
Program Memorandum

Intermediaries

Department of Health and
Human Services (DHHS)
HEALTH CARE FINANCING
ADMINISTRATION (HCFA)

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CHANGE REQUEST 1343

This PM is informational only. Specific contractor claims processing instructions will follow.

SUBJECT: Inpatient Rehabilitation Facility Prospective Payment System

BACKGROUND

Section 4421 of the Balanced Budget Act (BBA) of 1997 (Public Law 105-33), as amended by §125 of the Balanced Budget Refinement Act (BBRA) of 1999 (Public Law 106-113, Appendix F), authorizes the implementation of a per discharge prospective payment system (PPS), through new §1886(j) of the Social Security Act, for inpatient rehabilitation hospitals and rehabilitation units – referred to as inpatient rehabilitation facilities (IRFs).

The new IRF PPS will utilize information from a patient assessment instrument to classify patients into distinct groups based on clinical characteristics and expected resource needs. Separate payments are calculated for each group, including the application of case and facility level adjustments. A notice of proposed rule making was published in the *Federal Register* on November 3, 2000, (65 FR 66304) that provides details concerning the new payment system. Specific contractor instructions regarding claims processing and implementation will follow at a later date.

Major elements of the proposed IRF PPS include:

- **The MDS-PAC Patient Assessment Instrument**

Under the proposed PPS, IRFs are required to submit the data deemed necessary to establish and administer an IRF PPS. The collection of patient data allows patients to be classified into discrete case-mix groups (CMGs) for payment purposes that are predictive of the resources needed to furnish patient care to various types of patients. We are proposing that IRFs use the Minimum Data Set for Post Acute Care (MDS-PAC) to collect patient data. The MDS-PAC is a patient-centered assessment instrument that places the emphasis on a patient's care needs instead of the characteristics of the provider. In addition, we believe that the MDS-PAC supports an appropriate quality of care monitoring system in IRFs, which has some similarity to the quality of care monitoring performed in skilled nursing facilities (for example, the use of quality indicators).

We are proposing that IRFs must collect MDS-PAC data for patients who will be furnished Medicare-covered Part A services. The MDS-PAC assessments would be administered in accordance with the schedule specified in the proposed rule. The IRFs would encode the MDS-PAC data by entering the data into a HCFA-supplied computer software program, and then use that software to transmit the data to the HCFA MDS-PAC system.

- **The CMG Case Classification System**

In accordance with the law, the new IRF PPS provides payment for different classes of patient discharges, using functional-related groups based on impairment, age, comorbidities, and functional capability of the patient, and other factors which reflect resource use and care needs of the patients. The classification system we propose to use will allow us to classify cases that are clinically similar and have similar resource needs. The data elements used to construct the CMGs derive from the elements of the MDS-PAC that were deemed appropriate to improve explanatory power of the classification system.

HCFA-Pub. 60A

- **Payment Rates**

The per discharge payment for a Medicare patient will be made at a predetermined, specific amount for each CMG. Payments under the PPS will encompass all inpatient operating and capital costs of furnishing covered rehabilitation services, i.e., routine, ancillary, and capital costs other than those costs associated with bad debts, approved educational activities, and other costs not paid for under the PPS.

- **CMG Relative Weights**

In order to ensure both a fair distribution of Medicare payments and access to care for higher cost beneficiaries, the proposed IRF PPS is designed to pay each rehabilitation facility an appropriate rate for the efficient delivery of the care required by its set of Medicare beneficiaries. To accomplish this, payment for each CMG has been set using a national formula that adjusts for case-mix. In this payment system, relative weights are a primary element for accounting for the variance in cost per discharge and resource utilization among the CMGs. To ensure that beneficiaries in all CMGs will have access to care and to encourage efficiency, we calculate relative weights that are proportional to the resources needed by a typical case in a CMG.

- **Budget Neutrality Adjustment**

The statute specifies that per discharge payments during fiscal years 2001 and 2002 must be established in a manner that results in the amount of total payments, including any adjustments, being equal to 98 percent of the amount of estimated payments that would have been made during those fiscal years (for operating and capital costs) had the IRF PPS not been enacted. In general, a budget neutrality adjustment factor, when applied to payment group relative weights under a new payment system, ensures that payments under the new system will equal the payments that would have been made under the current system. Accordingly, the payment rates we are proposing will be budget neutral to estimated FY 2001 expenditures minus 2 percent. Further, the budget neutral provision will be applicable to the blended payments of the Federal prospective payment and the facility-specific payment during the transition period.

- **Special Payment Adjustments**

The law provides for the establishment of distinct payments for patients that are considered early transfer cases. Accordingly, the proposed PPS provides for a transfer policy to minimize the inherent incentives in a discharge-based payment system to transfer patients before they have completed their full course of treatment. The transfer policy that we are proposing will reduce the full CMG payment rate when a Medicare beneficiary is transferred prior to the average length of stay for non-transfer cases in a given CMG. This policy would apply to transfers to either another rehabilitation facility, a long term care hospital, an inpatient hospital, or nursing home that accepts payment under either the Medicare program or the Medicaid program, or both.

The proposed PPS also includes a payment adjustment for certain cases, such as short-stay outliers, interrupted stays, and cases that expire. Specifically, these cases, which are not considered transfers, have stays of less than the normal length of time and involve less than the typical course of rehabilitation treatment and, therefore, may be overpaid if the facility were to receive the full CMG payment.

The law also provides for an adjustment for high cost outliers. We are proposing outlier payments that will be 3 percent of total estimated expenditures for cases that meet a fixed loss threshold. We are also proposing to adjust payments for facilities located in rural areas, as well as to provide additional payments for facilities treating a disproportionate share of low income patients.

- **Phase-In Implementation**

During the transition phase covering the first 2 years of the PPS, rehabilitation facilities will receive a payment comprised of a blend between the facility-specific amount (based on the amount that would have been paid under Part A with respect to these costs if the PPS were not implemented) and the IRF Federal prospective payment. Medicare payment for IRFs will be based on the Federal prospective payment for cost reporting periods beginning on or after October 1, 2002.

- **Method of Payment**

A beneficiary will be classified into a CMG based on data obtained during the initial MDS-PAC assessment. The CMG will determine the IRF's Federal prospective payment for the Medicare covered Part A services that the IRF furnished during the Medicare beneficiary's episode of care. However, we propose to base the payment on the submission of a discharge bill. This will allow us to account for an event during the stay which would result in a reclassification to one of the five special CMGs (for cases in which the patient dies or has a very short length of stay) or an adjustment to the payment to reflect an early transfer, and to determine if the case qualifies for an outlier payment. Accordingly, the CMG and other information to determine if an adjustment to the payment is necessary will be recorded by the IRF on the beneficiary's discharge bill and submitted to its Medicare fiscal intermediary for processing.

Under the current payment system, an IRF may receive periodic interim payments. Since we propose to base payment under the PPS on the submission of a discharge bill and the average length of stay for IRFs is 16 days, we plan to retain the ability of an IRF to receive periodic interim payments. We believe that this will mitigate significant cash flow difficulties for those IRFs that qualify for periodic interim payments.

- **Billing Instructions**

As with other institutional claims processing systems under Medicare Part A, we anticipate use of an Inpatient Rehabilitation Facility PRICER and associated provider file that will facilitate the computation of the new payments. We will provide specific instructions that will enable contractors to make the necessary FI and standard systems changes at a later date.

The effective date for this Program Memorandum (PM) is November 30, 2000 since it is only informational.

This PM may be discarded after November 30, 2001.

If you have any questions, contact Todd Smith (410) 786-1420.