INPATIENT REHABILITATION FACILITIES PAYMENT SYSTEM

*payment***basics**

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After an illness, injury, or surgery, some patients need intensive inpatient rehabilitation services, such as physical, occupational, or speech therapy. Such services are frequently provided in skilled nursing facilities (SNFs) but are sometimes provided in inpatient rehabilitation facilities (IRFs). Comparatively few Medicare beneficiaries use IRFs, in part because nationwide there are fewer IRFs than SNFs but also because, to be eligible for treatment in an IRF, the patient generally must be able to tolerate and benefit from three hours of therapy per day.

IRFs may be freestanding facilities or specialized units within acute care hospitals. To qualify as an IRF, a facility must meet Medicare's conditions of participation for acute care hospitals. In addition, the facility must be primarily focused on treating one of 13 conditions that typically require intensive rehabilitation therapy (see the discussion of the IRF compliance threshold below), and must meet other requirements, such as having a medical director of rehabilitation who provides services in the facility on a full-time basis (or for at least 20 hours per week in hospital-based units). Medicare payments to IRFs totaled an estimated $7.7 billion in 2016. Medicare beneficiaries account for about 60 percent of IRF cases. In 2016, there were about 391,000 fee-for-service Medicare cases, and 1,200 facilities were Medicare certified. Freestanding IRFs accounted for 50 percent of Medicare IRF discharges but just 23 percent of facilities.

Beneficiaries transferred to an IRF from an acute care hospital pay no additional deductible. However, beneficiaries admitted from the community are responsible for a deductible—$1,340 in 2018—as the first admission during a spell of illness. Beneficiaries are responsible for a copayment—$335 per day—for the 61st through 90th days. Coverage of IRF stays is subject to Medicare's limits on inpatient hospital care; thus beneficiaries' IRF stays are covered for 90 days of hospital care per illness, with a 60-day lifetime reserve.[1]

Defining the inpatient rehabilitation facility product Medicare buys

Since January 2002, Medicare has paid IRFs predetermined per discharge rates based primarily on the patient's condition (diagnoses, functional and cognitive statuses, and age) and market area wages. Under the IRF prospective payment system (PPS), Medicare's payment rates are intended to cover all operating and capital costs that efficient facilities are expected to incur in furnishing intensive inpatient rehabilitation services.

Setting the payment rates

Payments to IRFs are determined by adjusting a base payment rate for geographic differences in labor costs and for case mix. The base payment rate for each IRF discharge is based on the national average routine operating, ancillary, and capital costs in IRFs in 1998, updated for inflation. The IRF base payment rate—$16,021 for fiscal year 2019—is adjusted for differences in labor costs by multiplying the labor-related portion of the base payment amount—71 percent—by a version of the hospital wage index (Figure 1).

The wage-adjusted base rate is then case-mix adjusted. Medicare patients are assigned to case-mix groups (CMGs) based on the primary reason for intensive rehabilitation care (for example, a stroke or hip fracture), age, and level of motor and cognitive function. Within each of these CMGs, patients are further categorized into one of four tiers based on the presence of specific comorbidities that have been found to increase the cost of care. Each CMG

This document does not reflect proposed legislation or regulatory actions.

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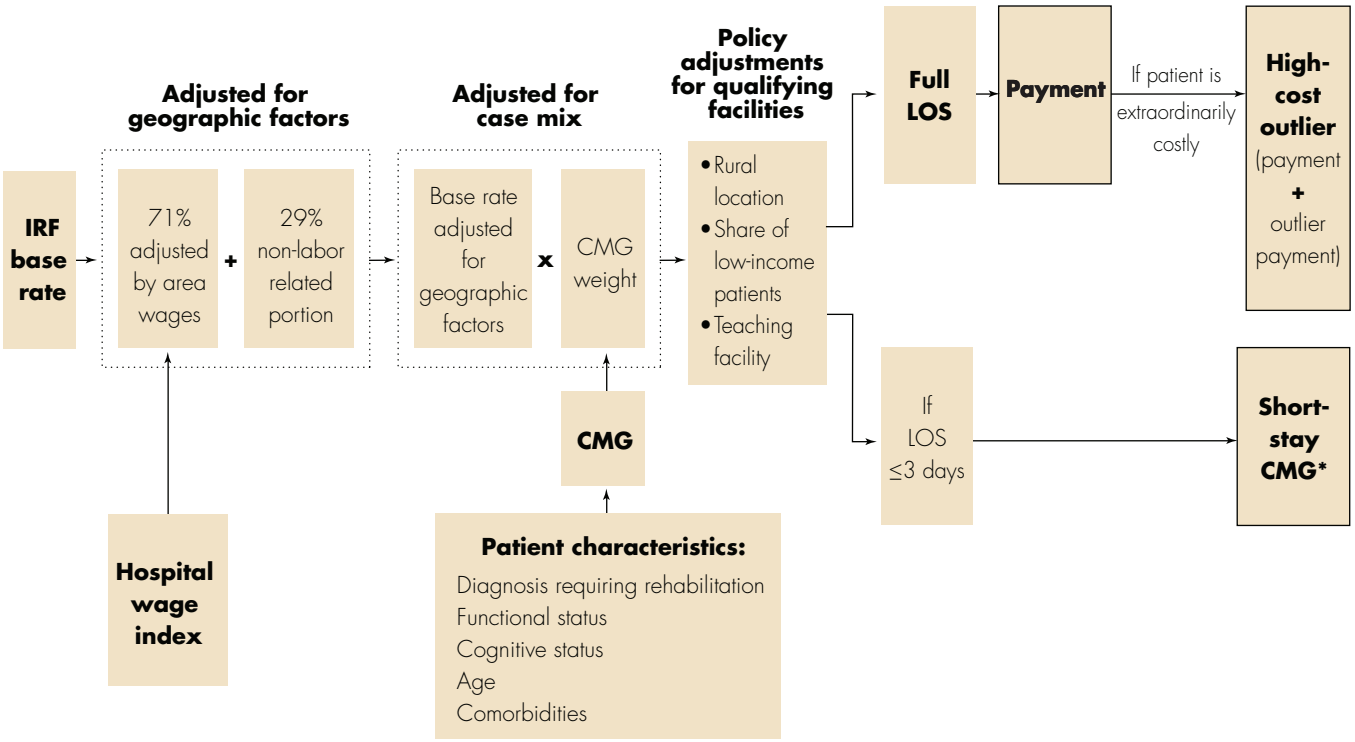
Figure 1 Inpatient rehabilitation facility prospective payment system



Note: IRF (inpatient rehabilitation facility), CMG (case-mix group), LOS (length of stay).
*IRFs with a wage index of 1.0 are paid $2,562 for short-stay cases in fiscal year 2019.

tier has a specific weight that is used to adjust the base payment rate up or down, to reflect the costliness of patients in that CMG tier relative to the costliness of the average Medicare IRF patient. Patients with a length of stay less than 4 days are assigned to a single CMG regardless of diagnosis, age, level of function, or presence of comorbidities.[2]

Payment rates are also adjusted to account for certain facility characteristics. Rural facilities' payment rates are increased by 14.9 percent because they tend to have fewer cases, longer lengths of stay, and higher average costs per case. Payments for IRFs that are teaching institutions are adjusted upward based on the ratio of residents to average daily census. In addition, an IRF's payments are adjusted for the share of low-income patients it treats. This adjustment is based on the facility's combined share of Medicare days furnished to beneficiaries eligible for Supplemental Security Income benefits and the share of all patient days furnished to Medicaid patients not covered by Medicare.[3]

High-cost outliers—The IRF PPS has an outlier policy for cases that are extraordinarily costly. Medicare makes outlier payments when an IRF's estimated total costs for a case exceed a cost threshold. The outlier payment for a case is equal to 80 percent of costs above this threshold. The cost threshold is equal to the sum of the IRF's usual payment for the case-mix group plus a fixed-loss amount (For fiscal year 2019, the fixed-loss amount is $9,402, adjusted for the applicable wage index and the facility characteristics outlined above). High-cost outlier payments are funded by reducing

the standard base payment amount for all IRFs by an amount estimated to equal 3 percent of total spending for IRFs.

Interrupted stays—IRFs receive one payment for"interrupted-stay" patients. An interrupted stay is when a patient is discharged from an IRF and returns to the same IRF within 3 days.

The IRF compliance threshold ("60 percent rule")

To receive payment under the IRF PPS, a facility must demonstrate that it is primarily engaged in furnishing intensive rehabilitation services. The compliance threshold requires that no less than 60 percent of an IRF's patient population (Medicare and other) have as a primary diagnosis or comorbidity at least one of 13 conditions that typically require intensive rehabilitation therapy. The 13 qualifying medical conditions, specified by CMS, are:

- stroke
- spinal cord injury
- congenital deformity
- amputation
- major multiple trauma
- hip fracture
- brain injury
- certain neurological conditions (e.g., multiple sclerosis, Parkinson's disease)
- burns
- three arthritis conditions for which appropriate, aggressive, and sustained outpatient therapy has failed
- hip or knee replacement when it is bilateral, when the patient's body mass index is greater than or equal to 50, or when the patient is age 85 or older.

The intent of the compliance threshold is to distinguish IRFs from acute care hospitals. Facilities that cannot demonstrate compliance with the 60 percent rule are paid as acute care hospitals under the inpatient PPS.

Payment updates

Both the base rate and relative weights are updated annually. The base rate is updated using an IRF-specific market basket index, which measures the price increases of goods and services IRFs buy to produce patient care.[4] The Patient Protection and Affordable Care Act of 2010 (PPACA) requires that the annual update to the IRF payment rates be reduced by an adjustment for productivity, beginning in FY 2012. PPACA required that the update be further reduced by an additional adjustment through FY 2019. ■

1 Beneficiaries are liable for a higher copayment for each lifetime reserve day—$670 per day in 2018.

2 The few patients who die in IRFs are assigned to one of four CMGs depending on the primary reason for IRF care and the patient's length of stay.

3 Unlike acute care hospitals, IRFs do not have to reach a threshold share of low-income patients before payments are adjusted.

4 By law, the market basket increase is reduced by 2 percentage points for IRFs that fail to provide data on quality indicators specified by CMS.