American Hospital Association

Regulatory Advisory

August 21, 2006

INPATIENT REHABILITATION FACILITY PPS FINAL RULE FOR FY 2007

AT A GLANCE

The Issue:

The Centers for Medicare & Medicaid Services (CMS) published the inpatient rehabilitation facility prospective payment system (IRF PPS) final rule for fiscal year (FY) 2007 in the August 18 *Federal Register*. The agency estimates that Medicare payments to IRFs will increase by $50 million (an increase of 0.8 percent) for a total of $7 billion in IRF payments in FY 2007. This estimate reflects a 3.3 percent market basket update and a 2.6 percent coding decrease, among other provisions. The final rule, available at http://www.cms.hhs.gov/inpatientrehabfacpps/downloads/cms_1540f.pdf, takes effect October 1.

Our Take:

The AHA is disappointed that CMS has authorized another across-the-board coding adjustment to reduce Medicare payments to IRFs. The payment cut, in addition to other pressures such as the 75% Rule and CMS' local coverage determinations, imposes additional stress on the inpatient rehabilitation field.

What You Can Do:

- Calculate the impact of these changes on your expected 2007 Medicare payments.
- Share this advisory and your impact assessment with your senior management team, chief financial officer, billing and coding staff, nurse managers and key physician leaders.

Further Questions:

Please contact Rochelle Archuleta, AHA senior associate director of policy, at (202) 626-2320 or rarchuleta@aha.org.

AHA's Regulatory Advisories are produced whenever there are significant regulatory developments that affect the job you do in your community. A four-page, in-depth examination of this issue follows.

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BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) issued the inpatient rehabilitation facility prospective payment system (IRF PPS) final rule for fiscal year (FY) 2007 on August 1. As it did for FY 2006, CMS again implements an across-the-board coding adjustment, reducing payments by 2.6 percent. The agency estimates that Medicare payments to IRFs will increase by $50 million – that's a mere 0.8 percent increase – for a total of $7 billion in payments to IRFs in FY 2007. This estimate reflects a 3.3 percent market basket update and a 2.6 percent coding decrease, as well as other provisions. The final rule, available at http://www.cms.hhs.gov/inpatientrehabfacpps/downloads/cms_1540f.pdf, takes effect October 1.

The final rule also codifies the modified phase-in schedule for the 75% Rule. Currently, the threshold is set at 60 percent, where it will remain through June 2007 due to the one-year extension authorized by the Deficit Reduction Act of 2005. A June 2006 study by The Moran Company found that approximately 40,000 fewer Medicare beneficiaries were treated by IRFs during the first year of the phase-in with a further reduction of 60,000 patients estimated for the second year of the phase-in. The scale of reduced access – approximately 100,000 patients in the first two years of the phase-in – significantly exceeds CMS' projection that 7,000 patients would be turned away by the revamped 75% Rule.

The combined impact of the 75% Rule with local coverage determinations is causing substantial volatility for the IRF field and its patients. The FY 2007 final rule will contribute to greater instability. We are especially concerned that CMS based the final rule on data and assumptions that do not reflect the current environment facing IRFs and their patients. The AHA will continue urging CMS to restrain from further restricting access to IRF care.

AT ISSUE

Update to Standard Payment
As required by law, CMS will apply a 3.3 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 and calculates health inflation for IRFs, inpatient psychiatric hospitals and long-term care hospitals.

The FY 2007 standard payment conversion factor will be $12,981 – a small increase from the current $12,762. This amount is slightly greater than CMS proposed due to newer market basket and labor-related share data and a smaller coding adjustment. The low-income patient, rural and teaching status adjustments remain unchanged. Table 8 in the final rule provides a sample calculation of an IRF PPS payment, including adjustments.

Wage Index
The FY 2007 wage adjustments to the standard payment conversion factor are budget neutral and based on the pre-classification area wage indices used for the acute care inpatient PPS. In addition, CMS decreased the labor-related share from 75.865 to 75.612, as a result of more recent data. The combined budget neutrality factor for the wage index and labor-related share changes will be 1.0016.

FY 2007 marks the second year of the three-year hold harmless period for IRFs moving from rural to urban status under the Core-based Statistical Areas, which requires an additional budget neutrality adjustment of 1.0013. Each IRF's wage index for FY 2007 can be found in Table 1 of the addendum.

Outlier Threshold Increased Slightly
The outlier loss threshold for FY 2007 will increase to $5,534 from $5,129. This amount is slightly less than proposed in order to set outlier payments at 3 percent of total Medicare payments to IRFs in FY 2007. In addition, as proposed, CMS will use a single cost-to-charge ratio (CCR) for each IRF instead of separate CCRs for operating and capital costs. CMS also will apply national urban and rural CCRs to new IRFs, IRFs with a CCR above the allowed ceiling, and IRFs with inadequate data. The FY 2007 national CCR will be 0.600 for rural IRFs and 0.484 for urban IRFs.

Relative Weights Updated
Although the IRF case-mix groups (CMG) remain unchanged from the revisions adopted in FY 2006, the CMG relative weights were recalibrated in a budget neutral manner, and are shown in Table 4 along with the updated lengths of stay. These changes align several ICD-9 codes with rehabilitation impairment categories 14 and 15 and remove two ICD-9 comorbidity codes that were included by mistake.

Comorbidity Coding Changes Implemented
Based on more recent data and coding, CMS will refine the IRF PPS comorbidity tiers through several budget neutral changes. The final rule:

- Adds four comorbidity codes noted in Table 1 to the IRF PPS grouper. These changes will align the grouper with current ICD-9 coding structure.
- Deletes five comorbidity codes noted in Table 2 from the IRF PPS grouper. They were inadvertently added at an earlier point.
- Moves nine comorbidity codes from tier 2 to tier 3, as shown in Table 3, because they are associated with higher costs than previous data indicated.
- Deletes all category codes from the IRF PPS grouper to emphasize using ICD-9 codes for indicating comorbidities on the IRF patient assessment form.
- Continues to revise the 2007 IRF PPS grouper to reflect current ICD-9-CM national coding guidelines.

Payments Reduced to Offset Coding Increases
As in FY 2006, CMS will implement an across-the-board cut that the agency believes is necessary to offset coding increases that occurred from 1999 to 2002. CMS estimates that between 1.9 and 5.9 percent of the increase in payments from 1999-2002 was due to changes in coding practices that were not associated with increased patient acuity. The agency claims that the total adjustment of negative 4.5 percent (FYs 2006 and 2007 reductions combined) is appropriate since this amount falls within the 1.9 – 5.9 percent range of change CMS attributes to coding increases.

While the final cut was 0.3 percent smaller than proposed, the AHA views the policy as an unwarranted penalty, which is predicated on outdated data and analysis. CMS fails to recognize that today IRFs are facing higher costs per case and an increasing case-mix. The AHA will continue to seek relief from these coding adjustments, the 75% Rule and local coverage determinations in partnership with other national organizations.

75% Rule Phase-in
CMS codifies the modified phase-in schedule for the 75% Rule, as required by the Deficit Reduction Act. The 60 percent threshold is extended for one year, through June 30, 2007. In addition, the 65 percent threshold effective date moves to July 1, 2007 and the 75 percent threshold effective date becomes July 1, 2008. CMS also clarifies that the current comorbidities provision will be in effect through June 30, 2008.

Post-Acute Care Plans
CMS will move forward with developing a common patient assessment instrument for use in all post-acute settings. The agency will convene technical advisory panels to provide input into this congressionally-mandated demonstration project. The panels will include representatives from long-term care hospitals, IRFs, skilled nursing facilities, home health agencies and outpatient care. The AHA will participate in CMS' effort.

NEXT STEPS

The AHA will continue to press CMS and Congress to implement policy changes that preserve, rather than restrict, patient access to care. We also will continue to collaborate with other national organizations to develop a unified strategy that provides relief from the pending increases to the 75% Rule threshold and inappropriate enforcement of local coverage determinations.