MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, October 9, 2003
10:11 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Inpatient rehabilitation facilities: changes under PPS
-- Sally Kaplan

DR. KAPLAN: The prospective payment system for inpatient rehabilitation facilities, better known as IRFs, at least by some people, began on January 1, 2002. The research I'm presenting today begins our examination of IRFs and the PPS. At then end of the presentation I'll talk about some questions we plan to research and I'll ask you for significant issues you'd like addressed in the June chapter.

IRFs are generally characterized as specializing in intensive rehab; physical therapy, occupational therapy, and speech therapy. To be eligible for this care in the Medicare program, beneficiaries have to be capable of sustaining three hours of therapy per day.

Inpatient rehab facilities are defined as distinct from acute hospitals by a series of requirements. The most important requirement is that 75 percent of an inpatient rehab facility's cases have to be in 10 diagnoses that are believed to require intensive rehab. One of the 10 diagnoses, polyarthritis, has become very controversial. It is the condition by which patients with major joint replacements have been counted in the 75 percent for IRFs. When major joint replacement cases are not counted, few of the IRFs are in compliance with the rule. As you'll see in a moment, major joint replacement is the most frequent diagnosis treated in IRFs. CMS's new proposed 75 percent rule make it difficult for IRFs to admit beneficiaries with joint disease or major joint replacement.

Before I talk about what changed between 1999 to 2002 I'd like to explain why I'm talking about 1999. Most of the information you'll see today is from RAND's research. They designed the payment system using 1999 data. Although we cannot say that these changes between '99 and 2002 were caused by the PPS, some of the changes are consistent with changes we saw in response to the acute hospital prospective payment system.

In addition, in 1999 the BBRA mandated a per-discharge payment system for IRFs so these facilities were aware of the type of PPS they would have and may have changed behavior in preparation for the PPS.

The number of Medicare cases increased 6 percent per year between 1999 and 2002. Other changes include the distribution of diagnoses, the inpatient rehab facility length of stay decreased, the case-mix index increased, and the acute hospital length of stay decreased for patients discharged to an IRF.

Now let's look a little closer at most of these changes. As you can see on this chart, the largest changes in distribution of cases by RIC, or rehabilitation impairment category, are in stroke and major joint replacements; the two biggest RICs in 1999 and 2002. The other changes were small. In some RICs the share of cases didn't change and I've not shown them. Between 1999 and 2002 stroke and major joint replacement changed places as far as

number one and number two.

In the acute hospital in these years there also was a big change in these two groups of patients. For example, stroke cases decreased by 28 percent over the three years and major joint replacement cases increased 17 percent from '99 to 2002.

It is also possible that payment policy may have driven the changes in distribution. Although the payment rate was the same for the lowest level of impairment and no comorbidities for the two diagnoses, the rate increases faster as comorbidities increase for major joint replacement cases.

On average, the decrease in IRF length of stay was about 5 percent per year. Decreases in length of stay are consistent with a per-discharge prospective payment system. This decrease is similar to the 4 percent decrease in length of stay we saw in the first year after the hospital PPS was implemented.

Changes to the case-mix index may include reach changes in case mix in addition to improvement in coding and upcoding. The national IRF case-mix index increased about 1 percent per year from '99 to 2002. To compare, the acute hospital case-mix index increased 4.4 percent in the first year of PPS alone. Earlier transfers from acute hospitals probably would result in real case-mix index change. Because comorbidities increase payments, IRFs are more likely to code comorbidities under the PPS. This would result in coding improvement.

Almost 90 percent of IRF patients are transferred from acute hospitals. It is surprising that the acute hospital length of stay and the IRF length of stay both would decrease at the same time. Unfortunately, we'll be unable to directly assess the effect of these length of stay decreases on patient's outcomes because the measurement of functional status and cognitive status in IRFs changed from '99 to 2002. We will be able to examine whether discharge destinations changed pre and post-PPS. In the future, if length of stay continues to drop we will be able to assess the effect of the drop because we will have more than one year of data.

As you remember, in the June 2003 report we recommended that CMS conduct a demonstration on payment for quality and we pointed out that IRFs were a good place to start because they have a data collection system that is robust, well accepted, and standardized. Payment for quality might reduce decreases in length of stay that implicate quality.

There are many things that we could examine in our research on IRFs and the PPS. Some of them are on the screen now. The question for you is, are there other significant issues you'd like addressed for the June 2004 report?

DR. ROWE: Sally, just a comment about the change in the proportion of cases, the stroke and major joint that you commented on. First of all, I think this is fabulous. This is the best news I've heard. I've been sitting here five years. A 28 percent reduction in acute hospitalization for stroke between 1998 and 2002 is fabulous. If that reflects better anti-coagulation of people with atrial fibrillation or more rapid intervention in patients with evolving stroke, which I think it may, I think it's great.

In fact the 28 percent reduction is so high that it would explain this whole thing. It's almost not worth going into the payment issues. You do mention this could be due to the fact that there are 28 percent fewer strokes, and then you go into all this stuff about how the payment mechanism might be causing it, when in fact you may have already explained it. But that's because this is MedPAC and we're into payment. If this were the American Society of Neurologists we wouldn't go to that second level.

But in the first level I think perhaps even more important than the number of strokes in hospitals is the severity of the strokes, which you don't comment on. If we're getting more effective in treating stroke and treating it more rapidly, then for any given group of patients admitted to the hospital with stroke there will be fewer very severe strokes, and those are the ones that are likely to go to the inpatient rehabilitation facility. And there will be more people with less severe strokes, and they're more likely to go home or get home care or visiting nurse care or something else as they get rehab.

So I would mention something about the severity, and I would see if there are any data with respect to severity within the population of stroke patients because it may be that in fact there's been a shift, in addition to the number of patients.

DR. REISCHAUER: Sally, you were talking about the decline in the length of stay, and then noting that it was surprising that the length of stay in acute care hospitals declined at the same time as the IRF length of stay. The explanation may be, if you look at your Table 2, over those two years or three years there was a 58 percent increase in the number of people going to IRFs. What might have happened is those that would have been discharged somewhere else who were the less severe cases ended up going to the IRF, and that would have lowered both of these length of stay at the same time. Just the existence of more beds and more facilities in effect produces a result that on the surface looks like good news but in fact it could be troubling news.

DR. NEWHOUSE: This is a second-order question but since the transfer payment DRG issue is likely to be around, I wondered if this differential length of stay in IRFs--I'm sorry, if the length of stay decline was differential by the transfer DRGs versus the non-transfer guarantees?

MR. HACKBARTH: Anyone else? Okay, Sally, thank you.