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To: Inpatient Rehabilitation Facility Clients

From: Glen Langlinais

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Subject: Proposed PPS Rule

Well, the wait is finally over! The Health Care Financing Administration (HCFA) has published the long-awaited PROPOSED rules for the Prospective Payment System (PPS) reimbursement for Inpatient Rehab Facilities. There will be a 60-day comment period before the Final rules are to be released. The proposed regulation is subject to significant modification, and the proposed rates of payment may be adjusted. In this letter, we present a preliminary analysis of the proposed regulation.

A proposed rule that would implement the prospective payment system (PPS) for inpatient rehabilitation facilities (IRFs) was published in the *Federal Register* on Nov. 3, 2000. Sec. 4421 of the Balanced Budget Act of 1997, as amended by Sec. 125 of the Balanced Budget Refinement Act of 1999, which authorized the IRF PPS, provided for implementation for cost reporting periods beginning on or after Oct. 1, 2000. Because of the extensive changes to HCFA's claims processing system that implementation requires, however, the IRF PPS would not be implemented until cost reporting periods beginning on or after April 1, 2001.

Implementation and administration of the IRF PPS would be driven by the Minimum Data Set for Post Acute Care (MDS-PAC). The MDS-PAC is a patient assessment instrument that focuses on patient care needs as opposed to provider characteristics. Using the MDS-PAC, patients would be classified into distinct groups and payments would be calculated based on clinical and resource needs. Data from the MDS-PAC would be used also to classify discharges by case-mix groups (CMGs). CMG analysis would indicate the level of patient care required by various types of patients. Relative weights would be calculated in proportion to the resource needs of a typical case in a
CMG.

During the two-year payment transition period, an IRF's payments under PPS would consist of a hybrid of the federal prospective payment and the IRF's payment under the current reasonable cost system. For the first transition year, payments would consist of 66⅔% of the amount based on the current system and 33⅓% based on the federal prospective payment. For cost reporting periods beginning during fiscal year 2002, payments would consist of 33⅓% under the current system and 66⅔% of the federal prospective payment. Medicare payments for IRF's for cost reporting periods beginning on or after Oct. 1, 2002, would be based solely on PPS.

We provide a number of discussions useful in understanding the development and implementation of the IRF prospective payment system.. Much of this discussion cites excerpts from the November 3, 2000 Federal Register. The following discussions are divided into the following sections:

- General Overview
- Patient Assessment Instrument (MDS-PAC)
- Case-Mix Group Classification System
- Payment Rates
- Observations

GENERAL OVERVIEW

A prospective payment system for IRFs that will replace the current reasonable cost-based payment system. The new prospective payment system will utilize information from a patient assessment instrument to classify patients into distinct groups based on clinical characteristics and expected resource needs. Separate payments are calculated for each group with additional case and facility level adjustments applied, as described below.

Patient Assessment

The MDS-PAC patient assessment instrument will be required for all Medicare patients admitted or discharged on or after April 1, 2001. In accordance with our proposed assessment schedule, the MDS-PAC would be completed on the 4th, 11th, 30th, and 60th day from the admission date of a Medicare patient and upon the discharge of a Medicare patient. In general, a 3-day observation period would be required prior to the completion of the MDS-PAC. Data from the MDS-PAC will be used to:

- Determine the appropriate classification of a Medicare patient into a CMG for payment under PPS (using data from only the MDS-PAC completed on the fourth day);
- Implement a system to monitor the quality of care furnished to Medicare patients; and
- Ensure appropriate case-mix and other adjustments can be made.

A computerized MDS-PAC data collection system will be developed. Facilities will be required to input the MDS-PAC data into the data system. In general, this system consists of a computerized patient grouping software program (grouper software) and data transmission software.

Upon the discharge of the patient, the existing Medicare claim form will be completed with the appropriate CMG indicated on the claim form so that the prospective payment can be made. The operational aspects and instructions for completing and submitting Medicare claims under the IRF prospective payment system will be addressed in a Medicare Program Memorandum once the final system requirements are developed and implemented.

Patient Classification

A patient classification system that uses case-mix groups (CMGs) will be used to classify patient discharges by functional-related groups (FRGs) based on a patient's:

- impairment,
- age,
- comorbidities, and
- functional capability.

Payment Rate

The payment unit for the proposed IRF prospective payment system for Medicare patients will be a discharge. The payment rates will encompass inpatient operating and capital costs of furnishing covered inpatient rehabilitation hospital services, including routine, ancillary, and capital costs, but not the costs of bad debts or of approved educational activities. Beneficiaries may be charged only for deductibles, coinsurance amounts, and non-covered services (for example, telephone, and television, etc.).

The prospective payment rates are determined using relative weights to account for the variation in resource needs among CMGs. The payment rates would be further adjusted to account for area wage index, and the per discharge payment amounts would be updated annually. Total payments for IRFs during fiscal years 2001 and 2002 will be projected to equal 98 percent of the amount of payments that would have been paid for operating and capital costs of IRFs had this new payment system not been enacted.

Additional adjustment will also be made to the payment rates for:

- facilities located in rural areas
- costs associated with treating low income patients (disproportional share)
- "outlier" cases that have unusually high costs
- short stay cases
- cases that expire
- transfers

Implementation

The statute provides for a 2-year transition period. During that time, 2 payment percentages will be used to determine an IRF's total payment under the prospective payment system as follows. For a cost reporting period beginning on or after April 1, 2001 and before October 1, 2001, the total prospective payment will consist of 66 ⅔ percent of the amount based on the current payment system and 33 ⅓ percent of the proposed Federal prospective payment. For a cost reporting period beginning during FY 2002, the total prospective payment will consist of 33 ⅓ percent of the amount based on the current payment system and 66 ⅔ percent of the proposed Federal prospective payment. For cost reporting periods beginning on or after October 1, 2002, Medicare payment for IRFs will be determined entirely under the proposed Federal prospective payment methodology.

Applicability

This proposed rule would not change the criteria for a hospital or hospital unit to be classified as a rehabilitation hospital or a rehabilitation unit that is excluded from the hospital prospective payment systems under sections 1886(d) and 1886(g) of the Act, nor would it revise the survey and certification procedures applicable to entities seeking this classification. Accordingly, for cost reporting periods beginning on or after April 1, 2001, hospitals or hospital units that are classified as rehabilitation hospitals or rehabilitation units will be paid under the proposed IRF prospective payment system. VA hospitals, hospitals that are reimbursed under State cost control systems, and hopitals that are reimbursed in accordance with demonstration projects are not subject to the proposed IRF prospective payment system rules.

The following discussion focuses of specific elements of the PPS system.

PATIENT ASSESSMENT INSTRUMENT

MINIMUM DATA SET FOR POST-ACUTE CARE (MDS-PAC)

Implementation of the MDS-PAC

The implementation of the per-case prospective payment system based on the "functional-related group" methodology requires the use of a standardized data collection instrument that contains the elements required to classify a patient into a distinct CMG. The data collection instrument:

- first assigns the patient into one of the various high level categories (called Rehabilitation Impairment Categories) that are based principally on ICD-9-CM diagnoses plus some additional patient information. The level of the patient's impairment are used to classify a patient into a distinct CMG within the higher level Rehabilitation Impairment Group, as determined by the patient's:
  - motor and function scores,
  - cognitive function scores, and
  - age.

- then classifies a patient's comorbidity data.

Many rehabilitation hospitals already use a patient assessment instrument that contains the functional independence measures (FIM). The proposed rule would require facilities to use the MDS-PAC assessment to facilitate continuity of care in that comparable baseline data would accompany the patient's transfer from one setting to the other. It is HCFA's objective to standardize information across provider types to enable comparison of patient characteristics and appropriateness of care in different settings that serve the same populations.

HCFA is seeking public comment on the use of MDS-PAC as the assessment instrument for the IRF prospective payment system, including:

- *comments and supporting data regarding the additional burden and cost associated with this instrument;*
- *the suitability of the instrument for the rehabilitation setting;*
- *views on whether the instrument has been properly tested and validated for industry-wide use; and*

- *the utility and reliability of the quality data items contained in the instrument*

Overview of the MDS-PAC Assessment Process

Description of the MDS-PAC: Beginning on April 1, 2001, IRFs must collect MDS-PAC data as part of the IRF's inpatient assessment process. This MDS-PAC data collection requirement applies to Medicare beneficiaries who are already inpatients as of April 1, 2001, as well as beneficiaries admitted as inpatients on or after April 1, 2001. In addition, IRFs must use the MDS-PAC to assess inpatients in accordance with the MDS-PAC assessment schedule specified in the next section. It is also proposed that IRFs computerize and electronically report the MDS-PAC data.

We enclose, with this letter, the MDS-PAC Version 1 (Appendix BB). Appendix BBB of the proposed rule also contains the Item-by-Item Guide to the MDS-PAC, which consists of instructions for completing the MDS-PAC. These instructions are approximately 125 pages and can be obtained on the HCFA web site at www.hcfa.gov/medicare/irfpps.htm.

The MDS-PAC assessment instrument consists of 15 sections, each collecting different categories of patient information. These categories include identification and demographic information about the patient, as well as the following categories of information: cognition; communication; behavior and mood; functional status; bowel and bladder continence; diagnoses; medical complexities and other health conditions; oral and nutritional information; pain status information; information on procedures and services; functional prognosis; and resources for discharge.

The IRFs would encode the MDS-PAC data by entering the MDS-PAC data into a computer software program. MDS-PAC records would be considered "locked" when they passed all HCFA-specified edits and were accepted by the MDS-PAC database to which the IRF transmitted its records.

Between February 1 and February 28, 2001, IRFs must complete a successful transmission of test MDS-PAC data to the HCFA MDS-PAC system. A successful transmission by the IRFs of test MDS-PAC data to the HCFA MDS-PAC system is necessary to determine connectivity with the system and to identify any transmission problems. The HCFA MDS-PAC system would transmit a test data feedback report to each IRF indicating that the test data transmission was either completely successful or experienced problems. The problems would be specified in the test data transmission report. On March 1, 2001, the HCFA MDS-PAC system would begin to purge all test data from the system to allow for acceptance of production data. In summary, the following time periods are specified for testing and transmission of MDS-PAC data:

February 1, 2001, to February 28, 2001--Period for *transmission* of test MDS-PAC data.

March 1, 2001, to March 7, 2001--The HCFA MDS-PAC system purges test data.

April 1, 2001--Assessments completed on or after this date must be transmitted as production data.

The MDS-PAC Assessment Reference Date

It is proposed that each assessment would have a specific assessment reference date to establish a common temporal reference point for the care team participating in the patient's assessment. The assessment reference date is a specific endpoint in the MDS-PAC assessment observation time period. Almost all MDS-PAC items refer to the patient's status over a continuous three calendar day time period, which is the observation time period. During the patient's current hospitalization, an IRF must indicate on the MDS-PAC one of the following assessment reference dates:

• For the assessment that covers calendar days 1 through 3 of the patient's current hospitalization the date that is the third calendar day after the patient started being furnished services.

• For the assessment that covers calendar days 8 through 10 of the patient's current hospitalization the date that is the 10th calendar day after the patient started being furnished services.

• For the assessment that covers calendar days 28 through 30 of the patient's current hospitalization the date that is the 30th calendar day after the patient started being furnished services.

• For the assessment that covers calendar days 58 through 60 of the patient's current hospitalization the date that is the 60th calendar day after the patient started being furnished services.

• For the assessment that must be completed when the patient stops receiving Medicare-covered Part A services but is not discharged from the IRF, the assessment reference date must be the actual date that the patient stops receiving services.

• For the assessment that is completed when the patient stops receiving services and is discharged from the IRF the assessment reference date must be the actual date of discharge from the patient rehabilitation facility.

• For discharge assessments, the date when the patient either is discharged or stops receiving Medicare-covered Part A services is the assessment reference date.

Performing the MDS-PAC Assessment

Medicare beneficiaries who are inpatients of an IRF must be assessed by a professional clinician(s), and that the MDS-PAC must be used to perform the patient assessment. The assessment process should be a collaborative team effort, employing the clinical skills of a variety of professional clinicians. A professional clinician may be a dietitian, an occupational therapist, a physical therapist, a physician, a practical (vocational) nurse, a registered nurse, a speech-language pathologist or a social worker. Physicians, registered nurses, physical therapists, and occupational therapists are the only disciplines equipped with the education and experience to accurately assess the entire range of an individual's functional/motor performance and medical/clinical status.

MDS-PAC Assessment Schedule

The length of the patient's hospitalization would determine how many MDS-PAC assessments are required. Table 4C below, entitled "MDS-PAC Assessment Schedule and Associated Dates," illustrates the proposed MDS-PAC assessment schedule for the following "MDS-PAC Assessment Type": Day 4, Day 11, Day 30, and Day 60 assessments.

TABLE 4C.--MDS-PAC ASSESSMENT SCHEDULE AND ASSOCIATED DATES

MDS-PAC Assessment Type	Hospitalization Time Period and Observation Time Period *	MDS-PAC Assessment Reference Date *	MDS-PAC Must Be Completed By: *	Hospitalization Episode Covered By This Assessment:	MDS-PAC Must Be Encoded By: *	MDS-PAC Must Be Transmitted By: *
Day 4	First 3 Days	Day 3	Day 4	Entire Hospitalization Time Period	Day 10	Day 16
Day 11	Days 8 to 10	Day 10	Day 11		Day 17	Day 23
Day 30	Days 28 to 30	Day 30	Day 31		Day 37	Day 43
Day 60	Days 58 to 60	Day 60	Day 61		Day 67	Day 73

Interrupted Stays: An interrupted stay is one in which an IRF patient is discharged from the IRF and returns to the same IRF within 3 calendar days. For purposes of the MDS-PAC assessment process, if a patient has an interrupted stay, then: (1) the initial CMG classification from the "initial" (Day 4) MDS-PAC assessment would remain in effect (no new initial MDS-PAC assessment would be performed); and (2) the required scheduled MDS-PAC update assessments must still be performed.

A patient who returns to the same IRF more than 3 calendar days after being discharged is considered a "new" patient for purposes of the MDS-PAC assessment schedule process. Being considered a "new" patient for the MDS-PAC assessment schedule process means that a new Day 4 assessment needs to be performed. That new Day 4 assessment would determine a new CMG. That new CMG may or may not be the same CMG into which the patient classified prior to the interrupted stay.

If an interruption of 3 calendar days or less occurred for any of the "MDS-PAC Assessment Type" assessment observation time periods, then the associated assessment reference dates, MDS-PAC completion dates, MDS-PAC encoded by dates, and MDS-PAC transmitted by dates for that particular "MDS-PAC Assessment Type" would be shifted forward by the number of days that the patient was not an inpatient of the IRF.

MDS-PAC Dates Associated with the Discharge Assessment: The assessment reference date for the discharge assessment is the day when one of two events occurs first: (1) the day the patient is discharged from the IRF or (2) the day the patient ceases receiving Medicare-covered Part A inpatient rehabilitation services. The MDS-PAC assessment is performed only at the first point in time either of these events occur. There may be cases when a patient ceases receiving inpatient rehabilitation Medicare-covered services, but is not discharged from the IRF.

After the assessment reference date for the discharge MDS-PAC assessment is determined the completion date for the discharge MDS-PAC assessment must be set. The completion date for the discharge MDS-PAC assessment is the 5th calendar day in the period beginning with the discharge MDS-PAC assessment reference date.

The method used to determine the completion date for the discharge MDS-PAC assessment is not the same method used to determine the completion date for the Day 4, Day 11, Day 30 or Day 60 MDS-PAC assessments. The reason for using a different method to determine the discharge MDS-PAC completion date is because of the definition of an interrupted stay. In order to ensure that a clinician does not perform a discharge assessment on a patient who meets the criteria of an interrupted stay, it is necessary to make the completion date of the discharge MDS-PAC assessment a date that exceeds the interrupted stay defined time period. This safeguard prevents the performance of unnecessary MDS-PAC discharge assessments by the IRF.

The vast majority of patients are discharged from IRFs within the first twenty calendar days of their hospitalization. Therefore, in most cases, IRFs would only perform three assessments under this proposal: The Day 4, Day 11, and the discharge assessment. Data indicated that the mean length of stay was 18.9 days, that the median length of stay was 16 days.

Assessment Rule to Use If Medicare Beneficiaries Are Receiving IRF Services on the Effective Date of this Regulation: A special MDS-PAC assessment rule for the Medicare beneficiaries who already are IRF patients on the date that this regulation becomes effective. For these patients one MDS-PAC assessment must be performed. The one MDS-PAC assessment would be used to classify a patient into a CMG, and that CMG would determine the payment the IRF would receive for all the Part A services the IRF furnished to the patient during the patient's current hospitalization.

For Medicare beneficiaries who already are IRF patients on the date that this regulation becomes effective the one MDS-PAC assessment would, as applicable, cover one of the following calendar day time periods and associated conditions: (1) When this regulation becomes effective if a patient currently hospitalized continues being an IRF patient for at least 3 calendar days, then the data for the MDS-PAC assessment items must be collected according to the instructions on the MDS-PAC form and the Item-by-Item Guide to the MDS-PAC. (2) When this regulation becomes effective if a patient currently hospitalized continues being an IRF patient for only 2 calendar days, then the data for the MDS-PAC assessment items that must be collected would pertain to only these 2 calendar days, unless the instructions on the MDS-PAC form and the Item-by-Item Guide to the MDS-PAC specify a shorter time period. (3) When this regulation becomes effective if a patient currently hospitalized continues being an IRF patient for only 1 or less than 1 calendar day then the data for the MDS-PAC assessment items that must be collected would pertain to 1

or less than 1 calendar day, unless the instructions on the MDS-PAC form and the Item-by-Item Guide to the MDS-PAC specify a shorter time period.

For this special MDS-PAC assessment, no later than 30 calendar days from the date this regulation becomes effective, all the following would apply--(1) the data for this special MDS-PAC assessment must be collected; (2) this special MDS-PAC must be completed; (3) the MDS-PAC data for this special assessment must be encoded; and (4) the MDS-PAC data for this special assessment must not only be transmitted to but also be accepted by the HCFA MDS-PAC system.

If the IRF does not, as specified above, collect, complete, encode, and transmit the data for this special MDS-PAC assessment, then the IRF would receive no payment for any of the Part A services furnished to Medicare beneficiaries who already are IRF patients on the date that this regulation becomes effective.

What MDS-PAC Items Are Collected On Each Assessment: The MDS-PAC assessments must be performed according to the schedule specified in Table 4C above. Table 7C's (enclosed) "MDS-PAC Items Required by Type of Assessment", indicates the data for each MDS-PAC item require collecting for the Day 4, Day 11, Day 30, Day 60, and discharge assessments. **Table 7C (attached) lists the MDS-PAC Items Required by Type of Assessment.**

For Day 4, Day 11, Day 30, and Day 60 assessments, IRFs must "complete" the MDS-PAC on the calendar day that follows the assessment reference date.

If the MDS-PAC assessment is late then the IRF would either receive a reduced CMG-determined payment or no payment. If the MDS-PAC assessment is less than or equal to 10 calendar days late then the reduced CMG-determined payment that would be 25 percent less than the CMG-determined payment that the IRF would otherwise have received. If any assessment is more than 10 calendar days late, then the IRF would receive no payment for the Medicare-covered Part A services furnished.

Transmission of the MDS-PAC Data: Encoded and edited data that has not previously been transmitted, must be transmitted within 7 calendar days of the day by which the data must be encoded by as specified in Table 4C "MDS-PAC Assessment Schedule and Associated Dates". The 7 calendar day transmission requirement would support claim review efforts, because prompt transmission of MDS-PAC data would facilitate the ability to compare a claim promptly against the associated MDS-PAC data which, in turn, would enhance the ability to make any necessary adjustment to the IRF's payment amount in a timely manner. HCFA will maintain a national MDS-PAC repository to which State Agencies, fiscal intermediaries and peer review organizations will have access. An adjustment to the IRF claim may be made if a discrepancy is discovered between what the MDS-PAC data indicated the CMG on the claim should be and what is actually on the claim.

In order to test transmission of MDS-PAC data using the HCFA MDS-PAC system IRFs must make a successful test transmission of test MDS-PAC data to the HCFA MDS-PAC system between February 1 and February 28, 2001. The initial test must include the following: (1) a transmission of MDS-PAC data that passes the HCFA edit checks built into the software program used by the IRF to encode the assessment data; and (2) a validation report back from the HCFA MDS-PAC system confirming transmission of data. This test data will not be included in the HCFA national repository. The test data are to contain MDS-PAC data on all Medicare inpatients, both newly admitted and those previously receiving care, that are inpatients during the test transmission time period.

Monitoring

HCFA is planning a system that can be used to monitor access to rehabilitation facilities as well as to monitor the quality of the care delivered in these facilities.

Medical Review

It is perceived that under a discharge-based prospective payment system IRFs might have financial incentives to reduce the quality and quantity of services furnished to a patient. To monitor for any reduction in the quality or quantity of services IRFs furnish, medical review may be conducted on both a random and targeted basis. Targeting may include claim-specific data and patterns of case-mix upcoding, as well as the general issues of the medical need for the episode of care and technical eligibility. There will be the capability for both prepayment and post-payment medical review that will deny claims in total or adjust payment to the correct case mix. Medical review will validate MDS-PAC data items against clinical records.

CASE-MIX GROUP CASE CLASSIFICATION SYSTEM

Under the classification system, patients would be classified into case-mix groups called CMGs based on clinical characteristics and resource needs.

Case-Mix Groups

General Description of the Case-Mix Groups:

The data elements used to construct the proposed CMGs include:

- rehabilitation impairment categories (RICs),

- functional status - (motor)
- functional status - (cognitive)
- age, and
- comorbidities (defined as additional medical conditions that increase the complexity of care delivered.

Specifically, CMGs were created to account for short-stays and expired cases.

- Cases that receive a typical, full course of inpatient rehabilitation care results in the construction of 21 RICs and 92 CMGs
- Cases that are not transfers results in the construction of 4 CMGs for cases that expire and 1CMG for cases that have a length of stay of 3 days or less.

Rehabilitation Impairment Categories: The first partition in creating the CMGs is based on the RIC of the case. RICs are groups of codes that indicate the primary cause of the rehabilitation hospitalization and are clinically homogeneous. The patient is first grouped into a RIC based on the impairment identified in the data described above. We have enclosed Table 1D from the proposed rule which is used to define and construct the first partition of the inpatient rehabilitation cases. For the majority of CMGs, the RIC represents the first two digits of the CMG. Thus, in Table 2D below, CMGs 0101 through 0111 are cases that are classified to the stroke (01) RIC. **Table 1D (attachment) lists the Rehabilitation Impairment Categories and Associated Impairment Group Codes**.

Functional Status Measures and Age: After using the RIC to define the first split among the inpatient rehabilitation cases, functional status measures and age were used to partition the cases further. Table 2D lists 92 CMGs and their respective descriptions, including the motor and cognitive scores and age that will be used to classify discharges into CMGs. Some CMGs may change based on further analysis of available data and comments we receive in response to this proposed rule.

Comorbidities: It was found that comorbidities have major effects on the cost of furnishing inpatient rehabilitation care. It was found that some comorbidities increased the cost of furnishing inpatient rehabilitation care. A list of the major comorbidities appears in Appendix C of the proposed rule. A case has to have only one of the listed comorbidities to be classified as a case with comorbidity. It was found that comorbidities affected cost per case for some of the CMGs, but not all.

Special Cases: Four CMGs were added to account for cases that expire and one CMG for all cases that have a length of stay of 3 days or less (not including transfer cases). Therefore, the total number of proposed CMGs is 97 as shown in Table 2D.

Methodology to Classify Patients into CMGs: Data from the MDS-PAC will be used to classify a patient into a CMG. Table 3D identifies the specific MDS-PAC items that must be completed in order to classify a patient into a CMG and to effectively implement the proposed prospective payment system. The MDS-PAC items will be used to establish the motor score, cognitive score, and age of the patient that corresponds with a specific CMG description.

Comment: The first two digits of the CMG number from 01 to 21 correspond with a specific RIC number shown

Case Example to Classify a Patient into a CMG:

The following example illustrates how a Medicare beneficiary would be classified to a CMG under the proposed classification system. An 82 year old woman has a left total hip replacement because of osteoarthritis, and is admitted to the IRF because of the need for rehabilitation after the hip replacement surgery. The beneficiary is first classified into RIC 08: Replacement of Left Extremity Joint with Associated Impairment Group Code 08.51: Status Post Unilateral Hip Replacement.

Assessment:

\MDS-PAC SCORE

0 Independent in eating (MDS-PAC section E, 1g);

1 Requires set up to dress upper body (MDS-PAC section E, 1e);

5 Requires maximum assistance to dress lower body (MDS-PAC section E, 1f);

1 Requires set up for grooming (MDS-PAC section E, 1j);

2 Requires minimal assistance for bed mobility (MDS-PAC section E, 1b);

5 Requires maximum assistance for bed to chair transfer (MDS-PAC section E, 1b);

5 Requires maximum assistance for walking (MDS-PAC section E, 1d);

5 Requires maximum assistance for toilet transfer (MDS-PAC section E, 1i);

5 Requires maximum assistance for bathing (MDS-PAC section E, 1k);

6 Dependent shower transfer (MDS-PAC section E, 1k);

6 Dependent stair climbing (MDS-PAC section E, 8c); and

0 Independent bowel and bladder sphincter control (MDS-PAC section F, 1 and 4.

Total MDS-PAC Motor Score: 41

This motor score places the Medicare beneficiary in CMG 0802, which is "Replacement of lower extremity joint" with a motor score from 41-33. (See footnote at the bottom of Table 2D) In developing this scoring conventions, the tables displayed only the FIM motor scores as MDS-PAC scores. We have not included the cognitive scores as MDS-PAC scores. HCFA is currently studying the aggregation of the MDS-PAC variable into the FIM cognitive categories.

Comment Concerning Tables 1E, 2D, and 5E*: The proposed rule presented a number of separate tables (Tables 1E, 2D, and 5E) which are interrelated .*

Table 2D presented the definitions of the various CMGs,

Table 1E presented the CMG Relative Weights, and

Table 5E presented the Federal Prospective Payments relative to the various CMG.

For ease of use, we have consolidated these tables and have enclosed ***combining Tables 1E, 2D, and 5E.***

PAYMENT RATES

The IRF prospective payment system proposed utilizes Federal prospective payment rates across 97 distinct CMGs. The Federal payment rates are established using a standard payment amount (referred to as the budget neutral conversion factor). A set of relative payment weights which account for the relative difference in resource use across the CMGs is applied to the budget neutral conversion factor, and finally a number of facility level and case level adjustments may apply. The facility level adjustments include those which account for geographic variation in wages (wage index), Disproportionate Share (DSH), and location in a rural area. Case level adjustments include those which apply for transfer, short-stay and outlier cases, as described later in this section. In addition, a budget neutral conversion factor provides the basis for determining the CMG based Federal payment rates.

A detailed description of each step and a discussion of the transfer policy, phase-in implementation and other policies follows.

CMG Relative Weights

Table 1E (enclosed) lists the CMGs and their respective relative weights. The relative weights reflect the inclusion of cases with a very short interruption (return on day of discharge or either of the next 2 days). As stated previously, comorbidities were found to affect the cost of certain CMGs, but not all. Thus, the value for CMGs not affected by comorbidities is the same in both the "No Comorbidity" and the "With Comorbidity" columns. Information obtained from the first assessment (Day 4 assessment) will be used to determine the appropriate CMG and corresponding payment, including existence of a comorbidity. If a relevant comorbidity is indicated on this assessment, payment will be based on the relative weight from the comorbidity column.

Transfer Payment Policy

It is HCFA's concern that incentives might exist for IRFs to discharge patients prematurely as well as admit patients that may not be able to endure intense inpatient therapy services. Patients might be transferred before receiving the typical, full course of inpatient rehabilitation, but the IRF would be paid the full CMG payment rate in the absence of a transfer policy. A transfer policy would reduce the full CMG payment rate when a Medicare beneficiary is transferred (as defined below).

Criteria for defining transfer cases:

In order for a discharge from an IRF to be classified as an early transfer:

- the length of stay for the discharge must be less than the average length of stay for non-transfer cases (cases in which the patient is discharged to the community and the length of stay is more than 3 days) in a given CMG, and

- the patient must be discharged to another rehabilitation facility, a long term care hospital, an inpatient hospital, or a nursing home that accepts payment under either the Medicare program or the Medicaid program, or both.

It is expected that some beneficiaries may require HHA or outpatient therapy services as a normal progression of care after their inpatient rehabilitation stay. There is concern that intensive use of these therapy services could be inappropriately used as a substitute for several days of an intensive therapy program in the IRF. Estimating the potential substitution of HHA therapy services is made more challenging because a HHA prospective payment system has just been recently developed, and it is difficult to anticipate how therapy services will be delivered after implementation of that system. Accordingly, there is no proposal *at this time* to include HHA, outpatient therapy, and "day programs" in the transfer policy.

A monitoring system is being developed that includes transfers or discharges from an IRF to "provider sites". This will include transfers or discharges:

- from an IRF to skilled nursing facility, long term care facilities, home health agencies and inpatient hospitals.

- from one IRF to a different IRF including situations where the transfer occurs between organizations of common ownership.

Transfer Case Payment:

Per-diem-based payment will be made for a transfer case as follows:

1. First, calculate the unadjusted per-diem amount for each CMG (except the short-stay CMG) by dividing the average length of stay for non-transfer cases (those cases discharged to the community with a length of stay more than 3 days) in the CMG into the Federal prospective payment for that CMG.

2. Next, multiply the CMG per-diem payment from the first step by the number of days that the beneficiary was in the IRF prior to their transfer. The result equals the unadjusted Federal prospective payment for the transfer case.

Special Cases That Are Not Transfers

Certain cases that have stays of less than the typical length of time and that receive less than the full course of rehabilitation treatment for a specific CMG would be paid inappropriately if the facility were to receive the full CMG payment. The three subsets are short-stay outliers, cases that expire, and interrupted stays.

Short-Stay Outlier: A short-stay outlier is defined as a case that has a length of stay of 3 days or fewer and that does not meet the definition of a transfer. A short-stay may occur when a beneficiary receives less than the full course of rehabilitative treatment because he or she leaves the facility against medical advice. Another circumstance warranting classification as a short-stay outlier involves patients who are admitted to rehabilitation facilities but are unable to tolerate intensive rehabilitative services. These patients may be discharged home and be readmitted once they are able to tolerate intensive rehabilitative services, or they may be discharged and not readmitted because they remain unable to tolerate these services. Short-stay outliers would be paid a relative weight of **0.1908**.

Cases That Expire: Where a beneficiary dies *within 3 days from admission* or fewer, the case would be classified into the short-stay CMG.

For expired cases with a length of stay *greater than 3 days*, the case would be classified into one of four CMGs, based on length of stay and whether or not the discharge falls within the orthopedic RIC.

- More specifically, one group includes orthopedic discharges with a length of stay of more than 3 days but less than or equal to the average length of stay for expired cases classified within the orthopedic RIC.

- The second group includes orthopedic discharges with a length of stay greater than the average length of stay for expired cases classified within the orthopedic RIC.

- The third group includes non-orthopedic discharges with a length of stay of more than 3 days but less than or equal to the average length of stay of expired cases that are not classified within the orthopedic RIC.

- The fourth group includes non-orthopedic discharges with a length of stay greater than the average length of stay of expired cases that are not classified within the orthopedic RIC.

Relative weights for each expired CMG are calculated using the hospital-specific relative value methodology discussed previously.

Interrupted Stay: Interrupted stay are those involving cases in which the beneficiary returns to the rehabilitation facility by midnight of the third day following a discharge. One discharge payment will be paid for these cases. The assessment from the initial stay would be used to determine the appropriate CMG.

Adjustments

In addition to the geographical wage adjustment, other adjustment payments are proposed for facilities located in rural areas. Further, adjustments are proposed to reflect the percentage of low income patients. These adjustments and the proposed payment methodologies are discussed below.

Area Wage Adjustment: The labor-related share proposed for rehabilitation facilities in FY 2001 is **71.301** percent, the same as the inpatient acute care hospital wage data. Consistent with the wage index methodologies in other prospective payment systems, hospitals are further divided into labor market areas Metropolitan Statistical Area (MSA).

To calculate the adjusted facility payments, the prospectively determined Federal prospective payment is multiplied by the labor-related percentage (0.71301) to determine the labor-related portion of the Federal prospective payments. This labor-related portion is then multiplied by the applicable IRF wage index shown in Table 3E for urban areas and Table 4E for rural areas. The resulting wage-adjusted labor-related portion is added to the nonlabor related portion, resulting in a wage-adjusted payment. For Louisiana based providers, the Wages Indices are summarized below:

Table 3E, 4E -- SELECTED Wage Index Data for LOUISIANA

MSA	Urban Area (Constituent Counties or County Equivalents)	Wage Index
0220	Alexandria, LA	0.7960
	Rapides, LA	
0760	Baton Rouge, LA	0.8782
	Ascension, LA, East Baton Rouge, Livingston, LA	
	West Baton Rouge	
3350	Houma, LA	0.7878
	Lafourche, LA	
	Terrebonne, LA	
3880	Lafayette, LA	0.8437
	Acadia, LA Lafayette, LA St. Landry, LA St. Martin, LA	
3960	Lake Charles, LA	0.8056
	Calcasieu, LA	
5200	Monroe, LA	0.8315
	Ouachita, LA	
5560	New Orleans, LA	0.9140
	Jefferson, LA Orleans, LA Plaquemines, LA St. Bernard, LA	
	St. Charles, LA St. James, LA St. John The Baptist, LA	
	St. Tammany, LA	
7680	Shreveport-Bossier City, LA	0.9126
	Bossier, LA Caddo, LA Webster, LA	
	Louisiana - Rural Areas	0.7456

The following example illustrates the calculation of the Adjusted Facility Federal prospective payment for inpatient rehabilitation facility services with a hypothetical Federal prospective payment of $10,000 for services provided in the rehabilitation facility located in Baton Rouge, Louisiana. The rehabilitation wage index value for facilities located in Baton Rouge is .8782.

The labor-related portion (71.301 percent) of the Federal prospective payment = $10,000*71.30%= $7,130.10

The wage index =. 8782

The labor related portion adjusted for wage index = ...$6,261.65

The nonlabor related portion (28.699 percent) of the Federal prospective payment = $10,000*28.699%=. . $2,869.90

Therefore, the wage-adjusted payment calculation = ($7130.10*.8782) + $2,869.90 = ... $ 9,131.55

Adjustments for Rural Location: Because the standardized cost per case for rural hospitals is 15 percent higher than the national average and on average tend to have fewer cases, a longer length of stay, and a higher average cost per case, a **1.1589** add-on adjustment is proposed for rural facilities.

Adjustments for Indirect Teaching Costs: The teaching variables were determined to be insignificant. Therefore, no adjustment is proposed for indirect teaching costs.

Adjustments for Disproportionate Share of Low-Income Patients: Each rehabilitation facility payment will be adjusted by the following formula to account for the cost of furnishing care to low income patients:

((.0001+DSH)raised to the power of .0905) / (.0001 raised to the power of .0905)):

Where DSH= Medicare SSI Days / Total Medicare Days + Medicaid, Non-Medicare Days / Total Days

Disproportionate Patient Percent	Disproportionate Share Add-on Adjustment
0%	0%
.01%	6.47%
1.00%	51.84%
5.00%	75.52%
10.00%	86.87%
20.00%	98.96%

Our preliminary calculations based on the above formula would reflect a disproportionate add-on as shown in the table at the right.

Comment: The Disproportionate Share Adjustment will play a significant role in the calculation of the PPS amount, as we explain in the latter portion of this letter.

Adjustments for Alaska and Hawaii: No adjustment is proposed, at this time, for rehabilitation facilities located in Alaska and Hawaii due to the lack of data.

Adjustments for Cost Outliers: Outlier payments will be made for discharges whose estimated cost exceeds an adjusted threshold amount ($7,066 multiplied by the facility's adjustments) plus the adjusted CMG payment. Both the loss threshold and the CMG payment amount are adjusted for wages, rural location, and disproportionate share. The estimated cost of a case will be calculated by multiplying an overall facility-specific cost-to-charge ratio by the charge. An amount will be paid equivalent to 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the CMG payment and the loss amount of $7,066, as adjusted).

Examples of Computing the Adjusted Facility Prospective Payments: The Federal prospective payments, described above, will be adjusted to account for geographic wage variation, disproportionate share and, if applicable, facilities located in rural areas.

To illustrate the methodology for adjusting the Federal prospective payments, we provide the following example.

One beneficiary is in rehabilitation facility A and another beneficiary is in rehabilitation facility B. Rehabilitation facility A has a disproportionate share adjustment of 1.0648, a wage index of 0.7456 and is located in a rural area. Rehabilitation facility B has a disproportionate share amount of 1.1337, a wage index of .8782, and is located in Baton Rouge MSA. Both Medicare beneficiaries are classified to CMG 0111 (without comorbidity). This CMG represents a stroke with motor scores in the 78-61 range and the patient is 83 years old or younger. To calculate the facility's total adjusted Federal prospective payment, we compute the wage adjusted Federal prospective payment and multiply the result by: the appropriate disproportionate share adjustment, and the rural adjustment (if applicable). The following calculation illustrates the components of the adjusted payment calculation.

Computation of a Facility's Federal Prospective Payment

	FACILITY A	**FACILITY B**
Federal Prospective Payment (From Table 5E)	$11,822.70	$11,822.70
Labor Share (From Table 2E)	x .71301	x .71301
Labor Portion of Federal Payment	= $8,429.70	= $8,429.70
Wage Index (From Tables 3E or 4E)	x 0.7456	x 0.8782
Wage Adjusted Amount	= $6,285.19	$7,402.97
Non-Labor Amount	+ $3,393.00	+ $3,393.00
Wage Adjusted Federal Payment	= $9,678.19	$10,795.97
Rural Adjustment	x 1.1589	x 1.0000
Subtotal	= $11,216.05	= $10,795.97
DSH Adjustment	x 1.0648	x 1.1337
Total Adjusted Federal Prospective Payment	**$11,942.85**	**$12,239.39**

Thus, the adjusted payment for facility A will be $11,942.85 and the adjusted payment for facility B will be $12,239.39.

Computing Total Payments

For cost reporting periods beginning on or after April 1, 2001 and before October 1, 2001, payments will be based on 66⅔ percent of the facility specific payment and 33⅓ percent of the IRF adjusted facility Federal prospective payment. The facility specific payment is the amount the facility would have been paid if the prospective payment system had not been implemented. Medicare fiscal intermediaries will continue to compute the facility specific payment amount.

Method of payment

A beneficiary will be classified into a CMG based on data obtained during the initial MDS-PAC assessment. The CMG will determine the Federal prospective payment the IRF will receive for the Medicare-covered Part-A services the IRF furnished during the Medicare beneficiary's episode of care. The payment will be based on the submission of a discharge bill, allow for intermediaries to account for the occurrence of an event during the stay which would result in a reclassification to one of the five special CMGs, for cases that

- expire or
- have a very short length of stay) or
- reflect an early transfer and
- qualifies for an outlier payment.

Accordingly, the CMG and other information to determine if an adjustment to the payment is necessary will be recorded by the IRF on the beneficiary's discharge bill and submitted to its Medicare fiscal intermediary for processing. The payment made represents payment in full for inpatient operating and capital costs, but not for the costs of an approved medical education program, bad debts, or other costs not paid for under the proposed IRF prospective payment system.

It should be noted the proposed rules will continue to allow payment under the PIP method. PIP amounts will be based on estimated prospective payments for the year rather than on estimated cost reimbursement. Of course, Intermediary approval of PIP is conditioned upon the intermediary's best judgment. Excluded from the PIP amount are outlier payments that are paid in final upon the submission of a discharge bill. In addition, Part A costs that are not paid for under PPS, including Medicare bad debts and costs of an approved educational program, will be subject to the interim payment provisions.

If an IRF is not paid under the PIP method it may qualify to receive an accelerated payment if it experiences financial difficulties due to a delay by the intermediary in making payment or there is a temporary delay in the IRF's preparation and submittal of bills to the intermediary beyond its normal billing cycle because of an exceptional situation.

Update to the Adjusted Facility Federal Prospective Payment

Future updates to the adjusted facility Federal prospective payments (budget neutral conversion factor) will include the use of an increase factor based on an appropriate percentage increase in a market basket of goods and services comprising services for which payment is made under the proposed IRF prospective payment system.

OBSERVATIONS

The IRF PPS proposal seems to follow similar parallels as was used for Hospitals in the establishment of DRG's and Home Health Agencies HHRG's. The system allows for changes in patient classification due to intervening events (transfers, death, etc) and provides for payment adjustments for high cost (Outlier) and other interrupted stay patients.

Concerns noted:

- Facilities must immediately start implementing MDS-PAC assessments. Test transmissions are required February 1st with full transition by March 31st. This time frame allows very little time to acquire, implement, test, educate, and train assessment personnel from all disciples in transition from previous assessment tools.

- Currently, Unadjusted TEFRA limits for "Old" and "New" facilities is $20,219 and $17,573. Review of Table 5E reflects Unadjusted Federal Prospective Payments amounts ranging from a low of $2,686.10 for a non-traumatic spinal cord injury with a motor score of 23-0 and no comorbidity to a high of $21,139.42 for a traumatic spinal cord injury with a motor score of 78-75 with comorbidity. The amount a case mix of 1.000 would be $6,024. This amount is significantly lower than the current TEFRA limits for Rehab Hospitals.

- The wildcard in the PPS Calculation is the Disproportionate Share (DSH) component. Our calculations reflect a DSH add-on of adjustment of 51.8% for hospitals serving Disproportionate Patient Percentage of 1% *[this is not a typo]*. Likewise, facilities would receive a DSH add-on adjustment of 75.5% if it services a Disproportionate Patient Percentage of 5%.

  Two components make up the DSH calculation: (1) the ratio of Medicaid Days to Total Days, plus (2) the ratio of Medicare SSI Days to Total Medicare Days. The Disproportionate share percentage for the Medicaid Days can easily be obtained from internal records. Serving a small Medicaid population can significantly enhance reimbursement. However, obtaining the Medicare SSI ratio is a bit more difficult. Normally, this ratio is obtained from HCFA, which accumulates this data, but this data is typically a couple of years behind schedule. This could present a problem for providers which have not been in existence long enough to build a Medicare SSI history. We strongly recommend that providers offer comment with regard to these "new" providers.

We strongly urge you to study the Proposed Rule and contact our firm concerning any questions or comments you may have. Keep in mind that this rule is subject to change before the final rule is issued. Also, while we have attempted to offer a comprehensive overview of the PPS rule, there is no substitute for reading the actual rule. A copy of the rule can be obtained on the HCFA web site at http://www.hcfa.gov/medicare/irfpps.htm.

Immediate Recommendations

We recommend that facilities immediately begin assessing the impact PPS will have on their particular facility.

- Start by selecting a representative sample of patients (ideally, all patients for the year would be preferable to a sample). At the very least, focus on your top 20 most frequent diagnosis, also targeting the longest length of stay diagnoses.

- Using MDS-PAC, score a sample of patients to determine the reimbursement under PPS

- Compare Actual Cost Reimbursement using cost reporting information with PPS Reimbursement.

PPS will completely change the way Inpatient Rehab Facilities operate. The success of your facility will hinge on the ability to adapt to these new changes. It seems that to be profitable, IRFs would need to take less complex cases while streamlining operations; or focus on complex patients while adjusting operations toward the more complicated diagnoses. It seems that it would be difficult to have it profitable operation by accepting a wide range of patients, forcing facilities to staff for more complicated cases, resulting in higher costs while still treating lower end cases.

It will become extremely important to undertake whatever steps are necessary to bring your agency technologically and operationally in line with the anticipated changes. We believe that one of the keys to success (and perhaps survival) will be the ability to gather the information in a timely fashion to properly bring clinical, billing, and financial aspects up to speed. If your computer hardware is more than two years old, it will be imperative to upgrade. Also, keep in close touch with your software vendor to monitor the progress being made to update the software to accommodate the new billing requirements. We have approximately three months left under this fully cost reimbursed environment. If you must invest in new computers, software, training, etc. now is the time.

Also, any suggestions or comments you may have to offer should be communicated to HCFA by January 1, 2001. We urge you do so.

If we can be of assistance in this matter, please do not hesitate to give us a call.

Sincerely,

LANGLINAIS & BROUSSARD

Certified Public Accountants