MEDPAC Medicare Payment Advisory Commission

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June 2, 2014

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC

RE: File Code CMS-1608-P

Dear Ms. Tavenner:

The Medicare Payment Advisory Commission (MedPAC) appreciates the opportunity to submit comments on the Center for Medicare & Medicaid Services (CMS) proposed rule entitled Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2015; Proposed Rule. We appreciate your staff's continuous efforts to administer and improve the Medicare payment system for inpatient rehabilitation facilities (IRFs), particularly given the competing demands on the agency.

This rule proposes a payment update for IRFs in FY2015 and details a number of additional proposals. We focus our comments on the payment update and the following proposals:

- Additions to the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI) to collect the amount and mode of therapy furnished to patients in IRFs; and
- Revisions and updates to the IRF Quality Reporting Program (IRFQR).

Proposed FY2015 update to payment rates for IRFs

CMS proposes a 2.1 percent increase to the IRF payment rate. CMS obtained this result by following the statutory formula of starting with a 2.7 percent market basket increase and subtracting a productivity estimate of 0.4 percentage points and an additional deduction of 0.2 percentage points; both are required by the Patient Protection and Affordable Care Act of 2010 (PPACA). CMS also proposes to increase outlier payments by 0.1 percent to maintain total outlier payments of 3 percent of total Medicare spending on IRFs.

Comments

We understand that CMS is required to implement this statutory update. However, we note that after reviewing many factors—including indicators of beneficiary access to rehabilitative services, the supply of providers, and Medicare margins—the Commission determined that Medicare's current payment rates for IRFs appear to be adequate and therefore recommended no update to IRF payment rates for FY2015. We appreciate that CMS cited our recommendation, even while noting that the Secretary does not have the authority to deviate from statutorily mandated updates.

Proposed data collection of the amount and mode of therapy provided in IRFs

Prior to the implementation of the IRF prospective payment system (PPS) in January 2002, Medicare payments to IRFs were based on the reasonable costs incurred in furnishing services to beneficiaries. Under a cost-based payment system, providers had few financial incentives to choose one mode of treatment over another. As CMS notes in the proposed rule, policy makers assumed that treatment decisions under this payment system were based on the needs of the patient. Under the IRF PPS, however, Medicare pays IRFs a set amount intended to cover the costs of all treatment and services, including therapy, furnished to a patient during an IRF stay. This method of payment creates incentives for IRFs to reduce their costs. Since individual therapy is generally more costly than group therapy, one way IRFs might lower their costs is by furnishing more group therapy and less individual therapy. To date, CMS has been unable to track changes in the provision of therapy to patients because Medicare does not collect data on therapy modalities (individual, group, concurrent).

To better understand the ways in which occupation, speech, and physical therapy services are currently being provided in IRFs, CMS proposes to add a new therapy information section to the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI) to record the amount (in minutes) and mode of therapy (that is, individual, group, or co-treatment) patients receive in each therapy discipline. The new therapy information section would be completed as part of the patient's discharge assessment and would record the amount and mode of therapy received in each discipline during each of the first and second weeks of the IRF stay, as well as the average number of minutes of individual, group, and co-treatment therapies the patient received during all subsequent weeks of the IRF stay.

For purposes of recording therapy services in IRFs, CMS proposes to define individual therapy as the provision of therapy services by one licensed or certified therapist (or one licensed therapy assistant under the appropriate direction of a licensed or certified therapist) to one patient at a time. CMS proposes to define group therapy as the provision of therapy services by one licensed or certified therapist (or licensed therapy assistant under the appropriate direction of a licensed or certified therapist) to between two and six IRF patients at one time, regardless of whether those patients are performing the same activity or different activities. CMS proposes to define co-treatment as the provision of therapy services by more than one licensed or certified therapist (or licensed therapy assistant under the appropriate direction of a licensed or certified therapist) from different therapy disciplines to one patient at the same time. CMS proposes to use these data to analyze the types of therapy services Medicare is currently paying for under the IRF prospective

payment system and to monitor the amount of therapy given and the use of different therapy modes in IRFs.

Comments

The Commission supports this proposal. Because Medicare does not collect data on the amount of individual versus group therapy that IRF patients receive, CMS has been unable to determine whether IRFs have altered the provision of therapy services and whether the current mix of therapy modalities is clinically appropriate. Although this proposal will be a new burden for providers, we believe that the potential benefits for quality of care and accuracy of payment are significant. Monitoring the amount of therapy given and the use of different therapy modalities will allow CMS to determine if patients are receiving an appropriate mix of therapy services and whether limits on the amount of group therapy that may be provided to IRF patients are needed. In addition, collecting this information will allow CMS to determine whether IRFs have materially changed the bundle of services provided to beneficiaries and paid for by Medicare. To ensure that Medicare's payments are appropriate, CMS must know what the program is paying for. Ultimately, this information could allow better calibration of Medicare's payments to the resources required and received by patients.

CMS proposes to collect data on the amount and mode of therapy furnished in IRFs but at the present time is not proposing to link payment to the reporting of this information. CMS will need to carefully monitor these data to ensure accuracy of reporting and may wish to consider whether the accuracy could be improved by linking reporting to payment for services.

Though the Commission supports collection of these data to improve the accuracy of Medicare's payments to IRFs, we reiterate our previous recommendations that CMS needs to ensure the comparability of payments across post-acute care (PAC) settings. To evaluate differences in the mix of patients treated in different PAC settings, the care providers furnish, and the outcomes patients achieve, CMS must implement a common patient assessment tool as soon as possible. In addition, as the Post-Acute Care Payment Reform Demonstration showed, a common patient assessment tool would enable the development of a single case-mix system to adjust payments based on patient characteristics, rather than on the setting in which care is provided. As you know, the Commission recommended in March 2014 that the Congress direct the Secretary to implement common patient assessment items for use in the four PAC settings (IRFs, skilled nursing facilities, home health agencies, and long-term care hospitals) beginning in 2016.

Proposed revisions and updates to the Quality Reporting Program for IRFs

CMS is required in fiscal year 2014 and each subsequent year to reduce the annual market basket update by 2 percentage points for any IRF that fails to successfully report on a specified set of quality measures. Five quality measures have been finalized for use in the IRF Quality Reporting Program (IRFQR) in FY 2015 and beyond:

- Rates of catheter-associated urinary tract infection for intensive care patients;

- Percent of residents with new or worsened pressure ulcers;
- Influenza vaccination coverage among health care personnel;
- Percent of patients who were assessed and appropriately given the seasonal influenza vaccine; and
- All-cause unplanned readmissions for 30-days post-discharge from the IRF.

The May 7, 2014 rule proposes to add two measures of healthcare associated infections (HAIs) to the IRFQR for FY 2017: methicillin-resistant staphylococcus aureus (MRSA) bacteremia and clostridium difficile infection (CDI) events. Both measures would be collected using the Center for Disease Control's National Health Safety Network reporting system. CMS also indicates that it is considering six additional measures for future inclusion in the IRFQR program: change in mobility score; change in self-care score; mobility score at discharge; self-care score at discharge; percent of long-stay residents experiencing one or more falls with major injury; and percent of residents who self-report moderate to severe pain.

Comments

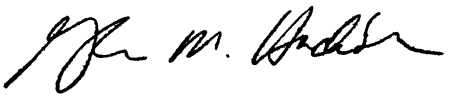
As noted in our June 25, 2013 comment letter to CMS on the acute and long-term care hospital prospective payment systems and the IPFQR, the Commission believes that Medicare's quality measurement programs should focus on patient outcomes, such as avoiding preventable readmissions and HAIs, because outcomes are more meaningful to patients, and focusing on outcomes rather than process measures can have a greater impact on provider behavior. We therefore support the inclusion of the HAI measures CMS has proposed for the IRFQR, and we encourage CMS to expedite the development of patient outcome measures such as change in mobility score and self-care. At the same time, we encourage CMS to drop and avoid process measures such as assessment of influenza vaccination that might deflect providers' attention and resources from more productive quality improvement activities. In considering future measures for the IRFQR, CMS should critically evaluate the extent to which potential measures will contribute to meaningful differences in IRF patients' health outcomes and should take care not to burden providers with too many measures. The Commission is mindful that Medicare is one of many payers that may be requiring providers to collect data for quality reporting. Finally, the Commission urges CMS to develop and implement, as soon as possible, outcome measures that can be compared across PAC settings so that policy makers and patients can evaluate and compare differences in the quality of care providers furnish and the outcomes patients achieve in different PAC settings.

Conclusion

MedPAC appreciates your consideration of these policy issues. The Commission values the ongoing collaboration between CMS and MedPAC staff on IRFs, and we look forward to continuing this relationship.

If you have any questions regarding our comments, please do not hesitate to contact Mark Miller, MedPAC's Executive Director, at 202-220-3700.

Sincerely,



Glenn M. Hackbarth, J.D.
Chairman

GMH/dkk