service program enrollment. As a result, many IRFs are unable to benefit from the “presumptive methodology” requirements. Currently, IRFs are not required to submit IRF-PAI data on MA patients.

**CMS’ Final Rule:** For FFY 2011, CMS has not changed the compliance threshold requirements.

## **VI. FACILITY-LEVEL ADJUSTMENTS**

### **Wage Index**

*Federal Register* pages 42849 - 42850

**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, IPFs, and home health agencies.

**CMS’ Final Rule:** For FFY 2011, CMS continues “*using the Core-Based Statistical Area (CBSA) labor market area definitions and the 2010 pre-reclassification and pre-floor hospital wage index data*” based on 2006 cost report data.”

Based on the relative weights from the RPL marketbasket, CMS decreased the labor-related share from 75.779 percent for FFY 2010 to 75.271 percent for FFY 2011.

### **Low-Income Patient Adjustment**

*Federal Register* page 42848

**Background:** Currently, IRFs receive an adjustment to their standard payment conversion factor to account for the cost differences associated with treatment of low-income patients.

Prior to FFY 2010, the **LIP multiplier, rural location adjustment, and teaching status adjustment** were calculated using cost report data from FFY 2003. CMS implemented the use of a three-year moving average in FFY 2010 to “*provide greater stability and predictability of Medicare payments for IRFs.*”

The current LIP multiplier of 0.4613 was established in the final rule in FFY 2010 and was calculated using cost report data from the most recent three years (FFY 2006, FFY 2007, and FFY 2008).

The formula used to calculate the low-income patient (LIP) adjustment is:

(1 + DSH patient percentage) raised to the power of 0.4613 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 2011, CMS will continue to apply a LIP adjustment of 0.4613. *“This year, we are evaluating the effectiveness of the new methodology in stabilizing the IRF PPS rate structure. We plan to then, if necessary, propose further adjustments through a future rulemaking process.”*

### Rural Location Adjustment

*Federal Register* page 42848

**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 Corporation in FFY 2006, CMS determined that rural IRFs continue to incur higher costs caring for Medicare patients than their urban counterparts, and CMS increased the rural adjustment from 19.1 percent to 21.3 percent. In FFY 2010, CMS decreased the rural adjustment factor to 18.4 percent based on a methodology change for all facility level adjustments that uses the most recent three years of IRF data (FFY 2006, FFY 2007, and FFY 2008) rather than data from a single year to determine the adjustment.

**CMS’ Final Rule:** For FFY 2011, CMS will continue to apply a rural adjustment of 18.4 percent.

### Teaching Status Adjustment

*Federal Register* page 42848

**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.

In FFY 2010, CMS applied a teaching adjustment of 0.6876 for IRFs that participate in GME programs. The value of the adjustment is based on a methodology change adopted in FFY 2010 for all facility level adjustments that uses the most recent three years of IRF data (FFY 2006, FFY 2007, and FFY 2008) rather than data from a single year.

The IRF PPS teaching payment adjustment is:

$$(1 + [(Interns + Residents)/ADC]) \text{ raised to the power of } 0.6876.$$

An example of the calculation of the teaching adjustment is shown below. In this case, the IRF would receive a 12.22% 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 = 1.1222

CMS will continue to cap the number of IRF residents, similar to the cap that limits increases in residents under the Inpatient and 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 without full-time status and residents rotating through the IRF for less than one 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' Final Rule:** For FFY 2011, CMS will continue to apply a teaching adjustment of 0.6876.

## VII. CASE-LEVEL ADJUSTMENTS

### Cost Outliers

*Federal Register* page 42855

**Background:** Facilities qualify for IRF PPS outlier payments if the estimated cost of the case (measured by applying a facility's CCR to the charges for the discharge) exceeds a fixed-loss threshold (which equals the CMG payment for the case plus an outlier threshold).

CMS establishes the outlier threshold amount each year such that estimated outlier payments equal 3 percent of total estimated IRF PPS payments.

**CMS' Final Rule:** For FFY 2011, CMS will apply an outlier threshold amount of "... \$11,410 ... to reduce estimated outlier payments and thereby maintain estimated outlier payments at 3 percent of total estimated aggregate payments for FY 2011." CMS used the FFY 2009 IRF claims data to estimate the IRF outlier threshold amount for FFY 2011.

### IRF Cost-to-Charge Ratio Ceilings

*Federal Register* pages 42855 - 42856

**Background:** CMS established national CCR ceilings for urban and rural IRFs to ensure that outlier payments are equitably distributed.

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; and
- other IRFs that lack accurate data with which to calculate an overall CCR.

For FFY 2010, the national CCR average was 0.622 for rural IRFs and 0.494 for urban IRFs.

**CMS' Final Rule:** For FFY 2011, CMS will apply a "... national average CCR of 0.620 for rural IRFs ..." and a "... national CCR of 0.489 for urban 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 ALOS 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 ALOS for the CMG. The transfer payment amount includes an additional half-day payment for the first day.

**CMS' Final Rule:** For FFY 2011, CMS has not adopted changes to 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' Final Rule:** For FFY 2011, CMS has not adopted changes to the interrupted stay methodology.