CMS-1540-P2-2 **Prospective Payment System for Inpatient Rehabilitation Facilities for FY 2007**

Submitter : Mrs. Norelle Lundy **Date & Time:** 06/13/2006

Organization : DeTar Healthcare System

Category : Hospital

Issue Areas/Comments

Proposed FY 2007 Federal Prospective Payment Rates

Proposed FY 2007 Federal Prospective Payment Rates

This proposed negative coding adjustment would futher restrict patient access to medical rehabilitation services. The recent 75% Rule and CMS' Local Coverage Determinations presently demonstrates considerable limitations to the providers.

Submitter : Mrs. Martha Allen

Date: 06/20/2006

Organization : Oregon Rehab Center

Category : Social Worker

Issue Areas/Comments

Proposed FY 2007 Federal Prospective Payment Rates

Proposed FY 2007 Federal Prospective Payment Rates

Please understand that decreasing funding for rehab units is harmful to the patient, physican and communities. Patients who go through an acute rehab program are mostly discharge back into their community. It would be a disservice to everyone to decrease the funding for inpatient rehab. Acute rehab services is the best kept secret of success for the patient and communities. We need to have an increase in funding to help people get home, saving Medicare dollars that are spent of Skilled facilites that do not offer or have the same level of success at discharging to communities. Please increase the rate to acute rehab instead of decreasing.

Submitter : Mr. John Prochilo

Organization : Northeast Rehabilitation Health Network

Category : Health Care Provider/Association

Date: 06/21/2006

Issue Areas/Comments

Proposed FY 2007 Federal Prospective Payment Rates

Proposed FY 2007 Federal Prospective Payment Rates

See Attachment.

CMS-1540-P2-5-Attach-1.DOC

NRH
NORTHEAST REHABILITATION
HEALTH NETWORK
70 BUTLER STREET, SALEM, NEW HAMPSHIRE 03079
(603) 893-2900 FAX (603) 893-1628
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June 20, 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 20041

ATTN: CMS-1540-P

ATTN: FILE CODE CMS-1540-7

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

Dear Ms. Lambowitz:

We are writing to alert you to the serious, and probably unforeseen, impact that the Inpatient Rehabilitation Facility Prospective Payment System proposed rule for FY 2007 will have on Northeast Rehabilitation Hospital (NRH) and a small number of other inpatient rehabilitation facilities (IRFs). We thank you for the opportunity to work with you and CMS over the past year and appreciate the time and attention you have devoted to this issue. We have concluded, based on data from the first two quarters of FY 2006, that the transition to Core-Based Statistical Area (CBSA)-based wage index areas is already significantly compromising our ability to serve Medicare beneficiaries. We are especially concerned that the implementation of the FY 2007 proposed rule, as it is currently structured, will further decrease the wage index for Rockingham County, New Hampshire. Therefore, we respectfully request that the final rule for FY 2007 address a small number of IRFs that have been and will continue to be the most severely affected by the transition to a CBSA-based wage index. In particular, NRH urges CMS to extend the blended rate transition for another year to protect IRFs that will experience an (8) eight percent or greater reduction in their wage index.

The Impact of the 2006 Final Rule on NRH

CMS's adoption of CBSA-based area designations has had a uniquely negative effect on a small number of IRFs, including NRH. The new designations broke up the Greater Boston Metropolitan Statistical Area (MSA) into six smaller geographic areas. This outcome was unique to the Boston region, as no other metropolitan area experienced such a severe realignment. The effect was to separate numerous inpatient rehabilitation facilities in

Massachusetts and New Hampshire from the Boston statistical area and, as a result, to decrease the applicable wage index.

The magnitude of the wage index reduction that the proposed rule would impose on NRH makes it a significant outlier. CMS should therefore take appropriate steps in the Final Rule to accommodate NRH and similarly situated IRFs. Of the 1,188 IRFs subject to new PPS rates in 2006, NRH suffered one of the largest decreases. The transition from MSA- to CBSA-based area designations reduced NRH's wage index from 1.1233 in FY 2005 to 1.0221 in FY 2007. For NRH, this reduction translates into an annual loss of $1.2 million in Medicare revenue.

NRH is a freestanding rehabilitation hospital, and not part of a larger acute care hospital system. Medicare patients comprise 64% of our inpatient population. The one-year blended transition rate that CMS included in the 2006 Final Rule reduced by half the estimated loss of revenue to NRH, from $1.2 million to $600,000. This amounts to 4.3% of our facility's entire revenue base, and has already begun to limit both the number of patients we can treat and the services that we can provide.

The following table illustrates the disproportionate impact that the transition from MSA- to CBSA-based area designations has had on freestanding IRFs in New England:

IMPACT of FY 2006 Proposed IRFPPS Rule

			Number of Facilities	Dischg #	Change In Point 06MSA to 06CBSA	Change In %age 06MSA to 06CBSA	$ Impact 06MSA to 06CBSA	Per Facility$ Impact 06MSA to 06CBSA
National			1,188	461,738	(0.0005)	-0.0001%	$ (1,320)	$ (1)
National	Freestanding	Urban	196	158,968	0.0008	0.1300%	$ (926)	$ (5)
National	Hospital Based	Urban	802	261,229	0.0023	0.3100%	$ 3,931	$ 5
New England Excl NRI	Freestanding	Urban	11	13,296	(0.0147)	-1.3000%	$ (109,369)	$ (9,943)
New England	Hospital Based	Urban	23	6,284	(0.0013)	-0.1500%	$ (8,683)	$ (378)
Northeast Rehab	**Freestanding**		**1**	**1,032**	**(0.1069)**	**-9.4700%**	**$ (1,209,850)**	**$ (1,209,850)**

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The substantial decrease in Medicare margins from FY 2005 to FY 2006 further illustrates the severity of the impact on NRH. As the table below demonstrates, in the period from December 1, 2005 through February 28, 2006—the only complete cost reporting quarter available since the new wage index went into effect—NRH's Medicare margin fell to -1.31% from 18.3%, a decrease of almost 20%.

	FY 2005	**FY 2006 Q3**
	Cost report 12 Months ended 5/31/2005	**3 Months ended 2/28/2006 ACTUAL**
Wage Index	1.1290	**1.0756**
Medicare ADC	43	46
Medicare Payments	$15,530,288	$3,725,933
Medicare Cost	$12,688,305	$3,774,582
Medicare Margin	$2,841,983	-$48,649
Percentage	**18.30%**	**-1.31%**

NRH Fiscal Year end is 5/31
The FY 2005 data is per the NRH as filed cost report. The data for the three months ended 2/28/06 are from our internally prepared estimates. NRH does not prepare interim period cost reports.

Projected Impact of the 2007 Proposed Rule on NRH

The proposed rule would allow the transitional blended rate to expire, thus reducing NRH's wage index from 1.0756 for 2006, to 1.0374 for 2007. The result will be to decrease our revenue by an additional $500,000 for FY 2007. This will bring the total, after transition, impact to $1,016,595 (as shown on the following table). The one-year transition rate in the FY 2006 Rule reduced the impact of the MSA/CBSA change by one-half. Thus we estimated the FY 2007 impact on NRH to be $500,000.

Deleted: For the purpose of further comparison, the table below demonstrates that NRH will receive an estimated $500,000 less in revenue in FY 2007 than in 2006 under the new CBSA-based area designations.

IMPACT of FY 2007 Proposed IRFPPS Rule

			Number of Facilities	Dischg #	Change In Point 06MSA to 07CBSA	Change In %age 06MSA to 07CBSA	$ Impact 06MSA to 07CBSA	Per Facility$ Impact 06MSA to 07CBSA
National			1,157	478,942	(0.0019)	-0.15%	$ (7,954,114)	$ (6,875)
National	Freestanding	Urban	181	160,524	(0.0020)	-0.2200%	$ (415,335)	$ (2,295)
National	Hospital Based	Urban	760	262,921	(0.0029)	-0.2600%	$ (11,738,171)	$ (15,445)
New England Excl NRH	Freestanding	Urban	9	11,431	(0.0057)	-0.4900%	$ (17,246)	$ (1,916)
New England	Hospital Based	Urban	24	6,957	(0.0074)	-0.6900%	$ (466,061)	$ (19,419)
Northeast Rehab	**Freestanding**		**1**	**1,090**	**(0.0916)**	**-8.1000%**	**$ (1,016,595)**	**$ (1,016,595)**

Note: The CMS file included 1202 facilities. 45 had incomplete data, the remaining 1157 were used for this analysis.
This schedule also excludes the two Whittier Facilities that converted to LTACH on 10/1/05
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For a small number of IRFs, CMS's adoption of CBSA-based area designations will impose a severe decline in their wage index. NRH's wage index will decline a full 8.1% from its 2006 MSA-based wage index. This represents the fourth-highest decline of any free-standing urban IRF in the United States. Moreover, the negative impact of the proposed rule on NRH's revenue—approximately $1 million over FYs 2006 and 2007—**is the highest of any freestanding IRF in the nation**.

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As the table below demonstrates, the implementation of the proposed rule will cause 15 free-standing and hospital-based IRFs to experience a total two-year decline in their wage indices of greater than 8%. Of those, (4) four are located in New Hampshire.

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

The decrease in reimbursement that the proposed wage index reduction would inflict on NRH would significantly reduce the facility's operating income. Because NRH's wage index is already lower than the surrounding acute care hospitals, a further reduction for FY 2007 would seriously compromise its competitiveness in the recruitment and retention of clinical and other staff. NRH is located on the boarder between New Hampshire and Massachusetts, and is only a 35 minute drive from Boston. This location presents two particular challenges. First, we directly compete for staff with both IRFs and acute hospitals from both the Boston metropolitan area and southern New Hampshire. Second, the higher wages paid in Boston and the surrounding suburbs draw qualified staff southward. Both of these features place particular pressure on NRH wage rates.

Further, our area suffers from a chronic shortage of rehabilitation therapists. According to data published by the New Hampshire Hospital Association, the statewide vacancy rate for rehabilitation positions is 8.21%. NRH's vacancy rate for such positions is 13%. The statewide nursing vacancy rate is 6.1%; NRH's nursing vacancy rate is 11%. NRH is currently recruiting for 36 professional positions, which represent 8% of our staffing complement in those specialties. This year alone, NRH has been forced to expend an additional $278,000 in adjustments to starting salaries for clinical staff in order to compete with surrounding healthcare facilities. Notwithstanding these additional expenditures, certain clinical positions have remained vacant for over 6 months. We needed 8 months to recruit a speech language pathologist, even after engaging a professional recruiter. On average, the cost to recruit, hire, and orient a clinical staff member is $9,500. If a recruiting firm must be engaged, the cost of recruitment alone is $12,000.

Without some measure of relief from the proposed 2007 wage index reductions, we will be seriously handicapped in the competition for qualified staff with other facilities in our area. This will necessarily affect the types and number of clinical programs that we are able to offer. Faced with an annual decrease in Medicare reimbursement of more than $1 million, we will be forced to consider reductions in many of the following areas:

- Educational tools for patient care.
- Development of assistive technology to support the needs of disabled patients.
- Funding of patient support groups and other community services.
- Facilities upgrades for patient comfort and safety, including patient room and nursing unit renovations.
- Funding to develop more programming aimed at servicing acutely ill patients.
- Funding to develop programs focused on very low level brain injured and other neurologically impaired patients who require extensive highly focused and specialized rehabilitation services.
- Purchase of state of the art equipment to expand programming, particularly environmental control units for spinal cord injury and neuro patients that fall in the 75% rule of compliance, as well as home simulation modifications for the brain injury patient population.
- Education of professional staff to ensure that we continue to be a leader in the provision of rehabilitation services.

The adoption of CBSA-based area designations, and the resulting decrease in the wage index, have created for NRH the greatest operational challenge that we have ever faced. We ask that CMS work with us to avoid these unintended consequences of the proposed rule. An additional year at a blended rate will enable NRH to modify its programs and staffing in a way that does not disrupt patient care.

Legal Authority for Hold Harmless

Under section 1886(j) of the Social Security Act ("the Act"), the Secretary of Health and Human Services (HHS) 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). In addition to directing the Secretary to implement several categorically specific adjustments to the statutory average payment per payment unit, the Act empowers the Secretary to adjust payment rates "*by such other factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities.*" 42 U.S.C. 1886(j)(3)(A)(v). The sheer magnitude of the wage index decrease borne by NRH and a small number of other IRFs warrants such an exercise of statutory discretion.

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. The purpose of the transition period, according to CMS, is "to buffer the subsequent substantial impacts on numerous hospitals." 70 Fed. Reg. 47922. By providing IRFs "sufficient time to adjust their necessary business practices," the 2006 final rule explains, the transition period will ensure that the wage index reductions will have only a "minimal affect on IRFs." 70 Fed. Reg. 47923.

As we have explained in this letter, however, the impact of the adoption of CBSA-based area designations on NRH is anything but "minimal." Indeed, CMS acknowledges that a reduction of even 5 percent—a margin experienced by only 3 percent of IRFs—represents "a noticeable decrease . . . compared to what their wage index would have been for FY 2006 under the MSA-based designations." Fed. Reg. 47922. A one-year transitional blended wage index thus cannot adequately "mitigate" or "buffer" the severity of NRH's 8.1 percent decrease. IRFs experiencing particularly substantial wage index reductions therefore require some additional measure of protection.

NRH urges CMS to include in the Final Rule a modest accommodation for a small number of IRFs that have been and will continue to be the most severely affected by the transition to a CBSA-based wage index. In particular, CMS should institute a targeted three-year hold harmless for IRFs that would otherwise endure an 8 percent or greater wage index reduction. CMS applied an identical 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." As CMS explained, "the purpose of the hold harmless policy is to mitigate the significant payment implications for existing rural IRFs that may need time to adjust to the loss of their FY 2005 rural payment adjustment that experience a reduction in payments solely because of such redesignation." 70 Fed. Reg. 47924.

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. NRH therefore proposes that the following language be included in the 2007 Final Rule:

> *We recognize that the conversion from MSA-based area designations to CBSA-based area designations causes some IRFs to experience a substantial decrease in their wage index. Although CMS intended the one-year transitional blended rate to mitigate the impact on IRFs, we have concluded that this approach applied equally, in last year's final rule, still results in significant negative impacts for a small number of IRFs. Therefore, we are announcing a budget neutral three-year hold harmless provision for any county that experienced a wage index decrease of greater than 8 percent as the result of the adoption of a CBSA-based wage index.*

This provision would greatly enhance the ability of the 15 affected IRFs to operate effectively and compete in the marketplace, and would have a negligible budgetary impact of approximately $1.7 million.

NRH respectfully request to meet with CMS during the comment period, in order to discuss these issues further and to share with you the data from first two quarters of 2006.

Thank you for consideration of this issue. I look forward to meeting with you.

Sincerely,

John F. Prochilo, CEO/Administrator
Northeast Rehabilitation Hospital

cc: Zinnia Ng

Submitter : Jill Voegel

Date: 06/23/2006

Organization : Benefis Healthcare

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1540-P2-6-Attach-1.DOC

June 23, 2006

Concerning CMS-1540-P2

42 CFR Part 412
Part VI

The proposed rule states that when the compliance percentage has completed the transition to a full 75% level that comorbid conditions which would currently place the patient in the 75% category will no longer be accepted.

Our concern is that this will limit the patients ability to return to a prior functional level. Patients that have comorbid conditions such as Parkinsons, late effect of CVA, Multiple Sclerosis, and Amputations may end up being institutionalized when they could have returned to their home. Obtaining their prior level of function is more difficult because these conditions are usually exacerbated by an injury or illness that an otherwise healthy Individual would recover from.

Submitter : **Ms. Margaret Meschberger** **Date: 06/23/2006**

Organization : **Benefis Healthcare**

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1540-P2-7-Attach-1.DOC

June 23, 2006

Concerning CMS-1540-P2

42 CFR Part 412
Part VI

The proposed rule states that when the compliance percentage has completed the transition to a full 75% level that comorbid conditions which would currently place the patient in the 75% category will no longer be accepted.

Our concern is that this will limit the patients ability to return to a prior functional level. Patients that have comorbid conditions such as Parkinsons, late effect of CVA, Multiple Sclerosis, and Amputations may end up being institutionalized when they could have returned to their home. Obtaining their prior level of function is more difficult because these conditions are usually exacerbated by an injury or illness that an otherwise healthy Individual would recover from.

Submitter : Dr. BILL TACKE

Date: 06/28/2006

Organization : BENEFIS HEALTH CARE REHABILITATION UNIT

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

Proposed FY 2007 Federal Prospective Payment Rates

Proposed FY 2007 Federal Prospective Payment Rates

June 28, 2006

Department of Health and Human Services
Centers for Medicare and Medicaid Services

To Whom It May Concern:

FILE CODE: CMS-1540-P

This is my comment regarding Medicare programs; Inpatient Rehabilitation Facility Perspective Payment System for Federal Fiscal Year 2007; Proposed Rule in reference to Revisions to the Classification Criteria Percentage for IRF s .

I would like to comment in regard to the proposed change that once a facility has transitioned to the full 75% level under '412.23 (b) (2) (ii), patients who would currently qualify as one of the 13 medical conditions because of their co-morbidity would no longer qualify under that same criteria to count toward the 75% level. I would like to voice opposition to this proposed change. In another section of this Federal Registry report there was mention about the concern that stroke patients still have primary access to inpatient rehabilitation. I would point out that the rehabilitation needs for stroke patients do not end after their initial inpatient rehabilitation stay. As our population has aged and more people are recovering from medical conditions such as stroke, quite often they may be the individual who has been rehospitalized with a new illness or injury such as pneumonia or a broken leg. Their ability to recover in a normal fashion is undermined by the fact that they do have the disability due to their stroke. When they went through their initial rehabilitation they essentially worked diligently and often will use much of the reserve function. When illness or injury has then occurred their functional ability is easily undermined. Their new rehabilitation needs, therefore, are actually much more due to the fact that they have had a stroke than the fact that they have now had a broken leg, pneumonia or other condition. Since there stroke condition is now a co-morbidity, it puts them at a disadvantage in that if it no longer counts toward the 75% rule, they will have a decreased opportunity to be serviced in an inpatient rehabilitation facility since such facilities need to closely monitor that they are meeting that rule and may have to restrict admissions on that basis. In addition to individuals who have had stroke, there are a number of neurological conditions and even orthopedic conditions where this scenario can be occurring and often repeated. Generally, these people are the survivors . They have shown that they can be very diligent to work through rehabilitation at a very difficult time in their life. They have shown the motivation to go back to independent living. In may ways they are a better risk group because of this. I would strongly urge that this change be reconsidered and, thus, that there not be a new barrier toward their opportunities in rehabilitation.

Please give this matter a serious consideration when looking at how the 75% rule will apply once a facility has transitioned to the full 75% level.

Sincerely,

Bill J. Tacke, M.D.
Medical Director
Benefis Health Care Rehabilitation Unit
Great Falls, MT

Submitter : Ms. Carolyn Stergionis

Date: 06/29/2006

Organization : Benefis Rehabilitation Unit

Category : Individual

Issue Areas/Comments

Proposed Changes to the Existing List of Tier Comorbidities

Proposed Changes to the Existing List of Tier Comorbidities

The proposed rule states that when the compliance percentage has completed the transition to a full 75% level that comorbid conditions which would currently place the patient in the 75% category will no longer be accepted.

Our concern is that this will limit the patient's ability to return to a prior functional level. Patients that have comorbid conditions such as Parkinson's, late effect of CVA, MS, and amputations may end up being institutionalized when they could have returned to their homes. Return to their prior level of function is more difficult because these conditions are usually exacerbated by an injury or illness that an otherwise healthy indivudual would recover from.

It also appears unfair to penalize the payment to a Rehab Unit in dealing with patients with more than one malady when it is obvious there would be a slightly longer length of stay encumbent in this process, ie, rehab from a stroke if a person already is dealing with amputation is more difficult than just rehabbing from a stroke.

Submitter : Mr. Paul Salles

Date: 06/30/2006

Organization : Louisiana Hospital Association

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1540-P2-11-Attach-1.DOC

LOUISIANA HOSPITAL ASSOCIATION

JOHN A. MATESSINO
PRESIDENT & CEO

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June 30, 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 member hospitals and health care systems the Louisiana Hospital Association (LHA) 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 LHA strongly urges CMS to withdraw the negative 2.9 percent coding adjustment. We are very concerned that the -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 LHA is very concerned that CMS is again basing its proposals 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 being caused by the phase-in of the "75% Rule," which began in July 2004, yet the proposed rule is almost entirely based on data from 1999 through 2004. Today, the 75% 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% 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% 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% 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% Rule phase-in – appears to be entirely overlooked in this proposed rule.

The alarming scale of this impact exceeds by 7.5 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.

In addition to overlooking the impact of the 75% 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), 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. The IRFs undergoing these extreme 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.

The reality described above cannot be overlooked. 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. Therefore, we urge 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

It is inappropriate for CMS to proceed with rulemaking on IRF payment policy using old and irrelevant data, as it did for FY 2006 and again in its FY 2007 proposal. We encourage CMS to adjust its internal protocols to ensure that future rulemaking uses the most recent payment and claims data available. It is unclear why CMS allocates the resources to meet this standard for the inpatient PPS but fails to meet this reasonable and worthwhile goal 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, 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 CMS in association with annual rulemaking for the inpatient PPS. It is a critical step that enables hospitals to develop robust recommendations on how to improve the proposal. 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.

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. This opportunity has been inappropriately bypassed in this proposed rule and prior IRF PPS updates. **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. Given the need for more recent data to substantiate changes for FY 2007, we urge 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.**

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. 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. **Given the shaky analytical foundation and lack of further work showing the need, the proposed 2.9 percent cut should be withdrawn in the final 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 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 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 other questions: 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 of the CMGs in FY 2006? The comprehensive FY 2006 refinement should serve as a new baseline for this payment system. As such, CMS would need further data analysis using information after the refinement 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. It is unsubstantiated and excessive to recommend another across-the-board reduction for FY 2007. The LHA strongly urges CMS to withdraw the proposed 2.9 percent coding reduction.

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. 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% Rule was helpful in identifying what further analysis 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 proactively stepping forward to help fill the void in the medical literature on comparative analysis of medical rehabilitation costs and outcomes. 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 LHA is very supportive of the post-acute care demonstration authorized by the *Deficit Reduction Act of 2005*. The LHA 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 will 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 at psalles@lhaonline.org.

Sincerely,

Paul Salles
Vice President of Healthcare Reimbursement Policy

Submitter : Dr. Joseph Lang

Organization : ID Consultants

Category : Physician

Date: 07/03/2006

Issue Areas/Comments

Proposed FY 2007 Federal Prospective Payment Rates

Proposed FY 2007 Federal Prospective Payment Rates

Dear Sir, I would like to applaud the increase in payment rates for E and M codes for 2007. I believe these have historically been too low and this rate increase is appropriate and justly deserved.

CMS-1540-P2-2 **Prospective Payment System for Inpatient Rehabilitation Facilities for FY 2007**

Submitter : Mrs. Norelle Lundy **Date & Time:** 06/13/2006

Organization : DeTar Healthcare System

Category : Hospital

Issue Areas/Comments

Proposed FY 2007 Federal Prospective Payment Rates

Proposed FY 2007 Federal Prospective Payment Rates

This proposed negative coding adjustment would futher restrict patient access to medical rehabilitation services. The recent 75% Rule and CMS' Local Coverage Determinations presently demonstrates considerable limitations to the providers.