MEDPAC Medicare Payment Advisory Commission

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June 23, 2009

Charlene Frizzera, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1538-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: File code CMS-1538-P

Dear Ms. Frizzera:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS's) proposed rule entitled *Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2010; Proposed Rule.* We appreciate your staff's ongoing work to administer and improve the Medicare payment system for inpatient rehabilitation facilities (IRFs), particularly given the competing demands on the agency.

Teaching adjustment

The rule proposes to update the three IRF facility-level payments adjustments (rural, low-income, and teaching adjustments) for fiscal year (FY) 2010. The rule would use the same general methodology developed by RAND to originally establish and update these adjustments, but proposes to calculate the adjustment factors using a three-year moving average (2005, 2006, and 2007) rather than a single year of data (2007). The rule states that the proposal to adopt a three-year moving average is motivated by concern that adjustments based on only one year of data could result in unnecessarily large fluctuations in the adjustment factors from year to year.

The rule indicates that there is substantial year-to-year volatility in the teaching adjustment estimates. The teaching adjustment, established in FY 2006 using FY 2003 data, equals (1 + ratio of residents to average daily census) raised to the power 0.9012. The proposed rule indicates that the teaching adjustment would be 1.5155 calculated using 2005 data, 0.6732 using 2006 data, and 1.0451 using 2007 data. The rule proposes an adjustment of 1.0494 based on a three-year moving average for FY 2010, which would be an increase over the current adjustment of 0.9012.

The Commission is concerned about the year-to-year volatility in the teaching adjustment estimates. The additional patient care costs associated with teaching programs would not be expected to fluctuate substantially from one year to the next. The volatility in the teaching adjustment suggests that it may be measuring something other than just the additional patient care costs associated with a teaching program. It is also notable that the IRF teaching adjustment is substantially higher than the current law indirect medical education (IME) adjustment for inpatient prospective payment system (IPPS) hospitals, and even higher than the Commission's estimate of the empirically justified IPPS IME adjustment.[1] The IRF teaching adjustment is also higher than the teaching adjustment under the inpatient psychiatric facility (IPF) PPS.[2] While we have not independently modeled the IRF teaching adjustment, the volatility of the adjustment, as well as its size compared to the teaching adjustments in other sectors (IPPS and IPF PPS), raises questions about whether outliers, methodological issues, or data quality issues could be biasing the adjustment.

We understand the desire to smooth the volatility in the adjustment with a three-year moving average; however, smoothing does not resolve the underlying issue of whether the adjustment is measuring what it is intended to measure. The accuracy of the adjustment is important, especially since it is a budget neutral adjustment that shifts payments from non-teaching facilities to teaching facilities. We urge CMS to conduct additional research on the IRF teaching adjustment to determine what is accounting for the volatility and to evaluate the accuracy and reliability of the adjustment. In the meantime, we suggest that CMS consider alternative approaches to the proposed three-year moving average for the IRF teaching adjustment because it is based on estimates of questionable validity and would result in a potentially arbitrary increase in the teaching adjustment. We believe there are a range of options that CMS could pursue for establishing the teaching adjustment for FY 2010 that would be more reasonable than using the 3-year moving average of 1.0494, including (1) maintaining the IRF teaching adjustment at its current FY 2009 level, (2) capping the adjustment at the level currently paid to IPPS hospitals or IPFs, or (3) capping the IRF teaching adjustment at a level equivalent to the Commission's estimate of the empirically justified IME adjustment for IPPS hospitals. These alternatives would either maintain the IRF teaching adjustment at its current level or reduce the adjustment to be more consistent with other sectors until more research can be conducted to resolve questions about the accuracy of the IRF teaching adjustment estimates.

[1] The current law IME adjustment for IPPS operating payments is 5.5 percent for each 10 percent increment in teaching intensity, as measured by the ratio of residents to beds. MedPAC's March 2007 Report to Congress estimated that IPPS costs per case (combined operating and capital) increase about 2.2 percent for every 10 percent increment in the ratio of residents to beds. Our analysis also examined the use of residents to average daily census in place of residents per bed and found costs increase about 1.8 percent for each 10 percent increment in this measure.

[2] The IPF PPS teaching adjustment is equal to (1 + ratio of residents to average daily census) raised to the power 0.5150.

IRF Classification Requirements and Medical Necessity Criteria

The proposed rule and draft changes to the Medicare benefits policy manual seek to clarify and strengthen some of the requirements that facilities would have to meet to be considered an IRF and the criteria and processes for documenting medical necessity.

As part of the requirements for a facility to qualify as an IRF, the rule proposes enhanced requirements for IRF preadmission screenings. IRFs would be required to perform a comprehensive preadmission screening within 48 hours prior to admission. During the preadmission screening, IRFs would be required to evaluate whether the patient: (1) is sufficiently stable to participate in intensive rehabilitation, (2) requires therapy in at least two disciplines, one of which must be physical or occupational therapy, and (3) requires and can reasonably be expected to actively participate in at least 3 hours of therapy at least 5 days per week, and be expected to make measurable improvement that will be of practical value. The proposed rule would also clarify the existing requirement that IRF patients must need close medical supervision. The need for close medical supervision would be determined during the preadmission screening by evaluating each patient's risk for clinical complications. Receipt of close medical supervision would generally be considered to be satisfied by physician face-to-face visits with the patient at least 3 days per week.

The rule makes a number of proposals regarding the processes of care after a patient is admitted to an IRF. The rule would require a post-admission evaluation by a rehabilitation physician within 24 hours of admission to determine whether there have been any relevant changes since the preadmission screening and begin planning the expected course of treatment. The rule also would revise the requirements concerning the plan of care, by requiring that an individualized overall plan of care be developed for each patient by a rehabilitation physician with input from the interdisciplinary team within 72 hours of the patient's admission. The proposed rule also would make changes to requirements concerning the interdisciplinary team meetings, requiring the team to meet once per week, instead of once every two weeks, setting requirements for the type of staff involved, and requiring that the rehabilitation physician document his/her concurrence with all decisions made by the team.

In addition to the proposed rule, CMS has made available for comment draft revisions to the Medicare benefits policy manual on IRF services. The manual provides more details on the requirements proposed in the rule. In addition, the draft manual would revise the IRF medical necessity criteria to include the following 3 requirements: (1) the patient requires intensive rehabilitation (i.e., at least 3 hours per day at least 5 days per week), (2) the patient requires an intensive and coordinated interdisciplinary approach to providing rehabilitation, and (3) the patient is expected to make measurable improvement that will be of practical value as a result of the rehabilitation and that such improvement can be expected to be made within a prescribed period of time.

The Commission supports the general direction of these changes in the proposed rule and the draft Medicare benefits policy manual. Overall, the proposed rule would provide a clearer set of expectations regarding the preadmission screening process, as well as strengthening the requirements for certain aspects of IRF care (i.e., post-admission evaluation, individualized plan of care, rehabilitation physician involvement, interdisciplinary teams). With regard to the medical necessity criteria revisions in the draft manual, the Commission views these changes as a positive step forward. Compared with the prior medical necessity criteria, the proposed criteria focus more on patients' functional needs. The Commission has previously been supportive of more patient-specific criteria for IRFs, and we believe these changes are a step in that direction. To the extent that ambiguity exists in the IRF medical necessity criteria, we urge CMS to work with the rehabilitation community and other stakeholders to further refine the criteria to appropriately identify those patients who require the intensive level of therapy and medical management that IRFs provide.

Reporting of IRF-PAI data for Medicare Advantage Enrollees

The rule proposes to require that IRFs report IRF-PAI data for all Medicare Advantage enrollees in order to facilitate the determination of IRFs' compliance with the 60 percent rule. We support this proposal. Given the substantial increase in Medicare Advantage enrollment in recent years, we agree that having IRF-PAI data for Medicare Advantage enrollees would facilitate determinations of compliance with the 60 percent rule. The data would also be extremely valuable for research as it would allow for comparisons of patterns of care in fee-for-service Medicare and Medicare Advantage.

Market Basket

The proposed rule requests comments regarding the creation of a market basket specific to inpatient rehabilitation facilities (IRFs) that could be used in place of the rehabilitation, psychiatric, and long-term care hospital (RPL) market basket. The RPL market basket was developed to measure the rate of inflation for the resources used in treating the specific types of patients served by these facilities. It is based on data from freestanding IRFs, inpatient psychiatric facilities (IPFs), and long-term care hospitals (LTCHs). Ideally, the market basket used to update payment rates for IRFs would be based on the best available data that accurately reflect the cost structures of IRFs only. Therefore, MedPAC supports study of this issue for IRFs, as well as IPFs and LTCHs.

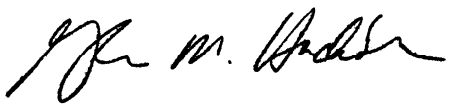
Creating a market basket specific to IRFs necessitates a better understanding of the differences in the underlying cost levels and structures of freestanding versus hospital-based IRFs. To date, research examining geographic variation, case mix, urban and rural status, share of low income patients, teaching status, and outliers has not yielded satisfactory explanations for these cost differences. Without an understanding of the reasons for the cost differences, it is impossible to know if Medicare should recognize them. Additional research is needed to determine the source of these differences and to determine whether they should be recognized. One area that may merit examination is facility size. On average, hospital-based IRF units have nearly two-thirds fewer

discharges than freestanding IRFs. To the extent that there are economies of scale, these facility size differences may be contributing to differences in the cost level or structure.

CMS has requested help from the public in the form of additional information or data to help the agency better understand differences in the cost level and structure across hospital-based and freestanding IRFs to inform the potential construction of a sector-specific market basket. While we believe that seeking outside input is appropriate, we advise the agency to proceed with caution in using outside data. It may be difficult for CMS to confirm that the methods used to collect outside data are sound and that the data are representative of the industry overall. For example, questions have been raised about whether some of the data used to determine the practice expense relative value units for the physician fee schedule were adequately representative of practice costs for certain specialties. This may have resulted in distorted physician payments. Therefore, as CMS reviews outside data, we urge the agency to evaluate (1) the soundness of any information submitted by providers to help explain observed cost differences between freestanding and hospital-based providers; and (2) whether the market basket should be based on the cost structure of both freestanding and hospital-based facilities, or of just one type of facility if higher costs in another type cannot be explained by differences in case mix and other patient characteristics.

MedPAC appreciates the opportunity to comment on the rule. The Commission also values the ongoing cooperation and collaboration between CMS and MedPAC staff on technical policy issues. We look forward to continuing this productive relationship. If you have any questions or require clarification of our comments, please feel free to contact Mark Miller, MedPAC's Executive Director, at 202-220-3700.

Sincerely,



Glenn M. Hackbarth, J.D.
Chairman