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Medicare Payment Issues Affecting Inpatient Rehabilitation Facilities (IRFs)

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Summary

Medicare spending on post-acute care, either those services provided in a facility after an acute hospitalization or home health services provided to eligible beneficiaries in the community, has elicited increasing attention as program spending on these services has grown. Beneficiaries can receive post-acute care in multiple settings, which introduces concerns with respect to identifying the most appropriate, cost-effective setting to provide necessary care. Recent implementation of prospective payment systems for the different settings has amplified concerns that post-acute providers are making decisions about beneficiaries' rehabilitative care in response to financial incentives rather than deciding on the basis of which setting is the most appropriate for the care needs of the patient.

Inpatient rehabilitation facilities (IRFs) are one post-acute provider participating in Medicare. IRFs are either freestanding hospitals or distinct part units of a hospital that are exempt from Medicare's payment system used to pay short-term general hospitals. The majority of the IRFs that participate in Medicare are distinct parts of other hospitals. In 2003, Medicare program payments to IRFs are estimated at $5 billion. Medicare is the largest single payer for inpatient rehabilitation services. Starting in 2002, Medicare began implementing a prospective payment system specifically for IRFs (IRF-PPS). Much of this report describes the new payment system, its adjustments, and a FY2005 payment calculation.

Recent administrative actions by the Centers for Medicare and Medicaid Services (CMS) to enforce the newly constituted "75% rule" have been causing certain amount of consternation among the provider community. The "75% rule" specifies criteria, including qualifying medical conditions and compliance thresholds (the percentage of patients treated that have those conditions), that a facility must meet in order to be paid as an IRF and not as a lower-paid general hospital. Local coverage determinations (LCDs) are policies established by Medicare contractors that clarify the existing national standards regarding IRF services that will be covered by Medicare in their area. The magnitude of Medicare's spending on post-acute care as well as the variety of post-acute providers underscores the importance of developing policies that ensure beneficiaries receive the appropriate level of care and service intensity. Policymakers remain concerned that payment incentives in the Medicare program may influence the type of post-acute care provided and unnecessarily increase program spending.

Over objections from the Administration, both the House and the Senate versions of the FY2005 Labor, Health and Human Services, and Education and Related Agencies appropriations bills included different provisions that would delay enforcement of the IRF compliance thresholds. The House version of the enforcement delay was included in the Consolidated Omnibus Appropriations Act for 2005 (P.L. 108-447) which was signed on December 8, 2004. Generally, enforcement for most IRFs would be delayed until 60 days after an already mandated study by the Government Accountability Office (GAO) is published. This CRS report will be updated as events warrant.

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Inpatient rehabilitation facilities (IRFs) are either freestanding hospitals or distinct part units of another hospital that are exempt from Medicare's payment system used to pay short-term general hospitals (also called acute hospitals). The majority of the IRFs that participate in Medicare are distinct parts of other hospitals; in 2002, 936 of the 1,152 (or 81%) Medicare participating IRFs were distinct part units. In 2003, Medicare program payments to IRFs are estimated at $5 billion; Medicare is the largest single payer for inpatient rehabilitation services. Starting in 2002, Medicare began implementing a prospective payment system specifically for IRFs (IRF-PPS). This report will discuss recent developments affecting the IRF-PPS and then will turn to an examination of other issues affecting Medicare's payment of these providers.

Recent Developments

Recent administrative actions by the Centers for Medicare and Medicaid Services (CMS) with respect to two longstanding policy issues have been causing a certain amount of consternation among the provider community and have prompted congressional action within the appropriations process for Health and Human Services. Despite objections from the Bush Administration, both H.R. 5006 and S. 2810, the House-passed and Senate committee versions of the FY2005 Labor, Health and Human Services, and Education and Related Agencies (Labor-HHS) Appropriations bills, included different provisions that would delay enforcement of the IRF compliance thresholds. The House version of the enforcement delay was included in the appropriations bill that was signed into law.

Enforcement of the Newly Constituted "75% Rule"

The Medicare statute gives the Secretary of HHS discretion to establish the criteria that facilities must meet in order to be exempt from the inpatient prospective payment system (IPPS) used to pay acute hospitals. Accordingly, the Secretary established in regulation that an IRF must demonstrate that at least 75% of its inpatients (all inpatients, not just Medicare beneficiaries) were treated for one or more specified conditions during its most recently completed 12-month cost reporting period. By January 1984, the 10 qualifying conditions were established as: (1) stroke; (2) spinal cord injury; (3) congenital deformity; (4) amputations; (5) major multiple trauma; (6) fracture of the femur (hip fracture); (7) brain injury; (8) polyarthritis (including rheumatoid arthritis); (9) neurological disorders (including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and

Parkinson's disease); and (10) burns.[1] The regulations established that when a facility does not meet the 75% rule (and certain other conditions of participation discussed later), it is no longer paid as an IRF, but will be paid as an short-term, general hospital under IPPS. As described later in the report, starting January 1, 2002, Medicare changed the payment system for IRFs, from cost-based to prospective payments, but did not change the qualification criteria for IRFs. In June 2002, CMS instructed its Medicare contractors (in this case, fiscal intermediaries, or FIs) to defer enforcement of the 75% rule due to concerns that the regulations had not been consistently applied among the different contractors. The contractors were directed to continue their verification activities for existing IRFs, but not change any facility's status until a systematic assessment of the different review procedures was completed and further guidance was issued.[2]

In addition to this review of FI administrative procedures, CMS analyzed IRF claims data from the first eight months of 2002 (submitted under the new payment system) to estimate the overall compliance with the existing 75% rule.[3] Subject to certain caveats, CMS estimated that only 13.35% of the 1,170 IRFs would meet the 75% threshold; the percentage in compliance would increase to 25.17% if the threshold was lowered to 65%.[4] The percentage of IRFs in compliance varied significantly by region and by certain facility characteristics.[5] CMS indicated that patients with lower extremity joint replacements, specifically knee and hip

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[1] Eight of these conditions were originally adopted in the Sept. 1, 1983 interim final rule. The list was supplemented with two additional conditions in the Jan. 3, 1984 final regulation; suggestions that chronic pain, pulmonary disorders, and cardiac disorders be included were not accepted.

[2] The temporary suspension did not appear to increase the number of nonqualifying patients treated by IRFs. From 1996 to 2002, there has been a steady, substantial downward trend in the percent of Medicare cases counted in one of the ten conditions. However, the decline was steeper from 1996 to 1999 than from 1999 to 2002. In 1996, 59.4% of the cases were in the qualifying conditions; this percentage fell to 53% in 1999 and 50.9% in 2002. Grace Carter, Orla Hayden, Susan Paddock, and Barbara Wynn, *Case Mix Certification Rule for Inpatient Rehabilitation Facilities*, Draft Report (DRU-2981-CMS), Rand Health, May 2003, pp. 13-15. (Hereafter cited as Carter et al., *Case Mix Certification*.)

[3] 68 *Federal Register* 26791, May 16, 2003.

[4] Diagnosis data from administrative data sets were used to estimate compliance percentages. In many case, the diagnosis indicated that rehabilitation procedures were used, not the specific condition. CMS indicated that compliance estimates would have likely been higher if more detailed information from the medical record had been available. Carter et al., *Case Mix Certification*, p. 10.

[5] For instance, almost half of the 121 IRFs in the Pacific region were estimated to be in compliance with the 75% rule and only 1.5% of the 66 IRFs in the East South Central region were judged to meet that standard. Interestingly, the compliance rate was three times higher in the IRF units (15.4%) than in the freestanding hospitals (4.7%). The compliance rate in the 135 government-run IRFs (18.5%) and the 700 nonprofit IRFs (15.3) was more than three times that in the 259 proprietary IRFs (5%). 68 *Federal Register* 26792, May 16, 2003.

replacements, are the largest group treated by IRFs that do not count toward compliance with the 75% rule.[6]

CMS published proposed regulations to change the classification criteria for IRFs in the September 9, 2003 *Federal Register*. Under this proposal, absent further regulatory actions, the compliance threshold would be lowered to 65% until January 1, 2007 (when it would revert to its original 75% standard). Also, among other changes, CMS proposed to replace the condition of polyarthritis with three other arthritis-related conditions.[7] CMS proposed two alternatives where patients whose secondary medical conditions included the 12 conditions would also count toward the compliance threshold until January 1, 2007.[8] One alternative was limited to counting these secondary conditions only for patients with joint replacements; the other would count secondary conditions for any admission. CMS declined to add cancer, cardiac, pulmonary, and pain conditions as qualifying criteria, in part because of a lack of studies that demonstrate an improvement in patients' outcomes when cared for in IRFs as compared to other settings.

CMS issued the final rule on May 7, 2004; it became effective July 1, 2004. In the final rule, CMS replaced polyarthritis with four arthritis-related conditions for a total of 13 qualifying conditions. Specifically, a patient with severe or advanced osteoarthritis involving two or more major joints (not including a joint that has been replaced) will count toward a facility's compliance threshold. Also, certain beneficiaries with bilateral joint replacements who are extremely obese or 85 years and older will count toward a facility's compliance. CMS adopted its more expansive proposal to consider secondary conditions for all patients (not just those who have had joint replacements). This provision expires for cost-reporting periods on or after July 1, 2007. CMS adopted a three-year transition period for the compliance threshold as follows: at 50% from July 1, 2004 and before July 1, 2005; at 60% from July 1, 2005 and before July 1, 2006; at 65 % from July 1, 2006 and before July 1, 2007; and at 75% from July 1, 2007 and thereafter. During this three-year period, CMS expects to convene a technical research panel with the assistance of the National Institutes of Health to examine which are the most appropriate clinical conditions for care in an IRF. In the impact analysis for the regulation, CMS expected to save $400,000 in program payments in FY2004, $10 million in FY2005; $90 million in FY2007 and $190 million in FY2008.[9]

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[6] According to the May 2003 proposed rule, nationally, less than 25% of Medicare beneficiaries with joint replacements are admitted to IRFs after surgery.

[7] The detailed description indicates that three or more major joints would need to be significantly affected; these conditions should not have improved after an appropriate, aggressive, sustained course of outpatient therapy preceding the admission. Also, a joint replaced by a prosthesis is considered to no longer have arthritis even though that condition was the reason for the joint replacement.

[8] The secondary condition (or comorbidity) must cause a significant decline in the patient's functioning that, even in the absence of the admitting condition, the patient would require intensive treatment unique to an IRF, rather than in another setting.

[9] 69 *Federal Register* 25769, May 7, 2004.

On June 25, 2004, CMS issued instructions on verification procedures that Medicare contractors should use to ensure that IRFs meet Medicare's new classification requirements.[10] Generally, the contractor will use the IRF's patient assessment instrument (IRF-PAI) data from the most recent, consecutive, and appropriate 12-month time period starting July 1, 2004 to verify compliance.[11] The manual instruction includes lists of diagnoses and impairment group codes that will be used to determine compliance with the specified conditions. The contractor (and the regional office) have the discretion to instruct the IRF to submit specific sections of medical records of a random sample of inpatients (or any selection of inpatients). Other procedures for verifying compliance with the established threshold may apply to IRFs that have Medicare admissions that constitute less than 50% of its total inpatient population or those whose Medicare admissions are not determined to be representative of the patient population served by the IRF.[12]

The changes to the proposed regulation adopted by CMS in the final rule including the three-year transition to the 75% threshold did not satisfy industry advocates. Although pleased by the lowering of the compliance standards, the temporary relief is not seen as addressing overriding concerns with the regulation, particularly the need to modernize the compliance standards. In the long run, they perceive that facilities will be compelled to revise admission policies which will result in large scale denial of access to IRF care.[13] Also, industry advocates have raised concerns with respect to the implementing instructions issued to the Medicare contractors by CMS. Among other issues, the standard for providing appropriate, aggressive and sustained therapy in another less intensive setting prior to an IRF admission is seen as burdensome for providers and costly to beneficiaries. Other objections about the recordkeeping and documentation requirements have been expressed as well.[14]

Use of Local Coverage Determinations (LCDs) by Medicare Contractors

Medicare contractors are required to ensure that payment is made only for those services that are reasonable and necessary. The medical review process is conducted

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[10] CMS Pub. 100-04, Medicare Claims Processing, Transmittal 221, Change Request 3332, June 25, 2004, at [http://www.cms.hhs.gov/manuals/pm_trans/R221CP.pdf].

[11] The contractor will use less than 12 months' worth of data for certain compliance reviews starting before July 1, 2005.

[12] Generally, CMS presumes that if an IRF's Medicare population meets the compliance threshold, then the facility's total population will satisfy this standard, particularly when the IRF's Medicare population represents at least a majority of its patients.

[13] Statement of the American Medical Rehabilitation Providers Association, Apr. 30, 2004, accessed on Oct. 7, 2004, at [http://www.amrpa.org/75statement.htm].

[14] Letter from the American Medical Rehabilitation Providers Association (AMRPA) to Mark McClellan, Administrator of CMS, on CMS Program Transmittal no. 221 for Inpatient Rehabilitation, July 29, 2004.

according to both national and local coverage policies.[15] In the absence of national policy, Medicare contractors can establish individual coverage policies, now known as local coverage determinations, which clarify the existing national standards with respect to Medicare covered services.[16] Contractors develop local policies by considering medical literature, the advice of local medical societies, and public comments. The policy only applies to the geographic area served by the contractor. CMS strongly encourages multi-state contractors to develop uniform policies across all of their jurisdictions. Generally, Medicare's IRF medical necessity standards for inpatient hospital services are included in the Medicare Benefit Policy manual.[17] The standards are based on criteria finalized in 1980 by the American Academy of Physical Medicine and Rehabilitation and the American Congress of Rehabilitation Medicine.

In November 2002, the Office of the Inspector General reported that PPS-exempt hospital inpatient services had not been routinely reviewed for medical necessity since 1995. Although Quality Improvement Organizations (QIOs, formerly peer review organizations, or PROs), FIs, and Medicare Integrity Program contractors all had the authority to conduct medical review in hospitals, none were conducting routine reviews prior to February 2002. At that point, CMS issued a program memorandum to notify FIs that they may include PPS-exempt hospitals in their reviews; no additional funding was provided for their expanded review responsibility, however.[18]

Since then, various Medicare contractors have proposed draft local coverage determinations. Of particular concern to the industry are draft proposals that would use diagnosis-specific guidelines as initial screens to determine the appropriateness of IRF admission and treatment. These screens are viewed as restricting the ability of the referring and receiving rehabilitation physician to make case-by-case determinations on the need for inpatient rehabilitation care for each patient.[19] Instead, providers are encouraging contractors to use broader, more flexible criteria to determine medical necessity. Industry advocates prefer policy proposals that do not use diagnosis-specific parameters for care, but instead cite the need for 24-hour specialized nursing care and physician availability, which are the screening standards

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[15] For more information, see CRS Report RL31711, *Medicare: Coverage Policy*, by Jennifer O'Sullivan.

[16] Effective Dec. 2003, Medicare contractors began issuing local coverage determinations (LCD) instead of local medical review policies (LMRP). Generally, both policies support decisions by contractors as to whether a particular service will be covered. A LCD consists of only reasonable and necessary information while a LMRP may also contain statutory exclusions. All existing LMRPs will be either retired or converted into LCDs no later than Dec. 2005.

[17] Chapter 1, Section 110 of the manual, covering inpatient rehabilitation services, can be found at [http://www.cms.hhs.gov/manuals/102_policy/bp102c01.pdf].

[18] Office of the Inspector General, *Oversight of Medicare PPS-Exempt Hospital Services*, OEI-12-02-00170, Nov. 2002.

[19] Comment letter from the American Hospital Association (AHA) to the Medical Director of Palmetto GBA, May 3, 2004, p. 2.

included in the Medicare Benefit Policy Manual. Industry advocates object that all proposed LCDs inappropriately establish a new condition of coverage for IRF care by including a requirement that the services could not be provided in a less intensive setting.[20] Skilled nursing facilities (SNFs) and their advocates, however, argue that certain IRF cases could be appropriately treated in less intensive settings.

Proposed Delay in Enforcement of the New 75% Rule and Implementation of LCDs

On July 14, 2004, the House Appropriations Committee approved an amendment to the FY2005 Labor, HHS and Education appropriation bill that would have prohibited any CMS funds from being used to implement the final rule establishing the new IRF classification criteria. The amendment would also prevent Medicare contractors from using any existing or new local medical review policies, local coverage determinations, or national coverage determinations establishing medical necessity standards for IRFs. The amendment directed the Secretary to contract with the Institute of Medicine (IOM) to study and make recommendations on the IRF classification requirements and appropriate medical necessity standards. The required report would have been due to Congress no later than October 1, 2005. Nine months after the report's submission, the prohibition on spending to enforce the final rule and medical necessity standards would lapse. The increased program expenditures associated with this amendment were offset by a $9 million reduction in CMS's appropriation for program administration.

According to industry press, provider advocates were concerned that the Chairman of the House Ways and Means Committee, Representative Thomas, would try to block the amendment by asking the House Rules Committee (which determines the procedures by which the House will consider specific legislation) to exempt the amendment from point-of-order protection so it could be challenged during the floor debate.[21] Instead, the IRF provision in the bill (H.R. 5006) that was approved in the House on September 8, 2004 was modified. It forbade HHS from spending money to enforce the revised 75% rule for IRFs certified on or before June 30, 2004 (the day before the regulations became effective) until a Government Accountability Office (GAO) report is published. GAO had been directed by the managers' statement accompanying the conference report for the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) to issue a report, in consultation with experts in the field of physical medicine and rehabilitation, that looks at whether the current list of conditions represents a clinically appropriate standard for defining IRF services. MMA required the Secretary either to determine that the new 75% rule is not inconsistent with GAO's

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[20] Analysis of Medicare Fiscal Intermediaries' Use of the "Less Intensive Setting" Concept in Local Coverage Determinations for Inpatient Rehabilitation, to CMS from AMRPA Joint Coalition written by Powers, Pyles, Sutter, and Verville PC, Attorneys at Law, Sept. 20, 2004.

[21] The Rules Committee's procedures permit any committee chairman the right to request that certain provisions of a bill be removed if those provisions pertain to issues that are within the jurisdiction of the chairman's committee. "Rehab Industry Urges Thomas Not to Block Moratorium on 75 Percent Rule," *Inside CMS*, July 29, 2004.

recommendations or to promulgate a regulation providing for new criteria no later than 60 days after receiving this GAO report.

The increased program expenditures associated with this amended appropriations provision was offset by a $12.5 million reduction in CMS's funding for program administration. In adopting this provision, the House disregarded guidance from the Administration, which indicated that a delay in enforcing the rule would result in inappropriate payments to hospitals that are not based on current clinical practices. The Administration's statement attributed savings of $10 million in 2005 and $1.8 billion over 2005 to 2014 to timely enforcement of the regulation.[22]

On September 15, 2004, the Senate Appropriations Committee included a provision in its Labor-HHS bill (S. 2810) that would have prohibited funds from being spent by HHS or any Medicare contractor to apply the IRF compliance criteria (the 75% rule) established in the *Federal Register* on May 7, 2004. The Committee directed HHS to contract with IOM to study and make recommendations based on the clinical consensus on how to modernize these criteria; the report is due no later than October 1, 2005. Under the HHS contract, IOM was expected to use a multidisciplinary panel of expert researchers and clinicians in the field of medical rehabilitation. According to industry press, nursing home advocates urged the Senate not to approve this moratorium on the 75% rule, in part because the delay would continue perceived overpayments to IRF's for care that skilled nursing facilities (SNFs) can provide at half the cost.[23]

The Labor-HHS bill was included in the Consolidated Omnibus Appropriations Act, 2005 (Division F, H.R. 4818, H.Rept. 108-792), which was approved by the House and the Senate on November 20, 2004. After subsequent congressional actions to remove a provision related to congressional access to individuals' tax return information, the omnibus appropriations act was signed on December 8, 2004 as P.L. 108-447. The legislation contains language comparable to the House passed enforcement delay of the 75% rule. Specifically, HHS cannot spend money to enforce the revised 75% rule for IRFs certified on or before June 30, 2004 until a previously mandated GAO report is published. No later than 60 days after receiving this GAO report, the Secretary is required either to determine that the new 75% rule is not inconsistent with GAO's recommendations or to promulgate a regulation providing for new criteria. The legislation does not include $12.5 million to offset the increased program expenditures attributed to the delay.[24]

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[22] Statement of Administration Policy, H.R. 5006, Labor, Health and Human Services, and Education, and Related Agencies Appropriations Bill, FY2005, Sept. 8, 2004, pp. 3-4.

[23] "Senate Appropriators Call for One-Year Delay of 75 Percent Rule," *Inside CMS*, Sept. 23, 2004.

[24] Section 219 can be found on page H10325 of the *Congressional Record*, November 19, 2004. The discussion of the omission of the $12.5 million offset can be found on page H10659

Background on IRFs

The following section will provide a general overview of rehabilitation services and post-acute care that may be provided by various Medicare entities. Medicare beneficiaries can receive post-acute care from different types of providers in both inpatient and outpatient settings. The availability of care from multiple sites introduces concerns that Medicare may be paying different amounts for the different types of post-acute care providers for patients with essentially similar needs for care. After presenting that basic framework, the report will then discuss different Medicare payment policies that are unique to IRFs. The remainder of this section will describe Medicare conditions of participation for IRFs and discuss the effect of the former cost-based reimbursement on IRFs. The last section of the report will discuss legislative developments shaping the direction of the IRF-PPS. It will present payment adjustments within the IRF-PPS and conclude with a example showing a rate calculation for FY2005.

Overview of Rehabilitation Services and Post-Acute Care

Rehabilitation services consist of physical therapy, occupational therapy, and speech and language services. These services are often furnished to patients following a hospital stay or an ambulatory surgical procedure and can be provided by a number of different Medicare-certified providers in either inpatient or outpatient settings. The diversity in post-acute care providers that furnish rehabilitation services provides for considerable variation and flexibility in the duration and intensity of beneficiaries' use of rehabilitation services and providers. Although the range of possible service settings permits patients (and their physicians) some choice in where beneficiaries receive the most appropriate care, it may also make rehabilitation providers more sensitive to changes in Medicare's payment policies and procedures.[25]

The term "post-acute care" is commonly used to refer to a continuum of service settings where rehabilitation, nursing, and other services can be provided to persons following treatment for an acute illness or injury. Depending upon the context, however, post-acute care may encompass more than vigorous rehabilitative services (often thought to be the primary focus of inpatient rehabilitation facilities or IRF) and include convalescent and palliative services, even pain management for terminal patients. Post-acute care also may be provided on an inpatient or outpatient basis. IRFs are one of the inpatient settings where such services may be provided. Other Medicare providers offering these services are long-term care hospitals (LTCH), SNFs, or home health agencies (HHAs).

Medicare beneficiaries use post-acute care frequently. In 2001, almost one-third of the beneficiaries discharged from acute hospitals used post-acute care with SNF care being the most common single care setting. Until the implementation of Medicare's acute hospital inpatient prospective payment system (IPPS) in 1984, however, follow-up care after hospital stays accounted for only a small part of Medicare spending. Following implementation of IPPS and other policy changes

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[25] Medicare Payment Advisory Commission (MedPAC), *Report to Congress: Context for a Changing Medicare Program*, June 1998, p. 79, 89.

affecting SNFs and HHAs in the late 1980s, Medicare spending for post-acute care began to grow rapidly. Total program spending for post-acute care increased 21% per year from 1992 to 1997, from $14 billion to $35.7 billion; of this total, IRF program spending increased from $2.8 billion in 1992 to $3.8 billion in 1997, an increase of 6% per year.[26] The change in Medicare's spending trends for post-acute care services was attributed to advances in technology combined with the incentives provided by the fixed price payments under IPPS for short-term general hospitals to discharge patients as quickly as possible to other settings for continuing care, together with clarifications of coverage policies for certain post-acute care settings.

In response to the rapid expenditure growth, the Balanced Budget Act of 1997 (BBA 97, P.L. 105-33) and subsequent legislation mandated development and use of prospective payment systems for all post-acute care settings; these new payment systems have been implemented gradually over the time period since passage of BBA 97.[27] Between 1997 and 2001, Medicare spending for post-acute care declined from $35.7 billion to $28.0 billion, by more than 20%, due to a decline of more than 50% for home health care services; Medicare spending in SNFs, IRFs, and long-term facilities increased by 12%, almost 11%, and 58% respectively in that time period. Implementation of the different payment systems has heightened concerns that providers are shifting beneficiaries' care in response to changing financial incentives provided by the reimbursement methods rather than basing the decision for care on the patient's medical condition. Similarly, some view Medicare's varying coverage rules and eligibility criteria, as well as the different requirements that post-acute providers must meet in order to participate in the program, as subject to manipulation.[28]

For example, a three-day prior hospitalization is required to trigger coverage for inpatient skilled nursing facility care, but is not required for other types of inpatient post-acute care under Medicare. In addition, the beneficiary must require daily skilled nursing or rehabilitation care. Beneficiaries who qualify for care in an IRF must be medically capable of undergoing at least three hours of rehabilitation per day that is expected to result in significant practical improvement within a reasonable period of time. Medicare beneficiaries have no special eligibility requirements in order to receive care in a LTCH; these facilities must only maintain an average inpatient length of stay of at least 25 days. Medicare's requirements for physician involvement in the care provided in the different inpatient settings also varies.

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[26] These figures reflect program spending and do not include beneficiary copayments. MedPAC, *Data Book: Healthcare Spending and the Medicare Program*, June 2004, p. 142. Medicare payments to IRFs (including beneficiary copayments) grew 20% annually between 1985 and 1995, from $70 million to $430 million. MedPAC, *Data Book: Health Care Spending and the Medicare Program*, July 1998, p. 104.

[27] Medicare's payment reforms included establishing a case-mix adjusted per diem PPS for SNFs using resource utilization groups (RUG-III) as a patient classification system, starting in 1998; a case-mix adjusted PPS for home health services, starting in 1999; a per discharge PPS for IRFs using function-related groups, starting in 2002; and a per discharge PPS for long-term hospitals using modified diagnosis-related groups (DRGs), starting in 2002.

[28] Medicare Payment Advisory Commission, *Report to Congress, Variation and Innovation in Medicare*, June 2003, p. 73.

Specifically, physicians must be integrally involved in care provided in IRFs and LTCHs, but are required to visit a SNF patient only once every 30 days for the first 90 days and every 60 days thereafter.

Between 1992 and 2004, the supply of all major types of Medicare inpatient post-acute care providers (as well as Medicare spending for these providers) experienced significant growth as well. The number of SNFs increased from 12,303 to 15,784; the number of IRFs increased from 907 to 1,206; the number of long-term hospitals increased from 97 to 307. Ownership of post-acute care providers has also been shifting, with for-profit status becoming more common. Within these overall trends, the regional distribution of different types of post-acute care providers has remained uneven. The pattern of post-acute care provider use is determined in large part by the supply of particular provider types in a given area. Because of wide geographic variation in supply of provider types, utilization patterns, even for patients with similar needs, may vary widely by geography.

The difference in the use of post-acute care services also likely reflects variations in practice standards as well as availability. In this case, practice standards are thought to include the inclinations of individual practitioners as affected by regulation and the policies of Medicare contractors, such as fiscal intermediaries, who influence the use of post-acute care services under Medicare (see earlier discussion of the use of LCDs).[29] Moreover, admissions to post-acute care are guided by a hospital discharge planner who, in turn, may be affected by the knowledge of which patients providers are willing to accept.[30]

Also, as noted in a 1999 study sponsored by the Assistant Secretary of Planning and Evaluation (ASPE), certain hospital characteristics appear to be associated with the type of post-acute care to which patients are discharged. Larger or teaching hospitals, for example, are more likely than other acute hospitals to discharge patients to IRFs. Proprietary hospitals are more likely than non-profit hospitals to discharge patients to home health care. The study found that there were some interactions between types of post-acute care that were used by Medicare beneficiaries. For example, IRF bed supply was positively associated with the rate of Medicare home health care use, which indicated that these two types of care are used in sequence for significant numbers of beneficiaries.[31]

Certain personal and health characteristics, in combination with some basic differences between the types of post-acute care providers, have been found to influence either the use of post-acute care or the propensity to use one type of provider relative to others. The characteristics include the health or functional status

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[29] Robert Kane, Wen-Chieh Lin, and Lynn Blewett, "Geographic Variation in the Use of Post-Acute Care," *Health Services Research*, vol. 37, no. 3 (June 2002), pp. 679-680.

[30] Melinda Butin, Anita Garten, Susan Paddock Debra Saliba, Mark Totten, and José Escarce, *How Much Is Post-Acute Care Use Affected by Its Availability?* National Bureau of Economic Research (NBER), Working Paper 10424, Apr. 2004, p. 4.

[31] Korbin Liu, Barbara Gage, Jennie Harvell, David Stevenson, and Niall Brennan, *Medicare's Post-Acute Care Benefit: Background, Trends, and Issues to Be Faced*, Urban Institute, Jan. 1999, p. 5.

of the patient as well as the patient's access to informal care (nonpaid care provided by family or friends). For example, frail beneficiaries may not be able to withstand the intensive therapy regimen (the minimum of three hours of daily therapy) required in an IRF. Alternatively, severely disabled beneficiaries may be more easily cared for in SNFs than in community settings with home health services. On the other hand, availability of informal care increases the likelihood that post-acute care could be provided in the community or in institutional settings where the goal is to return to the community, rather than in institutional settings explicitly designed to provide long-term care.[32]

The availability of multiple sites of post-acute care has led to concerns that the care provided to beneficiaries is influenced by the different levels of payment offered for similar services in the various settings. However, there is little definitive information on the extent of patient overlap, differences in Medicare's relative payment levels in different settings for the same quality of care, and the appropriate resource levels for the desired outcomes for patients with particular needs.[33] These shortcomings can be attributed, in part, to the fact that the existing administrative data used for Medicare's payment purposes (including patient assessment instruments used to classify patients into the relevant payment groups in the different post-acute care settings) do not contain information needed to measure the quality of care within and across post-acute settings. Although the different data systems include information on patients' functional status (generally measured in terms of activities of daily living, mobility, communication skills, and cognitive status), each of the patient assessment instruments collect different measures recorded at different times in the post-acute stay.[34] These differences make it difficult to identify whether similar patients are, in fact, treated in different settings and, if so, whether the outcomes of care are comparable.[35] Furthermore, patient assessment data are collected only as long as a patient is treated in any particular post-acute care setting, but the outcome of the care rendered may not be apparent until after the patient is discharged.[36]

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[32] Korbin Liu, *et al.*, *Medicare's Post-Acute Care Benefit: Background, Trends, and Issues to be Faced*, Urban Institute, Jan. 1999, pp. 24-25, 41-43.

[33] Marie Johnson, Danielle Hothaus, Jennie Harvell, Eric Coleman, Theresa Eilertsen and Andrew Kramer, *Medicare Post-Acute Care: Quality Measurement Final Report*, University of Colorado Health Sciences Center, Mar. 2001 (revised Mar. 2002), p. 7. (Hereafter cited as Johnson et al., *Medicare Post-Acute Care*.)

[34] SNFs provide functional status information on all Medicare and Medicaid patients using Minimum Data Set, version 2.0 (MDS 2.0) as the assessment tool; home health agencies provide Outcome and Assessment Information Set (OASIS) as the assessment tool for their Medicare patients, IRFs have incorporated the Functional Improvement Measure (FIM™) as part of its patient assessment instrument (IRF-PAI) to report patient status information.

[35] Alan M. Jette, Stephen M. Haley, and Pengsheng Ni, "Comparison on Functional Status Tools Used in Post-Acute Care," *Health Care Financing Review*, Spring 2003, vol. 24, no. 3, p. 13; Lisa I. Iezzoni and Marjorie S. Greenberg, "Capturing and Classifying Functional Status Information in Administrative Databases," *Health Care Financing Review*, Spring 2003, vol. 24, no. 3, p. 61.

[36] Johnson et al., *Medicare Post-Acute Care*, p. 3.

Medicare's Conditions of Participation for IRFs

IRFs and other specialty hospitals were excluded from IPPS when it was implemented for short-term, general hospitals in 1984 because the patient classification system for acute hospitals, diagnosis related groups or DRGs, was thought not to adequately account for the costs associated with treating their patients. As with other post-acute care services, functional and cognitive measures have been judged to be better predictors of resource use in rehabilitation hospitals than diagnoses. An IRF must perform basic hospital functions and also meet certain requirements to be excluded from IPPS and paid as an IRF. As discussed earlier, until recently, the exclusion required that at least 75% of a facility's inpatient discharges needed intensive rehabilitation services for one of 10 conditions. As of July 2004, IRF qualification criteria have been modified and the qualifying percentage has been lowered on a transition basis until January 1, 2007. In addition, patients in IRFs are expected to improve as a result of therapy. Medicare patients treated in an IRF must also be capable of receiving approximately three hours of daily therapy (generally five days a week). Also, patients must require frequent physician involvement, 24-hour rehabilitation nursing, and coordinated care by a multidisciplinary group of professionals.

Medicare has established requirements (or conditions of participation) for IRFs to receive payment from Medicare.[37] Specifically, the facility must review each prospective patient's condition and medical history prior to admission to determine whether the patient will benefit significantly from an intensive inpatient rehabilitation program. IRFs must have a plan of treatment for each inpatient that is established, reviewed and revised by a physician in consultation with other professional personnel who provide services to the patient. As mentioned earlier, facilities must use a coordinated multidisciplinary team approach documented by periodic clinical entries in the medical record that discuss the patient's progress toward a specified goal.[38] Team conferences must be held at least every two weeks to determine the appropriateness of treatment. IRFs must ensure that patients receive close medical supervision by a physician with specialized training or experience in rehabilitation. IRFs must assure 24-hour availability of such a physician as well as 24-hour availability of a registered nurse with specialized training or rehabilitation experience.[39] Each facility must also have a physician who acts as the full-time director of rehabilitation.[40]

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[37] See 42 Code of Federal Regulations (C.F.R.) § 412.23(b)(3)(7).

[38] A multidisciplinary team usually includes a physician, rehabilitation nurse, social worker and/or psychologist as well as those therapists involved in the patient's care. At a minimum, a team must include a physician and, rehabilitation nurse, and one therapist. *Medicare Benefit Policy Manual*, CMS Pub. 100-02, Section 110.4.4.

[39] The need is documented with frequent entries in the patient's medical record of the direct, medically necessary care by the physician at least every two or three days during the patient's stay. *Medicare Benefit Policy Manual*, CMS Pub. 100-02, Section 110.4.1.

[40] The doctor must have at least two years of training or experience in medical management of inpatients requiring rehabilitation services which is preceded by a one-year hospital internship.

IRFs that are distinct-part units of hospitals must meet additional conditions of participation. Among other requirements, these units must have beds that are physically separate from the hospital's other beds, separately identified admission and discharge records from those of the hospital, and policies that specify that necessary clinical information is sent to the unit upon transfer of a hospital's patient to the unit.[41]

Effect of Medicare's Prior Payment System for IRFs

Prior to implementation of the IRF-PPS, these facilities had been paid on a cost related basis subject to per discharge limits as originally established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Generally speaking, under TEFRA, those facilities with operating costs below its payment ceiling received costs plus an incentive payment; those with costs above their target were paid the ceiling plus a relief payment. Each facility had a separate payment limit or target amount established using its cost per discharge in its base year, subject to a cap; the target amounts were subject to annual increases or updates. Capital costs were paid on a pass-through basis, subject to certain limitations. New providers were exempt from payment ceilings for the first three years of operation.

This payment system encouraged new exempt facilities to maximize their costs in their base year to establish high, facility specific cost limits. Once subject to the TEFRA constraints, a recent entrant could fairly readily reduce its costs below its limit and receive Medicare payment for full costs. Older rehabilitation facilities could not inflate their target amounts in this fashion, were more likely to incur costs above their limits, and receive payments less than their costs.

Because of payment disparities between new and old IRFs, BBA 97 mandated changes to Medicare's existing IRF payment system and imposed national cost limits (or national target amounts) on payments to specific IRFs. Accordingly, an IRF would receive payments based on its costs per discharge, subject to the lower of facility specific TEFRA limits or the national target amounts established by BBA 97. The national target amount was set at the 75th percentile of the 1996 facility-specific target amounts updated for inflation. Prior to BBA 97, payments to new IRFs were based on their full Medicare allowable costs while their facility specific amount was determined. With BBA 97, Medicare's payments to new providers were limited to the lesser of the provider's costs or 110% of the wage adjusted, national median target amount of established IRFs. Also, BBA 97 permitted long-established IRFs (those with base years beginning before October 1990) to rebase (or update) their facility-specific target amount using averaged costs from certain of their three most recent cost reporting periods. Among other payment changes (including a reduction in capital payments), the legislation established a provider-specific update formula in order to reduce existing payment disparities; facilities with costs above their target amount received a larger update than those below their target amounts (which could

[41] See 42 C.F.R. § 412.25(a).

be no update). The amount and type of bonus and relief payments to IRFs were modified as well.[42]

The TEFRA system was intended to be a temporary measure to control Medicare hospital spending until prospective payment systems for the nonacute hospitals could be implemented. It remained in effect longer than expected, in part because of the difficulties in accounting for the variation in resource use across patients in exempt facilities.[43] Arguably, part of this unexplained cost variation may have stemmed from providers' responses to payment incentives within the TEFRA system.

IRF Prospective Payment System Issues

The following section will provide background on the legislative provisions shaping the implementation of the IRF-PPS, then present information on the IRF-PPS payment adjustments, and conclude with an example of a FY2005 payment calculation.

Legislative Overview

As well as the other provisions modifying the TEFRA payment system discussed earlier, BBA 97 provided for the establishment of a PPS for IRFs beginning by October 2000 and before October 2002. The IRF-PPS was to be implemented over a two-year transition period.[44] In that legislation, Congress did not specify the unit of payment or the patient classification system to be used with the IRF-PPS. Instead, the Secretary was given discretion to establish classes of IRF patients (called "case mix groups") based on appropriate factors such as impairment, age, related prior hospitalization, comorbidities, and functional capacity of the patient. The Secretary was required to establish weighting factors for each case-mix group that would be adjusted from time to time. These PPS amounts would be budget neutral, set at a rate that would equal 98% of the total payments that would have resulted without such changes, for FY2001 and FY2002. IRF payments would be subject to an area wage adjustment which would vary depending upon where the facility was located. BBA 97 directed that these relative wage values be updated every year in a fashion that does not increase payments as a result of those changes.

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[42] BBA 97 also expanded Medicare's transfer policy beyond discharges from one acute hospital to another to include certain transfers from acute hospitals to post-acute providers. This change reduced payments to acute hospitals for certain types of patients discharged to post-acute settings.

[43] Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy*, Mar. 1999, pp. 72-75.

[44] As mandated, the payments would be based on two-thirds of the TEFRA payment and one-third of the PPS payment from Oct. 1, 2000 and before Oct. 1, 2001; in the following year, payments would be based on one-third of the TEFRA payment and two-thirds of the PPS payment. Starting by Oct. 1, 2002, the IRF-PPS would be fully phased in.

The legislation included provisions establishing outlier payments that would be equal to no more than 5% of total IRF payments.

In an attempt to move toward more uniform payment policies across different post-acute care settings, the Health Care Financing Administration (HCFA, now called CMS) began to consider modifications to the patient assessment instrument (the Minimum Data Set or MDS) and the RUG-III classification system designed for use with per diem payment in SNFs for use in IRFs.[45] This effort was redirected by specific provisions in the Balanced Budget Refinement Act of 1999 (BBRA, P.L. 106-33) that mandated certain characteristics of the IRF-PPS.[46] Specifically, the Secretary was directed to use discharges as the unit of payment. The legislation also mandated use of a specific (and different) patient assessment and classification system than being considered by HCFA. The legislation directed the IRF-PPS to use case-mix groups based on impairment, age, comorbidities, and functional capability of the patient and such other appropriate factors deemed to improve the explanatory power of the functional independence measure-function related groups (FIM-FRG).[47] The law also stated that the Secretary was not precluded from establishing an adjustment in the IRF-PPS to account for early transfers of patients from IRFs to other settings. Finally, the Secretary was directed to study the effect of the new IRF-PPS on utilization and beneficiary access to services, which study is due to Congress no later than January 2005. Subsequent changes in the Benefits Improvement and Protection Act of 2000 (BIPA, P.L. 106-554) increased total payments in the IRF-PPS system by 2% in FY2002 and permitted facilities to make a one-time election before the start of PPS to be paid based on a fully phased-in PPS rate (and skip the two-year transition period). The IRF-PPS system began implementation as of January 1, 2002.

Description of IRF PPS and Payment Adjustments

Generally speaking, under PPS, Medicare pays an IRF a predetermined, fixed amount per discharge, depending upon a patient's impairment level, functional status, comorbid conditions and age. Certain adjustments are made for facility level characteristics to account for area wage variations, rural location, and the percentage of low-income patients (LIPs) served. IRF-PPS also includes case level adjustments. Specifically, reduced or additional amounts are paid for early transfers, short-stay outliers, patients who die before transfer and patients who are extraordinarily costly (outliers). These payments encompass inpatient operating and capital costs of furnishing covered rehabilitation services, but not the costs of approved educational activities, Medicare bad debts, and other services that are paid outside of the IRF-PPS for which the providers receive additional payments.

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[45] Medicare Payment Advisory Commission, *Report to Congress, Medicare Payment Policy*, Mar. 1998, vol. I, p. 96.

[46] This legislation was incorporated by reference into the conference agreement on H.R. 3194, the District of Columbia Appropriations Act.

[47] The Functional-Related Groups (FRGs) system was developed by Dr. Margaret Stineman and colleagues at the University of Pennsylvania and SUNY-Buffalo. This system is based on a rehabilitation coding system, the Functional Independence Measure (FIM), developed and owned by the Uniform Data System for Medical Rehabilitation (USDmr).

Medicare's IRF-PPS payment for any beneficiary will depend upon a clinician's comprehensive assessment of that patient upon admission and again at discharge. These documented assessments must be based on the direct observation of and communication with the patient; information may be supplemented with information from other sources, including family members or other clinicians. The prescribed patient assessment instrument (PAI) form, the Uniform Data Set for Medical Rehabilitation (UDSmr), encompasses about 55 questions used to ascertain a patient's functional independence including motor skills and cognitive capacities and to establish a patient's comorbidities. A patient's assessments (from both admission and discharge) are transmitted to CMS electronically once and at the same time. Failure to meet the IRF PAI transmission deadlines results in a 25% reduction in Medicare's payment in all but extraordinary circumstances.

Using data from the patient's initial assessment, each Medicare patient is classified into one of 100 mutually exclusive case-mix groups (CMGs). First, a patient is placed into one of 21 rehabilitation impairment categories (RICs) that encompass clinically similar conditions, such as stroke or traumatic brain injury, as the primary cause of admission. Next, a patient is placed into a CMG within the RIC; the CMG assignment depends upon the patient's functional status and, in some instances, age. Within a CMG, a patient is assigned to one of four categories or comorbidity tiers using clinical information from the patient's discharge assessment. The presence of comorbidities was found to substantially increase the average cost of a specific CMG. Patients with the most serious conditions are assigned to tier 1; patients with the least serious conditions are assigned to tier 3; those without any relevant comorbidities (or secondary conditions) are assigned to the "none" tier. The 21 RICs encompass the 95 CMGs; five other CMGs have been established for patients with special circumstances; one of the five CMGs is for patients with very short stays and the four remaining are for patients who die before treatment is completed. Each of these five special CMGs have only one payment rate and no comorbidity tiers.

CMS established relative or cost weights using cost report data from FY1996, FY1997, and FY1998 and charge data from calendar year (CY) 1999. The relative weights account for a patient's resource needs for each of the CMGs and payment tiers; 385 relative weights are used to determine Medicare payment rates. Unlike those used in IPPS, these relative weights are not updated annually. Within any given CMG, the cost weight for a patient with a high comorbidity is greater than the cost weights for those patients with low or no comorbidities.

This cost weight is multiplied by a standard payment conversion factor (formerly known as the budget neutral conversion factor) to calculate the payment for a given patient.[48] The standard payment amount was originally constructed using the facility-specific information from 508 facilities, including cost reports from FY1995, FY1996, and FY1997; applicable target amounts, as well as Medicare

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[48] As mentioned earlier, BBA 97 specified that budget neutral payments were to be established at 98% of what would have been spent under the prior system during FY2001 and FY2002. BIPA increased the amount of the IRF-PPS budget neutral payments to 100% in FY2002. The overall IRF-PPS budget neutrality provision is no longer in effect.

claims (including corresponding UDSmr data) from CY1996 and CY1997. Each year the IRF-PPS standard payment amount is increased based on the modified market basket (MB) for excluded hospitals (those not paid under IPPS). This MB is based on cost report data from Medicare participating inpatient rehabilitation and psychiatric facilities as well as long-term, children's, and cancer hospitals which were subject to TEFRA payment limitations. The TEFRA MB only includes operating costs, so the IRF-PPS update is based on a modified TEFRA MB that reflects capital costs. CMS revised and rebased the MB with capital for excluded hospitals to incorporate 1997 cost report data starting in FY2004. The new MB includes an explicit cost category for blood and blood products. Also, the calculation of this modified MB with capital is based on a ratio of operating to capital costs where operating costs account for 91.032% of the total costs and capital costs account for the remaining 8.968% of the total costs.

Medicare pays a reduced amount for a patient who is an early transfer. The patient has a length of stay that is greater than three days but less than the average for the assigned CMG and is transferred to another rehabilitation facility (which has been defined as a rehabilitation facility, a long-term hospital, a short-term hospital, or a nursing home.) No payment reduction applies for patients who are discharged to a home health agency or other outpatient therapy setting. Also, the IRF will receive the full amount if the transfer occurs after the patient has been treated for the average length of stay associated with the CMG. The payment rate for early transfers is based on the per diem payment for the applicable CMG (to which the patient has been assigned). The IRF will receive an additional one half day payment to recognize the higher costs generally associated with the patient's first day of care. The early transfer payment would include any facility level payment adjustments.

Medicare pays for short-stay outliers using one of the five special CMGs. These are patients who are not transfers, but are discharged from the facility after being hospitalized no more than three days. These short-stay outliers may occur because the patient could not tolerate a full course of intensive inpatient rehabilitation treatment, left against medical advice, or died within three days of admission. Also, patients who are discharged from and return to the same IRF by midnight of the third consecutive calendar day are considered interrupted stays. Medicare makes only one IRF-PPS payment for these cases. As mentioned earlier, in addition to PPS payments, Medicare will pay IRFs for certain items such as Medicare beneficiaries' bad debts, the costs of approved educational programs and for blood clotting factors provided to Medicare inpatients who have hemophilia outside of the PPS.

FY2005 IRF Payment Calculation

To establish the FY2005 payment rates, CMS increased the FY2004 IRF standard payment conversion factor by the update amount and applied the budget neutral wage adjustment (to account for updating the wage data from the previous year). In FY2005, the update amount equaled the market basket increase of 3.1%. The FY2005 budget neutral adjustment factor is 1.0035. Unlike the prior year, no

behavior offset to account for coding improvements was applied. In FY2005, the standard payment amount is $12,958.[49]

For FY2005 IRF-PPS payments, CMS uses FY2000 acute hospital wage data (used in the FY2003 IPPS) to compute the IRF wage index values. Unlike IPPS, the IRF-PPS does not permit geographic reassignments for facilities. The labor-related portion (72.359%) of the federal payment rate is multiplied by the IPPS wage index value for the IRF's area. An IRF is either in a metropolitan statistical area (MSA) or the rural area of the state (which is considered to be counties that have not been assigned to MSAs).[50] This wage-adjusted amount is added to the non-labor related portion of the rate to determine the wage-adjusted federal payment rate. IRFs in rural areas receive an additional 19.14% increase to the federal payment rate. An additional payment is made to IRFs that serve low-income patients (LIPs). The same measure, the percentage of poor Medicare and Medicaid days in a given facility, that is used to establish Disproportionate Share Hospital (DSH) payments for most IPPS hospitals is used as the measure for LIPs served in an IRF. However, in the IRF-PPS, the additional DSH payments are calculated using a different formula. Unlike Medicare's DSH payment adjustment for acute hospitals, an IRF will receive additional payments if it serves at least one low-income patient.

Table 1 shows the IRF-PPS adjusted payment calculation for CMG 0112 (without comorbidities) in two different facilities. CMG 0112 is used to establish Medicare payments for stroke patients from 82 to 88 years old who have motor scores that range from 12 and 26. The relative weight used for these patients who have no comorbidities is 2.0015; Medicare's federal prospective payment rate for this CMG is $25,935.44 ($12,958 * 2.0015 = $25,935.44). This represents the federal rate before the relevant facility level adjustments are applied. IRF-PPS payments will be adjusted to account for a facility's relative area wage, rural location, and low-income percentage. In FY2005 a facility in rural Louisiana has a wage index value of 0.7451 and one in the Oakland CA MSA has a wage index value of 1.4921. Both facilities have a 26% DSH percentage, which qualifies them for a LIP adjustment of 11.82%.

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[49] 69 *Federal Register* 45766, July 30, 2004.

[50] Unlike IPPS for acute hospitals, CMS has not yet incorporated the new MSA definitions based on the revised standards published by the Office of Management and Budget and using the 2000 census data into IRF-PPS.

Table 1. Example of IRF-PPS Payment Calculation for CMG 0112 (For Certain Stroke Patients Without Comorbidities) Including Facility Level Adjustments, for FY2005

Component	IRF in rural Louisiana	IRF in Oakland CA MSA
Federal prospective payment rate for CMG 0112	$25,935.44	$25,935.44
Labor portion of federal payment ($25,935.44 x 0.72359)	18,766.63	18,766.63
Wage index for IRF	0.7451	1.4921
Wage-adjusted amount	$13,983.01	$28,001.69
Nonlabor-related amount ($25,935.44 x 0.27641)	$7,168.81	$7,168.81
Wage-adjusted federal payment	$21,151.82	$35,170.50
Rural adjustment	1.1914	1.0
Subtotal	$25,200.28 ($21,151.82 x 1.1914)	$35,170.50
LIP adjustment	1.1182	1.1182
Total FY2005 adjusted federal prospective payment for CMG 0112	$28,178.95 ($25,200.28 x 1.1182)	$39,327.65 ($35,170.50 x 1.1182)

Source: CRS calculation based on information in FY2005 IRF-PPS regulation published in the *Federal Register* on July 30, 2004.

In addition to facility level adjustments, an IRF may receive additional or reduced Medicare payment for any given case, depending upon the Medicare patient's circumstances. Additional payments are made for cases that are high cost outliers. A patient will be considered to be an outlier if the estimated cost of the case exceeds an adjusted threshold amount. This cost is calculated by multiplying the charge by the facility's overall cost-to-charge ratio obtained from the latest settled or tentatively settled cost report.[51] An IRF will receive 80% of the difference between the estimated cost of the case and the outlier threshold (modified by facility level adjustments). For FY2005, the unadjusted threshold amount is $11,211, which CMS estimates will result in total estimated outlier payments of approximately 3% of total IRF-PPS payments.

[51] If a facility's cost to charge ratio is three standard deviations above the applicable national average cost to charge ratio, then a ceiling on this ratio is imposed. Separate national cost to charge ratios apply for urban and rural IRFs. The upper threshold for all IRFs in FY2005 is 1.461.

Concluding Observations

The magnitude of Medicare's spending on post-acute care, as well as the variety of post-acute providers, underscores the importance of developing policies that ensure beneficiaries receive the appropriate level of care and service intensity. Policymakers remain concerned that payment incentives in the Medicare program may influence the type of post-acute care provided and unnecessarily increase program spending. However, there is little definitive information on Medicare's relative payment levels in different settings for the same quality of care and desired outcomes for patients with particular needs. With respect to IRFs, the Medicare statute gives the Secretary of HHS discretion to establish the criteria that these facilities must meet in order to be exempt from the IPPS used to pay acute hospitals. Recent administrative actions by CMS and its contractors to develop and enforce these criteria have prompted House action and Senate committee action within the HHS appropriation process to delay enforcement of the criteria until mandated studies are completed. However, final action on this matter has yet to take place.