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June 11, 2007

Leslie V. Norwalk, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington DC 20201

Re: File code CMS-1551-P

Dear Ms. Norwalk:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule entitled *Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for FY 2008*, Federal Register, Vol. 72, No. 88, p. 26230 (May 8, 2007). We appreciate your staff's work on this prospective payment system (PPS), particularly given the competing demands on the agency.

Inpatient rehabilitation facilities' (IRF) admission practices have changed substantially as these facilities move through the transitional period to full compliance with the so-called "75 percent rule." Our analyses of IRF admissions presented in our March 2007 *Report to the Congress* indicate that the number of IRF cases decreased by over 9 percent between 2004 and 2005, while over the same period IRFs' aggregate case mix increased. This suggests that IRFs were reducing the number of less severe cases, leaving a residually more complex patient population. These changes are consistent with expectations of what should happen during the transitional period. However, these changes prompt us to offer two comments, both of which are related to the need for CMS to update the IRF PPS in light of next year's deadline for full compliance with the 75 percent rule.

Conditions that count toward IRFs' compliance with the 75 percent rule
Effective July 1, 2008, IRFs must fully comply with the 75 percent rule; at the same time, they will no longer be able to count patients with only comorbidities in one of the 13 conditions toward compliance.

MedPAC has been supportive of CMS's efforts to clinically distinguish IRFs from other Medicare providers; given the-high cost of care in the IRF setting, and the fact that rehabilitation can be provided in other settings, it is important to ensure that only those patients who truly need the level of care provided by IRFs are admitted to these facilities. However, MedPAC has characterized the current 75

percent rule as "a blunt instrument." The 13 diagnoses used to identify patients for whom Medicare will cover an IRF stay do not necessarily identify all patients who need, can tolerate, and benefit from intensive rehabilitation. For example, some patients in need of rehabilitation post-operative to an amputation may require IRF-level care, while others do not. By contrast, some patients with diagnoses not among the 13 defined conditions may benefit from the level of rehabilitation that only IRFs can provide (CMS provided examples of such patients in the September 9 2003 proposed rule on IRF criteria). In 2003, MedPAC recommended that the Secretary consult with an expert panel of clinicians to reach a consensus on the diagnoses to be included in the 75 percent rule as well as more specific clinical criteria for patients within the respective diagnoses. We also suggested that the Secretary periodically revisit the list of diagnoses and clinical criteria for rehabilitation patients, with the expectation of moving away from simple diagnosis-based criteria to more specific patient-based criteria.

MedPAC reiterates this recommendation now. While the 13 conditions used to qualify patients as appropriate for treatment in IRFs was a good first step, we believe CMS should now build on the existing criteria and focus on developing more specific patient criteria. In the May 7, 2004 final rule, CMS made a promising start in refining the criteria in its response to public comments on how patients having undergone hip and knee replacements, indicating specific clinical factors that would indicate a patient's condition was severe enough to warrant treatment in an IRF. We urge CMS to conduct a similar clinical analysis of each of the remaining conditions. This analysis should aim to identify characteristics of those patients within each of these general groups who most appropriately need the intensive services IRFs offer, and use these characteristics to develop patient-specific criteria for each of the groups. Similarly, CMS should examine patients whose diagnoses are not in one of the 13 specified conditions but who qualify during the transitional period, to determine whether they have characteristics in common with those who definitionally qualify, in order to ascertain whether certain patients in these groups could appropriately receive IRF-level care as well.

In conducting these analyses, we urge CMS to be as open and transparent as possible in its analyses and deliberations, so that the rehabilitation community will fully understand the data and the logic supporting any changes in the qualifying criteria. We strongly suggest that CMS formally obtain input from various stakeholders such as representatives of the rehabilitation sector, acute care hospital discharge planners, physicians who do and who do not refer their rehabilitation patients to IRFs, and representatives of other health care sectors who provide rehabilitation services. MedPAC urges CMS to actively push the development of patient criteria for the remaining 12 conditions, as well as other potentially appropriate clinical conditions. In parallel, guidance obtained through its ongoing collaboration with the National Institute of Child Health and Human Development (NICHD) or a comparable public forum could be helpful in identifying the most readily promising areas. We believe that in visibly and proactively taking such steps, Medicare will demonstrate a commitment to ensuring that policies governing IRF payments are based on appropriate clinical indicators.

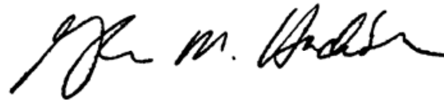
Data used to calculate case-mix group weights and length-of-stay

For the FY 2008 IRF PPS proposed rule, CMS proposes to use the same case-mix classification system that appeared in the FY 2007 final rule, as well as the same data that were the basis for calculating the case-mix group relative weights and length of stay for that year. These data reflect IRF cases in 2003, before implementation of the 75 percent rule prompted substantial changes in IRF admissions, which may have encouraged IRFs to make changes to their cost structures.

MedPAC strongly urges CMS to use more recent data in calculating the CMG weights and lengths of stay for the FY 2008 rate year. Early data indicate that the case-mix of IRFs' patients is becoming more complex as a result of IRFs no longer admitting less severe patients. As a result, the relative weights for the IRF CMGs are likely changing, corresponding to the change in patient mix. Additionally, IRFs may have responded to the financial incentives implicit in the IRF PPS by taking actions to control their costs that affect some types of cases more than others. The CMGs also need to be regularly updated to reflect contemporaneous changes in clinical practice that affect resource use. Further, once the 75 percent rule is fully implemented, we believe that CMS should use the most recent data available on an annual basis, similar to the process used to update DRG weights under the PPS for inpatient acute hospital care. This ongoing recalibration of the IRF CMG weights will be essential to ensuring that payments under the IRF PPS are as accurate as possible.

If you have any questions or require clarification of our comments, please feel free to contact Mark Miller, MedPAC's Executive Director.

Sincerely,



Glenn M. Hackbarth
Chairman

GMH/jm/wc