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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, elevating the importance of 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, either freestanding hospitals or distinct units of hospitals, are exempt from Medicare's payment system used to pay acute care hospitals. The majority of IRFs participating in Medicare are distinct parts units of acute care hospitals. Medicare is the largest single payer for IRF services. Starting in 2002, Medicare began implementing a prospective payment system specifically for IRFs (IRF-PPS). Much of this report describes the IRF payment system and concludes with an FY2006 payment calculation.

Recent administrative actions by the Centers for Medicare and Medicaid Services (CMS) to enforce the newly constituted "75% rule" have been causing a 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. Pending local coverage determinations (LCDs), the medical review policies established by Medicare contractors regarding IRF services that will be paid for by Medicare in their respective areas, have elicited objections from providers and their advocates as well.

Over objections from the Administration, the Consolidated Omnibus Appropriations Act for 2005 (P.L. 108-447) delayed implementation of the IRF rule. The Secretary of Health and Human Services (HHS) was required to review a pending study by the Government Accountability Office (GAO) before the 75% rule could be enforced for most IRFs. The GAO report was issued on April 22, 2005. On June 21, 2005, CMS announced that the compliance thresholds will be implemented as planned. Legislation that would hold the compliance threshold at 50% for two years, among other provisions, has been introduced in the 109th Congress. The two-year 50% compliance threshold was included in the Deficit Reduction Omnibus Reconciliation Act of 2005 (S. 1932), passed by the Senate on November 3, 2005. The conference report included a two-year 60% threshold that would postpone enforcement of a 75% threshold at 75% from July 1, 2007 until July 1, 2008.

This report will be updated as events warrant.

Contents

List of Tables

Medicare Payment Issues Affecting Inpatient Rehabilitation Facilities (IRFs)

Inpatient rehabilitation facilities (IRFs), either freestanding hospitals or distinct part units of other hospitals, are exempt from Medicare's prospective payment system used to pay short-term, acute care hospitals. The majority of the IRFs that participate in Medicare are distinct parts of other hospitals; in 2003, 971 of the 1,188 (or 82%) Medicare participating IRFs were distinct part units, the majority of which were in urban areas. In 2004, Medicare program payments to IRFs were estimated at $5.9 billion, making Medicare the largest single payer for inpatient rehabilitation services. This report discusses recent developments affecting IRFs, and then turns to a more detailed examination of issues attracting Congressional attention.

Recent Developments

Recent administrative actions by the Centers for Medicare and Medicaid Services (CMS) have prompted congressional action within the FY2006 budget reconciliation process. In May 2004, CMS published a final rule implementing changes in its policies regarding the criteria used to determine which facilities qualify for payment as IRFs. Simply put, this rule establishes that a certain proportion of patients treated by an IRF must have specified medical conditions in order for the facility to qualify as an IRF and receive higher Medicare payments. This proportion increases from 50% to 75% over a three-year transition period.

Despite objections from the Bush Administration, the FY2005 Labor, Health and Human Services, and Education and Related Agencies (Labor-HHS) Appropriation delayed enforcement of the IRF compliance thresholds embodied in the 75% rule. The HHS Secretary was required to review and respond to the issuance of a previously mandated congressional report by the Government Accountability Office (GAO) before the compliance thresholds for most IRFs (those certified before June 30, 2004) could be enforced. The GAO report was published on April 22, 2005.[1] On June 24, 2005, CMS announced that it was proceeding with the implementation of the revised and expanded compliance criteria adopted in the May 2004 final rule, as these criteria are "not inconsistent" with GAO findings.[2]

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[1] U.S. Government Accountability Office, *More Specific Criteria Needed to Classify Inpatient Rehabilitation Facilities*, GAO-05-366, Apr. 2005. (Hereafter cited as *GAO IRF report*).

[2] According to industry press, during a House Ways and Means, Subcommittee on Health hearing, GAO stated that the existing transition period provides CMS with sufficient time to make necessary refinements to the rule: "Top CMS Official Hints Agency Will Pursue

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Companion bills have been introduced in the House (H.R. 3373) and Senate (S. 1405) that will extend the 50% compliance threshold for two years, prevent the Secretary from changing the designation of an IRF that is in compliance with the 50% threshold, and preclude medical necessity reviews that are based on other criteria than those in the Medicare Benefits Policy Manual. A 17-member National Advisory Council on Medical Rehabilitation would also be established. The council would be charged with providing advice and recommendations regarding a variety of topics, including the appropriate criteria for determining the clinical appropriateness of IRF admissions and distinguishing an IRF from other providers. The provision to extend the 50% compliance threshold for two years was included in the Deficit Reduction Omnibus Reconciliation Act of 2005 (S. 1932), passed by the Senate on November 3, 2005. The conference report, which was renamed the Deficit Reduction Act of 2005, includes a provision that would extend the existing 60% compliance threshold for two years (until June 30, 2006), establish a 65% threshold for a 12-month period starting July 1, 2007, and establish the 75% threshold starting July 1, 2008. Under the current regulation, the 75% threshold would start on July 1, 2007.

Another provision in the conference report has the potential to affect the payment for IRF care. Under this provision, a three-year post-acute care payment reform demonstration program would examine the costs and outcomes across different post-acute care sites. A single standardized patient assessment instrument would be used across all sites of care to measure the functional status during treatment and at discharges. An additional assessment would be required at the end of the episode of care. Program participants would be required to provide information on the fixed and variable costs for each individual. A report to Congress, including program results and recommendations, would be submitted no later than six months after the completion of the demonstration. The costs of carrying out the program would be funded by a $6 million transfer from the Part A trust fund.

Evolution of the "75% Rule" and Enforcement Standards

Overview

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 care 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)

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[2] (...continued)
Full Implementation of 75 Percent Rule," *Inside CMS*, June 17, 2005.

polyarthritis (including rheumatoid arthritis); (9) neurological disorders (including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease); and (10) burns.[3] 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.

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.[4]

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.[5] 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%.[6] The percentage of IRFs in compliance varied significantly by region and by certain facility characteristics.[7] CMS indicated that

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[3] 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.

[4] 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 percentage 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*.)

[5] 68 *Federal Register* 26791, May 16, 2003.

[6] Diagnosis data from administrative data sets were used to estimate compliance percentages. In many cases, 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.

[7] 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

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patients with lower extremity joint replacements, specifically knee and hip replacements, are the largest group treated by IRFs that do not count toward compliance with the 75% rule.[8]

Modifications to the "75% Rule"

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, which would bring the total number of qualifying primary conditions to 12.[9] CMS proposed two alternatives where patients with secondary medical conditions in those 12 categories would also count toward the compliance threshold until January 1, 2007.[10] One alternative was limited to counting secondary conditions only for patients with joint replacements; the other would count secondary conditions for any admission. CMS declined the requests 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 with an effective date of July 1, 2004. In the final rule, CMS adopted several policy changes. First, it 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. Second, certain beneficiaries with bilateral joint replacements who are extremely obese or 85 years and older will count toward a facility's compliance. Third, 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. Fourth, 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,

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[7] (...continued)
16, 2003.

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

[9] 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.

[10] 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.

CMS pledged 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 developing the impact analysis for the regulation, CMS assumed that 10% of the noncompliant cases would meet clinical criteria because of coding improvements and that another 10% of the cases would become compliant when medical record data (rather than more readily available administrative data) was examined. CMS also assumed that 50% of the existing joint replacement cases would meet the clinical criteria established in the rule. All in all, CMS projected that 0.1% of the 459,682 current Medicare IRF cases would not be admitted to that setting. The agency stated that these cases would likely receive treatment in alternative settings. Since about half of the IRFs were located in hospital complexes that include skilled nursing facilities (SNF), CMS assumed that SNFs would have a higher probability of absorbing cases no longer admitted to IRFs. CMS projected savings of approximately $5,525 per case in FY2004; the savings represents the estimated difference between IRF care and the cost of the other treatment. CMS projected savings of $400,000 in program payments in FY2004, $10 million in FY2005, $30 million in 2006, $90 million in FY2007, and $190 million in FY2008.[11]

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 a 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.[12] 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.[13]

With respect to implementing the regulations, 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.[14] Generally, the

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[11] 69 *Federal Register* 25772, May 7, 2004.

[12] Statement of the American Medical Rehabilitation Providers Association, Apr. 30, 2004, accessed on Oct. 7, 2004, at [http://www.amrpa.org/75statement.htm], now available at subscription website [http://www.insidehealthpolicy.com].

[13] 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.

[14] CMS Pub. 100-04, Medicare Claims Processing, Transmittal 221, Change Request 3332, June 25, 2004. As indicated in footnote 17, these instructions have been subsequently

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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.[15] The 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 or RO) have the discretion to instruct the IRF to submit specific sections of medical records from 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 Part A fee-for-service admissions are not determined to be representative of the patient population served by the IRF.[16] A determination by the RO that a facility is classified as an IRF is generally made at the start of a facility's cost reporting period and applies to the entire cost reporting period for which the determination is made.[17] As of November 30, 2005, CMS contractors confirm that seven providers have been reclassified as acute care hospitals since the new regulation has been enforced.

Use of Local Coverage Determinations (LCDs) by Medicare Contractors

As discussed in the previous section, a facility may be subject to a threshold compliance review to determine its eligibility for payment as an IRF. IRFs are also subject to medical reviews to determine whether the care provided to an individual was reasonable and necessary based on the patient's condition as documented in the medical record. Simply, Medicare contractors are required to ensure that payment is made only for those services that are reasonable and necessary; the medical documentation must support the patient's need for an IRF level of care.

The medical review process is conducted according to both national and local coverage policies.[18] 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

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[14] (...continued)
clarified. All administrative publications affecting IRFs, including federal register notices, manual instructions, and transmittals can be found at [http://www.cms.hhs.gov/providers/irfpps/pubs.asp].

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

[16] 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.

[17] CMS Pub. 100-04, Medicare Claims Processing, Transmittal 347, Change Request 3503, Oct. 29, 2004 and CMS Pub. 100-04, Transmittal 478, Change Request 3704, Feb. 18, 2005.

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

services.[19] 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.[20] 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 IPPS-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.[21]

Certain of the draft local coverage determinations proposed by various Medicare contractors have elicited some objections from the industry. Of particular concern are those 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.[22] Instead, providers (and their advocates) 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 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

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[19] 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.

[20] 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].

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

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

setting.[23] 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 have prevented 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.[24] 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 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 recommendations or to promulgate a regulation providing for new criteria no later than 60 days after receiving this GAO report.

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[23] 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.

[24] 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.

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.[25]

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.[26]

The Labor-HHS bill was included in the Consolidated Omnibus Appropriations Act, 2005 (Division F, H.R. 4818, H.Rept. 108-792), which 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.[27]

The mandated GAO report was issued April 22, 2005. It analyzed FY2003 data on Medicare patients admitted to IRFs using the conditions in the current regulation that were not yet in effect. This analysis was supplemented by an examination of data from July through December 2004. GAO found that less than 44% of the Medicare admissions to IRFs had a primary condition that was included in the rule.[28] The largest group of these patients admitted to IRFs had orthopedic conditions, with

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[25] 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.

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

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

[28] The percentage of Medicare patients increased to 62% when comorbid conditions included in the rule were counted. *GAO IRF report*, pp. 13-14.

a predominant number of joint replacements.[29] GAO suggested that although some of these joint replacement patients may need intensive rehabilitation services, few patients had comorbidities that suggested a need for IRF care.[30] With respect to compliance, looking at primary conditions only, 6% of the IRFs met the 75% threshold required when the rule is fully phased-in; this percentage increased to 27% when comorbid conditions were considered. The compliance threshold in effect from July 1, 2004 though June 30, 2005 is 50%; looking at both primary and comorbid conditions, over 80% of IRFs met that threshold.

Experts interviewed by GAO and by the IOM differed on whether additional conditions should be added to the IRF compliance list, but agreed that condition alone does not provide sufficient criteria to identify the types of patients appropriately treated at an IRF; functional status should also be considered. In addition, certain experts suggested that facility characteristics be used to classify IRFs.

GAO recommended that Medicare contractors routinely review IRF admissions for medical necessity; that CMS encourage research on the effectiveness of intensive inpatient rehabilitation; and that CMS use the research and other information to refine the rule to describe more thoroughly the subgroups of patients with a given condition that are appropriately treated in an IRF. In responding to the GAO report, CMS has generally concurred with these recommendations, but stated that implementing other criteria to identify subgroups of appropriately treated patients could result in more a restrictive policy than currently implemented and thus would have to be carefully considered.

In the course of its mandated IRF study, GAO interviewed 10 officials representing Medicare FIs and reported that over half were not conducting reviews of patients admitted to IRFs. Those who were doing reviews used different approaches for selecting records or facilities to assess. CMS estimated that less than 1% of admissions in facilities excluded from IPPS, such as IRFs, are reviewed. In contrast, the major insurers interviewed by GAO indicated that private payers relied on individual preauthorization to ensure that the most appropriate patients are admitted to IRFs.[31]

In response to the GAO recommendation, CMS agreed that targeted reviews for medical necessity are needed and indicated that it had expanded its efforts to provide greater oversight of IRF admissions through local policies that have been

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[29] IRF patients with conditions not on the list were orthopedic cases (45.6%); about two-thirds of those cases were joint replacements (or 30.6% of the IRF admissions). *GAO IRF report*, p. 16.

[30] Eighty-seven percent of the joint replacement patients in 2003 had unilateral procedures and were younger than 85 years old and did not fit the criteria for joint replacement (based on primary condition) in the subsequently adopted rule. *GAO IRF report*, p. 16

[31] Officials from the three major insurers and one managed care plan interviewed by GAO indicated that each admission to an IRF required preauthorization to determine whether a specific patient should be admitted. Each case was judged individually on the basis of various factors which differed from payer to payer. *GAO IRF report*, p. 21.

implemented or are being developed by the FIs. Selected FI's have performed different types of medical reviews (using either widespread, focused, or random selection of cases) to examine the medical necessity of IRF patient admissions and, in certain instances, to shape the development of LCDs. For example, one contractor performed a widespread probe on patients who required rehabilitation therapy to restore strength, increase range of motion, or upgrade the ability to function. Examining 108 claims from 27 providers from June 1, 2003 to November 30, 2003, the FI found that 50 claims (46%) could have been provided in a less intensive rehabilitation setting. Another contractor reviewed 101 randomly selected claims from January 1, 2004 to June 30 2004; 17 claims were denied because medical records were not submitted on a timely basis; 72 of the 84 other claims were denied as well. Twenty-five of those patients were considered to be inappropriate admissions to the IRF.[32] One other contractor had an overall denial rate of 72.3% for IRF claims examined for medical necessity.[33]

On June 24, 2005, CMS announced that it was proceeding with the implementation of the revised and expanded compliance criteria adopted in the May 2004 final rule as these criteria are "not inconsistent" with GAO findings. The compliance criteria will be adopted over a transition period as planned (with the threshold increasing from 50% to 75% for cost reporting periods beginning July 1, 2007). CMS has also requested that National Institute of Health (NIH) convene a research panel to recommend future research on the types of patients that would most benefit from intensive inpatient rehabilitation. The research recommendations are now being evaluated; CMS intends to collaborate with NIH to determine how to best promote research into the effectiveness of rehabilitation.[34]

In its press release accompanying the above announcement, CMS stated that its monitoring efforts had detected no significant beneficiary problems in accessing IRF services. It found that the number of IRF cases increased 1.2% when comparing utilization in CY2003 to that in CY2004, when the revised regulations were implemented. In contrast, an industry study projects a 7.7% decline in Medicare discharges from IRFs from July 2004-June 2005, primarily in the diagnostic categories most affected by enforcement of the compliance thresholds. However, this study, based on data representing 77% of the IRF facilities and 66% of the Medicare discharges, shows a 1.3% decline in Medicare cases when comparing utilization in CY2003 to that in CY2004. The decline is not supported by CMS analysis of its claims data, which, as indicated earlier, shows an 1.2% increase.

Still, industry advocate remain concerned about the effect of the new compliance thresholds and enforcement efforts. CMS has released a November 2005 correspondence to Wall Street to discuss and refute these issues. Specifically, the purpose and underlying assumptions of the impact analysis included in the 75% rule

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[32] Six of those cases were admitted to the IRF for cardiac rehabilitation and the remaining 19 were deemed to be too ill to participate in the intense level of therapy required by the IRF.

[33] Information on contractors' LCDs and different medical reviews can be found at [http://www.cms.hhs.gov/mcd/search.asp], accessed Nov. 15, 2005.

[34] 70 *Federal Register* 36641, June 24, 2005.

is examined. According to CMS, the industry is concerned about differences in the impact analyses and the actual provider experience since July 2004. This concern is attributed to a misunderstanding of the mandated impact analyses, which are not treated as expenditure targets. Moreover, while CMS predicted a moderate increase in IRF expenditures based on historical growth rates, actual spending was significantly higher. [35]

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 calculation for FY2006.

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.[36]

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. Eligible beneficiaries who are referred from the community and use home health services without a prior

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[35] The CMS impact analyses projected that IRF-PPS expenditures would grow at a compound annual growth rate of 5.6% from 2001-2004. Actual expenditures grew at 13.8% compound annual growth rate from 2001-2004. See pp.7-8 of *CMS Memorandum to Interested Investors and Analysts* ,by Lambert van der Walde, Nov. 30, 2005.

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

hospitalization also use post-acute care. Depending upon the context, 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, physical or speech therapy, wound care, skilled nursing care, 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, and home health agencies (HHAs).

Medicare beneficiaries use post-acute care frequently. In 2001, almost one-third of the beneficiaries discharged from acute care hospitals used post-acute care with SNF care being the most common single care setting. Until the implementation of Medicare's acute care 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 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 an average of about 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 average increase of 6% per year.[37] 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.[38] Between 1997 and 2001 (the year before implementation of IRF-PPS), Medicare spending for post-acute care declined by more than 20%, from $35.7 billion to $28.0 billion, 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. Between 2001 and 2004, Medicare post-acute spending increased from $28.0 billion to $35.9 billion, slightly more than its 1997 peak. Over the same time period, Medicare spending in IRFs increased from $4.2 billion to $5.9 billion, more than 50% above 1997 IRF expenditures.

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[37] These figures reflect program spending and do not include beneficiary copayments. MedPAC, *Data Book: Healthcare Spending and the Medicare Program (Data Book)*, June 2004, p. 142 and MedPAC, *Data Book*, June 2005, p. 150. Medicare payments to IRFs (including beneficiary copayments) grew 20% annually between 1985 and 1995, from $70 million to $430 million. MedPAC, *Data Book*, July 1998, p. 104.

[38] 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.

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.[39] 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. 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 2005, 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 15,632; the number of IRFs increased from 907 to 1,232; the number of long-term hospitals increased from 97 to 365. 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).[40] 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.[41]

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[39] MedPAC, *Report to Congress, Variation and Innovation in Medicare*, June 2003, p. 73.

[40] 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.

[41] 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.

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.[42]

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 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.[43]

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.[44] 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

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[42] 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.

[43] 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.

[44] 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*.)

in the post-acute stay.[45] 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.[46] 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.[47]

Interestingly, policy makers (and legislators) have returned to a discussion of the importance of using common patient assessment tools across post-acute settings. The House Ways and Means, Subcommittee on Health held a hearing on this and related topics on June 16, 2005.[48] Recent MedPAC analysis indicates that the information collected by Medicare's current assessment tools cannot be easily integrated.[49] Also, CMS has not met a Congressional mandate report on the development of an instrument to assess the health and functional status of beneficiaries who use post-acute services.[50] A seminal effort led by CMS to identify and establish consistent terms and common measures for a clinical assessment of the quality of post-acute care has not been successful. CMS has indicated that it will begin testing a patient assessment tool for all post-acute care services by spring, 2006 as a first step toward the possible creation of an integrated payment system across all settings.[51]

In support of this initiative, a provision in the Deficit Reduction Act of 2005 would establish a three-year post-acute care payment reform demonstration program to examine the costs and outcomes across different post-acute care sites. A single

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[45] 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. See MedPAC, *Report to Congress: Issues in a Modernized Medicare Program*, June 2005, pp. 114-119 for a detailed comparison of the different patient assessment tools used in post-acute settings.

[46] 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.

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

[48] Detailed information (testimonies, submissions for the record, and the hearing transcript can be found at [http://waysandmeans.house.gov/hearings.asp?formmode=detail&hearing=422&comm=1].

[49] MedPAC, *Report to Congress: Issues in a Modernized Medicare Program*, June 2005, p. 120.

[50] The Medicare, Medicaid, and SCHIP Benefits Improvement Protection Act of 2000 (BIPA) instructed the Secretary to report on the development of an instrument to assess the health and functional status of beneficiaries who use SNF services by Jan. 2005.

[51] Bureau of National Affairs, "Medicare: CMS Says Patient Assessment Tool For Use in Medicare Expected in 2006," *Health Care Daily*, vol. 10, no. 116, June 17, 2005.

standardized patient assessment instrument would be used across all sites of care to measure the functional status during treatment and at discharges. An additional assessment would be required at the end of the episode of care. Program participants would be required to provide information on the fixed and variable costs for each individual. A report to Congress, including program results and recommendations, would be submitted no later than six months after the completion of the demonstration. The costs of carrying out the program would be funded by a $6 million transfer from the Part A trust fund.

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.[52] 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.[53] 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

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

[53] 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.

experience.[54] Each facility must also have a physician who acts as the full-time director of rehabilitation.[55]

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.[56]

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

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[54] 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.

[55] 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.

[56] See 42 C.F.R. § 412.25(a).

(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 be no update). The amount and type of bonus and relief payments to IRFs were modified as well.[57]

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.[58] 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 FY2006 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 with a two-year transition period beginning by October 2000 and before October 2002. [59] 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

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[57] 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.

[58] MedPAC, *Report to Congress: Medicare Payment Policy*, Mar. 1999, pp. 72-75.

[59] 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.

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. 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.[60] 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.[61] 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).[62] 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, with the study due to Congress no later than January 2005. (The study was submitted in August 2005). Subsequent changes in BIPA 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 FY2006 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. Starting in FY2006, the payment system includes an adjustment to increase payments to teaching facilities. 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

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[60] MedPAC, *Report to Congress, Medicare Payment Policy*, Mar. 1998, vol. I, p. 96.

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

[62] 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).

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.

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 at the end of the patient's stay. 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 92 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 87 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.

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.[63]

Originally, CMS established relative or cost weights for the different CMGs using cost report data from FY1996, FY1997, and FY1998 and charge data from calendar year (CY) 1999.[64] The weights were updated for FY2006 using the same methodology and data after the IRF-PPS was implemented. Although updated for FY2006, unlike those used in IPPS, these relative weights are not updated annually. The relative weights account for a patient's resource needs for each of the CMGs and payment tiers; 353 relative weights are used to determine Medicare payment rates. 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. CMS did apply a budget neutrality factor to ensure that the estimated aggregate payments due to FY2006 changes in the relative weights (and other changes to the CMGs) did not increase.

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.[65] 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 claims (including corresponding UDSmr data) from CY1996 and CY1997. CMS reduced the standard payment amount by 1.9% in FY2006 to account for coding changes that do not reflect real changes in case mix (or increases in the intensity of the illness of patients who are treated). An analysis of CY2002 data indicated that payments to IRFs were about $140 million more than expected because of changes in patient classification.[66]

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[63] 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.

[64] Centers for Medicare and Medicaid Services, "Medicare Program; Prospective Payment System for Inpatient Rehabilitation Facilities," 66 *Federal Register* 41351-41353, Aug. 7, 2001.

[65] 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.

[66] RAND recommended decreasing the standard payment amount by between 1.9% and 5.8% to adjust for coding changes. 70 *Federal Register* 47904-47908, Aug. 15, 2005.

Until FY2006, 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 had been based on a modified TEFRA MB that reflects capital costs. Starting in FY2006, CMS is increasing IRF payments using a market basket reflecting the operating and capital cost structures for rehabilitation, psychiatric and long-term facilities (referred to as the RPL MB). CMS revised and rebased the RPL MB to incorporate 2002 cost report data starting in FY2006. The change in market basket and use of the 2002 cost data will increase the labor related share (or effect of the IRF's wage index) and increase the relative influence of the capital to operating costs.[67]

IRF-PPS incorporates an adjustment to reflect the relative area wage levels of a facility's labor market. Generally speaking, an IRF's labor market is defined using standards established by the Office of Management and Budget (OMB). Counties that are not included as part of a metropolitan area (by virtue of commuting patterns and population density) are considered to be rural. An IRF is not required to submit wage index data to Medicare. This adjustment uses data submitted by acute care hospitals and is compiled for the labor market area where they are located without taking into account any geographic reclassifications of those hospitals. Also, IRF wage index values are not subject to the rural floor applied to IPPS hospitals (where the wage index value in any urban area cannot be lower than the rural wage index in that state). The IRF wage data is commonly referred to as a pre-reclassification, pre-floor data.

In FY2006, CMS adopted revised OMB labor market definitions using the core based statistical area (CBSA) classifications to determine urban and rural areas. These labor market definitions were adopted in IPPS in FY2005. The change is implemented with a budget neutral one-year transition period; the wage index of all IRFs (not just those that are disadvantaged by the new labor market definitions) will have half of their wage index based on the old labor market definitions and half based on the new definitions. IRFs that had previously been in rural areas who are now considered to be in urban areas will have their rural payment adjustment phased out over a three-year period. Generally, these IRFs will receive two-thirds of the FY2005 rural adjustment of 19.14% (or 12.76%) with a blended wage index in FY2006; one-third of the adjustment (6.38%) with a CBSA wage index in FY2007 and a CBSA wage index in FY2008. This transition will be implemented on a budget neutral basis. IRFs that had been in urban areas that are now considered to be located in rural areas will receive the full FY2006 rural payment adjustment of 21.3%.

Other facility adjustments (aside from the rural adjustment) may apply to an IRF's payment calculation. Starting in FY2006, a teaching facility will receive

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[67] The labor related share in IRF-PPS will change from 72.024 in FY2005 to 75.865 in FY2006. 70 *Federal Register* 47916, Aug. 15, 2005. A discussion of the RPL MB can be found on the preceding six pages of that *Federal Register*.

additional payments. RAND's regression analyses of CY2002 and CY2003 data indicated that teaching facilities had higher costs than IRFs without teaching programs. Subject to a cap on the number of residents, teaching facilities will receive additional payments based on a logarithmic formula comparable to that used for the indirect medical education (IME) adjustment used in capital IPPS. Teaching intensity will be measured by dividing the number of approved resident full-time equivalents (FTEs) by the average daily census of the IRF. This will be raised to the 0.9012 power. An IRF's FTE resident cap will be based on the number shown in the final settlement of the IRF's most recent cost reporting period ending on or before November 15, 2004.

An IRF may also receive additional Medicare payments depending on the number of low-income patients (LIP) it serves. The LIP adjustment incorporate the same measure used to establish the disproportionate share hospital (DSH) adjustment in IPPS. Specifically, the adjustment uses the number of days provided to poor Medicare beneficiaries (those who receive SSI) divided by the total number of Medicare days plus the number of Medicaid (non-Medicare days) divided by the total number of days in the hospital. In FY2005 (and previously) this measure was raised to the 0.4836 power. Starting in FY2006, this is raised to the 0.6226 power.

FY2006 IRF Payment Calculation

To establish the FY2006 payment rates, CMS increased the FY2005 IRF standard payment conversion factor by the update amount, reduced that by 1.9% to account for coding changes, and applied various budget neutral adjustments (to account for certain changes from the previous year). In FY2006, the update amount equaled the market basket increase of 3.6%. The FY2006 budget neutral adjustment factor for the labor related change and the CBSA transition period is 0.9995; that for CMG changes is 0.9995; that for changes in the rural adjustment is 0.9957; that for the LIP adjustment change is 0.9851; that for implementing the teaching adjustment is 0.9889. The FY2005 standard payment was $12,958. After the MB increase and the budget neutrality decreases, the FY2006 standard payment is $12,762.[68]

For FY2006 IRF-PPS payments, CMS uses FY2001 acute hospital wage data to compute the IRF wage index values. As mentioned earlier, unlike IPPS, the IRF-PPS does not permit geographic reassignments for facilities. The labor-related portion (75.865%) of the federal payment rate is multiplied by the IPPS wage index value for the IRF's area.[69] 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). 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 21.3% increase to the federal payment rate. Depending upon the percentage of poor Medicare and Medicaid days in a given facility, a facility will receive additional LIP adjustment.

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[68] 70 *Federal Register* 47939, Aug. 15, 2005 as corrected by 70 *Federal Register* 57168, Sept. 30, 2005

[69] The labor-related share was 72.359 in prior years.

Table 1 shows the IRF-PPS adjusted payment calculation for CMG 0109 (without comorbidities) in three different facilities. CMG 0109 is used to establish Medicare payments for stroke patients who are less than 84.5 years old who have motor scores that range from 22.35 and 26.15. The relative weight used for these patients who have no comorbidities is 1.8147; Medicare's federal prospective payment rate for this CMG is $23,159.20 ($12,762 * 1.8147 = $23,159.20). 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, low- income percentage, and teaching status. The example will use three facilities. Facility A is a non-teaching IRF located in Duke County, MA. It has a DSH patient share percentage of 5% which translates into a LIP adjustment of 1.031. Facility B is a teaching IRF in urban Queens County, NY with a DSH patient share percentage of 10% which translates into a LIP adjustment of 1.0612. It will also receive a teaching adjustment of 1.0910. Facility C is a non-teaching IRF located in Kings County, CA, which was considered to be a rural area prior to FY2006. This IRF will receive a hold harmless rural adjustment of 12.76%.

Table 1. Example of IRF-PPS Payment Calculation for CMG 0109 (for Certain Stroke Patients Without Comorbidities), Including Facility-Level Adjustments, for FY2006

Component	IRF A in Duke County, MA	IRF B in Queens County, NY	IRF C in Kings County, CA
Federal prospective payment rate for CMG 0109	$23,159.20	$23,159.20	$23,159.20
Labor portion of federal payment ($23,159.20 x 0.75865)	$17,569.73	$17,569.73	$17,569.73
Blended transition wage index for the IRF's location	1.0216	1.3449	0.9797
Wage-adjusted amount	$17,949.23 ($17,569.73 x 1.0216)	$23,629.53 ($17,569.73 x 1.3449)	$17,213.06 ($17,569.73 x 0.9797)
Nonlabor-related amount ($23,159.20 x 0.24135)	$5,589.47	$5,589.47	$5,589.47
Wage-adjusted federal payment	$23,538.70 ($17,949.23 + $5,589.47)	$29,219 ($23,629.53 + $5,589.47)	$22,802.53 ($17,213.06 + $5,589/47)
Rural adjustment	1.2130	1.00	1.1276
Subtotal	$28,552.44 (23,538.70 x 1.2130)	$29,219 ($29,219 x 1.00)	$25,712.13 ($22,802.53 x 1.1276)
LIP adjustment	1.0310	1.0612	1.1203

Component	IRF A in Duke County, MA	IRF B in Queens County, NY	IRF C in Kings County, CA
Subtotal	$29,437.57 ($28,552.40 x 1.0310)	$31,007.20 ($29,219 x 1.0612)	$28,805.30 ($25,712.13 x 1.1203)
Teaching adjustment	1.00	1.090	1.00
Total FY2006 adjusted federal prospective payment for CMG 0109	$29,437.57 ($29,437.57 x 1.00)	$33,797.85 ($31,007.20 x 1.09)	$28,805.30 ($28,805.30 x 1.00)

Source: CRS calculation based on information in FY2006 IRF-PPS regulation published in the *Federal Register* on August 15, 2005 and September 30, 2005.

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.[70] 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 FY2006, the unadjusted threshold amount is $5,129 (down from $11,211 in 2005), which CMS estimates will result in total estimated outlier payments of approximately 3% of total IRF-PPS payments.

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 congressional actions to delay enforcement of the criteria. At this point, absent further action, CMS will enforce the 60% compliance threshold starting July 1, 2005. However, the Deficit Reduction Act of 2005 includes a provision that would extend the existing 60% compliance threshold for two years

[70] 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.

(until June 30, 2006), establish a 65% threshold for a 12-month period starting July 1, 2007, and establish the 75% threshold starting July 1, 2008. Under the current regulation, the 75% threshold would start on July 1, 2007.