Submitter : Ms. Rochelle Archuleta

Date: 07/05/2006

Organization : American Hospital Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-1540-P2-13-Attach-1.DOC

American Hospital Association

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

July 7, 2006

Mark McClellan, M.D., Ph.D.
Administrator, Centers for Medicare & Medicaid Services
Attn: CMS—1540—P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

RE: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Fiscal Year 2007; Proposed Rule.

Dear Dr. McClellan:

On behalf of our 4,800 member hospitals and health care systems, and our 35,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the fiscal year (FY) 2007 proposed rule for the inpatient rehabilitation facility prospective payment system (IRF PPS).

Among other changes, the Centers for Medicare & Medicaid Services (CMS) proposes providing an inflationary update at the statutorily required market-basket rate of 3.4 percent, a 2.9 percent across-the-board reduction to adjust for coding increases, and several adjustments to the changes made in last year's system refinement that significantly revised the IRF PPS. The AHA strongly urges CMS to withdraw the negative 2.9 percent coding adjustment. We are very concerned that the negative 2.9 percent coding adjustment and other proposals in this rule are based on substandard and limited analysis of old data that do not reflect the current environment. We urge CMS to update its data and analysis in subsequent rules. Our detailed comments follow.

Volatile Regulatory Environment for IRFs

As with the FY 2006 changes to the IRF PPS, the AHA is very concerned that CMS is again basing its proposals on old data that fail to account for the serious challenges currently facing IRFs. The FY 2007 proposed rule ignores significant changes being caused by the phase-in of the "75% Rule," which began in July 2004, by using data from 1999 through 2004. The Moran Company's June 2006 report on the impact of the 75% Rule, "Utilization Trends in Inpatient Rehabilitation: Update through QI 2006," estimates that approximately 37,000 fewer patients were treated by IRFs during the first year of 75% Rule implementation (under a 50 percent threshold from July 2004 through June 2005). The Moran Company's review of

claims data through March 2006 estimates that during the second year of the 75% Rule phase-in (under a 60 percent threshold from July 2005 through June 2006) approximately 62,000 fewer patients will access IRFs. The combined impact of these analyses – a reduction of 100,000 patients accessing IRFs in the first two years of the 75% Rule phase-in – is ignored in this proposed rule. These estimates exceed by 14 times CMS' estimate that 7,000 fewer patients would be treated in IRFs during the first two years of 75% Rule phase-in. We expect further reductions once the threshold moves to 65 percent in July 2007.

The proposed rule also fails to recognize other significant changes faced by IRFs in recent months due to several local coverage determinations (LCDs), notably the LCDs being enforced by Mutual of Omaha and Tri-Span fiscal intermediaries (FIs). Medical necessity reviews are being conducted by these and other FIs on both a pre-payment and post-payment basis. Mutual of Omaha's 2006 probe audits are producing shocking denial rates, ranging from 25 percent to 90 percent, and are denying Medicare payment for a broad array of diagnoses, including cases within the 75% Rule's qualifying conditions. The IRFs undergoing these audits are in compliance with the 75% Rule, and many of these FI denials are being appealed.

The 75% Rule by itself has not led to IRF closures. However, its impact in combination with the LCD enforcement has already produced closures in 2006, with more pending. LCD-related disruptions are greatest in communities where inconsistent medical necessity standards are being imposed, such as Boston, St. Louis and Shreveport. IRFs in these communities are struggling with an uneven regulatory playing field that is causing confusion for patients and referring physicians who cannot understand the inconsistent levels of access among local IRFs.

Given the current instability faced by IRFs due to the 75% Rule, LCDs and the FY 2006 1.9 percent across-the-board cut in Medicare payments, we urge CMS to withdraw the negative 2.9 percent coding adjustment.

In future rulemaking, CMS should use the most recent payment and claims data and publicly disseminate it along with the paid, current and proposed case-mix groups and associated IRF patient-assessment instrument data, as they do with annual rulemaking for the inpatient PPS.

Proposed Changes to the CMG Relative Weights

CMS is proposing to reweight the IRF PPS case-mix groups (CMG) to account for proposed changes to the comorbidity codes used to calculate Medicare payments per patient. The agency states that it "propose[s] to update the CMG relative weights for FY 2007 to ensure that they continue to reflect as accurately as possible the costs of treatment for various types of patients in IRFs." Yet CMS also fails to rebase the CMG weights, as it annually does for the diagnosis-related groups of the inpatient PPS by incorporating the latest claims data. **We urge CMS to rerun the recalibration of the weights so that it includes not only the proposed new comorbidity codes, but also utilizes the latest available data, rather than using the same 2002 and 2003 data used for the FY 2006 proposed and final rules, and issue them in an interim final rule for FY 2007.**

Proposed 2.9 Percent Coding Reduction

In FY 2006, CMS implemented a 1.9 percent across-the-board payment cut to offset coding increases from 1999 to 2002. The RAND Corporation had estimated coding increases ranging from an increase of 1.9 percent to 5.8 percent. However, RAND questioned the accuracy of its own coding analysis, and CMS acknowledged the inconclusive finding in setting the reduction at the low end of the range in the FY 2006 rule.

CMS' premise that coding increases during the first three years of IRF PPS implementation were largely due to coding behavior must be revisited to consider case mix and cost structure changes that have occurred since 2004. As noted by both the Medicare Payment Advisory Commission in March 2006 and the Moran Company analysis discussed above, overall case mix in IRFs has changed since 2004 in response to the 75% Rule. The percentage of joint-replacement cases is dropping and the percentage of stroke cases is growing, resulting in a higher overall case mix. This pattern also increases the average length of stay and cost per case for IRFs, and is in direct contrast to the conditions that existed from 1999 through 2003, the period of focus in the proposed rule. CMS noted this change in IRF cost structures in its FY 2006 proposed and final rules.

Questions have recently been raised pertaining to the transition to restructured and rebased CMGs in FY 2006. Early analyses by the Lewin Group and others indicate this transition likely produced a 3 percent decrease in overall case mix and, subsequently, Medicare payments to IRFs during FY 2006. The effect of transitioning to the new CMGs was neither discussed nor accounted for in the budget neutrality adjustments in the FY 2006 final rule. This reduction was distinct from the FY 2006 coding-related cut of 1.9 percent. Final analysis of this matter is pending and we urge CMS to evaluate this work closely. It would be appropriate for CMS to discuss its findings on this sensitive matter in an interim final rule for FY 2007.

The proposed 2.9 percent cut raises another question: Why should CMS impose further adjustments to the IRF PPS based on data from 1999 through 2002 when the payment system was refined by restructuring and reweighting the CMGs in FY 2006? The comprehensive FY 2006 refinement should serve as a new baseline for this payment system and analysis using information after the refinement would be needed to substantiate further reductions.

Furthermore, CMS again has overlooked the 16 percent behavioral offset already applied to the payment system when the IRF PPS was initially implemented in January 2002. As noted by CMS in the August 2001 final rule, the behavioral offset:

> "account(s) for change in practice patterns due to new incentives in order to maintain a budget neutral payment system. Efficient providers are adept at modifying and adjusting practice patterns to maximize revenues while still maintaining optimum quality of care for the patient. We take this behavior into account in the behavioral offset."

Both the 1.9 percent coding reduction implemented in FY 2006 and the proposed negative 2.9 percent coding adjustment for FY 2007 are redundant with the original behavioral offset.

CMS has already made sufficient, if not excessive, downward adjustments with the implementation of the IRF PPS and its 2006 refinement. IRF case mix, average length of stay and costs per stay are increasing. **The AHA strongly urges CMS to withdraw the proposed 2.9 percent coding reduction.**

Research on Medical Rehabilitation

CMS believes that less-intensive settings save money for the Medicare program, especially for joint-replacement patients, but this is as yet unproven. The work done by the Government Accountability Office and the National Institutes of Health on the 75% Rule was helpful in identifying what further research is needed in order to modernize the 75% Rule, more clearly define the role of IRFs relative to other post-acute care providers and better understand the cost effectiveness of IRFs and other post-acute providers. The IRF field is stepping forward to help fill the void in the medical literature on comparative analysis of medical rehabilitation costs and outcomes. CMS should do the same by providing research funding in this area.

Post-acute Care Demonstration

The AHA is very supportive of the post-acute care demonstration authorized by the *Deficit Reduction Act of 2005*. The AHA is uniquely positioned to provide insights on the demonstration given our broad membership, which includes 1,500 home health agencies, 1,200 SNFs, 1,200 IRFs, 150 long-term care hospitals and more than 5,000 outpatient departments. We have been in contact with the many CMS departments involved in developing and implementing the demonstration and continue to urge the agency to adopt a balanced position that fairly considers the unique merits of each post-acute provider group. We support this effort, which may ultimately help align Medicare payments more closely with the clinical characteristics of post-acute patients.

We thank CMS for the opportunity to comment on this proposed rule. Please address any comments or questions to me or Rochelle Archuleta, senior associate director of policy, at 202-626-2320 or rarchuleta@aha.org.

Sincerely,

Rick Pollack
Executive Vice President

Submitter : **Ms. Teresa Finkell**

Organization : **New York State Department of Health**

Category : **State Government**

Date: 07/05/2006

Issue Areas/Comments

Proposed Revisions to the Classification Criteria

Proposed Revisions to the Classification Criteria Percentage for IRFs

The attached comments are submitted on behalf of the New York State Department of Health regarding:

CMS-1540-P
Section VI. Proposed Revisions to the Classification Criteria Percentage for IRF's.

Thank you for this opportunity to share comments.

CMS-1540-P2-14-Attach-1.DOC

STATE OF NEW YORK
DEPARTMENT OF HEALTH
Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

July 5, 2006

Administrator Mark B. McClellan, MD
Center for Medicare & Medicaid Services
Room 314G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1540-P
Medicare Program; Inpatient Rehabilitation Facility
Prospective Payment System for FFY 2007

Dear Dr. McClellan:

New York has twice commented on the implementation of the Inpatient Rehabilitation Facility (IRF) classification. (letters attached) In both instances, the State requested that a moratorium be placed on the "75% rule" until a comprehensive review of current rehabilitation practices is undertaken and the results carefully analyzed before executing a final rule that will significantly limit patient access to inpatient rehabilitative services. We again ask that you consider delaying the implementation and enforcement of a final rule that is so potentially harmful to the person in need of acute rehabilitative services and the facilities that provide them.

Those with cardiac, pulmonary and physical debility diagnoses, to name a few, are now being sent to nursing homes where the rate of discharge to home is significantly lower than when these patients were able to access acute rehabilitation. According to national outcome studies based on disability specific information, those who availed themselves to an acute level of care were returned to their homes 80-90% of the time. Those now being assigned to nursing homes are returning to their homes at a much lower level of discharge with the burden of care and medical complication rates much higher. The nursing home infrastructure cannot sustain the demand for rehabilitative services for the patients being diverted from the four rehabilitation hospitals and sixty-nine rehabilitative units within acute care hospitals in New York.

New York, once more, strongly urges that the utmost serious consideration be given to postponing the implementation of the 75% rule until the proposed evaluation of the current system is conducted and informed decisions can be made based on the outcomes.

We very much would like the opportunity to work with you to ensure that additional limitations to patient access, further deterioration in the quality of care and even greater financial consequences are prevented.

Sincerely,

Dennis P. Whalen
Executive Deputy Commissioner

Attachments

STATE OF NEW YORK
DEPARTMENT OF HEALTH
Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

May 28, 2004

Administrator Mark B. McClellan
Center for Medicare & Medicaid Services
Room 314G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Doctor McClellan:

New York State requests that CMS place a moratorium on the implementation of the Inpatient Rehabilitation Facility (IRF) classification or what has become known as the "75% rule final rule and maintain the current moratorium on enforcement. In addition, fiscal intermediaries should be directed not to issue Local Medical Review Policies until an independent study of the rule can be conducted. A comprehensive review of current rehabilitation practices must be undertaken and studied for use in making the changes that would modernize the regulation for facilities providing rehabilitative services.

Implementation of the final rule, as published, will significantly limit patient access to inpatient rehabilitative services for anyone needing them, subsequently, causing serious fiscal consequences for many hospitals operating in New York State. Currently, there are four rehabilitation hospitals and sixty-nine rehabilitation units within acute care hospitals operating in the state. This rule will have a significant impact on New York's nursing home infrastructure that will be unable to support the demand for rehabilitative services.

We share your concern for continuity of care and look forward to working together to prevent limitations to patient access, deterioration in quality of care and considerable fiscal consequences.

Thank you for your consideration of this request.

Sincerely,

Dennis P. Whalen
Executive Deputy Commissioner

STATE OF NEW YORK
DEPARTMENT OF HEALTH
Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

November 3, 2003

Thomas A. Scully
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1262-P
P.O. Box 8010
Baltimore, MD 21244-8010

Re: CMS-1262-P-Medicare Program: Changes to the criteria for being classified as an Inpatient Rehabilitation Facility; Proposed Rule

Dear Mr. Scully:

The New York State Department of Health has reviewed and would like to submit the following comments to the proposed changes to 42 CFR Part 412 as published in the Federal Register on September 9, 2003. This proposed rule would revise the classification criterion, commonly known as the "75 percent rule", used to classify a hospital or a distinct unit of a hospital as an inpatient rehabilitation hospital or unit for Medicare reimbursement purposes. This proposed rule would also modify and expand the medical conditions listed from ten to twelve in the 75 percent rule regulatory requirements as well as lower the percentage, from 75% to 65% for three years, of patients required to fall within one of the specified list of medical criteria.

The State of New York is concerned that the proposed changes as published and the lifting of the suspension of enforcement of the rule would significantly limit patient access to inpatient rehabilitated services for all patients and result in serious fiscal consequences to many hospitals operating in the State. Although CMS did expand the qualifying diagnoses from ten to twelve by replacing polyarthritis with three more clearly defined arthritis-related conditions, it has chosen not to make changes to the rule based on new standards of medical practice and rehabilitation. Thus enforcement of the rule will continue to be based on a listing of diagnoses

established in 1983 with no consideration being given to interrelated factors such as functional deficits, patient characteristics or medical treatments. In addition, CMS has chosen to consider neither patients with cardiac and pulmonary conditions nor arthritis patients who require intensive therapy as the result of joint replacement procedures in the types of diagnosis that count towards the rule. This could result in diminished access to inpatient rehabilitation care for not only these patients but for all patients in need of these services due to reduced availability caused by closures and reductions of services. In addition, the proposed rule could seriously impact access to inpatient rehabilitation services in geographic areas or communities that lack alternative post-acute sites of care.

The State recommends that CMS either delay implementation and enforcement of the proposed rule or implement a further lowering of the compliance threshold until a more thorough analysis or study can be completed on the clinical efficacy, access concerns (including geographical concerns) and fiscal impact of this proposed rule. This will allow for rule and policy changes that offer the regulatory flexibility to address rehabilitation needs now and in the future without serious access and fiscal implication.

Thank you for allowing the State the opportunity to comment on the proposed rule and for any consideration given to our remarks.

Sincerely,

Dennis P. Whalen
Executive Deputy Commissioner

Submitter : Ms. Patricia Motyka

Date: 07/05/2006

Organization : St. Joseph Hospital Rehabilitation Center

Category : Hospital

Issue Areas/Comments

Regulatory Impact Analysis

Regulatory Impact Analysis

The impact to our facility financially would result in a projected loss of $150,000 in 2007.

Submitter : Mr. James T. Kirkpatrick **Date:** 07/05/2006

Organization : Massachusetts Hospital Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1540-P2-16-Attach-1.DOC

MHA

Massachusetts Hospital
Association

July 5, 2006

Mark McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Attn: CMS-1540-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, DC 20201

RE: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Fiscal Year 2007; Proposed Rule

Dear Dr. McClellan:

On behalf or our member hospitals, the Massachusetts Hospital Association (MHA) submits these comments on the fiscal year (FY) 2007 proposed rule for the inpatient rehabilitation facility (IRF) prospective payment system.

These comments are made in the context of a very volatile regulatory environment for IRFs. The FY 2007 proposed rule overlooks the impact of the 75% Rule and neglects the instability being caused by its phase-in, which began in July 2004. The 75% Rule continues to reduce IRF admissions based on out-of-date, restrictive and ineffective diagnosis-based criteria. In addition, the proposed rule also fails to recognize that the IRF environment has worsened further in recent months due to the negative impact of several local coverage determinations (LCDs), notably the LCDs being enforced by Mutual of Omaha and Tri-Span fiscal intermediaries (FIs). Medical necessity reviews are being conducted by these and other FIs on both a pre-payment and post-payment basis. Mutual of Omaha's 2006 probe audits are producing shocking denial rates, ranging from 25 percent to 90 percent, and are denying Medicare payment to a broad array of diagnoses, including cases within the 75% Rule's qualifying conditions. Given the current instability facing IRFs due to the 75% Rule, LCDs and the FY 2006 1.9 percent across-the-board cut, it is inappropriate for CMS to create further volatility.

Data-related Concerns

CMS is using old and irrelevant data to justify and rationalize the FY 2007 proposed rule changes. We encourage CMS to adjust its internal protocols to ensure that future rulemaking uses the most recent payment and claims data available. In addition to using the most recent payment and claims data, CMS should publicly disseminate this data along with the paid, current and proposed case-mix groups and associated IRF patient-assessment instrument data. Under the current scenario, in which the IRF PPS proposed rule has been published without the provider-identified facility-level impact file, the field faces an analytical handicap that, in the long run, is also a hindrance to CMS, since the resulting analytical limitations prevents stakeholders from developing stronger public comments.

Submitter : Mr. Richard Plamondon

Date: 07/06/2006

Organization : St. Joseph Hospital

Category : Hospital

Issue Areas/Comments

Proposed FY 2007 Federal Prospective Payment Rates

Proposed FY 2007 Federal Prospective Payment Rates

See attachment

CMS-1540-P2-17-Attach-1.DOC

ST. JOSEPH
HOSPITAL

July 5, 2006

Sheila Lambowitz, Director
Division of Institutional Post Acute Care
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Blvd
Baltimore, MD 21244

ATTN: FILE CODE CMS-1540-7

Re: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for FY 2007; Proposed Rule

Dear Ms. Lambowitz:

I am submitting this public comment letter on the Inpatient Rehabilitation Facility Prospective Payment System proposed rule for FY 2007 to alert you to the negative impact on our facility due to the transition to Core-Based Statistical Area (CBSA)-based wage index areas. Based on the publicly available data from the first two quarters of FY 2006, the transition to CBSA-based wage index areas is already significantly compromising our ability to serve Medicare beneficiaries, and believe that the implementation of the FY 2007 proposed rule will further decrease the wage index for our facility. I respectfully request that CMS mitigate the impact of the Final Rule for FY 2007 by extending the blended rate transition for one more year to IRFs that will experience an eight percent or greater reduction in their wage index.

Impact of Proposed Rule

St. Joseph Hospital is a 208-bed acute care hospital located in Nashua, NH. Our inpatient Rehabilitation Center is a CARF accredited, 24-bed specialty unit offering personalized care for patients recovering from a wide variety of conditions, including stroke, head trauma, amputation, and joint replacement surgery. For more than two decades, the Rehabilitation Center at St. Joseph Hospital has been a leader in delivering high-quality care for patients in the region, routinely exceeding regional benchmarks for quality. Our unique setting within an acute care hospital allows seamless access to ancillary and emergency support services, 24 hours a day.

The significant impact of the transition to the CBSA-based wage index areas on our facility is not unique. As the table below demonstrates, the implementation of the proposed rule will cause a total of fifteen free-standing and hospital-based IRFs nationwide to experience a total two-year decline in their wage indices of greater than eight percent.

Facilities Impacted more than 8%

Provider Number	State	Dischg #	Proposed 2007 Wage Index	FY 06 MSA Wage Index	Change In Point 06MSA to 07CBSA	Change In %age 06MSA to 07CBSA	$ Impact 06MSA to 07CBSA	FY 06 CBSA Wage Index	FY06 Blended Wage Index
FREESTANDING									
303026	NH	1090	1.0374	1.1290	(0.0916)	-8.1%	$(1,016,595)	1.0221	1.0756
363026	OH	851	0.8603	0.9517	(0.0914)	-9.6%	$ (731,047)	0.9237	0.9377
363032	OH	367	0.8603	0.9517	(0.0914)	-9.6%	$ (232,976)	0.9237	0.9377
303027	NH	742	1.0354	1.1290	(0.0936)	-8.3%	$ (720,696)	1.0642	1.0966
233025	MI	502	0.9508	1.0350	(0.0842)	-8.1%	$ (361,645)	0.9366	0.9858
HOSPITAL BASED									
110163	GA	379	0.8628	1.1266	(0.2638)	-23.4%	$ (792,751)	1.1266	1.1266
110007	GA	317	0.8628	1.1266	(0.2638)	-23.4%	$ (717,767)	1.1266	1.1266
150088	IN	297	0.8586	1.0039	(0.1453)	-14.5%	$ (345,268)	0.8713	0.9376
350019	ND	467	0.7901	0.9091	(0.1190)	-13.1%	$ (421,372)	0.9091	0.9091
360064	OH	496	0.8603	0.9517	(0.0914)	-9.6%	$ (353,228)	0.9237	0.9377
360086	OH	203	0.8396	0.9231	(0.0835)	-9.0%	$ (123,578)	0.8748	0.8990
360187	OH	186	0.8396	0.9231	(0.0835)	-9.0%	$ (122,494)	0.8748	0.8990
390066	PA	272	0.8459	0.9286	(0.0827)	-8.9%	$ (133,858)	0.8570	0.8928
300034	NH	375	1.0354	1.1290	(0.0936)	-8.3%	$ (362,291)	1.0642	1.0966
300011	NH	377	1.0354	1.1290	(0.0936)	-8.3%	$ (324,193)	1.0642	1.0966

Extension of Blended Rate

The Final Rule for 2006 provided for a one year blended rate for all IRFs nationwide, irrespective of the severity of the wage index adjustment. The proposed rule for 2007 would allow the transitional blended rate to expire. IRFs experiencing particularly substantial wage index reductions therefore require some additional measure of protection.

CMS acknowledged that its adoption of CBSA-based area designations would result in wage index reductions for some IRFs, and has attempted to mitigate the impact by providing a one-year transition period for FY 2006, during which Medicare payment rates have been calculated based on a blended wage index. Under section 1886(j) of the Social Security Act, the Secretary of Health and Human Services enjoys "broad authority in developing the IRF PPS, including whether and how to make adjustments" to the Medicare prospective payment rate. 70 Fed. Reg. 47921 (Aug. 15, 2005). CMS applied a similar provision in the IRF Final Rule for FY 2006 to IRFs that lost their rural adjustment as the result of their reclassification from "rural" to "urban," in order to mitigate significant payment reductions. 70 Fed. Reg. 47924.

I urge CMS in the Final Rule to extend the blended rate for one additional year for IRFs that would otherwise endure an eight percent or greater wage index reduction. This rationale applies with equal force to the small number of outlier IRFs experiencing severe reductions in their wage index as a result of their new CBSA designation.

Please feel free to contact me with any additional questions. I appreciate your attention to this matter.

Sincerely,

Richard J. Plamondon
Vice President Finance

Submitter : **Mrs. Roshunda Drummond-Dye** **Date: 07/06/2006**

Organization : **American Physical Therapy Association**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Proposed Revisions to the Classification Criteria

Proposed Revisions to the Classification Criteria Percentage for IRFs

Please see attached comments on behalf of the American Physical Therapy Association (APTA)

CMS-1540-P2-18-Attach-1.PDF

APTA
American Physical Therapy Association

1111 North Fairfax Street
Alexandria, VA 22314-1488
703 684 2782
703 684 7343 fax
www.apta.org

July 6, 2006

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1540-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Submitted electronically and by hand

RE: Comments of the American Physical Therapy Association on the Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2007

Dear Dr. McClellan:

The Center for Medicare and Medicaid Services (CMS) published a proposed rule in the Federal Register *(71 FR 28105)* on May 15, 2006, to update the prospective payment rates and revise existing policies for the inpatient rehabilitation facilities (IRFs) for Federal Fiscal Year 2007. The purpose of this correspondence is to submit comments on behalf of the American Physical Therapy Association (APTA) in response to the proposed rule. The APTA is a professional organization representing the interests of more than 66,000 physical therapists, physical therapist assistants, and students of physical therapy. APTA members furnish services to Medicare beneficiaries in inpatient rehabilitation facilities, and we are very concerned about proposed changes to the IRF PPS system.

APTA commends CMS for its efforts to update the prospective payment system to accurately reflect the costs of treatment in the inpatient rehabilitation setting. Although

we feel that CMS has made strides in the right direction, there are a few issues that we would like to address that affect the practice of physical therapy.

"Revisions to the Classification Criteria Percentage for IRFs"

As with previous rules, APTA is still very concerned about the implementation of the classification criteria percentage for inpatient rehabilitation facilities, known as the "75% rule". The criterion sets a minimum percentage of the facility's total inpatient population that must meet one of thirteen medical conditions listed in the regulation in order for the facility to be classified as an IRF. This minimum percentage is known as the "compliance threshold". The FY 2007 proposed rule discusses the revised "75% rule" phase-in implementation as mandated by the Deficit Reduction Act of 2005 (DRA) which extends the full compliance threshold of 75 percent until July 1, 2008. APTA contends that the "75% rule" continues to reduce IRF admissions based on outdated diagnosis-based criteria.

When Medicare first implemented the inpatient acute care hospital prospective payment system (PPS) in 1983, the regulation included a set of rules by which an IRF could exclude itself from the Inpatient Acute Care PPS. These rules included the original version of what we call the "75% rule" today. The "75% rule" was a methodology adopted by CMS for the purpose of establishing that the IRF was primarily engaged in providing intensive rehabilitation services.

Although the ten specified conditions were recently expanded to thirteen conditions, the implementation of this policy still remains archaic and does not take into account the changing needs of IRFs and their patient population. Physical therapists working in inpatient rehabilitation facilities often treat patients with complex orthopedic diagnoses, organ transplants, cancer, cardiopulmonary conditions, and other comorbidities that are not included in the current specified conditions. For certain patients, the rehabilitation hospital is the most appropriate setting for the patient to receive the level of intense treatment needed for their condition.

The practice of medicine and rehabilitation, current imaging techniques and the use of modern day pharmaceutical therapy has dramatically changed since the original implementation of the "75% rule" in 1983. Medicare beneficiaries are living longer, and many of them must manage multiple chronic conditions. The "75% rule" needs to account for these changes in the patient population and advances in medical technology.

For example, beneficiaries undergoing life-saving organ transplants or procedures for cardiopulmonary ailments that did not exist when these criteria were established are among those who are in the greatest need of the multi-disciplinary services that an IRF provides. It would not be medically prudent or in the best interest of the patient to provide these life-saving interventions, while at the same time failing to provide the necessary post-acute care rehabilitation care so that patients can return to their maximum function levels.

CMS' "75% rule", as described in the FY 2007 proposed rule, jeopardizes the care of a significant amount of patients that require treatment in an inpatient rehabilitation facility. While we understand the need to manage treatment and streamline Medicare costs in the inpatient rehabilitation setting, we believe CMS needs to rethink the implementation of the "75% rule" and develop a policy that ensures that individual needs are at the center of the decision concerning the Medicare beneficiary's post-acute care. Further research is necessary to determine the types of patients who should be treated in the inpatient rehabilitation facility setting.

Inpatient Rehabilitation Providers Are Being Penalized for Reconciliation of the "75% Rule" and Local Coverage Determinations

In addition to the problematic environment created by the implementation of the "75% rule", the proposed rule has failed to recognize the emerging issues of reconciliation between national policies on compliance thresholds and the impact of local coverage determinations. When determining what diagnoses are permissible for treatment in the IRF, providers are not only required to know and adhere to the "75% rule" criteria, but they are also required to follow "Local Coverage Determinations" (LCDs) issued by their fiscal intermediaries. In many instances, the two policies are not always easy to reconcile.

Unlike the "75% rule", LCDs do not provide direct statements about which conditions are appropriate for IRF services. These particular LCDs are intended to provide guidance for making a determination whether any given patient, regardless of diagnosis, meets the overriding criteria for determining whether inpatient rehabilitation is medically necessary. When attempting to comply with both the "75% rule" and the LCDs, inpatient rehabilitation providers are being subjected to strict pre-payment and post-payment medical necessity reviews/audits that are resulting in considerable high denial rates.

Of note, is the current LCD of the largest fiscal intermediary Mutual of Omaha *(LCD for Inpatient Rehabilitation Services, L19890 May 14, 2005)*. This policy is generally representative of current LCDs being issued by fiscal intermediaries and was the first to go into effect. The general criteria for medical necessity in the LCD are not controversial, since they generally reiterate CMS' national guidance. However, the LCD goes on to state the fiscal intermediary's opinion regarding whether types of diagnoses generally would require inpatient rehabilitation. Furthermore, the LCD states that patients with certain conditions that are within the "75% rule" should "rarely" be treated within an IRF.

For example, the LCD states that "Recovery from a single hip fracture rarely requires inpatient rehabilitation." The use of the term "rarely" may result in inappropriate denials. This statement would seem to be in direct conflict with the "75% rule". CMS has recognized fracture of the femur (e.g. hip fracture) as one the thirteen delineated conditions that should compose the case mix of patients being admitted to the IRF. The LCD language must permit the inclusion of coverage for physical therapy for a

beneficiary with significant and pertinent comorbidities affecting recovery after a hip fracture and other similar conditions. The current language of the LCD is too restrictive.

For example, a patient with a simple intertrocanteric fracture of the hip and subsequent pinning may not require inpatient rehabilitation. However, a patient with a subcapital fracture of the hip that is not a candidate for an arthroplasty requires up to three months of non-weight bearing status and may be an excellent candidate for inpatient rehabilitation. In addition, a patient with either type of fracture may have comorbidities including obesity, cardiac and pulmonary problems that will limit the patient's ability to use assistive ambulation aides and seriously decrease their potential to achieve independence in activities of daily living.

Therefore, it is not equitable that the fiscal intermediary would oppose the admission of such patients. Mutual of Omaha's 2006 probe audits are producing alarming denial rates, ranging from 25 percent to 90 percent, and are denying Medicare payment for a number of diagnoses, including cases within the "75% rule's" qualifying conditions. The IRFs, being subjected to these unfair audits, are in compliance with the"75% rule" and are currently appealing the decisions.

Due to the current situation facing IRFs, the implementation of the "75% rule", issuance of LCDs, and potential conflicts arising in complying with both policies, APTA urges CMS to (1) issue guidance to fiscal intermediaries mandating continuity of national and local medical review policies, (2) update its analyses so that CMS policy reflects the current reality facing patients, physical therapists, and IRFs, and (3) conduct further study of the current practice of medicine and rehabilitation.

Post Acute Care Demonstration

In the Deficit Reduction Act of 2005, Congress established a three-year demonstration project for the purposes of understanding costs and outcomes across different post-acute care sites. The demonstration project was mandated to track patients based on a delineated list of diagnoses specified by HHS. In the DRA, it was stated that patients who receive treatment from a health care provider for one of the specified diagnosis will receive a comprehensive assessment on the needs of the patient and the clinical characteristics upon discharge from the hospital, and this assessment will be used to determine the post-acute care site.

The DRA further stated that a post-acute care assessment tool will be created to measure functional status and other factors during treatment and at discharge from the post-acute care site. Providers who participate in this demonstration project will be required to provide information on the fixed and variable costs for each patient. An additional comprehensive assessment will be conducted at the end of the episode of care, and a full report to Congress will be submitted with six-months after the demonstration project.

Physical therapy is practiced in a number of settings including hospitals, outpatient clinics or offices; inpatient rehabilitation facilities; skilled nursing facilities; patients' homes, education or research centers, schools, and hospices. **Therefore, APTA is very interested in the implementation and outcomes of this demonstration project, and we support this effort to help align Medicare payments more closely with the clinical characteristics of post-acute patients. We are eager to assist in anyway, during implementation, and welcome the opportunity to meet with CMS to discuss the demonstration project.**

APTA thanks CMS for the opportunity to comment on this proposed rule, and we look forward to working with the agency to craft patient-centered reimbursement policies that reflect quality health care. If you have any questions regarding our comments, please contact Roshunda Drummond-Dye, Associate Director of Regulatory Affairs, at (703) 706-8547 or roshundadrummond-dye@apta.org.

Sincerely,

G. David Mason
Vice President, Government Affairs

Submitter : **Heather Hulscher** **Date: 07/06/2006**

Organization : **Iowa Hospital Association**

Category : **Health Care Provider/Association**

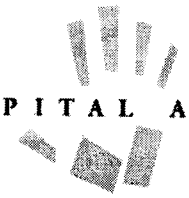
Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1540-P2-19-Attach-1.PDF



IOWA HOSPITAL ASSOCIATION

July 07, 2006

The Honorable Dr. Mark McClellan
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention CMS -1450-P
P.O. Box 8012
Baltimore, MD 21244-8012

Ref: CMS 1450-P Medicare Program: Inpatient Rehabilitation Facility Prospective Payment System for FY 2007: Proposed Rule (71 *Federal Register 28106*).

Dear Dr. McClellan,

On behalf of the 11 Iowa hospitals with an Inpatient Rehabilitation Facility (IRF) distinct part unit, the Iowa Hospital Association (IHA) is pleased to take this opportunity to provide comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule for the FY 2007 IRF prospective payment system (PPS) published in the May 15, 2006 *Federal Register*. Although the system calls for a market basket update of 3.4 percent, **this rule proposes a substantial reduction to the standard payment rate of 2.9 percent for coding changes, resulting in a total payment cut of 4.8 percent, when combined with the FY 2006 reduction of 1.9 percent based on the same rationale.** The following are IHA's comments.

Proposed 2.9 Percent Coding Reduction

Approaching the fifth year of the IRF PPS implementation, CMS is proposing the third major reduction in payments to IRFs based on its position that case-mix indices have increased since the implementation of the PPS due to coding changes. The first reduction occurred in January 2002 with the 16 percent behavioral offset reduction, followed by the FY 2006 cut of 1.9 percent for coding changes. **IHA urges CMS to withdraw its proposal to yet again reduce payment rates to IRFs by 2.9 percent for the following reasons.**

First, payment policy changes in the IRF PPS cannot be considered exclusive of the impact of the 75 Percent Rule. Until the implementation of the IRF PPS, CMS paid little, if any, attention to IRF compliance with this threshold, and offered no support through education to IRFs or its contractors. IRFs are now focused on ensuring compliance with the 75 Percent Rule, and Medicare contractors have implemented edits in the claims processing system to monitor compliance. Thus, CMS should expect to see changes in case-mix indices.

Second, CMS is using data for its analysis from years *prior* to the implementation of the IRF PPS, and as noted above, prior to enforcement of the 75 Percent Rule. To better tie payment to the cost of care

100 EAST GRAND DES MOINES, IOWA 50309-1835 515.288.1955 FAX 515.283.9366
www.ihaonline.org

delivered in IRFs, CMS should, in addition to recalibrating the weights of the CMGs, rebase the weights to better capture the resources necessary to provide care for each CMG, and in doing so, use the most recent available claims data.

Third, many payment policy changes have recently been made to the IRF PPS that will greatly redistribute payments to IRFs and negate the need for payment reductions. The policy changes include: the FY 2006 case-mix group (CMG) modifications, tiered comorbidities, and relative weight changes, and for FY 2007 CMS is proposing refinements to the CMG relative weights. In addition to changes made at the national level, Medicare contractors have implemented IRF local coverage determinations (LCDs) that will establish more concise parameters for determining medical necessity.

CMS should withdraw its proposal to reduce IRF rates, and rather, use the most recent claims data to analyze the impact of recent changes in the IRF reimbursement system, and recalibrate and rebase the CMG weights to better tie payment to the cost of care delivered in IRFs. It is premature for CMS to make a proposal that would harm IRFs, without allowing time to fully review the impact of existing policy changes and the impact of compliance with the 75 Percent Rule.

Thank you for your review and consideration of these comments. If you have questions, please contact me at the Iowa Hospital Association at 515/288-1955.

Sincerely,

Heather J. Hulscher

Heather Hulscher
Director, Finance Policy

cc: Iowa Congressional Delegation
IHA Board of Trustees
Iowa hospitals

100 EAST GRAND DES MOINES, IOWA 50309-1835 515.288.1955 FAX 515.283.9366
www.ihaonline.org

Submitter : **Dr. David Weingarden** **Date: 07/06/2006**

Organization : **Dr. David Weingarden**

Category : **Physician**

Issue Areas/Comments

Proposed Changes to the Existing List of Tier Comorbidities

Proposed Changes to the Existing List of Tier Comorbidities

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1540-P
Room 445-G, Robert H. Humphrey Building
200 Independence Avenue, SW.,
Washington, D.C. 20201

RE: File Code CMS-1540-P
Section: Refinements to the Patient Classification System
Sub-Section: Proposed Changes to the Existing List of Tier Comorbidities

To Whom It May Concern:

I request that another Tier Comorbidity be added to the existing list, as this comorbidity appears to meet inclusionary criteria.

The Tier Comorbidity is that of HYPOALBUMINEMIA. The ICD9-CM code for this will be discussed at the end of the following discussion.

This request is based upon a threefold rationale; Medical Evidence, the published RAND Study of Rehab Data, and the presence of multiple alternatives to the previous coding issues raised.

First, numerous studies (see Appendix A for a partial list) have demonstrated that low serum albumins are primary predictors of increased cost of care via dramatic increases in length of stay, morbidity, and mortality. These studies were performed both in inpatient rehabilitation populations as well as other inpatient medical populations. The studies have found that these negative outcomes of increased morbidity, length of stay, cost, and mortality, occurred similarly in both Inpatient Rehabilitation Facility patients as well as in acute medical patients. In summary, multiple published studies in peer review medical journals, support the linkage between low serum albumin and increased cost of care.

Second, both RAND and CMS have agreed that low serum proteins are found to be related to increased cost. As stated on page 15 of the study performed by The Rand Corporation on previous PPS data submitted:

The next three lines in the table deal with the rapidly increasing malnutrition codes. Of these, only kwashiorkor is positively related to cost, and the amount of the marginal cost is much less than the increase in payment associated with assignment to tier 1.

Also described in the Federal Register / Volume 70, No. 156 in the Proposed Rule of August 15, 2005 it states,

This comorbidity is positively related to cost in our data. However, RAND s technical expert panel (TEP) found the large number of cases coded with this rare disease to be unrealistic and recommended that it be removed from the tier list

Third, the diagnosis of 260 kwashiorkor was removed from the then existing Tier Comorbidity list due to the RAND panel of experts conclusion that although these patients did have a higher cost of care, kwashiorkor was being over-reported as it is both rare in the United States and applies to pediatric populations.

This conclusion is problematic as there is proven increased cost. We request that CMS and RAND choose the most appropriate code to reflect a low albumin state and add the code to the appropriate tier (tier 2 or tier 3).

We have traditionally used the diagnosis of 260 kwashiorkor for this form of low albumin state. The reason for this is multiple. First, it appears that ICD9-CM Coding software appear to use the kwashiorkor code as a group code, not as a specific disease entity code. In other words, if one types in protein deficiency the coding software groups it under 260 kwashiorkor . Second, in the Malnutrition Guidelines Coding Clinic, Fourth Quarter 1992, Page 24 to 25, Effective with Discharges of October 1, 1992, the Coding Clinics state:

Malnutrition is generally thought of as a problem associated with children. Increasingly, it is becoming a problem of the elderly of this country who are unable to properly care for themselves, and who do not have the resources to obtain daily care. ..... Effective October 1, 1992, all the inclusion statements from the malnutrition codes have been deleted. With this change, it is hoped that coders will no longer feel restricted in the use of these codes and use these codes for all age group

Submitter : **Dr. David Weingarden** **Date: 07/06/2006**

Organization : **Dr. David Weingarden**

Category : **Physician**

Issue Areas/Comments

Proposed Changes to the Existing List of Tier Comorbidities

Proposed Changes to the Existing List of Tier Comorbidities

Please see the attached Word document for the full comment.

CMS-1540-P2-21-Attach-1.DOC

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1540-P
Room 445-G, Robert H. Humphrey Building
200 Independence Avenue, SW.,
Washington, D.C. 20201

RE: **File Code CMS-1540-P**
Section: **Refinements to the Patient Classification System**
Sub-Section: **Proposed Changes to the Existing List of Tier Comorbidities**

To Whom It May Concern:

I request that another Tier Comorbidity be added to the existing list, as this comorbidity appears to meet reasonable inclusionary criteria.

The Tier Comorbidity is that of **HYPOALBUMINEMIA.** The ICD9-CM code for this will be discussed at the end of the following discussion.

The reason hypoalbuminemia should be added is threefold; Medical Evidence, the published RAND Study of Rehab Data, and the presence of multiple alternatives to the coding issues raised.

First, numerous studies (see Appendix A for a partial list) have demonstrated that low serum albumins are primary predictors of increased cost of care via dramatic increases in length of stay, morbidity, and mortality. These studies were performed both in inpatient rehabilitation populations as well as other inpatient medical populations. The studies have found that these negative outcomes of increased morbidity, length of stay, cost, and mortality, occurred similarly in both Inpatient Rehabilitation Facility patients as well as in acute medical patients. In summary, multiple published studies in peer review medical journals, support the linkage between low serum albumin and increased cost of care.

Second, both RAND and CMS have agreed that low serum proteins are found to be related to increased cost. As stated on page 15 of the study performed by The Rand Corporation on previous PPS data submitted:

> "The next three lines in the table deal with the rapidly increasing malnutrition codes. Of these, **only kwashiorkor is positively related to cost**, and the amount of the marginal cost is much less than the increase in payment associated with assignment to tier 1."

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> "**This comorbidity is positively related to cost** in our data. However, RAND's technical expert panel (TEP) found the large number of cases coded with this rare disease to be unrealistic and recommended that it be removed from the tier list"

Third, the diagnosis of 260 kwashiorkor was removed from the then existing Tier Comorbidity list due to the RAND panel of experts conclusion that although these patients did have a higher cost of care, kwashiorkor was being over-reported as it is both rare in the United States and applies to pediatric populations.

This conclusion is problematic as there is proven increased cost. We request that CMS and RAND choose the most appropriate code to reflect a low albumin state and add the code to the appropriate tier (tier 2 or tier 3).

We have traditionally used the diagnosis of 260 kwashiorkor for this form of low albumin state. The reason for this is multiple. First, it appears that ICD9-CM Coding software appear to use the kwashiorkor code as a group code, not as a specific disease entity code. In other words, if one types in "protein deficiency" the coding software groups it under "260 kwashiorkor". Second, in the Malnutrition Guidelines Coding Clinic, Fourth Quarter 1992, Page 24 to 25, Effective with Discharges of October 1, 1992, the Coding Clinics state:

> "Malnutrition is generally thought of as a problem associated with children. Increasingly, it is becoming a problem of the elderly of this country who are unable to properly care for themselves, and who do not have the resources to obtain daily care. ..... Effective October 1, 1992, all the inclusion statements from the malnutrition codes have been deleted. With this change, it is hoped that coders will no longer feel restricted in the use of these codes and use these codes for all age groups, not just children, as the original inclusion statement implied. In order to improve the reporting of malnutrition among the elderly, it is important for physicians to document the condition in the medical record and for coders to be aware of malnutrition as a potential diagnosis."

Third, we have been unable to identify a more appropriate code to use. The only other codes that we can find that could apply to a low albumin state are 273.8 and 273.9 but these codes identify a disorder of metabolism of plasma proteins, which is usually not the case in these rehab patients. Elderly rehab patients do not appear to have an albumin metabolism problem, as they respond beautifully to protein supplementation. Instead, they appear to suffer from protein malnutrition before even entering the hospital and then this worsens with decreased dietary intake during their acute illness and occasionally is severely compounded in cases of surgery with a post-op catabolic state. Simply stated, the most common cause of a low albumin state in these patients is protein malnutrition, which once again codes to 260 kwashiorkor. According to the Coding Clinics, this does apply to adults as well and without the limitations stated by the specifics of kwashiorkor.

As a side note, it has been our understanding that 260 kwashiorkor is similar to other "group" codes in ICD9-CM. For example, there is no code that we can find for "hemiparesis". A patient that is weak but not paralyzed on one side after a stroke, has no available code to use. We have no option but to use the "hemiparalysis" code as there is no paresis code. We must code this as a paralysis, even though we know fully well that this is not what the patient has. Our coding experts have advised us that "hemiparalysis" is a group code that includes all forms of paralysis or weakness that effect one side of the body. Similarly, our coding experts have advised us that "kwashiorkor" is a group code that not only includes kwashiorkor, but all forms of protein deficient states.

If at all possible, we request that the addition of a tiered code for hypoalbuminemia, be made retroactive to October, 2005 as rehab facilities have had to bear the increased cost of care of these patients, regardless.

We strongly feel that by making this diagnosis a Tier Comorbidity, CMS will also be correctly drawing the attention of rehabilitation health care providers to this treatable cause of increased morbidity and mortality and thereby reduce the morbidity and mortality of these patients and greatly benefit the health and welfare of patients in Inpatient Rehabilitation Programs across the country.

Thank you for your consideration.
David S. Weingarden, M.D.

APPENDIX A - REFERENCES

a. GLENN MB, CARFI J, BELLE SE, ET AL; SERUM ALBUMIN AS A PREDICTOR OF COURSE AND OUTCOME ON A REHABILITATION SERVICE. ARCH PHYS MED REHABIL 1985;66:294-7

b. HERMANN FR, SAFRAN C, LEVKOFF SE, ET AL; SERUM ALBUMIN LEVEL ON ADMISSION AS A PREDICTOR OF DEATH, LEGTH OF STAY AND READMISSION; ARCH INTERN MED 1992;152:125-130

c. ROZZINI R, BARBISONI P, FRISONI GB, ET AL; ALBUMIN AS A PREDICTOR OF MORTALITY IN ELDERLY PATIENTS (LETTER), J CLIN EPIDIMIOL 1997;50:865-867

d. FINESTONE HM, GREEN-FINESTONE LS, WILSON ES, ET AL; PROLONGED LENGTH OF STAY AND REDUCED FUNCTIONAL IMPROVEMENT RATE IN MALNOURISHED STROKE REHABILITATION PATIENTS. ARCH PHYS MED REHABIL 1996;77:340-5

e. CHIMA CS, BARCO K, DEWITT MA, ET AL; RELATIONSHIP OF NUTRITIONAL STATUS TO LENGTH OF STAY, HOSPITAL COSTS, AND DISCHARGE STATUS OF PATIENTS HOSPITALIZED IN THE MEDICINE SERVICE. J AM DIET ASSOC 1997;97:975-8

f. STRAKOWSKI MM, STRAKOWSKI JA, MITCHELL MC; MALNUTRITION IN REHABILITATION; AM J PHYS MED REHABIL; 2002;81:77-78

Submitter : Mr. Michael McBride

Date: 07/06/2006

Organization : CHRISTUS Santa Rosa Medical Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : Mr. Ron Ashworth

Date: 07/06/2006

Organization : Sisters of Mercy Health System

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

Comments attached.

Proposed FY 2007 Federal Prospective Payment Rates

Proposed FY 2007 Federal Prospective Payment Rates

Comments attached.

CMS-1540-P2-23-Attach-1.DOC

CMS-1540-P2-23-Attach-2.DOC

SISTERS OF MERCY
HEALTH SYSTEM

July 7, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1540-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: "Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2007"

The Sisters of Mercy Health System (Mercy) is a 19-hospital system operating in Missouri, Kansas, Oklahoma, and Arkansas. We have a significant number of Medicare certified rehabilitation programs and rely heavily on Medicare as a major payor for those services. We are writing to provide comments in areas of concern relating to the proposed rule. Thank you for considering our comments.

Specifically, we offer the following comments:

Proposed Reduction of the Standard Payment Amount to Account for Coding Changes

Section 1886(j)(2)©(ii) of the Act requires the Secretary to adjust the per unit payment rate for Inpatient Rehabilitation Facility (IRF) services to eliminate the effect of coding or classification changes that do not reflect real changes in case mix. As described in the FY 2006 IRF PPS final rule (70 FR 47880), CMS applied a one-time adjustment of 1.9 percent to the standard payment amount for FY 2006 to account for provider coding practices that, according to research conducted by the RAND Corporation, increased Medicare payments to IRF's between 1999 and 2002. RAND had estimated that between 1.9 and 5.8 percent of the increase in payments to IRFs was attributable to coding. CMS further analyzed trends, from 2002 through 2005, in the distribution of patients in each of the four payment tiers and found that a proportion of patients shifted each year from the lowest to the higher-paying tiers. Based on these analyses and MedPAC's findings, costs were not increasing substantially during the same time period, therefore CMS proposes to reduce the IRF standard payment amount by 2.9 percent for FY 2007. The 1.9 percent reduction from 2006, combined with this 2.9 percent proposed reduction, equates to an overall 4.8 percent payment reduction over a two-year period.

Mercy strongly disagrees with CMS's proposal to reduce the IRF standard payment amount by 2.9 percent for the following reasons:

- ***Coding Changes*** – Prior to IRPPS, for a rehabilitation unit or hospital to be reimbursed their cost, at least 75 percent of patients treated must meet specific medical conditions that require intensive rehabilitation services. With the advent of IRPPS, CMS acknowledged (May 16, 2003 proposed rule) that many rehabilitation units/hospitals were not meeting the compliance threshold of 75 percent. Rather than decertify these noncompliant units/hospitals from IRPPS immediately, CMS has provided rehab units/hospitals a transition period to meet the compliance threshold of 75 percent. Incrementally, the compliance threshold percentages are 50% (year 1), 60% (year 2), 60% (3), 65% (4), 75% (5). Mercy IRFs have always adhered to the compliance threshold of 75%. However, we believe CMS provided this transition period to allow IRFs to correct their practice patterns and more accurately document patients who require intensive rehabilitation services. By moving toward the 75 percent compliance threshold, it appears reasonable that hospitals are treating patients that require greater resources with major medical complexities. Within our own rehab units, the case-mix index (CMI) **increased** over 4 percent from 2003 through 2005. The national CMI increased over 4.5 percent during this same time period (from the Uniform Data System for Medical Rehabilitation). In recent comments regarding the FY 2007 Hospital IPPS proposed rule, MedPAC indicates that hospitals often lag in training physicians to document and coders to code more accurately. Mercy believes this rationale supports the comorbidity tier trends exhibited in Table 6 on page 28124 of the FY 2007 IRPPS proposed rule. CMS's example, of "upcoding" ICD-9 code 278.02 (overweight) on the same page, only reflects this as a relatively **simple** comorbidity to document (from CMS's published list). CMS offers no such examples explaining the trends in Table 6 other than to conclude that the proportion of patients in each of the three higher-paying payment tiers increased each year and a MedPAC analysis suggests costs have not increased over the same time period.

- ***Cost Changes*** – CMS believes that cost increases have lagged far behind payment increases. CMS cites a MedPAC analysis (March 2006) that found IRF cost increases of 2.4 percent and 3.6 percent in 2003 and 2004 (market basket increases were 3.0 and 3.2 percent, respectively, for the same time period). A regression analysis of this cost trend (2.4 percent to 3.6 percent) would support the resource consumption required for intensive rehabilitation services. In the IRPPS, relative weights are a primary element to account for the variance in cost per discharge and resource utilization among the Case-Mix Related Groups (CMG). From 2002 through 2005, there were no changes to the number of CMGs, CMG relative weights, lengths of stay or comorbidity tiers. We understand there was not enough IRPPS data to support any changes during that period. For FY 2006, CMS made significant changes to the CMG relative weights, lengths of stay, and comorbidity tiers. Mercy presumes these changes were made to adjust for resource consumption among CMGs based on historical claim data under IRPPS. That is the purpose of establishing, and periodically adjusting, relative weights, whether for IPPS, OPPS, IRPPS, or RUGs.

Based on the above rationale, Mercy believes CMS's proposal to reduce the IRF standard payment amount by 2.9 percent is inappropriate. If only **those** units/hospitals, that actually met the 75 percent compliance threshold, were paid under IRPPS (as CMS originally intended), a 2.9 percent payment reduction would not be necessary. Rather than penalize ALL rehab units/hospitals with a blanket percent decrease, we believe changes in resource consumption should be accounted for completely through the CMG relative weights.

Proposed Update to Payments for High-Cost Outliers Under the IRF PPS

If the estimated costs of a case are higher than the adjusted outlier threshold, CMS makes an outlier payment for the case equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold, similar to the outlier payment calculation for hospital acute care stays. CMS sets the outlier threshold in order to maintain outlier payments equal to approximately three percent of all estimated payments. For fiscal year (FY) 2006, CMS set the outlier threshold at $5,129. The proposed threshold for FY 2007 is $5,609, or an increase of over nine percent.

CMS states that due to the anticipated increase in Inpatient Rehab Facilities (IRF) costs, an overall increase of .5 percent in "non-outlier" payments should be expected (3.4 percent market basket increase less the 2.9 percent decrease in payment adjustment). CMS goes on to state that due to estimated costs being greater than the overall increase in payments, more cases should qualify for outlier payments. CMS does not however, provide data on whether or not we are expected (based on year-to-date data) to be paid approximately 3 percent in outlier payments in FY 2006 based on the final outlier threshold currently being used of $5,129. Therefore, providers are unaware if the current threshold being utilized is a "valid" estimate for current outlier payments.

CMS assumes (without providing any supporting documentation) that the FY 2006 threshold is estimated to generate outlier payments at approximately 3 percent of overall payments **but** increased the proposed FY 2007 threshold by over 9 percent (again without providing supporting documentation for calculation of the proposed increase). This percentage increase is greater than the one proposed (in the April 25th proposed rule) for the Hospital (acute care) Inpatient Prospective Payment System (IPPS).

CMS does estimate outlier payments for the Hospital IPPS will represent only 4.71% of total DRG payments in FFY 06, and 4.10% in FFY 05. These estimates are considerably less than the 6% allowed by the act for this type of hospital setting.

Based on CMS' estimates for the Hospital IPPS FFY 05 and 06 thresholds, combined with the underpayments made from the outlier pool for a number of years, we urge CMS to reconsider the proposed increase in the outlier payment threshold. We respectfully recommend the FY 2007 threshold be at least held constant at the FFY 06 level of $5,129.

Thank you again for considering our comments. Should you have additional questions, please contact Bill Colletta at 314-364-3525.

Sincerely,

Ron Ashworth
President / Chief Executive Officer

SISTERS OF MERCY
HEALTH SYSTEM

July 7, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1540-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: "Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2007"

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Specifically, we offer the following comments:

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Section 1886(j)(2)©(ii) of the Act requires the Secretary to adjust the per unit payment rate for Inpatient Rehabilitation Facility (IRF) services to eliminate the effect of coding or classification changes that do not reflect real changes in case mix. As described in the FY 2006 IRF PPS final rule (70 FR 47880), CMS applied a one-time adjustment of 1.9 percent to the standard payment amount for FY 2006 to account for provider coding practices that, according to research conducted by the RAND Corporation, increased Medicare payments to IRF's between 1999 and 2002. RAND had estimated that between 1.9 and 5.8 percent of the increase in payments to IRFs was attributable to coding. CMS further analyzed trends, from 2002 through 2005, in the distribution of patients in each of the four payment tiers and found that a proportion of patients shifted each year from the lowest to the higher-paying tiers. Based on these analyses and MedPAC's findings, costs were not increasing substantially during the same time period, therefore CMS proposes to reduce the IRF standard payment amount by 2.9 percent for FY 2007. The 1.9 percent reduction from 2006, combined with this 2.9 percent proposed reduction, equates to an overall 4.8 percent payment reduction over a two-year period.

Mercy strongly disagrees with CMS's proposal to reduce the IRF standard payment amount by 2.9 percent for the following reasons:

- ***Coding Changes*** – Prior to IRPPS, for a rehabilitation unit or hospital to be reimbursed their cost, at least 75 percent of patients treated must meet specific medical conditions that require intensive rehabilitation services. With the advent of IRPPS, CMS acknowledged (May 16, 2003 proposed rule) that many rehabilitation units/hospitals were not meeting the compliance threshold of 75 percent. Rather than decertify these noncompliant units/hospitals from IRPPS immediately, CMS has provided rehab units/hospitals a transition period to meet the compliance threshold of 75 percent. Incrementally, the compliance threshold percentages are 50% (year 1), 60% (year 2), 60% (3), 65% (4), 75% (5). Mercy IRFs have always adhered to the compliance threshold of 75%. However, we believe CMS provided this transition period to allow IRFs to correct their practice patterns and more accurately document patients who require intensive rehabilitation services. By moving toward the 75 percent compliance threshold, it appears reasonable that hospitals are treating patients that require greater resources with major medical complexities. Within our own rehab units, the case-mix index (CMI) **increased** over 4 percent from 2003 through 2005. The national CMI increased over 4.5 percent during this same time period (from the Uniform Data System for Medical Rehabilitation). In recent comments regarding the FY 2007 Hospital IPPS proposed rule, MedPAC indicates that hospitals often lag in training physicians to document and coders to code more accurately. Mercy believes this rationale supports the comorbidity tier trends exhibited in Table 6 on page 28124 of the FY 2007 IRPPS proposed rule. CMS's example, of "upcoding" ICD-9 code 278.02 (overweight) on the same page, only reflects this as a relatively **simple** comorbidity to document (from CMS's published list). CMS offers no such examples explaining the trends in Table 6 other than to conclude that the proportion of patients in each of the three higher-paying payment tiers increased each year and a MedPAC analysis suggests costs have not increased over the same time period.

- ***Cost Changes*** – CMS believes that cost increases have lagged far behind payment increases. CMS cites a MedPAC analysis (March 2006) that found IRF cost increases of 2.4 percent and 3.6 percent in 2003 and 2004 (market basket increases were 3.0 and 3.2 percent, respectively, for the same time period). A regression analysis of this cost trend (2.4 percent to 3.6 percent) would support the resource consumption required for intensive rehabilitation services. In the IRPPS, relative weights are a primary element to account for the variance in cost per discharge and resource utilization among the Case-Mix Related Groups (CMG). From 2002 through 2005, there were no changes to the number of CMGs, CMG relative weights, lengths of stay or comorbidity tiers. We understand there was not enough IRPPS data to support any changes during that period. For FY 2006, CMS made significant changes to the CMG relative weights, lengths of stay, and comorbidity tiers. Mercy presumes these changes were made to adjust for resource consumption among CMGs based on historical claim data under IRPPS. That is the purpose of establishing, and periodically adjusting, relative weights, whether for IPPS, OPPS, IRPPS, or RUGs.

Based on the above rationale, Mercy believes CMS's proposal to reduce the IRF standard payment amount by 2.9 percent is inappropriate. If only **those** units/hospitals, that actually met the 75 percent compliance threshold, were paid under IRPPS (as CMS originally intended), a 2.9 percent payment reduction would not be necessary. Rather than penalize ALL rehab units/hospitals with a blanket percent decrease, we believe changes in resource consumption should be accounted for completely through the CMG relative weights.

Proposed Update to Payments for High-Cost Outliers Under the IRF PPS

If the estimated costs of a case are higher than the adjusted outlier threshold, CMS makes an outlier payment for the case equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold, similar to the outlier payment calculation for hospital acute care stays. CMS sets the outlier threshold in order to maintain outlier payments equal to approximately three percent of all estimated payments. For fiscal year (FY) 2006, CMS set the outlier threshold at $5,129. The proposed threshold for FY 2007 is $5,609, or an increase of over nine percent.

CMS states that due to the anticipated increase in Inpatient Rehab Facilities (IRF) costs, an overall increase of .5 percent in "non-outlier" payments should be expected (3.4 percent market basket increase less the 2.9 percent decrease in payment adjustment). CMS goes on to state that due to estimated costs being greater than the overall increase in payments, more cases should qualify for outlier payments. CMS does not however, provide data on whether or not we are expected (based on year-to-date data) to be paid approximately 3 percent in outlier payments in FY 2006 based on the final outlier threshold currently being used of $5,129. Therefore, providers are unaware if the current threshold being utilized is a "valid" estimate for current outlier payments.

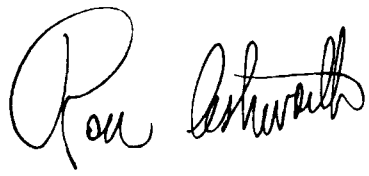
CMS assumes (without providing any supporting documentation) that the FY 2006 threshold is estimated to generate outlier payments at approximately 3 percent of overall payments **but** increased the proposed FY 2007 threshold by over 9 percent (again without providing supporting documentation for calculation of the proposed increase). This percentage increase is greater than the one proposed (in the April 25th proposed rule) for the Hospital (acute care) Inpatient Prospective Payment System (IPPS).

CMS does estimate outlier payments for the Hospital IPPS will represent only 4.71% of total DRG payments in FFY 06, and 4.10% in FFY 05. These estimates are considerably less than the 6% allowed by the act for this type of hospital setting.

Based on CMS' estimates for the Hospital IPPS FFY 05 and 06 thresholds, combined with the underpayments made from the outlier pool for a number of years, we urge CMS to reconsider the proposed increase in the outlier payment threshold. We respectfully recommend the FY 2007 threshold be at least held constant at the FFY 06 level of $5,129.

Thank you again for considering our comments. Should you have additional questions, please contact Bill Colletta at 314-364-3525.

Sincerely,



Ron Ashworth
President / Chief Executive Officer

Submitter : Mr. Andre Therrien **Date:** 07/06/2006

Organization : Catholic Medical Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1540-P2-24-Attach-1.RTF

July 5, 2006

Sheila Lambowitz, Director
Division of Institutional Post Acute Care
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Blvd
Baltimore, MD 21244

ATTN: FILE CODE CMS-1540-7

Re: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for FY 2007; Proposed Rule

Dear Ms. Lambowitz:

I am submitting this public comment letter on the Inpatient Rehabilitation Facility Prospective Payment System proposed rule for FY 2007 to alert you to the negative impact on our facility due to the transition to Core-Based Statistical Area (CBSA)-based wage index areas. Based on the publicly available data from the first two quarters of FY 2006, the transition to CBSA-based wage index areas is already significantly compromising our ability to serve Medicare beneficiaries, and believe that the implementation of the FY 2007 proposed rule will further decrease the wage index for our facility. I respectfully request that CMS mitigate the impact of the Final Rule for FY 2007 by extending the blended rate transition for one more year to IRFs that will experience an eight percent or greater reduction in their wage index.

Impact of Proposed Rule

Catholic Medical Center (CMC) (Medicare provider # 30-0034) is a licensed 330 bed full service acute care hospital located in Manchester, NH, the State's largest city. The Medical Center is known for its advanced cardiac and general surgical capabilities and its comprehensive programs for high acuity patients. In addition, CMC offers both inpatient and outpatient rehabilitation programs, as well as psychiatric services. CMC cares for some of the most acutely ill patients in the State as demonstrated by its high case mix index.

Catholic Medical Centers RMU (Medicare provider # 30-T034)is a comprehensive rehabilitation program providing services to patients who have suffered stroke, brain injury, spinal cord injury, neuromuscular disorders, amputations, orthopedic injuries / surgeries, cardiac conditions and other medical / surgical complications. CMC's 25-bed unit is comprised of a core team of specialists, including: physiatry, rehabilitation nursing, occupational therapy, physical therapy, speech therapy, case management / social services, as well as nutritional assessments, recreational therapy and other ancillary services.

The significant impact of the transition to the CBSA-based wage index areas on our facility is not unique. As the table below demonstrates, the implementation of the proposed rule will cause a total of fifteen free-standing and hospital-based IRFs nationwide to experience a

total two-year decline in their wage indices of greater than eight percent.

Facilities Impacted more than 8%

Provider Number	State	Dischg #	Proposed 2007 Wage Index	FY 06 MSA Wage Index	Change In Point 06MSA to 07CBSA	Change In %age 06MSA to 07CBSA	$ Impact 06MSA to 07CBSA	FY 06 CBSA Wage Index	FY06 Blended Wage Index
FREESTANDING									
303026	NH	1090	1.0374	1.1290	(0.0916)	-8.1%	$(1,016,595)	1.0221	1.0756
363026	OH	851	0.8603	0.9517	(0.0914)	-9.6%	$ (731,047)	0.9237	0.9377
363032	OH	367	0.8603	0.9517	(0.0914)	-9.6%	$ (232,976)	0.9237	0.9377
303027	NH	742	1.0354	1.1290	(0.0936)	-8.3%	$ (720,696)	1.0642	1.0966
233025	MI	502	0.9508	1.0350	(0.0842)	-8.1%	$ (361,645)	0.9366	0.9858
HOSPITAL BASED									
110163	GA	379	0.8628	1.1266	(0.2638)	-23.4%	$ (792,751)	1.1266	1.1266
110007	GA	317	0.8628	1.1266	(0.2638)	-23.4%	$ (717,767)	1.1266	1.1266
150088	IN	297	0.8586	1.0039	(0.1453)	-14.5%	$ (345,268)	0.8713	0.9376
350019	ND	467	0.7901	0.9091	(0.1190)	-13.1%	$ (421,372)	0.9091	0.9091
360064	OH	496	0.8603	0.9517	(0.0914)	-9.6%	$ (353,228)	0.9237	0.9377
360086	OH	203	0.8396	0.9231	(0.0835)	-9.0%	$ (123,578)	0.8748	0.8990
360187	OH	186	0.8396	0.9231	(0.0835)	-9.0%	$ (122,494)	0.8748	0.8990
390066	PA	272	0.8459	0.9286	(0.0827)	-8.9%	$ (133,858)	0.8570	0.8928
300034	NH	375	1.0354	1.1290	(0.0936)	-8.3%	$ (362,291)	1.0642	1.0966
300011	NH	377	1.0354	1.1290	(0.0936)	-8.3%	$ (324,193)	1.0642	1.0966

Extension of Blended Rate

The Final Rule for 2006 provided for a one year blended rate for all IRFs nationwide, irrespective of the severity of the wage index adjustment. The proposed rule for 2007 would allow the transitional blended rate to expire. IRFs experiencing particularly substantial wage index reductions therefore require some additional measure of protection.

CMS acknowledged that its adoption of CBSA-based area designations would result in wage index reductions for some IRFs, and has attempted to mitigate the impact by providing a one-year transition period for FY 2006, during which Medicare payment rates have been calculated based on a blended wage index. Under section 1886(j) of the Social Security Act, the Secretary of Health and Human Services enjoys "broad authority in developing the IRF PPS, including whether and how to make adjustments" to the Medicare prospective payment rate. 70 Fed. Reg. 47921 (Aug. 15, 2005). CMS applied a similar provision in the IRF Final Rule for FY 2006 to IRFs that lost their rural adjustment as the result of their reclassification from "rural" to "urban," in order to mitigate significant payment reductions. 70 Fed. Reg. 47924.

I urge CMS in the Final Rule to extend the blended rate for one additional year for IRFs that would otherwise endure an eight percent or greater wage index reduction. This rationale applies with equal force to the small number of outlier IRFs experiencing severe reductions in their wage index as a result of their new CBSA designation.

Please feel free to contact me with any additional questions. I appreciate your attention to this matter.

Sincerely,

Andre L. Therrien
Controller

Submitter : Ms. Marilyn Litka-Klein **Date:** 07/06/2006

Organization : Michigan Health & Hospital Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Please our attached comment letter.

Thanks!

CMS-1540-P2-25-Attach-1.DOC

CMS-1540-P2-25-Attach-2.DOC

MICHIGAN HEALTH & HOSPITAL ASSOCIATION

Advocating for hospitals and the patients they serve.

July 6, 2006

Mark McClellan, M.D., Ph.D.
Administrator, Centers for Medicare & Medicaid Services
Attn: CMS—1540—P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

RE: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Fiscal Year 2007; Proposed Rule.

Dear Dr. McClellan:

On behalf of Michigan's 145 nonprofit hospitals, the Michigan Health & Hospital Association (MHA) appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services regarding the fiscal year (FY) 2007 proposed rule for the inpatient rehabilitation facility prospective payment system (IRF PPS).

Among other changes, the Centers for Medicare & Medicaid Services (CMS) proposes to provide an inflationary update at the statutorily required market-basket rate of 3.4 percent, a 2.9 percent across-the-board reduction to adjust for coding increases, and several adjustments to the changes made in last year's system refinement that significantly revised the IRF PPS. **The MHA strongly opposes the negative 2.9 percent coding adjustment and urges the CMS to withdraw the reduction, which is inappropriate.** We believe that the negative 2.9 percent coding adjustment and other modifications included in the proposed rule are based on substandard and limited data analysis of outdated data that fails to reflect the current environment. The MHA urges the CMS to update its data and analysis in subsequent rules. Please see below for our detailed comments.

Proposed 2.9 Percent Coding Reduction

For FY 2006, the CMS implemented a 1.9 percent across-the-board payment reduction to offset coding increases from 1999 to 2002. RAND Corporation had estimated coding increases ranging from an increase of 1.9 percent to 5.8 percent. However, RAND questioned the accuracy of its own coding analysis, and the CMS acknowledged the inconclusive finding in setting the reduction at the low end of the range in the FY 2006 rule. **Given the lack of a solid**

SPENCER JOHNSON, PRESIDENT

CORPORATE HEADQUARTERS ◆ 6215 West St. Joseph Highway ◆ Lansing, Michigan 48917 ◆ (517) 323-3443 ◆ Fax (517) 323-0946
CAPITOL ADVOCACY CENTER ◆ 110 West Michigan Avenue, Suite 1200 ◆ Lansing, Michigan 48933 ◆ (517) 323-3443 ◆ Fax (517) 703-8620
www.mha.org

analytical foundation and further efforts to demonstrate the need, the MHA believes it is crucial that the CMS withdraw the proposed 2.9 percent reduction.

The CMS' premise that coding increases during the first three years of IRF PPS implementation were largely due to coding behavior must be revisited to consider case mix and cost structure changes that have occurred since 2004. We believe that implementation of any new PPS, such as the IRF PPS, will result in changes in provider behavior which are reflected in changes in patient characteristics as measured by the case mix. According to the CMS, since IRF PPS payment levels correspond directly to patient characteristics, the IRF PPS may have provided incentives to admit patients with greater impairments, lower function, or more comorbidities than under the previous payment systems. Case mix changes due to these factors are "real changes" and are appropriately reflected in increased payments. The CMS should not implement an adjustment for coding improvements that might inappropriately reduce payments without completing a thorough analysis that more definitively differentiates between changes in coding practices and changes in patient characteristics. As noted by both the Medicare Payment Advisory Commission (MedPAC) in March 2006 and the Moran Company analysis, the overall case mix in IRFs has changed since 2004 in response to the 75 Percent Rule. The percentage of joint-replacement cases is dropping and the percentage of stroke cases is growing, resulting in a higher overall case mix. This pattern also increases the average length of stay and cost per case for IRFs, and is in direct contrast to the conditions that existed from 1999 through 2003, the period of focus in the proposed rule. The CMS also noted this change in IRF cost structures in its FY 2006 proposed and final rules.

Questions have recently been raised pertaining to the transition to restructured and rebased CMGs in FY 2006. Early analyses by the Lewin Group and others indicate this transition likely produced a 3 percent decrease in overall case mix – and, subsequently, Medicare payments to IRFs during FY 2006. The effect of transitioning to the new CMGs was neither discussed nor accounted for in the budget neutrality adjustments in the FY 2006 final rule. This reduction was distinct from the FY 2006 coding-related cut of 1.9 percent. Final analysis of this matter is pending and we urge the CMS to evaluate this work closely. We believe that it would be appropriate for the CMS to discuss its findings regarding this matter in an interim final rule for FY 2007.

The proposed 2.9 percent cut raises other questions including: Why should the CMS impose further adjustments to the IRF PPS based on data from 1999 through 2002 when the payment system was refined by restructuring and re-weighting of the CMGs in FY 2006? The comprehensive FY 2006 refinement should serve as a new baseline for this payment system. As such, the CMS would need further data analysis using information after the refinement to substantiate further reductions.

Furthermore, the CMS has overlooked the 16 percent behavioral offset already applied to the payment system when the IRF PPS was initially implemented in January 2002. As noted by the CMS in the August 2001 final rule, the behavioral offset:

> "account(s) for change in practice patterns due to new incentives in order to maintain a budget neutral payment system. Efficient providers are adept at modifying and adjusting practice patterns to maximize revenues while still maintaining optimum quality of care for the patient. We take this behavior into account in the behavioral offset."

Both the 1.9 percent coding reduction implemented in FY 2006 and the proposed FY 2007 negative 2.9 percent coding adjustment are redundant with the original behavioral offset.

The CMS has already made sufficient, if not excessive, downward adjustments with the implementation of the IRF PPS and its 2006 refinement. IRF case mix, average length of stay and costs per stay are increasing. It is unsubstantiated and excessive to recommend another across-the-board reduction for FY 2007. As a result, the MHA strongly urges the CMS to withdraw the proposed 2.9 percent coding reduction.

75 Percent Rule

The MHA remains concerned that the CMS has once again based its proposal on outdated data that fail to account for the serious environmental challenges currently facing IRFs. The FY 2007 proposed rule also neglects the significant instability caused by the phase-in of the "75 Percent Rule," which began in July 2004, yet the proposed rule is almost entirely based on data from 1999 through 2004. Today, the 75 Percent Rule continues to reduce IRF admissions based on out-of-date, restrictive and ineffective diagnosis-based criteria. The Moran Company's December 2005 report on the impact of the 75 Percent Rule, "Utilization Trends in Inpatient Rehabilitation: Update through QIII 2005," estimates that approximately 40,000 fewer patients were treated by IRFs during the first year of 75 Percent Rule implementation (under a 50 percent threshold from July 2004 through June 2005). The Moran Company's recent review of claims data through March 2006 from eRehabData and Uniform Data System for Medical Rehabilitation estimates that during the second year of the 75 Percent Rule phase-in (under a 60 percent threshold from July 2005 through June 2006), approximately 20,000 fewer patients will access IRFs. The combined impact of these analyses – a reduction of 60,000 patients accessing IRFs in the first two years of the 75 Percent Rule phase-in – appears to be entirely overlooked in this proposed rule. The alarming scale of this impact exceeds by 7.5 times the CMS' estimate that 7,000 fewer patients would be treated in IRFs during the first two years of 75 Percent Rule phase-in. We anticipate that further reductions in patient access will occur when the threshold is reduced to 65 percent in July 2007.

In addition to overlooking the impact of the 75 Percent Rule, the proposed rule also fails to recognize that the IRF environment has worsened further in recent months due to the negative impact of several local coverage determinations (LCDs), by some fiscal intermediaries (FIs). Medical necessity reviews are being conducted by these and other FIs on both a pre-payment and post-payment basis.

As a single factor, the 75 Percent Rule has not resulted in IRF closures. However, in combination with the LCD enforcement, the 75 Percent Rule has already resulted in facility

closures in 2006, with more pending. Given the current instability facing IRFs due to the 75 Percent Rule, LCDs and the FY 2006 1.9 percent across-the-board cut, it is inappropriate for the CMS to create further volatility. **Therefore, the MHA urges the CMS to:**

- **withdraw the negative 2.9 percent coding adjustment;**
- **update its analyses so that they reflect the current reality facing patients, referring physicians and IRFs; and**
- **study the current medical rehabilitation environment.**

Data-related Concerns

We believe it is inappropriate for the CMS to proceed with rulemaking on IRF payment policy using outdated and irrelevant data. We encourage the CMS to adjust its internal protocols to ensure that future rulemaking utilized the most recent payment and claims data available. It is unclear why the CMS allocates the resources to meet this standard for the inpatient PPS but fails to comply with this standard for other payment systems such as the IRF PPS. For instance, the proposed FY 2007 inpatient IPPS rule was based on the May 2006 update of the 2005 MEDPAR data, but this proposed IRF PPS rule uses data based on the 2004 claims data.

In addition to using the most recent payment and claims data, the CMS should publicly disseminate this data along with the paid, current and proposed case-mix groups and associated IRF patient-assessment instrument data. This type of data release would be comparable to that made by the CMS as part of the annual rulemaking process for the inpatient PPS. It is a critical step that enables hospitals to develop robust recommendations on how to improve the proposal.

The current scenario, in which the IRF PPS proposed rule has been published without the provider-identified facility-level impact file, results in the field facing an analytical handicap which, in the long run, is also a hindrance to the CMS, since the resulting analytical limitations prevents stakeholders from developing stronger public comments.

Proposed Changes to the CMG Relative Weights

The CMS is proposing to reweight the IRF PPS case-mix groups (CMG) to account for proposed changes to the comorbidity codes used to calculate Medicare payments per patient. The CMS states that it "propose[s] to update the CMG relative weights for FY 2007 to ensure that they continue to reflect, with accuracy, the treatment costs for various types of patients in IRFs." However, the CMS fails to rebase the CMG weights, as done annually for the diagnosis-related groups (DRGs) of the inpatient PPS, by incorporating the latest claims data. This opportunity has been inappropriately bypassed in this proposed rule and prior IRF PPS updates. **We urge the CMS to rerun the recalibration of the weights so that it includes not only the proposed new comorbidity codes, but also utilizes the latest available data, rather than using the same 2002 and 2003 data used for the FY 2006 proposed and final rules. Given the need for more recent data to substantiate changes for FY 2007, we urge the CMS to implement an interim final rule for FY 2007 that is based on more recent data. An interim**

final rule would enable stakeholders to comment on the revised data and policies for FY 2007.

Research on Medical Rehabilitation

Whether overall Medicare savings have or will be achieved by the significant reduction in IRF cases due to the 75% Rule remains unknown. The CMS has taken a position that less-intensive settings are an overall value for the Medicare program, especially for joint-replacement patients, but this position has not yet been scientifically reviewed. The work done by the Government Accountability Office and the National Institutes of Health on the 75 Percent Rule was helpful for identifying what further analysis is needed in order to modernize the 75 Percent Rule, more clearly define the role of IRFs relative to other post-acute care providers and better understand the cost effectiveness of IRFs and other post-acute providers. The IRF field is proactively stepping forward to help fill the void in the medical literature on comparative analysis of medical rehabilitation costs and outcomes. **The MHA believes that the CMS should strongly support these efforts by providing project funding and issuing thoughtful regulatory changes that recognize the need to provide stability in the IRF environment while research is conducted.**

Post-acute Care Demonstration

The MHA is supportive of the post-acute care demonstration authorized by the Deficit Reduction Act of 2005 (DRA) and will continue to urge the CMS to adopt a balanced position that fairly considers the unique merits of each post-acute provider group. We support this effort, which may ultimately help align Medicare payments more closely with the clinical characteristics of post-acute patients.

Again, the MHA appreciates the opportunity to provide comments to the CMS regarding this proposed rule. Please contact me if you have any questions or require additional information at 517-703-8603 or via email at mklein@mha.org.

Sincerely,

Marilyn Litka-Klein

Marilyn Litka-Klein
Senior Director, Health Policy & Delivery