Sorting Out the Inpatient Rehabilitation PPS

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FRGs, RIC, CMGs, FIM, MDS-PAC, IRF, RPPS, UDSMR...What do these letters mean? They are all part of the inpatient rehabilitation prospective payment system (RPPS). This article will explain the history and key pieces of this system.

A Brief History of PPS

As we know, the Social Security Act sets forth a payment system for the operating costs of acute care hospital inpatient stays under Medicare Part A (hospital insurance), based on prospectively set rates. The act requires the Health Care Financing Administration (HCFA) to pay for the capital-related costs of hospital inpatient stays under a prospective payment system. Under these inpatient PPSs, Medicare payments for hospital inpatient operating and capital-related costs are made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis related groups (DRGs).

However, certain specialty hospitals and hospital units are excluded from the prospective payment systems: psychiatric hospitals and units, rehabilitation hospitals and units, children's hospitals, long-term care hospitals, and cancer hospitals. For these hospitals and units, Medicare payment for operating costs is based on reasonable costs subject to a hospital-specific annual limit.

The Balanced Budget Act of 1997 (BBA) required the Secretary of Health and Human Services to implement a prospective payment system for inpatient rehabilitation facilities (IRF) and rehabilitation units. The BBA mandated the phase-in of a case mix-adjusted PPS.

This RPPS was to be fully implemented for cost reporting periods beginning on or after October 1, 2002, with payment provisions during a transitional period of October 1, 2000, to October 1, 2002, based on target amounts. However, after an extensive analysis of the changes required to HCFA's systems, HCFA concluded that it was "infeasible" to implement the IRF prospective payment system as of October 1, 2000.

Now HCFA plans to implement the IRF PPS for cost reporting periods beginning on or after April 1, 2000. The BBA also required HCFA to use the discharge as the payment unit under the PPS for inpatient rehabilitation services and to establish classes of patient discharges by functional related groups (FRGs).

According to the American Medical Rehabilitation Providers Association (AMRPA), "The only classification system that has been proven to predict the cost of treating various types of rehabilitation patients is the FRGs." Rehabilitation patients were originally excluded in 1982 from the DRGs because of a lack of data. It was then determined that the cost of treating rehabilitation patients could not be predicted based on the patient's diagnosis. As the rehabilitation industry adopted the practice of tracking the functional status of patients, a large core of detailed patient data was developed. Several entities support the adoption of the FRGs: The Medicare Payment Advisory Commission (MedPAC), American Hospital Association (AHA), American Medical Rehabilitation Providers Association (AMRPA), Federation of American Health Systems, American Academy of Physical Medicine and Rehabilitation, and the American Academy of Neurology.

Data Collection Systems

The Uniform Data System for Medical Rehabilitation (UDSMR) is a performance measurement system. In 1990, the UDSMR developed the Functional Independence Measure (FIM) instrument for documenting the severity of patient disability and the outcomes of medical rehabilitation. According to the AMRPA, "The Functional Independence Measure (FIM) became the industry standard for tracking the functional abilities of patients at admission, discharge and post-discharge."

Dr. Margaret Stineman, an associate professor in rehabilitation medicine at the University of Pennsylvania, determined in a 1990 study that the predictive variables for the length of stay (LOS) for rehabilitation patient were diagnosis, age, and FIM scores. For the first time, it appeared that the episode of care for rehabilitation could be predicted. Then in 1995, UDSMR and HCFA entered into a formal agreement that granted HCFA a license to use the FIM instrument for the purposes of a RPPS. Additionally, HCFA contracted with the RAND Corporation, a nonprofit organization that uses research and development to improve policy and decision making, to study the feasibility of using the FIM-FRG system. This study, published in 1997, showed that not only could FRGs predict the LOS of a patient, they could also predict the cost to treat that patient. Further, it included a complete and comprehensive design of a PPS for rehabilitation, including suggested modifiers to the standard payments and outlier contingencies.

During the past several years, according to HCFA, the population served by many such facilities has changed to include an increased number of individuals receiving care of a short-term, rehabilitative nature. While no parameters for defining a "short stay" have officially been established, the industry has generally viewed this as approximately 30 days or less. Many providers of what the industry refers to as "subacute" care have long called for an exemption from the statutory requirement or an alternative to the Resident Assessment Instrument (RAI) that is tailored more to the needs of this growing population.

It was noted that since 1990, all Medicare and Medicaid-certified long-term care facilities have been statutorily required to use the RAI. The RAI is comprised of the minimum data set (MDS) and resident assessment protocols (RAPs) to assess any individual who resides in the facility for more than 14 days. In 1997, HCFA began work on developing an MDS-based assessment instrument for use with the growing population that receives "subacute" care.

In 1997, HCFA contracted with the Hebrew Rehabilitation Center for the Aged (HRCA) to develop a clinical assessment tool to be used in SNFs, rehabilitation providers and long-term care hospitals, now known as MDS-PAC (Minimum Data Set-Post Acute Care). HRCA stated that it has incorporated the essence of the FIM into the MDS-PAC.

In July 1999, HCFA announced plans to use a classification system based upon FRGs. In addition, HCFA then indicated that they were considering using a consistent data set across all post-acute care settings. Later in 1999, HCFA announced its plan to use the MDS-PAC as a comprehensive patient assessment instrument.

There was some controversy over HCFA's decision to use the MDS-PAC versus the FIM. The AMRPA's position on the MDS-PAC is that "it seems inefficient to switch the only sector of the healthcare industry that has tracked patient outcomes from the system it has used historically (FIM) to MDS-PAC." Still, the AMRPA is working to help improve MDS-PAC.1 RAND, Harvard University Medical School, and the Sargent College of Health and Rehabilitation Sciences at Boston University are conducting an MDS-PAC and FIM study and are currently recruiting facilities to participate.

RAND's FIM-FRG RPPS System

RAND recently published its Interim Report on an Inpatient Rehabilitation Prospective Payment System, which investigated the validity of the FRG concept.2 The FRGs are currently based on 100,000 patients from 1994. There are 20 rehabilitation impairment categories (RIC) and 82 FRGs. RAND found that complications and co-morbidities affected some of the RICs and did not affect others. Separate weights were calculated for the FRGs that had higher or lower cost due to complications.

Some experts question whether the FRG groups are too broad. However, a classification system has to balance accuracy against bulk. RAND limited the number of FRGs to fewer than 100 by only allowing five FRGs within each RIC. If HCFA felt that increased accuracy and the associated increase in the number of groups would be desirable, the FRGs methodology could accommodate these changes without any difficulty.

The FRGs are based on data that is currently collected voluntarily by 80 percent of rehabilitation providers. The financial data is collected by HCFA and the clinical data is gathered by UDSMR and Caredata.com. No site visits to hospitals are required. RAND matches the clinical and financial databases on a patient-by-patient basis using sex, birthdate, and admission date. The charge data collected from bills by HCFA is converted to cost through multiplication of the charge by the cost/charge ratios contained on the Medicare cost reports. This is done on a per-cost center basis.

The FRGs are currently based on 100,000 patients from 1994. However, there is now data to support the creation of revised FRGs based on 220,000 patients from 1997. This will update the FRGs to a more recent year. To account for practice pattern evolution and patient mix, the FRGs could be recalculated every year.

There are, however, some shortcomings in this data due to the way that Medicare accounts for routine cost. Rather than using a variable charge dependent on services rendered, the charge is a fixed daily rate for all patients. This posed a similar problem during the development of the DRGs, but it was deemed adequate to let the routine cost float with the ancillary cost. Some improvements may be made, however.

The RAND report identified three specific groups of patients to be paid on a different basis than the norm. Paying these groups separately increases the accuracy of the system. These "outliers" include transfer patients and high- and low-cost outliers.

Case Mix Groups

In the November 3, 2000, Federal Register, HCFA proposed a patient classification system that uses case mix groups called CMGs. The CMGs classify patient discharges by FRGs based on a patient's impairment, age, comorbidities, and functional capability. By using the FIM-FRG classification system with the most recent data, HCFA identified clinical aspects of the FIM-FRG system that could be improved to increase the ability of the CMGs to predict resource use.

In the development of the proposed CMGs, the earlier FIM-FRG analysis was updated using more recent data from 1996 and 1997, Medicare bills, and functional status measures from USDMR and Caredata.com. The proposed CMGs include a refined set of rehabilitation impairment categories, a modified set of relevant comorbidities, groups for cases that expire, and other types of atypical discharges (such as short-stay cases).

The data elements used to construct the proposed CMGs include RIC, functional status (both motor and cognitive), age, and comorbidities. There are 97 proposed CMGs. There are special considerations being made in the areas of transfer payment policy, short-stay outlier, cases that expire, interrupted stay, area wage adjustment, adjustments for rural location, adjustments for indirect teaching costs, adjustments for disproportionate share of low-income patients, adjustments for Alaska and Hawaii, and adjustments for cost outliers.

HCFA proposes to develop prospective payments for IRFs using the following major steps:

- develop the CMG relative weights
- determine the payment adjustments
- calculate the budget neutral conversion factor, minus 2 percent
- calculate the federal CMG prospective payments

Readiness for RPPS

HCFA will make available a public use version of the MDS-PAC software including the patient classification grouper FRGs that can be downloaded from the Internet. The HCFA version of the software will be relatively simple but will permit the coding of all MDS-PAC fields, the classification of each patient by the FRG grouper, and transmission of this data to provider billing systems and to state data centers. This version of MDS-PAC software will be the most limited and will not necessarily support such functions as rapid preadmission assessments, cost forecasting, patient costing, outcomes analysis, care plans, and case management. To perform such functions, data from this version will have to be downloaded to other software that has these analytical and reporting capabilities.

The MDS-PAC software can also be purchased from vendors, such as UDSMR of the State University of New York at Buffalo. UDSMR will make available the MDS-PAC software with the FRG grouper to its subscribers, along with training in the use of the instrument. This version will support transmission of FRGs for patient billing, transmission of MDS-PAC data to state data centers, and collection and reporting of outcomes data through the UDSMR system.

Other software vendors are planning to imbed the MDS-PAC instrument and FRG grouper in their software packages. These versions will then enable transmission of FRG data to the patient billing system and export of MDS-PAC data to state data centers. Although some of these software packages may provide preadmission assessment capability, they do not seem to support cost forecasting, outlier identification, patient costs, outcomes analysis, or case management.

A recent article in the Interdisciplinary Journal of Rehabilitation suggests the following steps for RPPS preparation:

1. Identify MDS-PAC software, installation, and training
2. Provide protocols for MDS-PAC data transmission to billing systems and state data centers
3. Develop customized software programs linking cost, clinical, and reimbursement data
4. Determine the need for cost-accounting software and related customization requirements
5. Evaluate the desirability and requirements for linking care plans with clinical and financial data3

Current RPPS issues

The Proposed Inpatient Rehabilitation Facility Prospective Payment System (HCFA-1069-P) was published in the November 3, 2000 Federal Register. HCFA plans to implement the IRF prospective payment system for cost reporting periods beginning on or after April 1, 2001. HCFA is proposing to require IRF to complete the MDS-PAC for all Medicare patients admitted or discharged after April 1, 2001.

HCFA's Web site contains information on the Inpatient Rehabilitation Facility Patient Assessment Instrument. For more information, visit www.hcfa.gov/medicaid/rehabpac/ postacut.pdf.

HCFA is also developing training for the IRF PPS. It has asked its professional business partners to submit a proposal for education and training for implementation of the RPPS. The RFP is focused on training for the MDS-PAC. The contractor would be working with UDSMR and HRCA. According to the RFP, HCFA plans to hold a train-the-trainers session with representatives of state survey agencies for five days early next year. These individuals are then expected to hold two-day seminars for rehabilitation facility staff. The training period is expected to be from January through March 2001.

For periodically updated information on the RPPS, visit the HCFA Web site at www.hcfa.gov.

Notes

1. AMRPA's recommendations to the MDS-PAC developers are available at www.amrpa.org/pps.16htm.
2. RAND's interim report is available at www.rand.org/organization/health/newnav.html.
3. Morrison, Malcolm H. "Preparation for RPPS." Interdisciplinary Journal of Rehabilitation. Available at www.rehabpub.com/features/452000/3.asp.

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- Federal Register is available at http://www.access.gpo.gov/ su_docs/aces/aces140.html.
- Care Financing Administration Web site at http://www.hcfa.gov/.
- Minimum Data Set-Post Acute Care is available at www.hcfa.gov/medicaid/rehabpac/irfppshm.htm.
- Data System for Medical Rehabilitation Web site, http://www.udsmr.org/.

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