MEDPAC Medicare Payment Advisory Commission

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

Re: File code CMS-1474-P

Dear Mr. Scully:

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 2004; Proposed Rule*, 68 Fed. Reg. 26786 (May 16, 2003). We appreciate your staff's careful work on this prospective payment system, particularly considering the competing demands on the agency.

Inpatient rehabilitation facilities (IRFs) are one of several settings that provide Medicare patients with rehabilitation services. Medicare also covers rehabilitation services in skilled nursing facilities, long-term care hospitals, at home from home health agencies, and on an outpatient basis (e.g., from a hospital outpatient department). Medicare generally varies its payments based on the setting and type of services.

CMS's criteria to distinguish IRFs from acute care hospitals and other settings for payment purposes require IRFs to:

- Have provider agreements to participate in Medicare as a hospital.
- Determine whether patients are likely to benefit significantly from intensive inpatient hospital programs or assessments by preadmission screening.
- Ensure that patients receive close medical supervision and furnish rehabilitation nursing, physical therapy, occupational therapy, speech therapy, social or psychological services, and orthotic and prosthetic services.

- Have full-time medical directors experienced in medical management of inpatients requiring rehabilitation.
- Use physicians to establish, review and revise the plan of care for each IRF patient.
- Use coordinated multidisciplinary team approaches in the rehabilitation of each inpatient.
- Have 75 percent of their cases in 10 diagnoses—stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, fracture of femur (hip fracture), brain injury, and polyarthritis, including rheumatoid arthritis, neurological disorders, and burns.

Further, in order to be eligible for IRF care, patients must be able to sustain three hours of therapy a day.

Only one of the IRF standards is under debate: the rule requiring IRFs to have 75 percent of their cases in 10 diagnoses (the "75 percent rule"). Many have argued that the 10 diagnoses no longer represent a clinically appropriate standard for defining IRF services. The issue of variation in patient need within diagnoses has always existed. Finally, an estimated 87 percent of IRFs are currently out of compliance with the rule.

We recognize the need to distinguish IRFs from other Medicare providers in order to pay appropriately for their services. As you know, IRFs are paid more than acute hospitals. Given the current state of clinical evidence and patient classification systems, the dilemma is how to construct a fair rule that allows Medicare beneficiaries to receive appropriate rehabilitation services and avoids undesirable financial incentives to expand the types of patients in IRFs beyond what is clinically necessary. On the one hand, an unchanging list of 10 diagnoses to characterize an appropriate patient population for the IRF setting is a blunt instrument. Medical practice may have changed since 1983, when the 10 diagnoses were first included in the 75 percent rule. On the other hand, using instead the 20 diagnoses in the IRF-prospective payment system (PPS) reflects IRFs' past admitting practice but does not necessarily identify a clinically appropriate population.

In the short term, the Secretary has few other options but to enforce the 75 percent rule consistently; the issue is which diagnoses should go into the calculation. One short-term strategy that the Secretary could pursue is to lower the percentage of cases (required to be from 10 diagnoses) in the current 75 percent rule to 50 percent for some period of time, not to exceed one year. According to CMS's analysis, most IRFs could meet this standard. During that period of time, the Secretary could 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 the appropriate clinical criteria for patients within the respective diagnoses. It is most imperative that the panel resolve the joint replacement issue because a large and growing proportion of IRF patients likely fall into this category. If the Secretary can complete this consultation prior to the October 1, 2003 proposed implementation date, it may be unnecessary to lower the 75 percent to 50 percent.

Over the long run, the Secretary also may want to periodically revisit the list of diagnoses and clinical criteria for rehabilitation patients. The expectation would be to move away from simple

diagnosis-based criteria to patient-based criteria. Consistent with that objective, MedPAC is interested in linking payment to high-quality outcomes, as evidenced by our recommendation in the June 2003 Report to the Congress. In that report, we find that IRFs are particularly suited to linking payment for quality because the patient assessment instrument is standardized, credible, and data are routinely collected; also a risk-adjustment mechanism is built into the PPS. In the future, the IRF payments could be based on the patient-specific criteria and linked to outcomes. This also could be part of the criteria CMS could use to decide whether a facility would be designated as an IRF, potentially eliminating the need for criteria such as the 75 percent rule, although practically we see the need for such rules in the short term.

We look forward to offering any assistance we can to CMS in these endeavors.

Sincerely,

Glenn M. Hackbarth, J.D.
Chair

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