

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COULD HAVE SAVED
APPROXIMATELY \$993 MILLION
IN 2017 AND 2018 IF IT HAD
IMPLEMENTED AN INPATIENT
REHABILITATION FACILITY
TRANSFER PAYMENT POLICY
FOR EARLY DISCHARGES TO
HOME HEALTH SERVICES**

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A-01-20-00501

Office of Inspector General

<https://oig.hhs.gov>

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The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Report in Brief

Date: December 2021

Report No. A-01-20-00501

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Audit

In 2020, the Trustees of the Part A Hospital Insurance Trust Fund urged policymakers to take timely action to address projected deficits that could lead to deficits of \$9.6 billion by 2026. We performed this audit because an audit regarding the Centers for Medicare & Medicaid Services' (CMS's) early transfer payment policies for hospitals to hospice care indicated that significant savings could be realized for the Medicare program if CMS implemented an inpatient rehabilitation facility (IRF) transfer payment policy for early discharges to home health agencies (HHAs).

Our objective was to determine how much Medicare could have saved in calendar years 2017 and 2018 if CMS had expanded the IRF transfer payment policy to include early discharges to home health care.

How OIG Did This Audit

For IRF stays that occurred in 2017 and 2018, 1,152 IRFs submitted 802,275 claims with payments totaling \$16.1 billion. Our audit covered 230,725 claims totaling \$4.8 billion for which the length of stay: (1) was more than 3 days but less than the case-mix group average length of stay and (2) matched an actual HHA date of service that was within 3 days of the IRF discharge date. We calculated the savings CMS would have realized for these claims if the transfer payment policy covered discharges to home health. We used claims with a date of service within 3 days of the IRF discharge date for our calculations to be consistent with regulations for discharges from acute-care hospitals to home health care.

Medicare Could Have Saved Approximately \$993 Million in 2017 and 2018 if It Had Implemented an Inpatient Rehabilitation Facility Transfer Payment Policy for Early Discharges to Home Health Agencies

What OIG Found

Medicare could have saved approximately \$993 million in 2017 and 2018 if CMS had expanded its IRF transfer payment policy to apply to early discharges to home health care. We determined that this payment policy would generally result in payments to IRFs that would cover their costs to provide care. When CMS announced its proposed IRF transfer payment policy in 2001, it stated that it would analyze claims data to compare billing patterns prior to and after its implementation and refine IRF payments in the future, if warranted. CMS officials did not explain why CMS has not expanded the IRF transfer payment policy to cover discharges to home health care. CMS also did not analyze claims data to compare billing patterns prior to and after the implementation of the Medicare prospective payment system for IRFs in January 2002, which could have provided information in support of expanding the IRF transfer payment policy to include early discharges to home health care.

What OIG Recommends and CMS Comments

We recommend that CMS take the necessary steps to establish an IRF transfer payment policy for early discharges to home health care. If this expanded policy had been in place, Medicare could have saved \$993,134,059 in 2017 and 2018.

CMS stated that it will consider our recommendation when determining the appropriate next steps for the IRF prospective payment system. It said that expanding the IRF transfer payment policy would require notice and comment rulemaking, and that the policy developed during a notice and comment period would ultimately determine any potential savings.

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INTRODUCTION

WHY WE DID THIS AUDIT

In their 2020 report, the Trustees of the Part A Hospital Insurance Trust Fund urged policymakers to take timely and effective action to address projected deficits that could lead to Medicare Part A deficits of \$9.6 billion by 2026.¹ The Trustees stated in their report that the sooner significant reforms were enacted, the more flexible and gradual the reforms could be. We performed this audit because an audit regarding the Centers for Medicare & Medicaid Services' (CMS's) early transfer payment policies for hospitals to hospice care indicated that significant savings could be realized for the Medicare program if CMS implemented an inpatient rehabilitation facility (IRF) transfer payment policy for early discharges to home health agencies (HHAs).² Our prior work resulted in Congress enacting a hospital early discharge to hospice policy that went into effect on October 1, 2018.

OBJECTIVE

Our objective was to determine how much Medicare could have saved in calendar years (CYs) 2017 and 2018 if CMS had expanded the IRF transfer payment policy to include early discharges to home health care.

BACKGROUND

Inpatient Rehabilitation Facilities

IRFs, which include inpatient rehabilitation hospitals and rehabilitation units of acute-care hospitals, provide intensive inpatient rehabilitation therapy for patients who have complex nursing, medical management, and rehabilitation needs that require treatment in an inpatient hospital environment.³

Inpatient Rehabilitation Facility Prospective Payment System

The Social Security Act (the Act) established a Medicare prospective payment system (PPS) for IRFs (§ 1886(j)).⁴ Under PPS, IRFs are reimbursed at a rate greater than 2.5 times the inpatient

¹ *2020 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds*, Apr. 22, 2020, pp. 4, 40, 41, and 216.

² *Medicare Could Save Millions by Implementing a Hospital Transfer Payment Policy for Early Discharges to Hospice Care*, A-01-12-00507.

³ *Medicare Benefit Policy Manual*, Pub. No. 100-02, ch. 1, § 110.

⁴ CMS implemented PPS for IRFs for cost-reporting periods beginning on or after Jan. 1, 2002.

prospective payment system (IPPS) rate. In exchange for this greater reimbursement, Medicare requires IRFs to provide intensive rehabilitation to higher severity patients.⁵

To implement PPS for IRFs, CMS established IRF payment rates for 92 intensive rehabilitation case-mix groups on the basis of clinical characteristics of the beneficiaries and the resources needed to treat them.⁶ These IRF payment rates vary based on the underlying case-mix group that is adjusted for a variety of factors, such as geographic location, and the case-mix group's average length of stay.⁷ Therefore, when an IRF transfers a patient to an HHA the IRF receives a flat-rate payment from Medicare on the basis of the case-mix group and the adjusted factors without regard for the patient's length of stay.

Inpatient Rehabilitation Facility Transfer Payment Policy

Under the IRF transfer payment policy implemented in January 2002, CMS established an IRF transfer payment based on a per diem amount that would reduce the payment for each case-mix group for which the discharge occurred earlier than the average length of stay for the respective case-mix group. This policy applies to early IRF discharges to another IRF, an inpatient hospital, a nursing home that accepts payments under Medicare or Medicaid, or a long-term care hospital. But the policy does not apply to early IRF discharges to home health care.⁸ In addition, the IPPS transfer payment policy for acute-care inpatient hospitals includes transfers to home health care.⁹ CMS excluded early IRF discharges to home health care from the IRF transfer payment policy, which it implemented almost 20 years ago, because the HHA PPS had just been developed and HHA claims data were not available for CMS to analyze.¹⁰ Moreover, the Act states that CMS is not prohibited from developing an IRF transfer payment policy for early discharges to another site of care (§ 1886(j)(1)(E)) such as home health.

⁵ B. Gage, L. Smith, et al., *Analysis of the Classification Criteria for Inpatient Rehabilitation Facilities*, Report to Congress, Sept. 2009, p. 13. Prepared for CMS by RTI International, RTI Project Number 0211995.

⁶ Medicare Learning Network, *Inpatient Rehabilitation Facility Prospective Payment System*, ICN 006847, Jan. 2017, and 66 Fed. Reg. 41316, 41342 (Aug. 7, 2001).

⁷ The regulations (42 CFR § 412.624 (e) and (f)) state that these adjustments include labor, wage, and other geographic location adjustments.

⁸ 42 CFR §§ 412.602 and 412.624 (f) and the *Medicare Claims Processing Manual* Pub. No. 100 – 04, ch. 3, § 140.2.4 – Case-Level Adjustments (Rev. 2673, Apr. 22, 2013).

⁹ The transfer payment policy from acute-care hospitals to home health care applies when home health services begin within 3 days of discharge (42 CFR § 412.4).

¹⁰ The term “early discharge” refers to a discharge that occurred earlier than the average length of stay for the respective case-mix group.

Home Health Agencies

In general, Medicare beneficiaries who are restricted to their homes are eligible to receive from HHAs skilled nursing; physical, occupational, or speech therapy; and medical social work on a part-time or intermittent basis. In 2017 and 2018, about 3.4 million beneficiaries received services each year from 11,800 HHAs that were reimbursed by both Medicare Part A and Part B.¹¹ Patients often continue a course of care in home settings after being discharged from institutional settings.

HOW WE CONDUCTED THIS AUDIT

For IRF stays that occurred in CYs 2017 and 2018, 1,152 IRFs submitted 802,275 claims with payments totaling \$16.1 billion. Of these claims, our audit covered 230,725 IRF claims with payments totaling \$4.8 billion for stays that ended in early discharges to home health care (i.e., the length of the IRF stay was more than 3 days but less than the case-mix group average length of stay and the actual HHA claim date of service was within 3 days of the IRF discharge date).^{12, 13, 14} We calculated the savings CMS would have realized for these claims if the transfer payment policy had covered discharges to home health. We used claims with a date of service within 3 days of the IRF discharge date for our calculations in order to be consistent with CMS regulations for discharges from acute-care hospitals to home health care.¹⁵

In addition, we compared the payments that would have been made under an expanded transfer policy with the IRFs' calculated costs to provide care. To do so, we calculated the IRFs' transfer payments and compared them with the IRFs' costs to provide care.¹⁶

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

¹¹ MedPAC, *Home Health Agency Basics*, p. 1, Oct. 2019.

¹² We used lengths of stay that were more than 3 days because IRF stays of 3 days or fewer are reimbursed at a reduced rate.

¹³ The average length of stay varies depending on the fiscal year and case-mix group ranging from 7 to 52 days.

¹⁴ These discharges included all case-mix groups.

¹⁵ The regulations (42 CFR § 412.4 (c)(3)) state that hospital discharges to home under a written plan of care for the provision of home health services from an HHA are post-acute-care transfers when services begin within 3 days after the date of discharge.

¹⁶ The IRFs' covered costs were calculated by converting the IRFs' total charges to costs using CMS's quarterly cost-to-charge ratios for 1,140 IRFs with 229,685 IRF claims. The cost-to-charge ratio is the factor applied to an IRF's charges to determine an IRF's estimated costs. The CMS quarterly cost-to-charge ratios were not available for 10 IRFs corresponding to 1,040 IRF claims.

Appendix A contains our audit scope and methodology, Appendix B contains our savings and costs calculation methodology and cost-coverage analysis, and Appendix C contains a summary of a report on the IRF cost of care and claim error rate issued by MedPAC.¹⁷

FINDING

Medicare could have saved approximately \$993 million in CYs 2017 and 2018 if CMS had expanded its IRF transfer payment policy to apply to early discharges to home health care.¹⁸ We determined that this payment policy would generally result in payments to IRFs that would cover their costs to provide care. When CMS announced its proposed IRF transfer payment policy in 2001, it stated that it would analyze claims data to compare billing patterns prior to and after its implementation and refine IRF payments in the future, if warranted.¹⁹ For this audit, CMS officials did not explain why CMS has not expanded the IRF transfer payment policy to cover discharges to home health care. CMS also did not analyze claims data to compare billing patterns prior to and after the implementation of the PPS for IRFs in January 2002, which could have provided information in support of expanding the IRF transfer payment policy to include early discharges to home health care.

CMS COULD HAVE SAVED APPROXIMATELY \$993 MILLION OVER 2 YEARS IF IT HAD EXPANDED THE IRF TRANSFER PAYMENT POLICY TO APPLY TO EARLY DISCHARGES TO HOME HEALTH CARE

We determined that Medicare could have saved approximately \$993 million of \$4.8 billion in CYs 2017 and 2018 if CMS had expanded its IRF transfer payment policy to apply to early discharges to home health care. (See Appendix B for the detailed methodology we used to determine the Medicare cost savings.) In addition, CMS has not monitored how often early IRF discharges to home health care occur. Of the 802,275 IRF stays, more than half of all discharges were to home health care. Of those discharges to home health care, approximately 55 percent were early discharges that would have been subject to lower payments under an IRF transfer payment policy.

¹⁷ MedPAC is a nonpartisan, legislative branch agency that provides Congress with Medicare program analysis and policy advice.

¹⁸ Our calculations assume no change in the CYs 2017 and 2018 billing practices of the IRFs if such a policy were adopted.

¹⁹ 66 Fed. Reg. 41316, 41354 (Aug. 7, 2001).

The following example shows the cost savings for a representative IRF stay.

Example 1: Payment for an IRF Early Discharge to Home Health Care Under the Expanded Transfer Policy

An IRF admitted a beneficiary on February 9, 2017, and discharged the beneficiary on February 16, 2017 (for a total stay of 7.5 days). The beneficiary began HHA services on February 17, 2017. The IRF billed Medicare for case-mix group C0404 (traumatic spinal cord injury) with an average length of stay of 37 days. Medicare made a full payment of \$50,629 to the IRF. If CMS's IRF transfer payment policy had applied, the per diem rate would have been \$1,368 ($\$50,629 / 37$), and Medicare would have paid the IRF \$10,263 ($\$1,368 \times 7.5$ days), a difference of \$40,366 ($\$50,629 - \$10,263$).²⁰

TRANSFER PAYMENTS FOR EARLY DISCHARGES TO HOME HEALTH CARE WOULD COVER THE COSTS OF PROVIDING CARE

We determined that an IRF transfer payment policy for early discharges to home health care would generally result in IRF transfer payments that would cover the IRFs' costs to provide care. We calculated that the IRF transfer payments associated with early discharges to home health care under an expanded IRF transfer payment policy would have exceeded IRFs' costs on average by \$1,275 per discharge (Appendix B).²¹ The following example shows an IRF transfer payment for an IRF early discharge that exceeded the IRF's cost of providing care.

Example 2: Payment Under the Expanded Transfer Policy for an IRF Early Discharge to an HHA That Exceeded the IRF's Cost

For the representative stay in Example 1, which showed that the IRF would have received \$10,263 if the IRF transfer payment policy applied to discharges to home health care, we determined that the IRF's costs would have been \$8,173 (the IRF's billed charges of \$14,942 multiplied by the IRF's cost-to-charge ratio of 54.7 percent). Thus, the reduced payment to the IRF would have exceeded its costs by \$2,090 ($\$10,263 - \$8,173$).

When CMS announced its proposed IRF transfer payment policy in 2001, it stated that it would analyze claims data to compare billing patterns prior to and after its implementation and refine IRF payments in the future, if warranted. However, for this audit CMS officials informed us that CMS has not performed such an analysis. In addition, CMS has not determined whether the IRF

²⁰ The day of admission adds an additional half day for per diem purposes.

²¹ The IRF transfer payments associated with early discharges to home health care under an expanded IRF transfer payment policy would have exceeded the IRFs' costs for approximately 68 percent of the claims per discharge. The payments for the remaining 32 percent of the claims would not have fully covered the IRFs' cost per discharge. However, the expanded IRF transfer payment policy would have exceeded the IRFs' costs for all discharges on average by \$1,275.

transfer payment policy should apply to such discharges. We asked CMS officials about this, and they did not explain why they had not implemented an IRF transfer payment policy.

CONCLUSION

One reform CMS could implement to help alleviate the projected Medicare Part A deficit of \$9.6 billion by 2026 would be to expand its IRF transfer payment policy to cover early discharges to home health care. This policy would be consistent with the transfer payment policies currently in effect for early discharges from one IRF to another IRF, a long-term care hospital, an inpatient hospital, or a nursing home. Furthermore, it would promote greater consistency among inpatient facilities' transfer payment policies because the existing transfer policy for IPPS hospitals includes early discharges to home health care. Implementation of such a policy would result in immediate and significant Medicare savings. Moreover, it would generally provide IRFs with payments that are greater than their costs to provide care.

RECOMMENDATION

We recommend that the Centers for Medicare & Medicaid Services expand the IRF transfer payment policy to apply to early discharges to home health care. If this expanded policy had been in place, Medicare could have saved \$993,134,059 in 2017 and 2018.

CMS COMMENTS

CMS stated that it will consider our recommendation when determining the appropriate next steps for the IRF PPS. It said that expanding the IRF transfer payment policy would require notice and comment rulemaking, and the policy developed during a notice and comment period would ultimately determine any potential savings. CMS's comments are included in their entirety as Appendix D.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered IRF stays that occurred in CYs 2017 and 2018 during which 1,152 IRFs submitted 802,275 claims with payments totaling \$16,130,630,160.

We did not review CMS's complete internal control structure because our objective did not require us to do so. Rather, we limited our review of internal controls to CMS's IRF transfer payment policies for early discharges.

We established reasonable assurance of the authenticity and accuracy of data obtained from CMS's National Claims History (NCH) file by comparing it with the Common Working File and medical records. But we did not assess the completeness of the file.

We conducted our audit from December 2019 through September 2021. The CY 2017 through CY 2018 IRF claims data were the most recent data available at the start of the audit.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws;
- discussed with CMS officials the IRF transfer payment policy, case-mix group tier relative weights and average lengths of stay, and quarterly cost-to-charge ratios in effect for all IRFs during our audit period;
- extracted claims data by paid date from CMS's NCH file resulting in 802,275 IRF claims totaling \$16,130,630,160;
- reviewed data from CMS's Common Working File to the IRFs and corresponding HHA claims for a judgmental sample of 60 IRF claims to validate claim information extracted from the NCH file and determine whether any of the selected claims had been canceled or adjusted;
- identified 230,725 IRF stays totaling \$4,841,557,758 that exceeded 3 days but were less than the average length of stay for the assigned case-mix group and after which home health care had begun within 3 days of discharge;
- calculated the cost savings that CMS could have realized if the IRF transfer payment policy had applied to 230,725 IRF stays (Appendix B);
- calculated the IRFs' cost coverage for 229,685 IRF claims by converting the IRFs' total charges to costs using CMS's quarterly cost-to-charge ratios;

- compared the calculated transfer payments to the cost coverage calculations; and
- discussed the results of our audit with CMS officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: SAVINGS AND COSTS CALCULATION METHODOLOGY

We used the following methodology to determine the approximate amount that Medicare could have saved in CYs 2017 and 2018 if CMS had expanded the IRF transfer payment policy to include early discharges in which home health care began within 3 days of discharge.

METHODOLOGY TO CALCULATE AN IRF REDUCED PAYMENT AMOUNT

Step 1: Calculated the length of stay to identify the IRF claims with a length of stay that was less than the specific case-mix group tier average length of stay per the Federal Register for the relevant calendar year. $\text{IRF Claim Discharge Date} - \text{IRF Claim Admission Date} = \text{Length of Stay}$.

Step 2: Added a 0.5 day to the length of stay. The additional 0.5 day is added per the *Medicare Claims Processing Manual* (Pub. No. 100-04) to account for the level of care provided on the admission date.

Step 3: Calculated the average daily payment amount (Claim Payment Amount / Average Length of Stay for the specific case-mix group tier) and multiplied it by the length of stay plus 0.5 day to determine the reduced payment amount. For example, $(\$1,000 / 5) \times (4 + 0.5) = \900

METHODOLOGY TO CALCULATE THE COST SAVINGS

Calculated the cost savings of using a reduced payment for less than an average length of stay. $\text{Claim Payment Amount} - \text{Reduced Payment Amount} = \text{Cost Savings Per Claim}$.

Calculated the total cost savings by summing up all Cost Savings Per Claim figures.

METHODOLOGY TO CALCULATE IRF COSTS

Calculated each IRF's costs by multiplying each IRF's submitted charges for each claim by its cost-to-charge ratio.

METHODOLOGY TO DETERMINE WHETHER REDUCED PAYMENT COVERS IRF COSTS

Calculated the difference between the IRF reduced payment amount and the IRF's costs for each claim to identify whether the IRF's reduced payment amount will cover the IRF's costs. If the difference for each claim was more than \$0, we considered the IRF's costs to be covered.

APPENDIX C: MEDICARE PAYMENTS TO INPATIENT REHABILITATION FACILITIES SUBSTANTIALLY EXCEED THE COSTS OF CARING FOR BENEFICIARIES

Medicare payments to IRFs continue to substantially exceed the costs of caring for beneficiaries, as aggregate Medicare margins have consistently increased from 8.6 percent in 2010 to 14.7 percent in 2018.^{22, 23, 24} In recent reports, MedPAC recommended that Congress reduce Medicare payment rates for IRFs by 5 percent.²⁵

Furthermore, both the CMS Comprehensive Error Rate Testing Program and our audit of IRF compliance with Medicare requirements found that the IRFs' lack of compliance with program requirements has led to significant Medicare overpayments.²⁶ The CMS Comprehensive Error Rate Testing program determined that freestanding IRF hospitals and hospital-based IRF units had Medicare improper payment rates over the past 5 years (as shown in the following table).

²² Medicare Margins occur when Medicare payments exceed marginal (variable) costs by a substantial amount. They are calculated using the following formula: $(\text{Medicare Payment Rate} - \text{Total Medicare Costs}) / \text{Medicare Payment Rate}$.

²³ MedPAC, "MedPAC Presents New Marginal Cost Analysis," *MedPAC Blog*, Dec. 21, 2015.

²⁴ MedPAC, "Health Care Spending and the Medicare Program," *July 2020 MedPAC Data Book*, sec. 8, Post-acute Care, Skilled Nursing Facilities, Home Health Services, Inpatient Rehabilitation Facilities, Long-Term Care Hospitals, p. 111. From 2010 through 2018, freestanding IRF average Medicare margins ranged from 21.4 to 25.4 percent while average margins for hospital-based units ranged from -0.5 percent to 2.5 percent.

²⁵ MedPAC, "Inpatient Rehabilitation Facility Services: Assessing Payment Adequacy and Updating Payments," *Report to Congress: Medicare Payment Policy*, ch. 10, Mar. 2017, p. 259. MedPAC recommended for fiscal year (FY) 2018 a payment rate reduction of 5 percent "coupled with an expansion of the high-cost outlier pool, as previously recommended by MedPAC, to redistribute payments within the PPS for IRFs and reduce the impact of potential misalignments between IRF payments and costs." MedPAC also reiterated this 5 percent reduction in its May 15, 2020, letter to CMS in response to the proposed rule entitled "Medicare Program; Inpatient Rehabilitation Facility (IRF) Prospective Payment System for Federal Fiscal Year 2021; Proposed Rule," 85 Fed. Reg. 22065 (Apr. 21, 2020): "However, we note that after reviewing many factors—including indicators of beneficiary access to rehabilitative services, the supply of providers, and aggregate IRF Medicare margins, which have been above 12 percent since 2014—the Commission determined that Medicare's current payment rates for IRFs appear to be more than adequate and therefore recommended that the Congress reduce the IRF payment rate by 5 percent for FY 2021."

²⁶ CMS implemented the Comprehensive Error Rate Testing Program to measure improper payments in the Medicare fee-for-service program. Comprehensive error rate testing is designed to comply with the Payment Integrity Information Act of 2019.

Table: Medicare Improper Payment Rates for IRF Hospitals and Hospital-Based IRF Units

Year	IRF Hospital Improper Payment Rate	Hospital-Based IRF Units' Improper Payment Rate
2016	73%	53%
2017	44%	35%
2018	44%	39%
2019	36%	34%
2020	31%	31%

Additionally, we estimated in our nationwide IRF Medicare compliance audit that in 2013 Medicare paid IRFs nationwide \$5.7 billion for beneficiary care that was neither reasonable nor necessary.²⁷

²⁷ *Many Inpatient Rehabilitation Facility Stays Did Not Meet Medicare Coverage and Documentation Requirements*, A-01-15-00500, available online at <https://oig.hhs.gov/oas/reports/region1/11500500.asp>.



APPENDIX D: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator

Washington, DC 20201

DATE: October 18, 2021

TO: Christi A. Grimm
Principal Deputy Inspector General
Office of Inspector General

FROM: Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services *Chiquita LaSure*

SUBJECT: Office of Inspector General (OIG) Draft Report: Medicare Could Have Saved Approximately \$993 Million in 2017 and 2018 if It Had Implemented an Inpatient Rehabilitation Facility Transfer Payment Policy for Early Discharges to Home Health Agencies (A-01-20-00501)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is committed to providing Medicare beneficiaries with high quality health care while, at the same time, working to protect the Medicare Trust Funds from improper payments.

Section 1886(j) of the Social Security Act established a per discharge prospective payment system (PPS) for inpatient rehabilitation hospitals and rehabilitation units, referred to as inpatient rehabilitation facilities (IRFs). The IRF PPS utilizes information from a patient assessment instrument to classify patients into distinct groups based on clinical characteristics and expected resource needs. Separate payments are calculated for each group, including the application of case and facility level adjustments.

CMS consistently evaluates and updates, as necessary, the IRF PPS. CMS engages in an annual notice and comment rulemaking process to update the classification and weighting factors for case mix groups and describe the methodologies and data used in computing the prospective payment rates. CMS also uses this process to implement any legislative provisions or regulatory changes that are determined to be necessary at that time. For example, the Fiscal Year 2010 IRF PPS Final Rule significantly modified the IRF coverage requirements to reflect changes that had occurred in medical practice over time. This update established a requirement for preadmission screening to assist with identifying appropriate candidates for IRF care, along with requirements for evaluating the appropriateness of an IRF admission. The rule also established or modified requirements for post-admission physician evaluation, individualized overall care plans, and interdisciplinary team meetings.¹

Additionally, to further protect the Medicare Trust Funds from improper payments, CMS has announced its intention to develop and implement the Review Choice Demonstration for IRF

¹ A detailed discussion of the various regulatory and legislative provisions that have affected the IRF PPS over the years is available on the CMS website <https://www.cms.gov/files/document/irf-regulatory-and-legislative-history.pdf>

Services via Federal Register Notice CMS-10765.² Section 402(a)(1)(J) of the Social Security Amendments of 1967 authorizes the Secretary to develop or demonstrate improved methods for the investigation and prosecution of fraud in the provision of care or services under the health programs established by the Social Security Act. Pursuant to this authority, CMS seeks to develop and implement a Medicare demonstration project, which CMS believes will help assist in developing improved procedures for the identification, investigation, and prosecution of Medicare fraud occurring among IRFs providing services to Medicare beneficiaries.

The proposed demonstration will ensure that payments for IRF services are appropriate through either pre-claim or postpayment review, thereby working towards the prevention and identification of potential fraud, waste, and abuse, as well as protecting the Medicare Trust Funds from improper payments while reducing Medicare appeals.

The OIG's recommendations and CMS' responses are below.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services expand the IRF transfer payment policy to apply to early discharges to home health care.

CMS Response

Expanding the IRF transfer payment policy would require notice and comment rulemaking, and the policy developed during a notice and comment period would ultimately determine any potential savings. CMS thanks OIG for the work done on this issue and will consider the OIG's recommendation when determining appropriate next steps for the IRF PPS.

² <https://www.govinfo.gov/content/pkg/FR-2020-12-15/pdf/2020-27579.pdf>;
<https://www.govinfo.gov/content/pkg/FR-2021-09-08/pdf/2021-19476.pdf>