

(c) *Definitions.* As used in this section—

Rehabilitation physician means a licensed physician who is determined by the IRF to have specialized training and experience in inpatient rehabilitation.

State (or region, as applicable) that is experiencing a surge means a state (or region, as applicable) that is in phase 1 of the President's Guidelines for Opening Up America Again (<https://www.whitehouse.gov/openingamerica/>), specifically, a state (or region, as applicable) that satisfies all of the following, as determined by applicable state and local officials:

- (i) All vulnerable individuals continue to shelter in place.
- (ii) Individuals continue social distancing.
- (iii) Individuals avoid socializing in groups of more than 10.
- (iv) Non-essential travel is minimized.
- (v) Visits to senior living facilities and hospitals are prohibited.
- (vi) Schools and organized youth activities remain closed.

Week means a period of 7 consecutive calendar days beginning with the date of admission to the IRF.

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§412.624 Methodology for calculating the Federal prospective payment rates.

(a) *Data used.* To calculate the prospective payment rates for inpatient hospital services furnished by inpatient rehabilitation facilities, we use—

(1) The most recent Medicare data available, as of the date of establishing the inpatient rehabilitation facility prospective payment system, to estimate payments for inpatient operating and capital-related costs made under part 413 of this subchapter;

(2) An appropriate wage index to adjust for area wage differences;

(3) An increase factor to adjust for the most recent estimate of increases in the prices of an appropriate market basket of goods and services included

in covered inpatient rehabilitation services; and

(4) Patient assessment data described in §412.606 and other data that account for the relative resource utilization of different patient types.

(b) *Determining the average costs per discharge for fiscal year 2001.* We determine the average inpatient operating and capital costs per discharge for which payment is made to each inpatient rehabilitation facility using the available data specified under paragraph (a)(1) of this section. The cost per discharge is adjusted to fiscal year 2001 by an increase factor, described in paragraph (a)(3) of this section, under the update methodology described in section 1886(b)(3)(B)(ii) of the Act for each year through the midpoint of fiscal year 2001.

(c) *Determining the Federal prospective payment rates—(1) General.* The Federal prospective payment rates will be established using a standard payment amount referred to as the standard payment conversion factor. The standard payment conversion factor is a standardized payment amount based on average costs from a base year that reflects the combined aggregate effects of the weighting factors, various facility and case level adjustments, and other adjustments.

(2) *Update the cost per discharge.* CMS applies the increase factor described in paragraph (a)(3) of this section to the facility's cost per discharge determined under paragraph (b) of this section to compute the cost per discharge for fiscal year 2002. Based on the updated cost per discharge, CMS estimates the payments that would have been made to the facility for fiscal year 2002 under part 413 of this chapter without regard to the prospective payment system implemented under this subpart.

(3) *Computation of the standard payment conversion factor.* The standard payment conversion factor is computed as follows:

(i) *For fiscal year 2002.* Based on the updated costs per discharge and estimated payments for fiscal year 2002 determined in paragraph (c)(2) of this section, CMS computes a standard payment conversion factor for fiscal year 2002, as specified by CMS, that reflects,

as appropriate, the adjustments described in paragraph (d) of this section.

(ii) *For fiscal years after 2002.* The standard payment conversion factor for fiscal years after 2002 will be the standardized payments for the previous fiscal year updated by the increase factor described in paragraph (a)(3) of this section, including adjustments described in paragraph (d) of this section as appropriate.

(4) Applicable increase factor for FY 2014 and for subsequent FY. Subject to the provisions of paragraphs (c)(4)(i) and (c)(4)(ii) of this section, the applicable increase factor for FY 2014 and for subsequent years for updating the standard payment conversion factor is the increase factor described in paragraph (a)(3) of this section, including adjustments described in paragraph (d) of this section as appropriate.

(i) In the case of an IRF that is paid under the prospective payment system specified in § 412.1(a)(3) that does not submit quality data to CMS in accordance with § 412.634, the applicable increase factor specified in paragraph (a)(3) of this section, after application of subparagraphs (C)(iii) and (D) of section 1886(j)(3) of the Act, is reduced by 2 percentage points.

(ii) Any reduction of the increase factor will apply only to the fiscal year involved and will not be taken into account in computing the applicable increase factor for a subsequent fiscal year.

(iii) The 2 percentage point reduction described in paragraph (c)(4)(i) of this section may result in the applicable increase factor specified in paragraph (a)(3) of this section being less than 0.0 for a fiscal year, and may result in payment rates under the prospective payment system specified in § 412.1(a)(3) for a fiscal year being less than such payment rates for the preceding fiscal year.

(5) *Determining the Federal prospective payment rate for each case-mix group.* The Federal prospective payment rates for each case-mix group is the product of the weighting factors described in § 412.620(b) and the standard payment conversion factor described in paragraph (c)(3) of this section.

(d) *Adjustments to the standard payment conversion factor.* The standard

payment conversion factor described in paragraph (c)(3) of this section will be adjusted for the following:

(1) *Outlier payments.* CMS determines a reduction factor equal to the estimated proportion of additional outlier payments described in paragraph (e)(5) of this section.

(2) *Budget neutrality.* CMS adjusts the Federal prospective payment rates for fiscal year 2002 so that aggregate payments under the prospective payment system, excluding any additional payments associated with elections not to be paid under the transition period methodology under § 412.626(b), are estimated to equal the amount that would have been made to inpatient rehabilitation facilities under part 413 of this chapter without regard to the prospective payment system implemented under this subpart.

(3) *Coding and classification changes.* CMS adjusts the standard payment conversion factor for a given year if CMS determines that revisions in case-mix classifications or weighting factors for a previous fiscal year (or estimates that those revisions for a future fiscal year) did result in (or would otherwise result in) a change in aggregate payments that are a result of changes in the coding or classification of patients that do not reflect real changes in case-mix.

(4) *Payment adjustment for Federal fiscal year 2006 and applicable Federal fiscal years.* CMS adjusts the standard payment conversion factor based on any updates to the adjustments specified in paragraph (e)(2), (3), (4) and (6), of this section, and to any revision specified in § 412.620(c) by a factor as specified by the Secretary.

(e) *Calculation of the adjusted Federal prospective payment.* For each discharge, an inpatient rehabilitation facility's Federal prospective payment is computed on the basis of the Federal prospective payment rate that is in effect for its cost reporting period that begins in a Federal fiscal year specified under paragraph (c) of this section. A facility's Federal prospective payment rate will be adjusted, as appropriate, to account for area wage levels, payments for outliers and transfers, and for other factors as follows:

(1) *Adjustment for area wage levels.* The labor portion of a facility's Federal prospective payment is adjusted to account for geographical differences in the area wage levels using an appropriate wage index.

(i) The application of the wage index is made on the basis of the location of the facility in an urban or rural area as defined in § 412.602.

(ii) Starting on October 1, 2022, CMS applies a cap on decreases to the wage index such that the wage index applied to an IRF is not less than 95 percent of the wage index applied to that IRF in the prior FY.

(iii) Adjustments or updates to the wage data used to adjust a facility's Federal prospective payment rate under paragraph (e)(1) of this section will be made in a budget neutral manner. CMS determines a budget neutral wage adjustment factor, based on any adjustment or update to the wage data, to apply to the standard payment conversion factor.

(2) *Adjustments for low-income patients.* We adjust the Federal prospective payment, on a facility basis, for the proportion of low-income patients that receive inpatient rehabilitation services as determined by us.

(3) *Adjustments for rural areas.* We adjust the Federal prospective payment by a factor, as specified by us for facilities located in rural areas, as defined in § 412.602.

(4) *Adjustments for teaching hospitals.* (i) *General.* For discharges on or after October 1, 2005, CMS adjusts the Federal prospective payment on a facility basis by a factor as specified by CMS for facilities that are teaching institutions or units of teaching institutions.

(A) An IRF's teaching adjustment is based on the ratio of the number of full-time equivalent residents training in the IRF divided by the facility's average daily census.

(B) As described in § 412.105(f)(1)(iii)(A), residents with less than full-time status are counted as partial full time equivalent based on the proportion of time assigned to the inpatient rehabilitation facility compared to the total time necessary to fill a residency slot. Residents rotating to more than one hospital or non-hospital setting will be counted in proportion to

the time they are assigned to inpatient rehabilitation facility compared to the total time worked in all locations. An inpatient rehabilitation facility cannot claim time spent by the resident at another inpatient rehabilitation facility or hospital.

(C) Except as described in paragraph (e)(4)(i)(D) of this section, the actual number of current year full-time equivalent residents used in calculating the teaching adjustment is limited to the number of full-time equivalent residents in the IRF's final settled cost report for the most recent cost reporting period ending on or before November 15, 2004 (base year).

(D) If the inpatient rehabilitation facility first begins training residents in a new approved graduate medical education program after November 15, 2004, the number of full-time equivalent residents determined under paragraph (e)(4)(i)(C) of this section may be adjusted using the method described in § 413.79(e)(1)(i).

(E) The teaching adjustment is made on a claim basis as an interim payment, and the final payment in full for the claim is made during the final settlement of the cost report.

(ii) *Closure of an IRF or IRF residency training program.* (A) *Closure of an IRF.* For cost reporting periods beginning on or after October 1, 2011, an IRF may receive a temporary adjustment to its FTE cap to reflect displaced residents added because of another IRF's closure if the IRF meets the following criteria:

(1) The IRF is training additional displaced residents from an IRF that closed on or after October 1, 2011.

(2) No later than 60 days after the IRF begins to train the displaced residents, the IRF submits a request to its Medicare contractor for a temporary adjustment by identifying the displaced residents who have come from the closed IRF and have caused the IRF to exceed its cap, and specifies the length of time the adjustment is needed.

(B) *Closure of an IRF's residency training program.* If an IRF that closes its residency training program on or after October 1, 2011, agrees to temporarily reduce its FTE cap according to the criteria specified in paragraph (e)(4)(ii)(A)(2) of this section, another

IRF(s) may receive a temporary adjustment to its FTE cap to reflect displaced residents added because of the closure of the residency training program if the criteria specified in paragraph (e)(4)(ii)(A)(1) of this section are met.

(1) *Receiving IRF(s).* For cost reporting periods beginning on or after October 1, 2011, an IRF may receive a temporary adjustment to its FTE cap to reflect displaced residents added because of the closure of another IRF's residency training program if the IRF is training additional displaced residents from the residency training program of an IRF that closed a program; and if no later than 60 days after the IRF begins to train the displaced residents the IRF submits to its Medicare Contractor a request for a temporary adjustment to its FTE cap, documents that it is eligible for this temporary adjustment by identifying the displaced residents who have come from another IRF's closed program and have caused the IRF to exceed its cap, specifies the length of time the adjustment is needed, and submits to its Medicare Contractor a copy of the FTE reduction statement by the hospital that closed its program, as specified in paragraph (e)(4)(ii)(A)(2) of this section.

(2) *IRF that closed its program.* An IRF that agrees to train displaced residents who have been displaced by the closure of another IRF's program may receive a temporary FTE cap adjustment only if the hospital with the closed program temporarily reduces its FTE cap based on the FTE of displaced residents in each program year training in the program at the time of the programs closure. This yearly reduction in the FTE cap will be determined based on the number of those displaced residents who would have been training in the program during that year had the program not closed. No later than 60 days after the displaced residents who were in the hospital that closed its program(s) begin training at another hospital must submit to its Medicare Contractor a statement signed and dated by its representative that specifies that it agrees to the temporary reduction in its FTE cap to allow the IRF training the displaced residents to obtain a temporary adjustment to its

cap; identifies the displaced residents who were in the training at the time of the program's closure; identifies the IRFs to which the displaced residents are transferring once the program closes; and specifies the reduction for the applicable program years.

(5) *Adjustment for high-cost outliers.* CMS provides for an additional payment to an inpatient rehabilitation facility if its estimated costs for a patient exceed a fixed dollar amount (adjusted for area wage levels and factors to account for treating low-income patients, for rural location, and for teaching programs) as specified by CMS. The additional payment equals 80 percent of the difference between the estimated cost of the patient and the sum of the adjusted Federal prospective payment computed under this section and the adjusted fixed dollar amount. Effective for discharges occurring on or after October 1, 2003, additional payments made under this section will be subject to the adjustments at § 412.84(i), except that CMS calculates a single overall (combined operating and capital) cost-to-charge ratio and national averages that will be used instead of statewide averages. Effective for discharges occurring on or after October 1, 2003, additional payments made under this section will also be subject to adjustments at § 412.84(m), except that CMS calculates a single overall (combined operating and capital) cost-to-charge ratio.

(6) *Adjustments for certain facilities geographically redesignated in FY 2006—*

(i) *General.* For a facility defined as an urban facility under § 412.602 in FY 2006 that was previously defined as a rural facility in FY 2005 as the term rural was defined in FY 2005 under § 412.602 and whose payment, after applying the adjustment under this paragraph, will be lower only because of being defined as an urban facility in FY 2006 and it no longer qualified for the rural adjustment under § 412.624(e)(3) in FY 2006, CMS will adjust the facility's payment using the following method:

(A) For discharges occurring on or after October 1, 2005, and on or before September 30, 2006, the facility's payment will be increased by an adjustment of two thirds of its prior FY 2005 19.14 percent rural adjustment.

(B) For discharges occurring on or after October 1, 2006, and on or before September 30, 2007, the facility's payment will be increased by an adjustment of one third of its FY 2005 19.14 percent rural adjustment.

(ii) *Exception.* For discharges occurring on or after October 1, 2005 and on or before September 30, 2007, facilities whose payments, after applying the adjustment under this paragraph (e)(7)(i) of this section, will be higher because of being defined as an urban facility in FY 2006 and no longer being qualified for the rural adjustment under §412.624(e)(3) in FY 2006, CMS will adjust the facility's payment by a portion of the applicable additional adjustment described in paragraph (e)(6)(i)(A) and (B) of this section as determined by us.

(f) *Special payment provision for patients that are transferred.* (1) A facility's Federal prospective payment will be adjusted to account for a discharge of a patient who—

(i) Is transferred from the inpatient rehabilitation facility to another site of care, as defined in §412.602; and

(ii) Stays in the facility for a number of days that is less than the average length of stay for nontransfer cases in the case-mix group to which the patient is classified.

(2) We calculate the adjusted Federal prospective payment for patients who are transferred in the following manner:

(i) By dividing the Federal prospective payment by the average length of stay for nontransfer cases in the case-mix group to which the patient is classified to equal the payment per day.

(ii) By multiplying the payment per day under paragraph (f)(2)(i) of this section by the number of days the patient stayed in the facility prior to being discharged to equal the per day payment amount.

(iii) By multiplying the payment per day under paragraph (f)(2)(i) by 0.5 to equal an additional one half day payment for the first day of the stay before the discharge.

(iv) By adding the per day payment amount under paragraph (f)(2)(ii) and the additional one-half day payment under paragraph (f)(2)(iii) to equal the unadjusted payment amount.

(v) By applying the adjustment described in paragraphs (e)(1), (2), (3), (4), and (6) of this section to the unadjusted payment amount determined in paragraph (f)(2)(iv) of this section to equal the adjusted transfer payment amount and making a payment in accordance with paragraph (e)(5) of this section, if applicable.

(g) *Special payment provision for interrupted stays.* When a patient in an inpatient rehabilitation facility has one or more interruptions in the stay, as defined in §412.602 and as indicated on the patient assessment instrument in accordance with §412.618(b), we will make payments in the following manner:

(1) *Patient is discharged and returns on the same day.* Payment for a patient who is discharged and returns to the same inpatient rehabilitation facility on the same day will be the adjusted Federal prospective payment under paragraph (e) of this section that is based on the patient assessment data specified in §412.618(a)(1). Payment for a patient who is discharged and returns to the same inpatient rehabilitation facility on the same day will only be made to the inpatient rehabilitation facility.

(2) *Patient is discharged and does not return by the end of the same day.* Payment for a patient who is discharged and does not return on the same day but does return to the same inpatient rehabilitation facility by or on midnight of the third day, defined as an interrupted stay under §412.602, will be—

(i) The adjusted Federal prospective payment under paragraph (e) of this section that is based on the patient assessment data specified in §412.618(a)(1) made to the inpatient rehabilitation facility; and

(ii) If the reason for the interrupted patient stay is to receive inpatient acute care hospital services, an amount based on the prospective payment systems described in §412.1(a)(1) made to the acute care hospital.

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