INPATIENT REHABILITATION FACILITIES PAYMENT SYSTEM

*payment***basics**

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After an illness, injury, or surgical care, some patients need intensive inpatient rehabilitation services, such as physical, occupational, or speech therapy. Relatively few beneficiaries use intensive rehabilitation therapy because they generally must be able to tolerate and benefit from three hours of therapy per day to be eligible for treatment in an inpatient rehabilitation setting. Inpatient rehabilitation facilities (IRFs) may be freestanding hospitals or specialized, hospital-based units. Medicare payments to IRFs were an estimated $6.07 billion in 2009. Medicare accounts for about 60 percent of IRF cases. In 2009, there were about 361,000 Medicare cases, and in 2010 about 1,180 facilities were Medicare certified.

Beneficiaries transferred to an IRF from an acute care hospital pay no additional deductible. However, beneficiaries admitted from the community are responsible for a deductible—$1,132 in 2011—as the first admission during a spell of illness, and for a copayment—$283 per day—for the 61st through 90th days. Coverage of IRF stays is subject to Medicare's limits on inpatient hospital care; thus beneficiaries' IRF stays are covered for 90 days of hospital care per illness, with a 60-day lifetime reserve.[1]

In January 2002, CMS implemented the inpatient rehabilitation facility prospective payment system (PPS). Under the IRF PPS, IRFs are paid predetermined per-discharge rates based primarily on the patient's condition (diagnoses, functional and cognitive statuses, and age) and market area wages. Before 2002, IRFs were paid for furnishing care to Medicare beneficiaries on the basis of their average costs per discharge, as long as they did not exceed the facility-specific limit that was adjusted annually.

Under the PPS, discharges are assigned to case-mix categories organized by clinical problems and expected resource needs. Each case-mix category has a national relative weight reflecting the expected relative costliness of treatment for patients in that category compared with that for the average Medicare inpatient rehabilitation patient.

Defining the inpatient rehabilitation products Medicare buys

Under the inpatient rehabilitation facility PPS, Medicare patients are assigned to one of 100 intensive rehabilitation categories called case-mix groups (CMGs). In 95 of these treatment categories, patients are assigned based on the primary reason for intensive rehabilitation care (for example, a stroke or burns); their age and levels of functional and cognitive impairments; and the types of comorbidities (coexisting conditions) present during the stay. Within each of these CMGs, patients are further categorized into one of four tiers based on any comorbidities they may have; each tier has a specific payment that reflects the costliness of patients in that tier relative to others in the CMG. The other five categories are for patients discharged before the fourth day—called short-stay outliers—and for those few who die in a facility. Further, IRFs may receive lower payments for other patients who are discharged to another facility and the length of stay is less than that typically provided to patients with the same condition.

Setting the payment rates

The PPS payment rates cover all operating and capital costs that IRFs would be expected to incur in furnishing intensive rehabilitation services. The base rate—$14,076 for fiscal year 2012—is adjusted for area wages by multiplying the labor-related portion of the base payment amount—70 percent—by a version of the hospital wage index and the result is added to the

This document does not reflect proposed legislation or regulatory actions.

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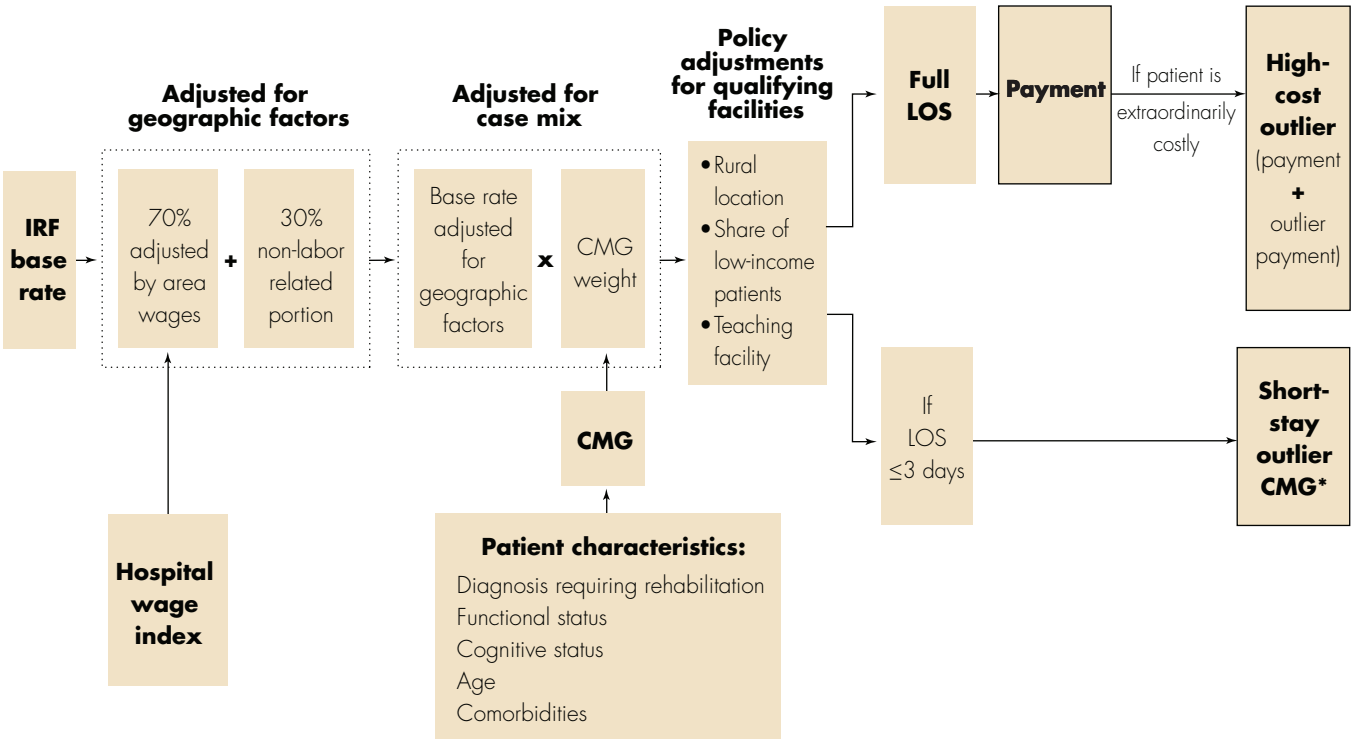
Figure 1 Inpatient rehabilitation facility prospective payment system



Note: IRF (inpatient rehabilitation facility), CMG (case-mix group), LOS (length of stay).
*IRFs with a wage index of 1.0 are paid $2,076.21 for short-stay outliers.

nonlabor portion (Figure 1). The sum is then case-mix adjusted by multiplying the local base rate by the relative weight for the CMG to create the PPS payment rate for each patient.

Payment rates are increased for IRFs located in rural markets, that treat low-income patients, and that are teaching institutions. Rural facilities' payment rates are increased by 18.4 percent because they tend to have fewer cases, longer lengths of stay, and higher average costs per case. An IRF's payments are adjusted for the share of low-income patients it treats—the adjustment is based on the sum of two proportions: the proportion of total Medicare days furnished to beneficiaries eligible for Supplemental Security Income benefits and the proportion of total patient days furnished to Medicaid patients not covered by Medicare. Unlike acute care hospitals, IRFs do not have to reach a threshold of the share of low-income patients before payments are adjusted. Payments for IRFs that are teaching institutions are adjusted according to the ratio of their residents to their average daily census.

IRFs have two outlier policies. One is for patients with short stays (less than or equal to three days) for which IRFs are paid lower rates—in fiscal year 2012, $2,076 for an IRF with a wage index of 1.0. The other is for high-cost outliers when costs exceed a fixed-loss threshold. This outlier threshold is the regular payment rate plus a national fixed-loss amount ($10,660 for fiscal year 2012), adjusted by the wage index and the other facility-level payment adjustments. For high-cost outliers, IRFs receive their regular payment rates plus 80 percent of their costs above the fixed-loss threshold. Total outlier payments are estimated to be 3 percent of spending for IRFs.

Both the base rate and relative weights are updated annually. The base rate is

updated using the market basket index (including capital) for facilities originally excluded from the acute care hospital PPS (IRFs, long-term care hospitals, inpatient psychiatric facilities, cancer, and children's hospitals). The Patient Protection and Affordable Care Act of 2010 (PPACA) provided a 0.25 percentage point reduction to the fiscal year 2010 update for discharges occurring on or after April 1, 2010. PPACA also provided for a 0.25 percentage point reduction to the update for fiscal year 2011, resulting in an adjusted fiscal year 2011 market basket increase factor of 2.25 percent. For fiscal year 2012, PPACA provided a 0.1 percentage point reduction and an adjustment for productivity, resulting in an adjusted fiscal year 2012 market basket increase factor of 1.8 percent. The relative weights are updated based on changes in national average charges per discharge for each CMG.

The 60 percent rule

The 60 percent rule, formerly known as the 75 percent rule, is a criterion used to define inpatient rehabilitation facilities in order for them to receive payment as an IRF. The rule requires that at least 60 percent of cases an IRF admits have one or more selected conditions. The 13 qualifying medical conditions used to classify a facility as an IRF are:

- stroke
- spinal cord injury
- congenital deformity
- amputation
- major multiple trauma
- hip fracture
- brain injury
- neurological disorders (e.g., multiple sclerosis, Parkinson's disease)
- burns
- three arthritis conditions for which appropriate, aggressive, and sustained outpatient therapy has failed, and
- joint replacement for both knees or hips when the surgery immediately precedes admission, when body mass index ≥50, or age 85+.

The 60 percent rule, established in 2007 by the Medicare, Medicaid, and SCHIP Extension Act (MMSEA), replaces the 75 percent rule that preceded it. CMS had, in 2002, suspended enforcement of the 75 percent rule due to inconsistent implementation by the claims processing contractors. CMS resumed enforcement of the 75 percent rule in 2004 and was in the midst of gradually phasing in the threshold from 50 percent to 75 percent over a five-year period when the MMSEA permanently rolled back the threshold to 60 percent.[2]

The MMSEA also made permanent a policy allowing secondary medical conditions to meet the 13 medical conditions that qualify towards the threshold. The secondary condition, even in the absence of the admitting condition, must cause a significant enough decline in the patient's functioning that the individual would need intensive rehabilitation services best provided in an IRF. ■

1 Beneficiaries are liable for a higher copayment for each lifetime reserve day—$566 per day in 2011.

2 The threshold was 50 percent for cost reporting periods beginning on or after July 1, 2004, through June 30, 2005, and 60 percent for cost reporting periods beginning on or after July 1, 2005, through June 30, 2007. The threshold was scheduled to be 65 percent for cost reporting periods beginning on or after July 1, 2007, through June 30, 2008, after which time the threshold would have been fixed at 75 percent. The MMSEA capped the threshold at 60 percent, retroactive to cost reporting periods beginning on or after July 1, 2007.