425 Eye Street, NW • Suite 701
Washington, DC 20001
202-220-3700 • Fax: 202-220-3759
www.medpac.gov

Glenn M. Hackbarth, J.D., Chairman
Michael Chernew, Ph.D., Vice Chairman
Mark E. Miller, Ph.D., Executive Director

June 25, 2013

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1448-P
P.O. Box 8016
Baltimore, MD 21244-1850

Re: File code CMS-1448-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 2014; 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 FY2014 and details a number of additional proposals. We focus our comments on the payment update and the following proposals:

- Refined list of diagnosis codes used to determine presumptive compliance with the "60 percent rule"
- Updating the payment adjustment factors
- New quality measures to the IRF quality reporting program for FY2016 and FY2017

Proposed FY 2014 update to payment rates for IRFs

CMS proposes a 1.8 percent increase to the IRF payment rate. CMS obtained this result by following the statutory formula of starting with a 2.5 percent market basket increase and subtracting a productivity estimate of 0.4 percentage points and an additional deduction of 0.3

percentage points; both are required by the Patient Protection and Affordable Care Act of 2010 (PPACA). CMS also proposes to increase outlier payments by 0.2 percent to maintain total outlier payments of 3.0 percent of total Medicare spending on IRFs.

Comments

We understand that CMS is required to implement this statutory update. However, given indicators of stable quality of care and beneficiary access, as well as high margins, MedPAC has recommended that the IRF payment rates not be updated in FY 2014.[1] We appreciate that CMS cited our recommendation, even while noting that the Secretary does not have the authority to deviate from the statutorily mandated updates.

Refined list of diagnosis codes for presumptive compliance

The 60 percent rule (formerly the 75 percent rule) aims to distinguish IRFs from acute care hospitals for purposes of IRFs receiving payment under the IRF prospective payment system (PPS) rather than the inpatient prospective payment system (IPPS). The rule mandates that at least 60 percent of cases that an IRF admits require intensive rehabilitation services for treatment of one or more of 13 specified conditions, as either a primary diagnosis or comorbidity. Compliance is evaluated either through medical review or through the "presumptive" method, in which a computer program compares all of a facility's IRF-PAI assessments from the year to a list of eligible codes. CMS proposes removing a large number of ICD-9-CM codes from the list used to qualify for presumptive compliance because the codes alone do not provide sufficient information that the patient would reasonably require intensive rehabilitation. Examples include non-specific or miscellaneous diagnosis codes and codes for arthritis conditions that would meet the compliance criteria only if severity and prior treatment criteria are met, which could only be determined through medical review. In the absence of provider behavioral changes, CMS estimates that these refinements would result in savings of $520 million in FY 2014. However, CMS assumes that providers will adapt to code more specifically, resulting in no net change in spending.

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[1] Medicare Payment Advisory Commission. 2013. *Report to the Congress: Medicare payment policy.*

Comments

Ideally, payment systems would be focused on patient-based criteria at the level of the episode of care or other broader site-neutral systems, but our current fee-for-service payment systems are generally specific to provider types and therefore require regulatory distinctions to calibrate payments to the various post-acute care providers. In this context of our current system, MedPAC supports this proposal.

Given the high levels of Medicare payments to IRFs, it is extremely important that only the most clinically-appropriate patients receive care in this high-cost setting. We strongly agree with CMS' goal to improve accuracy in determining the need for the intensive rehabilitation services that IRFs provide. By requiring IRFs to use more detailed coding, CMS could potentially collect information on IRF patients that would differentiate them from patients with similar conditions who are treated in other settings (e.g., skilled nursing facilities, home health agencies, or outpatient therapy providers). Absent such differentiators, it may be prudent for Medicare to pay a rate for a therapy service based on the lowest-cost setting where it can be safely performed, rather than paying based on the setting where the service happens to be delivered. We support efforts to expand the use of specific patient-based criteria in the IRF payment system and move away from the simple diagnosis-based criteria used for most of the 13 conditions that qualify for the 60 percent rule. The criteria for hip and knee replacement and for arthritis conditions detail specific clinical factors that indicate both whether a patient's condition is severe enough to warrant treatment in an IRF, and that the patient can tolerate the advanced regimen of therapy that the IRF provides. CMS should replicate this process and create detailed criteria for all of the 13 conditions. We believe the current proposal represents a positive step in targeting resources more accurately and appropriately in a patient-based manner, and we encourage additional efforts to this end.

Updating the payment adjustment factors

CMS provides payment adjustments to account for the higher costs associated with location in a rural area, teaching status, and low-income patient percentage (LIP). Substantial differences in costs exist between freestanding and hospital-based IRFs, and the facilities that would receive the payment adjustment for these factors are disproportionately hospital-based. CMS proposes

controlling for facility type in the model to estimate the adjustment factors for FY 2014, asserting that including facility type as a variable in the regression model improves the model's ability to predict an IRF's average cost per case (the R-squared of the regression model increases from 11 percent to 41 percent). The updated adjustment factors that CMS proposes also reflect a new three years of data used in calculating the three-year average, since FY 2010 was the most recent year that CMS updated the payment adjustment factors. For FY 2014, the proposed updates would net decrease the rural adjustment factor from 18.4 percent to 14.3 percent and net decrease the LIP adjustment factor from 0.46 to 0.32. For the teaching status adjustment factor in FY 2014, the adjustment of controlling for facility type and the adjustment resulting from new years of data have a net effect of increasing the teaching status adjustment factor from 0.69 to 0.99. This year continues a trend of estimates for the teaching status adjustment fluctuating substantially year to year.

Comments

As a general principle, MedPAC believes that the regression models used to determine relative weights for Medicare's payment systems should incorporate only factors for which the payment system will adjust payments, and we would not be inclined to support CMS' proposal to control for facility type in the IRF regression model. Beyond this general principle, however, we continue to note large fluctuations in the teaching adjustment from year to year, an issue on which we have commented frequently. The proposal to control for facility type does not address the issue of fluctuations in the teaching adjustment estimate, and we again urge CMS to determine a solution. Stabilizing the large fluctuations is important, particularly because it is a budget neutral adjustment that shifts payments from non-teaching facilities to teaching facilities. We have previously suggested additional research into the causes of the instability. If efforts in this area have not identified an empirical solution, it may be prudent to tie the IRF teaching adjustment to a more stable source, such as the indirect medical education (IME) adjustment factor in the IPPS or the teaching adjustment paid to inpatient psychiatric facilities (IPFs). Alternatives could include capping the adjustment at the level currently paid to IPPS hospitals or blending the calculated IRF

adjustment with the IPPS or IPF adjustment.[2] In addition to its estimates being unstable, the IRF teaching adjustment is substantially higher than both the IPPS and IPF adjustments, and the difference would widen considerably under the proposed update. In FY 2013, for a facility with a resident-to-bed ratio of 10 percent, the teaching adjustment rates for an IRF would be 89 percent higher than the IPPS IME adjustment. Under the proposed updates, the teaching adjustment rates for an IRF would be 2.78 times higher than the IPPS IME adjustment.[3] The alternatives we have proposed would reduce the IRF adjustment to be more consistent with other sectors and maintain more stable levels over time.

New quality measures for the IRF quality reporting program in FY2016 and FY2017

PPACA established a new quality reporting program for IRFs, in which providers that failed to report performance on measures specified by CMS would see their payment rates reduced by two percentage points, beginning in FY 2014. CMS previously established two measures for FY 2014 and FY 2015: catheter-associated urinary tract infections and pressure ulcers that are new or worsened. CMS has proposed measures for FY 2016 and FY 2017. Beginning in FY 2016, CMS proposes to add a measure of influenza vaccination coverage among health care personnel. For FY 2017, in addition to modifying the pressure ulcer measure to enable risk-adjustment, CMS proposes to add two new measures: percent of patients who were assessed and appropriately given the influenza vaccine, as well as a readmissions measure. The readmissions measure estimates the risk-standardized rate of unplanned, all-cause hospital readmissions for cases discharged from an IRF who were readmitted to a short-stay acute care hospital or a long-term care hospital (LTCH), within 30 days of an IRF discharge. This measure would not carry penalties for failure to report since the measure is based on claims and does not require IRFs to report new data.

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[2] The current law IME adjustment for IPPS operating payments for FY 2013 is roughly 5.5 percent for every 10 percent incremental increase in the resident-to-bed ratio. The IPF PPS teaching adjustment for FY 2013 is equal to (1 + the ratio of residents to average daily census) raised to the power of 0.5150.

[3] We used the average IRF occupancy rate of 63 percent to compare the IRF and IPPS teaching adjustment because the IRF adjustment uses a ratio of residents per average daily census and the IPPS adjustment uses a ratio of residents to beds. If we assume a 100 percent occupancy rate to set equal the ratios of residents per average daily census and residents to beds, the IRF teaching adjustment would be 27 percent higher than the IPPS adjustment under current rates and 85 percent higher under the proposed rates.

Comments

MedPAC commends CMS for including a hospital readmission measure in the IRF quality reporting program. We appreciate CMS' work on this topic. However, we favor a measure that would estimate the rate of potentially preventable all-condition hospital readmissions, as detailed in our June 2013 report. We would expect that providers could more readily develop changes to reduce readmissions that are potentially preventable than those that may be unrelated to the index admission.

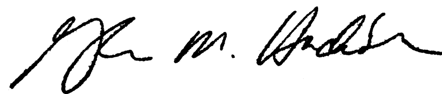
In addition, we strongly encourage CMS to focus efforts on outcomes-based measures. In particular, we suggest that CMS consider adding a measure of functional improvement, since regaining functional status represents a central goal of IRF care and is an outcome of primary importance to beneficiaries. We also suggest consideration of a measure of discharge home. This outcome is also very important to beneficiaries and would serve as a useful corollary to the 30-day readmissions measure because it reflects whether a patient returns home, rather than returning directly to the acute hospital or another inpatient facility. MedPAC's March 2013 report presents results for the IRF sector on both of these measures, and we are available to discuss the findings with CMS staff in more detail.

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/sns