

PPS Prospective payment system
RIC Rehabilitation impairment category
SNF Skilled nursing facility

I. Background

A. Overview of the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)

Section 1886(j) of the Social Security Act (the Act) provides for the implementation of a prospective payment system under Medicare for inpatient hospital services furnished by a rehabilitation hospital or a rehabilitation unit of a hospital (referred to as an inpatient rehabilitation facility (IRF)). Sections 1886(d)(1)(B) and 1886(d)(1)(B)(ii) of the Act give the Secretary of Health and Human Services (the Secretary) discretion in defining a rehabilitation hospital and rehabilitation unit of a hospital. The regulations at 42 CFR 412.23(b), 412.25, and 412.29, specify the criteria for a hospital to be classified as a rehabilitation hospital or rehabilitation unit. Hospitals and units meeting such criteria are eligible to be paid on a prospective payment basis as an IRF under the IRF PPS.

Payments made under the IRF PPS cover inpatient operating and capital costs of furnishing covered rehabilitation services (that is, routine, ancillary, and capital costs), but not costs of approved educational activities, bad debts, and other services or items outside the scope of the IRF PPS. Covered rehabilitation services include services for which benefits are provided under Medicare Part A (Hospital Insurance).

Payments under the IRF PPS are made on a per discharge basis. A patient classification system is used to classify patients in IRFs into case-mix groups (CMGs). The IRF PPS uses Federal prospective payment rates across distinct CMGs. A majority of the CMGs are constructed using rehabilitation impairment categories (RICs), functional status (both motor and cognitive), and age (in some cases, cognitive status and age may not be a factor in defining a CMG). Special CMGs are constructed to account for very short stays, and for patients who expire in the IRF.

For each CMG, we develop relative weighting factors to account for a patient's clinical characteristics and expected resource needs. Thus, the weighting factors account for the relative difference in resource use across all CMGs. Within each CMG, the weighting factors are "tiered" based on the estimated effect that the existence of certain comorbidities have on resource use.

The Federal prospective payment rates are established using a standard payment amount (also referred to as the budget neutral conversion factor). For each of the tiers within a CMG, the relative weighting factors are applied to the budget neutral conversion factor to compute the unadjusted Federal prospective payment rates.

Adjustments that account for geographic variations in wages (wage index), for the percentage of low-income patients, and for facilities located in a rural area are applied to the unadjusted Federal prospective payment rates. In addition, adjustments are made for early transfers of patients, interrupted stays, and high-cost outliers (cases with unusually high costs).

(We note that, for cost reporting periods that began on or after January 1, 2002 and before October 1, 2002, IRFs either transitioned into the prospective payment system and received a "blended payment," or elected to be paid 100 percent of the Federal IRF PPS rate. For cost reporting periods beginning on or after October 1, 2002 (FY 2003), the transition methodology has expired and payments for all IRFs are now based on 100 percent of the adjusted Federal prospective payment under the IRF PPS.)

Implementing regulations for the IRF PPS are located in 42 CFR part 412, subpart P. Regulations governing the requirements for classification of hospitals as IRFs are located in 42 CFR 412.22, 412.23, 412.25 and 412.29.

A complete discussion of the development of the IRF PPS is included in the August 7, 2001 final rule (66 FR 41316). We also have established a CMS Web site that contains useful information regarding the IRF PPS. The Web site URL is <http://www.cms.hhs.gov/providers/irfpps/default.asp> and may be accessed to download or view publications, software, and other information pertinent to the IRF PPS.

B. Requirements for Updating the Prospective Payment Rates Under the IRF PPS

Section 412.628 of the regulations requires us to publish information pertaining to the IRF prospective payment rates in the **Federal Register**, on or before August 1 of the preceding fiscal year. We are required to include in the **Federal Register** document the classifications of the IRF case-mix groups (CMGs), the weighting factors that are applied to the CMG in determining the payment rate, and a description of the methodology and data used to compute the prospective

payment rates for the applicable fiscal year.

The initial FY 2002 IRF prospective payment rates were established on August 7, 2001 in a final rule entitled "Medicare Program; Prospective Payment System for Inpatient Rehabilitation Facilities (CMS-1069-F)" in the **Federal Register** (66 FR 41316) and were effective for cost reporting periods beginning on or after January 1, 2002. On August 1, 2002, we published a notice in the **Federal Register** (67 FR 49928) that updated the IRF Federal prospective payment rates from FY 2002 to FY 2003 using the methodology specified in § 412.624 of the regulations. On July 1, 2002, we also published in the **Federal Register** (67 FR 44073) a correcting amendment to the August 1, 2001 final rule. Therefore, any reference in this final rule to the August 7, 2001 final rule includes the provisions effective in the correcting amendment.

As discussed in section II of this preamble, on May 16, 2003, we issued a proposed rule in the **Federal Register** (68 FR 26786) to update the IRF Federal prospective payment rates from FY 2003 to FY 2004, to be effective for discharges occurring on or after October 1, 2003 and before October 1, 2004. For the proposed FY 2004 updates, we used the same classifications and weighting factors that were used for the IRF CMGs set forth in the August 7, 2001 final rule to update the IRF Federal prospective payment rates from FY 2002 to FY 2003.

C. Operational Overview of the IRF PPS

In accordance with existing regulations at § 412.606, upon the admission and discharge of a Medicare Part A fee-for-service patient, the IRF is required to complete the appropriate sections of a patient assessment instrument. CMS has established the Inpatient Rehabilitation Facility—Patient Assessment Instrument (IRF-PAI) for this purpose. All required data must be electronically encoded into the IRF's PAI software product. Generally, the software product includes patient grouping programming called the GROUPER software. The GROUPER software uses specific PAI data elements to classify (or group) a patient into a distinct CMG and account for the existence of any relevant comorbidities. The GROUPER software produces a 5-digit CMG number. The first digit is an alpha-character that indicates the comorbidity tier. The last 4 digits represent the distinct CMG number. (Free downloads of the Inpatient Rehabilitation Validation and Entry (IRVEN) software product, including the GROUPER software, are available at the CMS Web site at <http://>