

June 13, 2006

## INPATIENT REHABILITATION FACILITIES PROPOSED RULE FOR FY 2007

### AT A GLANCE

**The Issue:**

The Centers for Medicare & Medicaid Services (CMS) published in the May 15 *Federal Register* the inpatient rehabilitation facility prospective payment system (IRF PPS) proposed rule for fiscal year 2007. The net effect of the proposed rule is an increase of a mere 0.6 percent. In fact, CMS estimates that Medicare payments to IRFs will increase by \$40 million in FY 2007. This estimate reflects a 3.4 percent market basket update and a 2.9 percent coding decrease, among other provisions. The proposed rule is available at [www.cms.hhs.gov/InpatientRehabFacPPS/downloads/cms1540p.pdf](http://www.cms.hhs.gov/InpatientRehabFacPPS/downloads/cms1540p.pdf). The final rule will follow later this summer and take effect October 1.

**Our Take:**

The AHA is concerned that CMS has again proposed a negative, across-the-board coding adjustment to reduce payments. The proposed negative coding adjustment, in addition to other pressures such as the 75% Rule and CMS' local coverage determinations, would further restrict patient access to medical rehabilitation services by heightening the current volatility within the IRF field.

**What You Can Do:**

- Share this advisory with your senior management team, chief financial officer, billing and coding staff, nurse managers and key physician leaders.
- Calculate the impact of these changes on your expected 2007 Medicare payments.
- Submit comments to CMS by July 7. Comments may be submitted electronically to [www.cms.hhs.gov/eRulemaking](http://www.cms.hhs.gov/eRulemaking).

**Further Questions:**

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### BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) published in the May 15 *Federal Register* the inpatient rehabilitation facility prospective payment system (IRF PPS) proposed rule for fiscal year (FY) 2007. As it did for 2006, CMS again proposes an across-the-board coding adjustment, reducing payments by 2.9 percent. The net effect of the proposed rule is a minor increase of 0.6 percent, which accounts for a 2.9 percent coding decrease, a 3.4 percent market basket update required by law and other provisions. CMS estimates that this proposed rule will increase Medicare payments to IRFs by \$40 million in FY 2007.

In addition, the phase-in of the 75% Rule continues to place great stress on IRFs. Currently, the threshold is set at 60 percent, where it will remain through June 2007 due to the one-year extension recently authorized by the Deficit Reduction Act of 2005 (DRA). Approximately 40,000 fewer Medicare beneficiaries were treated in rehabilitation facilities during the first year of the phase-in, and further significant reductions in access are projected for the second year. The scale of the reduced access substantially exceeds CMS' projection that just 7,000 patients would be turned away by the revamped 75% Rule. Clearly, CMS has gone too far.

The combined impact of the 75% Rule and local coverage determinations is causing substantial volatility for the IRF field and the patients we serve. This proposed rule would contribute to even greater instability. We are especially concerned that many of CMS' recommendations are based on analysis of old data that are inconsistent with the current environment facing IRFs and their patients. The AHA will continue to urge CMS to refrain from further restricting access to IRF care, which would be the anticipated outcome of this proposed rule.

## **AT ISSUE**

### **Update to Standard Payment**

As required by law, CMS would apply a 3.4 percent market basket update to the IRF PPS standard payment conversion factor in FY 2007. This update is based on the rehabilitation, psychiatric and long-term care (RPL) market basket, which was adopted in FY 2006. The RPL market basket calculates health inflation for IRFs, psychiatric hospitals and long-term care hospitals – all of which recently transitioned to prospective payment systems.

The proposed rule also would decrease the labor-related share from 75.865 to 75.720 as a result of more recent data. Therefore, based on the market basket and other changes in the proposed rule, the FY 2007 standard payment conversion factor for IRFs would be \$12,952 – a small increase from the current amount of \$12,762. Several key adjustments to the standard payment conversion factor would remain unchanged, including the low-income patient, rural and teaching status adjustments. Table 10 in the proposed rule provides a sample calculation of an IRF PPS payment using these and other adjustments.

### **Wage Index**

Wage adjustments to the standard payment conversion factor would be based solely on the Core-based Statistical Area (CBSA) wage index in FY 2007. The adjustments would be budget neutral and unaffected by hospital reclassifications under the inpatient PPS. The combined budget neutrality factor for the wage index and labor-related share changes would be 1.0017.

In FY 2006, the wage index for IRFs was a 50/50 blend between the CBSA index and the index based on Metropolitan Statistical Areas. The three-year hold-harmless provision for IRFs moving from rural to urban status under the CBSA index requires an additional budget neutrality adjustment, which is proposed to be 1.0012. The proposed CBSA-based wage index for FY 2007 can be found in Table 1 of the proposed rule addendum.

### **Outlier Threshold**

The outlier loss threshold would increase from \$5,129 to \$5,609. CMS estimates that at this level, approximately 3 percent of total Medicare payments to IRFs in FY 2007 would be high-cost outlier payments. In addition, CMS plans to use a single cost-to-charge ratio (CCR) for each IRF instead of separate CCR for operating and capital costs. CMS also intends to apply national urban and rural CCRs to new IRFs, IRFs with a CCR above the allowed ceiling (estimated for FY 2007 to be 1.57 plus 3 standard deviations), and IRFs with inadequate data. The proposed national CCR is 0.613 for rural IRFs and 0.488 for urban IRFs for FY 2007.

### **Update to Relative Weights**

Although the IRF case-mix groups (CMG) would remain unchanged from the revisions adopted in FY 2006, the CMG relative weights would be recalibrated in a budget neutral manner. After reanalyzing the data used to determine the FY 2006 relative weights, CMS is proposing to correctly align several ICD-9 codes pertaining to rehabilitation impairment categories 14 and 15, and to remove two ICD-9 comorbidity codes that were incorrectly included in the original analysis. CMS is recommending that the CMG relative weights be updated to correct for these discrepancies. Table 5 in the proposed rule has the proposed new relative weights and revised lengths of stay. The AHA is closely analyzing this proposal.

### **Proposed Comorbidity Coding Changes**

Based on recent analysis of updated data, CMS intends to refine the IRF PPS comorbidity tiers. The agency proposes the following budget-neutral changes:

- Add the four comorbidity codes noted in Table 1 to the IRF PPS grouper. These changes would align the grouper with current ICD-9 coding structure.
- Delete the five comorbidity codes noted in Table 2 from the IRF PPS grouper. CMS asserts these comorbidities were not initially included among the comorbidities list approved when the prospective payment system was implemented, but were inadvertently added and should therefore be removed.
- Continue to revise the 2007 IRF grouper to reflect current ICD-9-CM national coding guidelines.
- Move nine comorbidity codes from tier 2 to tier 3, as shown in Table 3, based on reanalysis showing that these comorbidities are associated with a higher cost of treatment than previous data indicated.
- Delete all category codes from the IRF Grouper, as shown in Table 4. CMS wants to emphasize that the ICD-9 codes, rather than category codes, should be used to indicate comorbidities on the IRF-patient assessment form.

The combined budget neutrality factor for the proposed revisions to the comorbidities tiers and the CMG relative weights would be 1.0079. The AHA is evaluating the data used by CMS to develop these recommendations.

### **Proposed Reduction to Offset Coding Increases**

As in FY 2006, CMS is proposing another across-the-board cut to offset coding increases that occurred from 1999 to 2002. CMS states that the proposed FY 2007 reduction of negative 2.9 percent would be in addition to the 1.9 percent reduction for FY 2006, for a total adjustment of negative 4.8 percent. CMS estimates that between 1.9 and 5.8 percent of the increase in payments during 1999-2002 was due to changes in coding practices that were not associated with increased patient acuity. In the proposed rule, CMS cites the following analyses to support its proposal:

- A review of IRF patients' acute care hospital records "found little evidence that the patients admitted to IRFs in 2002 had higher resource needs than the patients admitted in 1999."
- A 16 percent decrease in stroke cases and a corresponding 22 percent

increase in joint replacement cases from 1999 through 2002 resulted in lower overall patient acuity.

- Medicare margin data indicates that IRF costs from 2001 through 2004 were substantially below Medicare payments.
- IRF patient assessment data from 2002 through 2005 indicates a shift from the lowest to the higher-paying comorbidity tiers (Table 6).

The AHA is particularly concerned about this provision of the proposed rule and CMS' analysis of this information. This recommendation inappropriately responds to a scenario that no longer exists, in which IRFs faced lower costs and a decreasing case-mix index. The current reality is fundamentally different from this outdated assessment due to the impact of the 75% Rule phase-in, which is causing a dramatic decrease in the admission of joint replacement patients. This change is causing per-case costs to increase and the overall case-mix to rise. CMS should not proceed with this misguided and untimely proposal.

### **Legislative Changes to the 75% Rule**

CMS is proposing technical changes to the 75% Rule as a result of provisions in the DRA. The law extends the 60 percent threshold for one year, through June 30, 2007. The legislation also requires that the 65 percent threshold be implemented July 1, 2007, and that the 75 percent threshold be implemented July 1, 2008. The proposed rule specifies that the current comorbidities provision will be in effect through June 30, 2008.

### **Post-Acute Care Plans**

The DRA also authorizes a demonstration project to develop a common post-acute assessment instrument for use in all post-acute settings, including long-term care hospitals, IRFs, skilled nursing facilities, home health agencies and outpatient care. Key provisions of the demonstration are:

- The demonstration will be conducted over a three-year period beginning January 1, 2008.
- A CMS contractor will develop a common post-acute assessment instrument that will be used upon discharge from general acute hospitals and by participating post-acute providers upon admission, discharge and following discharge (perhaps at a six-month interval).
- This new instrument will target post-acute patients in selected markets and patients with selected diagnoses.
- The contractor also will develop tools to assess fixed and variable costs for patients in the demonstration in order to compare costs across sites.

The AHA will participate in CMS' effort to design and implement this demonstration. CMS requests that IRFs recommend methods to effectively compare patient populations, health outcomes and costs across these diverse settings.

## **NEXT STEPS**

The AHA will continue to press CMS and Congress to change the proposed rule and other rehabilitation policies, such as the 75% Rule, that inappropriately restrict IRF access. We also will continue collaborating with other national organizations to develop a unified strategy for the field. The AHA will submit comments on the proposed rule, and we urge IRFs to comment on the anticipated impact of this proposed rule on their patients, community and facility. Comments are due to CMS by July 7.