OVERVIEW OF THE PROPOSED PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT REHABILITATION HOSPITALS AND REHABILITATION UNITS

Section 4421 of the Balanced Budget Act (BBA) of 1997 (Public Law 105-33), as amended by section 125 of the Balanced Budget Refinement Act (BBRA) of 1999 (Public Law 106-113, Appendix F), authorizes the implementation of a per discharge prospective payment system (PPS), through new section 1886(j) of the Social Security Act, for inpatient rehabilitation hospitals and rehabilitation units – referred to as inpatient rehabilitation facilities (IRFs). To be paid under the proposed PPS, IRFs must meet the regulatory requirements to be classified as a rehabilitation hospital or rehabilitation unit that is excluded from the PPS for inpatient hospital services (acute care).

The new IRF PPS 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, including the application of case and facility level adjustments.

Major elements of the proposed IRF PPS include:

- Patient Assessment Instrument: To implement and administer the IRF PPS, we propose to use data from the Minimum Data Set for Post Acute Care (MDS-PAC) patient assessment instrument for all Medicare patients. The MDS-PAC is a patient-centered assessment instrument that places the emphasis on a patient's care needs, instead of the characteristics of the provider. The MDS-PAC supports the classification of patients for Medicare payment and an appropriate quality of care monitoring system in IRFs, including the use of quality indicators.

- Patient Classification System: The law requires the Secretary to establish classes of patient discharges of rehabilitation facilities by functional-related groups, based on impairment, age, comorbidities, and functional capability of the patient and other factors. The classification system we propose to use will allow us to classify discharges into case-mix groups called CMGs that are predictive of the resources needed to furnish patient care to various types of patients. The data used to construct the CMGs include rehabilitation impairment categories, functional status (both motor and cognitive), age, comorbidities, and other factors that were deemed appropriate to improve the explanatory power of the groups. We are proposing to use data elements from the MDS-PAC to classify a patient into a CMG.

- CMG Relative Weights: An important goal of the proposed IRF PPS is to pay each rehabilitation facility an appropriate rate for the efficient delivery of the care required by its set of Medicare beneficiaries. The system must be able to account adequately for each facility=s case-mix in order to ensure both fair distribution of Medicare payments and access to care for higher cost beneficiaries. To accomplish these goals, payment for each case has been set using a national formula that adjusts for case-mix. In this payment system, relative weights are a primary element to account for the variance in cost per discharge and resource utilization among the CMGs. To ensure that beneficiaries in all CMGs will have access to care and to encourage efficiency,

we calculate relative weights that are proportional to the resources needed by a typical case in a CMG.

- Payment Rates: The payment for a Medicare patient will be made at a predetermined, per discharge amount for each CMG. Payments under the IRF PPS will encompass all inpatient operating and capital costs of furnishing covered rehabilitation services (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 proposed IRF PPS 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 that account for geographic variation in wages (wage index), Disproportionate Share (DSH), and location in a rural area. Case level adjustments include those that apply for transfer, short-stay, interrupted stay and outlier cases.

- Adjustments to the Budget Neutral Conversion Factor: The budget neutral conversion factor will be adjusted for 1) the estimated proportion of additional outlier payments, 2) a reduction of aggregate payments under the PPS for FYs 2001 and 2002 that are estimated to be equal to 98 percent of the amount that would have been made to IRFs without regard to the PPS, and 3) changes in the coding and classification of patients that do not reflect real changes in case-mix.

- Annual Updates: Updates to the prospective payment rates for each Federal fiscal year will be promulgated in a *Federal Register* Notice.

- Payments under Transition Period: The law requires a 2-year payment transition period. During that time, an IRF's payment under the PPS will consist of a blend of the Federal prospective payment and the IRF's payment under the current (reasonable cost) system. 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 2/3 percent of the amount based on the current payment system and 33 1/3 percent of the proposed Federal prospective payment. For a cost reporting period beginning during FY 2002, the total prospective payment will consist of 33 1/3 percent of the amount based on the current payment system and 66 2/3 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.