MEDPAC Medicare Payment Advisory Commission

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July 13, 2005

Mark McClellan, 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-1290-P

Dear Dr. McClellan:

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 2006*, Federal Register, Vol. 70, No. 100, p. 30188 (May 25, 2005). We appreciate your staff's work on this prospective payment system (PPS), particularly given the competing demands on the agency. We have two comments: One is related to the need for CMS to be transparent in its rules and software used for determining whether inpatient rehabilitation facilities (IRFs) are in compliance with the 75 percent rule and one is related to the need for CMS to be consistent in implementing the new labor market areas.

Transparency on IRFs' compliance with the 75 percent rule

Both IRFs and CMS share responsibility for compliance. CMS must have clear, transparent rules and IRFs must follow them. Therefore, CMS needs to make the computer software used to determine compliance transparent and available to interested parties. To assist fiscal intermediaries in their determinations of compliance, the Iowa Foundation for Medical Care, under contract with CMS, created a computer software program called CASPER. CASPER uses ICD-9 codes from IRF patient assessment instruments with an algorithm to determine compliance. Having the CASPER software available to IRFs for their own use makes it fairer if a facility is found out of compliance with the 75 percent rule.

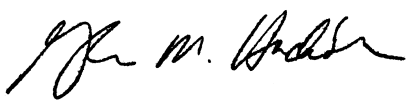
Consistency in implementing new labor market areas

CMS proposed a transition to new labor market areas for hospitals, but did not propose a similar transition for IRFs. Providers should be treated equitably so we support a change in areas. However, large payment changes should be phased in over time so IRFs should be

treated consistently with acute hospitals. Phasing in the new labor market areas would allow IRFs to transition to the new wage level, minimizing large disruptions in payments. The phase in should be budget neutral.

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