The final PPS rule was issued late last week. A few highlights about the rule.

- The Base rate is $11,838 per discharge, before applying any adjustments such as the wage index. For Baton Rouge, the wage adjusted rate is $10,808 before applying the appropriate Case Mix and Dispro Adjustment.

- In general, the Federal prospective payment rates are established using a standard payment amount. A set of relative payment weights (which account for the relative difference in resource use across the CMGs) is applied to the standard payment amount, and finally, a number of facility level and case level adjustments may apply. The facility level adjustments include those that account for geographic variation in wages (wage index), the percentage of low-income patients, and location in a rural area. Case level adjustments include those that apply for transfer, short-stay, interrupted stay and outlier cases.

- PPS utilizes Federal prospective payment rates across 100 distinct CMGs. Within a CMG, the existence of a specific comorbidity may be reflected in calculation of the Federal prospective payment rate. I have calculated the lowest CMG reimbursement for a Baton Rouge facility of approximately $4,170. The highest would be approximately $38,067. The payments will encompass inpatient operating and capital costs (that is, routine, ancillary, and capital costs) but not costs associated with bad debts, approved educational activities, and other costs not paid for under the PPS.

- The DSH adjustment (Dispro) is now going to have a much lesser impact. It has been drastically modified from the Proposed Rule. Based on preliminary calculations, a:

  - 5% Disproportionate Patient Population result in an additional 2.39%.

  - A 25% Disproportionate Patient Population will result in an additional 11.40%

  - A 100% Disproportionate Patient Population will result in an additional 39.8%.

- For new facilities, the DSH adjustment will be made after year-end when all of the data is in. For all facilities with a history, the adjustment will be added to the base rate at the start of PPS. Either way, the DSH adjustment is not nearly as significant as was initially proposed. It makes far more sense.

- PPS will be implemented for cost reporting periods beginning on or after January 1, 2002. The payments under the PPS for the first year will be based on **66 2/3% of the**

PPS payment and **33 1/3% of the TEFRA** payment. A facility will continue to be paid under the TEFRA (reasonable cost-based) system for its **entire** cost reporting period beginning prior to January 1, 2002. In addition, an IRF may elect to be paid 100% PPS payment, rather than payment based on the transition method. If a facility chooses not to be paid under the transition method, they must notify their intermediary no later than thirty days prior to its first cost-reporting period for which the IRF PPS applies to the facility. Year 2 will be 100% PPS.

- IRFs are required to complete a patient assessment instrument for all Medicare patients at **admission** and at **discharge**. Data elements from the assessment instrument will be used to classify a patient into a CMG. A version of **F.I.M.** will be used to assess and score the patient.

These are some of basics. Call me if you have any questions.