

The Hidden Danger:

HCFA's Proposed Transfer Rule for Inpatient Rehabilitation

By:

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HCFA's Proposed Rule outlining the requirements for the Prospective Payment System for Inpatient Rehabilitation has been of great concern for rehabilitation facilities across the country since its publication in November 2000. The focus in the industry has been on the proposed payment rates, the burdensome introduction of the MDS for post-acute care and the somewhat surprising disproportionate share formula. However, there is a little-discussed provision regarding transfers that could have a profound effect on many facilities.

The primary objective of the PPS for any venue is to reach the most effective reimbursement strategies for efficient and appropriate levels of care. HCFA suggests that a transfer policy should provide payments that accurately reflect resources used and services provided and should eliminate incentives to prematurely discharge patients. In the case of inpatient rehabilitation, the payment rates are slated to be adjusted according to the number of days a patient remains in a facility if the patient is then transferred to a designated type of facility. As stated in the Rule "*matching payment as closely as possible to expected costs is the best way to reduce opportunities for financial considerations to affect clinical decisions.*"

Definition of the Transfer Rule

The Inpatient Rehabilitation PPS Transfer Rule is similar to the transfer rule currently in effect for inpatient hospitals. For inpatient rehabilitation facilities, however, the rule covers all patient diagnoses. As published in the November 3, 2000 proposed rule, the transfer rule is as follows:

If a patient is transferred from the inpatient rehabilitation facility to one of four venues:

1. Another rehabilitation facility
2. An acute inpatient hospital
3. A long term care hospital or
4. A nursing home (that accepts payment under Medicare or Medicaid),

then the patient's length of stay must be reviewed. As the rule currently stands, a patient who is discharged to home, to outpatient therapy, to home health or to a day rehabilitation program is not considered a transfer.

The proposed rule has published an appropriate length of stay based on data that has been gathered from existing facilities, for each Case Mix Group (CMG), which is the patient classification system for PPS for inpatient rehabilitation. This published length of stay becomes the benchmark for the application of the Transfer Rule. If a patient remains in the facility for more than three days, which is the defining length of stay for a short stay carrying its own payment classification, but fewer days than defined by the CMG, the transfer payment methodology is triggered.

<u>Samples of Published ALOS</u>	
CMG 0106 Stroke with Motor Score of 41-45 (with comorbidities)	ALOS 17.2 Days
CMG 0205 Traumatic Brain Injury with Motor Score of 51-66	ALOS 22.3 Days
CMG 0703 Fracture of Lower Extremity with Motor Score of 46-51 (with comorbidities)	ALOS 17.5 Days

The transfer payment methodology proposes a per-diem-based payment for the number of days of care in the facility prior to a transfer.

Calculating the Transfer Payment

The transfer payment methodology involves calculating an unadjusted per diem rate for the particular CMG by dividing the unadjusted payment rate for the CMG by the published length of stay.

Unadjusted Per Diem =	$\frac{\text{Unadjusted Payment Rate for CMG}}{\text{Average Length of Stay for CMG}}$
Example	CMG 0805: Orthopedic Replacement of Lower Extremity with Motor Scores of 50-55 and Cognitive Scores of 5-33
Unadjusted Per Diem =	$\$7,054.10 / 16.7 \text{ days} = \422.40

The unadjusted per diem rate is then multiplied by the number of days that the patient was treated in the facility to produce the unadjusted transfer payment rate.

Unadjusted Transfer Payment Rate =	Unadjusted Per Diem x Number of Days Patient Was in Facility
Example	CMG 0805
Unadjusted Transfer Payment Rate =	\$422.40 x 12 days = \$ 5,068.80

Once an unadjusted transfer payment rate is determined, the rate must be adjusted by the facility-specific factors to arrive at the final adjusted transfer payment rate for the specific patient.

Adjusted Transfer Payment Rate =		Unadjusted Transfer Payment Rate x Facility-Specific Adjustments
Example		CMG 0805
Unadjusted Transfer Payment Rate x	Labor-Related Portion (.71301) of Unadjusted Transfer Payment Rate	= Unadjusted Labor-Related Portion of Transfer Payment Rate
\$ 5,068.80 x	.71301	\$ 3,614.11
Unadjusted Labor-Related Portion of Transfer Payment Rate x	Facility's Geographic Wage Index	= Wage Adjusted Labor-Related Portion of Transfer Payment Rate
\$ 3,614.11 x	0.9091	\$ 3,285.59
Wage Adjusted Labor-Related Portion of Transfer Payment Rate +	Non-Labor Related Portion of Unadjusted Transfer Payment Rate (Total Rate less Labor-Related Portion)	= Wage-Adjusted Transfer Payment Rate
\$ 3,285.59 +	\$ 1,454.69	\$ 4,740.28
Wage-Adjusted Transfer Payment Rate x	Urban Adjustment (if Rural, then 1.1589)	= Wage and Location-Adjusted Transfer Payment Rate
\$ 4,740.28 x	1	\$ 4,740.28
Wage and Location-Adjusted Transfer Payment Rate x	Disproportionate Share Adjustment	= Adjusted Transfer Payment Rate
\$ 4,740.28 x	1.8687	\$ 8,858.16

The example above assumes a wage index of 0.9091, an urban facility and a DSH of 10%.

The result of these complex calculations is the most appropriate payment to the inpatient rehabilitation facility for a patient transferred out of the facility.

Effect of the Transfer Rule

The table below demonstrates the significant effect of the Transfer Rule on the payment for a joint replacement patient who leaves an inpatient rehabilitation facility after 12 days and is transferred to a nursing home. As shown, for one patient, there is a 28% reduction in the payment amount. On the aggregate, even if only 8-10% of a facility's patients are transfers, the effect could be substantial.

Effect of Transfer Rule on Facility-Adjusted PPS Rate

CMG 0805 (with comorbidities)	Transfer	Non-Transfer	% Change (if Transfer)
Adjusted Rate	\$ 8,858.16	\$ 12,327.63	- 28 %

Implementation Strategies

Please note that with the implementation of new reimbursement methodologies for inpatient rehabilitation, the compliance requirements for participation in the Medicare program remain the same. In other words, the Three-Hour Rule, the 75% Rule and Medical Necessity remain critical requirements for inpatient rehabilitation facilities.

The proposed Transfer Rule calls for a shift in attitude and practice to result in a successful transition to the Prospective Payment System for Inpatient Rehabilitation Facilities. It will be imperative for a facility to closely monitor patient lengths of stay. To accomplish this task, precise documentation, clear staff attention and accurate and timely data systems will be mandatory in an inpatient rehabilitation facility.

As other venues have experienced, moving to a prospective payment system is an endeavor that requires precise planning, excellent leadership, informed staff and most of all cooperation and patience. The transition will be a challenge for most facilities, but it is certainly not insurmountable.

Changes Considered By HCFA

HCFA sources project that the Final Rule for Inpatient Rehabilitation Prospective Payment System will be published during May 2001. Facilities must be aware of the publication date of this Rule and carefully review its contents, once published.

The statutory authority for PPS for Inpatient Rehabilitation refers to early transfers as transferring a patient from a rehabilitation facility to another site of care. The statute, however, does not define "site of care." As the proposed rule discussed, the "site of care" could be defined as an "institutional site" or more broadly as a "provider site." Currently, the proposed rule defines "site of care" as only an "institutional site" as discussed above.

However, there will be more consideration given to expanding the definition to "provider site" to include, as transfers, discharges to home health, outpatient rehabilitation and day programs. After more analysis, HCFA can better assess whether these services should be considered to the extent they can determine when home health and outpatient services are used as a substitute for inpatient rehabilitation rather than in the normal progression of care. HCFA is considering instituting a monitoring system to capture data on patient transfers.

Additionally, HCFA will examine the distribution of costs over the length of a patient's stay. Currently, the payment methodology is based on the assumption that costs are distributed evenly over the course of a stay. If it is determined that there is a great variance in cost over time during the course of a patient's stay, HCFA could change their payment methodology for transfers to more accurately reflect the costs of care.

Conclusion

Inpatient Rehabilitation Facilities can minimize the financial and behavioral impact of the transition to PPS by being prepared both organizationally and psychologically for the change. Leadership and dissemination of information and new practice procedures will be paramount. Planning in the areas of finance, technology, staffing and organizational orientation can help smooth the transition period. Facing the changes armed with information and confidence to implement what will be one of the biggest challenges facing inpatient rehabilitation, will prove to give a facility an advantage over those who choose to postpone planning or passively allow the inevitable to materialize. Be aggressive in your implementation plan and your facility will benefit.

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Site of Care = ?

Institutional Site = other rehabilitation facilities, long-term care hospitals, inpatient hospitals, and nursing homes (that accept payment under Medicare or Medicaid)

Provider Site = Institutional Sites + home health, outpatient rehabilitation and day program services

This article can also be found in Rehab Management Magazine, June/July 2001 Issue, or visit there web-site at www.rehabpub.com.