

Deciphering the Details:

An update on implementing PPS for inpatient rehabilitation facilities.

By:

Cherilyn G. Murer, J.D., C.R.A.
President & CEO - The Murer Group

Reimbursement for operating costs of most hospital inpatient services has been subject to a prospective payment system for nearly two decades. The Hospital Inpatient Prospective Payment System (PPS) was implemented in October of 1983. While most services were subject to the new PPS, a number of specialty hospitals and units were excluded due to the particular nature of their patient population and the purpose of the venue.

With the advent of the Balanced Budget Amendment of 1997, Congress expressed its intent to transform the reimbursement scheme of all health care venues from one of cost-based reimbursement to one of prospective payment.

One of the more difficult methodologies to establish for a prospective payment system relates to comprehensive inpatient rehabilitation. Unlike acute care hospitals, which are diagnosis-based, rehabilitation programs primarily address functional and cognitive deficits where severity may vary greatly based on the same diagnosis. Nevertheless, after years of research and debate, a methodology has been developed and as required by the Balanced Budget Act of 1997 (BBA) and amended by the Balanced Budget Refinement Act of 1999 (BBRA) and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), the Inpatient Rehabilitation Facility (IRF) will soon be reimbursed by Medicare under the Prospective Payment System.

History of Inpatient Rehabilitation and the Prospective Payment System (PPS)

1983

- ❖ Implementation of Hospital Inpatient PPS
- ❖ Rehabilitation hospitals and units were excluded from PPS

1997

The Balanced Budget Act (BBA) required:

- ❖ Linking updates to financial performance
- ❖ Instituting limits to TEFRA caps for new and existing providers
- ❖ Mandating conversion to PPS

1999

The Balanced Budget Refinement Act (BBRA) instituted other changes including:

- ❖ Authorization for the implementation of a "per discharge" PPS.

On November 3rd, 2000, HCFA published the new proposed rule governing the Prospective Payment System for Inpatient Rehabilitation Facilities in the Federal Register (65 Fed. Reg. 66303). As it is a proposed rule, there was an appropriate period for public comment that recently ended on February 1, 2001 and the final rule will be published sometime thereafter. Obviously, the PPS is a sweeping change in reimbursement for inpatient rehabilitation. The PPS will replace the reasonable cost-based TEFRA payment system under which the rehabilitation hospitals and rehabilitation units are currently paid. Specialty hospitals and units throughout the country are now reviewing their strategic position in preparation for this change.

As to an implementation date, although the statute provides for PPS for inpatient rehab to be implemented for cost-reporting periods beginning on or after October 1, 2000, HCFA provided April 1, 2001 as the new implementation date in the proposed rule. HCFA has now stated that the April 1, 2001 implementation date is not feasible. HCFA will publish the implementation date for this important change in the Final Rule. It is quite possible that HCFA will choose the Federal fiscal year as a deadline, resulting in PPS for inpatient rehab to be implemented for cost-reporting periods beginning on or after October 1, 2001, but there are no guarantees.

HCFA has authorized a phase-in period over the next two years. The phase-in provides that the IRF's reimbursement ratio will be 2/3 of their facility specific TEFRA rate and 1/3 PPS payments for the first year. For the next year, the IRF will receive 1/3 of their facility specific TEFRA rate and 2/3 PPS payments. The following year the IRF will be completely integrated into the PPS by receiving 100% of their reimbursement payments through the new system. Since the implementation of the Rule has been postponed, the Final Rule will determine the specific dates applicable to the phase-in. Additionally, BIPA provides an opportunity for a facility to skip the phase-in and move directly to a fully phased-in PPS rate. This legislative change stemmed from the reaction of the skilled nursing facility (SNF) lobby when SNF PPS was implemented. There was no option for SNFs to skip the phase-in and that was not well accepted by some SNFs.

It is important to clarify what types of costs are covered by the PPS for inpatient rehabilitation. The new system encompasses routine, ancillary and capital costs for Inpatient Rehabilitation Facilities but will not cover educational activities, bad debt and other costs. One of the goals of the implementation of the PPS on IRF's is to pay each rehabilitation facility an appropriate payment for the efficient delivery of care required by the facility's Medicare patients.

As a payment unit, the Prospective Payment System uses a per discharge methodology. The payment rate for IRF's is based on the average payment per discharge for operating and capital costs adjusted by an additional increase factor, additional payments for outliers, geographic wage variations, case-mix weighing factors, and all other factors for which the Secretary of Health and Human Services deems appropriate.

The standard rate for IRF PPS is calculated using the relative payment weights for Case Mix Groups (CMGs) adjusted by both facility adjustments and case adjustments. A facility adjustment is an adjustment to the payment based on the specific costs of a facility due to its special circumstances, mostly with regard to geographic location. Facility adjustments include geographic wage index, disproportionate share and rural area considerations. Case adjustments relate to each specific patient by bringing items such as transfers, short stays, and outliers into the reimbursement formula. As recently imposed by BIPA, the total payments for IRF PPS must be equal the amount of payments that the facilities would have received under the cost-based system for fiscal year 2002.

Case Mix Groups are made up of four elements. These elements include a patient's age, functional status (motor and cognitive), comorbidities (additional medical conditions that increase the complexity of care delivered), and Rehabilitation Impairment Categories. There are 92 CMGs plus one for short stay patients (less than 3 days) and four categories for expired patients.

Rehabilitation Impairment Categories (RICs) are groups of codes that indicate the primary cause of the rehabilitation hospitalization. There are 21 RICs. The categories are Stroke, Traumatic Brain Injury, Non-traumatic Brain Injury, Traumatic Spinal Cord Injury, Non-traumatic Spinal Cord Injury, Neurological, Orthopedic Fracture of Lower Extremity, Orthopedic Replacement of Lower Extremity, Other Orthopedic, Amputation - Lower Extremity, Amputation - Other, Osteoarthritis, Rheumatoid and Other Arthritis, Cardiac, Pulmonary, Pain Syndrome, Major Multiple Trauma (without brain or spinal cord injury), Major Multiple Trauma (with brain or spinal cord injury), Guillian Barre, Miscellaneous, and Burns.

To determine the CMG's, staff must categorize the patient in the appropriate RIC based on their reason for admission. After the patient has been assigned to an RIC, the patient's motor and cognitive functional status, the patient's comorbidity data and the patient's age determine which CMG is assigned to the patient. To efficiently collect and use the appropriate patient data, the PPS-IRF rule proposes the use of a new patient assessment tool.

The History of Inpatient Rehabilitation and PPS (continued)

2000

Passage of the Medicare, Medicaid, SCHIP Benefits Improvement and Protection Act (BIPA):

- ❖ Providing total payments for rehabilitation facilities (hospitals and units) in FY 2002 will equal the amount of payments that would have been made if PPS for inpatient rehabilitation had not been enacted
- ❖ Allowing a rehabilitation hospital to make a one-time election, not later than 30 days prior to the beginning of its first cost reporting period under PPS, to be paid on the basis of a fully phased-in PPS rate

The rule proposes that Inpatient Rehabilitation Facilities will use the Minimum Data Set for Post Acute Care (MDS-PAC) as a patient assessment tool. This tool will allow staff to collect data to categorize the patient in the proper payment category.

The proposal to use a new assessment tool as opposed to the familiar FIM (functional independent measures) tool is to facilitate the ability to have a common measurement instrument across different post-acute provider settings. It is anticipated that the MDS-PAC can be such a tool. There is a possibility that through current study results, it will be determined that the MDS-PAC is not the proper tool to use, as it is written, and that modifications may be made to make the tool more in line with the FIM tool.

If used, the rule proposes that the MDS-PAC must be completed for all Medicare patients admitted or discharged on or after the effective date. Facilities would complete an MDS-PAC for each patient at the time of admission, on the 4th day, the 11th day, the 30th day, the 60th day and on the date of discharge.

The Minimum Data Set for Post Acute Care has twelve 12 sections. They are Cognition, Communication, Behavior and Mood, Functional Status, Bowel & Bladder Continence, Diagnoses, Medical Complexities, Oral & Nutritional Information, Pain Status Information, Information on Procedures & Services, Functional Prognosis, and Resources for Discharge.

HCFA mandates the MDS-PAC information must be electronically transferred to its new MDS-PAC computer system. HCFA has decided to work out any potential bugs this new system may have ahead of time. Any problems that HCFA's new computer system experiences and any bugs in the electronic transferring system, in general, will hopefully be uncovered during a trial period. The trial was originally scheduled to occur during February 2001 with the actual start date for electronic data submission on April 1, 2001. The new trial and start dates will be published in the Final Rule.

Prudent IRF's should have an effective system for MDS-PAC information submission in place as soon as possible, since HCFA's proposed penalties for information submitted late is quite substantial. Mishaps could cost providers huge losses. If a submission is made 1-10 days late, a default rate will be paid which will equal only 75% of the actual CMG-specific reimbursement rate. If a submission is over 10 days late, no payment will be paid for the corresponding discharge.

Confused? It is not difficult to get lost in the new terminology and complex formula. This makes preparation time absolutely essential. Outside legal consultation is also a valuable option.

There is a reason most CFOs have not been looking forward to the implementation of the Prospective Payment System for Inpatient Rehabilitation Facilities. The proposed reimbursement rates can be considerably lower than those IRF's currently receive.

For example, the typical IRF may have a facility-specific TEFRA rate of \$12,000 for all patients. Under IRF-PPS, for a stroke patient with moderate mobility and comorbidities, in an urban facility, the IRF will receive approximately \$7000. This amount will vary according to the IRF's disproportionate share adjustment, the wage index of the IRF's location and whether the IRF is classified as being located in an urban or rural area.

Because HCFA's proposed penalties for non-compliance can be costly, it is important that facilities have a compliance plan in place and strategic policies developed for implementing such a plan. There are many fundamental changes that these new proposed regulations create for Inpatient Rehabilitation Facilities. Developing strategies to ensure compliance is not only the most provident thing for healthcare leadership in IRF's to do, it is a necessity.

About the Author: Cherilyn G. Murer, J.D., C.R.A., is C.E.O. and founder of The Murer Group, a legal-based healthcare management consulting firm in Joliet, Illinois, specializing in strategic analysis and business development. Ms. Murer can be reached at (815) 727-3355. To learn more about Murer Consultants see their web-site at www.murer.com.

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