American Hospital Association

Regulatory Advisory

AHA's Regulatory Advisory, a service to members, is produced whenever there is a significant development that affects the job you do in your community.

Inpatient Rehabilitation Facility Final PPS Changes for 2006

A Message to AHA Members:

On August 15, 2005, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* a final rule on the inpatient rehabilitation facility prospective payment system (IRF PPS). This regulation includes the annual Medicare payment updates for IRFs and other substantial policy changes, such as re-weighting and restructuring IRF payment categories, an across-the-board payment reduction, significantly lowering the outlier loss threshold, and introducing a new adjustment for teaching facilities. The final rule includes few changes from the provisions in the proposed rule published May 25.

The final rule is available online at http://a257.g.akamaitech.net/7/257/2422/01jan20051800/edocket.access.gpo.gov/2005/pdf/05-15419.pdf.

Please review this advisory and share it with key hospital and IRF staff to assess its impact on your organization.

The American Hospital Association expressed strong concerns to CMS about the contents of this rule. We will continue to closely monitor how these changes and the 75% Rule affect IRFs, and will work with the agency throughout the year to identify ongoing policy and operational problems and remedies. To discuss any questions or concerns about this rule, contact Rochelle Archuleta, AHA senior associate director of policy, at (202) 626-2320.

Sincerely,

Rick Pollack
Executive Vice President

September 21, 2005

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Inpatient Rehabilitation Facilities Final PPS Changes for 2006

On August 15, 2005, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* the final rule on the inpatient rehabilitation facility prospective payment system (IRF PPS) for fiscal year (FY) 2006, which takes effect October 1, 2005. The rule includes a full market basket update, as well as substantial changes to key components of the payment system. These changes include restructuring current payment categories, known as case mix groups (CMG); recalibrating CMG weights; modifying the comorbidity codes; adopting a new adjustment for teaching facilities and new labor market definitions; reducing the outlier loss threshold; and other changes. CMS estimates an aggregate increase in IRF payments of 3.4 percent ($210 million) over FY 2005 payments. Table 13 on page 47947 of the rule provides CMS' estimates of the final rule's fiscal impact overall and per policy change, for each geographic region and by provider type.

Background

IRF patients currently are classified into 100 clinically distinct case mix groups (CMGs), which categorize patients according to primary diagnosis, functional level and age. Payments for each CMG are weighted to account for variance in the resources used for each category of patient. CMGs can be adjusted further to account for the presence of certain comorbidities that have been found to substantially increase the average cost of a CMG.

CMS used a RAND Corporation (RAND) analysis of payment and claims data from 1998 and 1999 to design the IRF PPS. Since implementation of the IRF PPS in January 2002, CMS has asked RAND to continue studying this payment system. RAND research, based on January 2002 through September 2003 data, is the basis for many of the IRF PPS changes for FY 2006. In developing the FY 2006 changes, RAND and CMS used the same statistical methodologies used to develop the initial IRF PPS.

RAND and CMS' Office of the Actuary have found that IRFs have experienced high Medicare margins since implementation of the IRF PPS. RAND estimates that in calendar year 2002, IRF PPS payments exceeded costs by approximately 17 percent. As a result, CMS will implement most changes in this regulation in a budget-neutral manner. RAND also found that from 1999 to 2002, lower extremity joint replacement cases increased by 22 percent, while stroke cases decreased by 16 percent.

During much of 2002 and 2003, the enforcement moratorium for the IRF classification criterion known as the "75% Rule" was in effect. The effect of the resumed enforcement of the 75% Rule on July 1, 2004 is not reflected in RAND's analysis. The final rule recognizes that more current data and analyses will be needed to assess the impact of the 75% Rule.

Market Basket Update

For FY 2006, the market basket update will be 3.6 percent, based on a newly-created market basket. The new market basket was created for IRFs, inpatient psychiatric facilities and long-term care facilities and is based on FY 2002 data. The rehabilitation, psychiatric, and long-term care facilities market basket replaces the "excluded hospital including capital market basket" (based on 1997 data) and represents both a revision and rebasing of the former market basket. Table 5 on page 47910 of the final rule describes the components of the current and new market baskets.

Standard Payment Conversion Factor

The standard payment conversion factor for FY 2006 (formerly called the budget-neutral conversion factor) will be $12,767. This reflects the FY 2005 amount adjusted by the FY 2006 market basket, and includes an adjustment for coding, new labor market area definitions, and a one-time budget neutrality adjustment, described below. The new standard payment conversion factor is a $191 reduction from FY 2005.

When calculating the FY 2006 standard payment conversion factor, CMS applied a one-time adjustment of 0.96662, allowing changes to the CMGs and comorbidity tiers, updates to the current rural and low-income patient adjustments, and the adoption of a new adjustment for teaching IRFs to be implemented in a budget-neutral manner.

Payment Reduction to Adjust for Coding

The Secretary of the U.S. Department of Health and Human Services is authorized to adjust the IRF PPS to eliminate the effect of coding and classification changes that do not reflect real changes in patient acuity. A RAND analysis found that during calendar year 2002 payments were approximately $140 million, or 3.4 percent, more than expected because of changes in IRF patient classification. Given analytical and data limitations, RAND estimated that changes in patient acuity from 1999 to 2002 contributed between negative 2.4 percent and 1.5 percent to this difference, while coding changes contributed between 1.9 percent and 5.8 percent. To offset these coding changes, CMS will decrease the FY 2006 standard payment conversion factor by 1.9 percent. In choosing to adjust the standard payment using the low end of the range, CMS stated that "IRFs current cost structure may be changing as they strive to comply with other recent Medicare policy changes, such as the criteria for IRF classification commonly known as the '75% Rule'." CMS also notes that it will continue to review the need for any further coding adjustments.

Revision of the IRF Classification System

Using RAND's regression analysis of FY 2003 data, CMS found that updating both the CMG classification system and recalibrating the relative weights of the CMGs would better align payments to costs. Therefore, beginning October 1, 2005, the agency will reduce the number of CMGs and modify their definitions and weights. These changes will be made in a budget neutral manner and should better align current IRF payments with costs by accounting for more current treatment patterns, technology, case mix, and other factors that affect resource utilization. However, as noted, these recommendations do not account for a major variable that will affect IRF case mix during FY 2006 – the 75% Rule.

Proposed CMG Changes. The CMG changes include the following:

- The number of CMGs will be reduced from 100 to 92.
- The cognitive index score will be applied only to two stroke CMGs and three CMGs for traumatic brain injury.
- Patient age will be used for three stroke CMGs, two traumatic spinal cord injury CMGs, and two joint replacement CMGs.

More specific information is detailed in Table 2 on page 74895 of the final rule.

Recalibration of Relative Weights. Using FY 2003 data and the new CMG parameters, CMS recalibrated the weights to account for relative cost of each CMG and the effect of comorbidities on costs. Table 4 on page 47902 of the rule provides the new relative weights and average lengths of stay per CMG and comorbidity tier. Many of the new average lengths of stay (ALOS) for each CMG and comorbidity tier are substantially changed from those presently used, with most being reduced, which reflects the common occurrence of diminishing ALOSs following implementation of a PPS. The ALOS is used by Medicare to determine whether an "early transfer" adjustment is needed. Early transfers occur when a patient is discharged to a non-community setting, such as a general acute hospital or skilled nursing facility, and the patient's length of stay is less than the ALOS noted in Table 4. The final ALOSs also are quite different than those in the proposed rule.

Revised Comorbidity Codes and Tiers

A comorbidity, a specific patient condition that is secondary to the patient's principal diagnosis or impairment, is one element used in the IRF PPS to assign payments. Patients are assigned a payment according to a CMG, which is adjusted by one of four comorbidity tiers. The comorbidity tiers capture the presence of three (Tier 1), two (Tier 2), one (Tier 3), or none (Tier 4) of the eligible comorbidities. The IRF PPS makes a payment adjustment only for those comorbidities that significantly increase the cost of providing care, occur frequently, and are clinically relevant to the diagnosis, rather than being inherently part of the diagnosis.

RAND found that from 1998 through 2003, the number of cases with one or more comorbidities increased by 52 percent, and that the number of Tier 1 comorbidities — the highest paid of the tiers — nearly quadrupled. CMS attributes these increases to both improved coding and unwarranted upcoding. CMS estimates that 1.6 percent of FY 2003 cases received a comorbidity tier adjustment that was not justified by a higher cost of providing care. Therefore, based on a RAND analysis applying the same methodology used to establish the original comorbidity adjustments to FY 2003 data, CMS will make the following changes in FY 2006:

- update the comorbidities to more closely match IRF PPS payments to their relative costs. CMS estimates that four percent of cases will move to tiers with lower payments;
- as described in Table 1 on page 47888 of the final rule, remove 19 comorbidity codes that CMS believes have no impact on cost, are indistinguishable from other codes, or are unrealistically overrepresented; and
- move dialysis to the highest paid comorbidity tier (Tier 1) to align payments with the high cost of providing care to these patients.

Motor Score Index Changes

To classify an IRF patient into a CMG, the patient's functional independence is assessed according to motor abilities for activities of daily living, cognitive level and age. Using the IRF patient assessment instrument, each cognitive and motor measure is assessed to gauge the patient's level of independence. In FY 2006, CMS will replace the current unweighted motor score index with a weighted system to improve the accuracy of the payment system. Table 3 on page 47898 describes how elements of the motor score index will be weighted, based on RAND regression analysis estimating the relative contribution of each component in the index to the prediction of costs. RAND found that the weighted index would improve the payment system's correlation to cost by approximately 9.5 percent. Since RAND found that a weighted *cognitive* score index did not alter the assignment of patients to a CMG, no change is being proposed for this index. CMS also proposes to reduce the motor score index value for the "transfer to toilet" variable from level 1 to level 2 when it is not observed to more accurately capture the cost of treating patients.

Lower Outlier Loss Threshold

For FY 2006, CMS will substantially reduce the current outlier loss threshold of $11,211 to $5,132, making it easier for high cost cases to qualify for outlier payments. CMS estimates that this change will produce total outlier payments equal to 3 percent of the estimated total IRF PPS payments for FY 2006. **This provision would increase total IRF PPS payments by 1.8 percent because CMS has not been spending the full outlier pool in previous years.**

A cost to charge ratio (CCR) for each IRF is used to estimate the cost of a case, and, in turn, determine whether a particular case qualifies for an outlier payment. In FY 2006, CMS will change the ceiling on CCRs, known as the upper threshold CCR, to 1.52 to account for the proposed change in costs resulting from the transition to new labor market definitions as described below. This upper threshold is used for IRFs with a CCR that is more than three standard deviations above the national mean CCR. CMS also will update the national urban CCR to 0.518 and the national rural CCR to 0.631. These national CCRs apply to the following providers:

- new IRFs that have not submitted their first Medicare cost report;
- IRFs whose operating or capital CCR is in excess of three standard deviations above the corresponding national geometric mean; and
- other IRFs for whom accurate data are not available with which to calculate either an operating or capital CCR (or both).

IRFs that do not fall into these categories would continue to use their facility-specific CCR.

New Payment Adjustment for Teaching Facilities

Beginning in FY 2006, CMS will adopt an adjustment for IRFs designated as teaching facilities. This new adjustment is based on analyses demonstrating a statistically significant relationship between an IRF's teaching status and the cost of caring for patients in an IRF. The amount of the adjustment will be based on the number of full time equivalent (FTE) residents training in an IRF relative to the facility's average daily census (ADC). The calculation will be made by raising a facility's teaching variable (1 + FTE residents/ADC) to the 1.9012 power. The number of FTE residents who may be counted will be limited to a cap that is equal to the number of FTE residents trained in an IRF, as recorded in the most recent, settled cost report ending on or before November 15, 2004. Resident eligibility will be counted on a pro-rated basis determined by residents' FTE level during the cost report period.

This new adjustment for teaching facilities will be implemented in a budget-neutral manner. The adjustment will be paid to IRFs on a claim basis as interim payments, but the final payment for the cost-reporting period would be made through the cost report. The difference between interim payments and the total amount computed in the cost report will be reconciled through lump sum payments/recoupments when the cost report is filed and ultimately settled.

For some IRFs status as a teaching facility was inaccurately reported in the proposed rule. CMS recommends that any remaining inaccuracies be raised with the IRF's fiscal intermediary to ensure correct teaching status is used for payment purposes.

Increase in Adjustment for Low-income Patients

The adjustment for low-income patients (LIP) will increase in FY 2006 to account for the higher cost of treating this population. The LIP adjustment will be calculated by applying a facility's disproportionate share hospital (DSH) amount raised to the power of 0.6229, an increase over the current 0.4838. The DSH amount calculates the proportion of low-income Medicare and Medicaid patients treated in each IRF. This change will be implemented in a budget-neutral manner to maintain aggregate IRF payments at the amount they would have been without the proposed increase.

Increase in Adjustment from Rural IRFs

Based on a RAND regression analysis of FY 2003 data, CMS will increase the payment adjustment for rural IRFs from 19.14 percent to 21.3 percent to account for higher costs in rural facilities. This change will be implemented in a budget-neutral manner to maintain aggregate IRF payments at the amount they would have been without the increase in the rural adjustment.

New Labor Market Area Definitions

Consistent with changes for general acute hospitals, long-term care hospitals, and skilled nursing facilities, labor market definitions based on core-based statistical areas (CBSA) will replace the metropolitan statistical area-based (MSA) labor market areas currently used for IRFs. CBSAs are county-based designations based on 2000 census data and reflect current labor markets, and account for wage differences across markets. For IRFs, CBSAs will be implemented through a budget neutral, one-year phase-in based on a 50-50 blend of the FY 2006 MSA and CBSA wage

indices. Only the CBSA wage index will be used in FY 2007 and beyond. Table 1, which begins on page 47954 of the final rule, provides a MSA to CBSA crosswalk.

In addition, IRFs currently designated as rural, but designated as urban under the FY 2006 CBSA wage index, and identified as experiencing a payment decrease due to this change in status, will be held harmless for three years. In FY 2006, such IRFs will receive a 12.76 percent adjustment (which equals two-thirds of the FY 2005 rural adjustment of 19.14 percent), as well as the MSA/CBSA blended wage index. For FY 2007, these IRFs will receive a 6.38 percent hold-harmless adjustment (one-third of the FY 2005 rural adjustment) and use the CBSA wage index. And in FY 2008, such IRFs will use the CBSA-based wage index with no rural adjustment.