Submitter : Mr. Michael Hill

Date: 07/06/2006

Organization : New Hampshire Hospital Association

Category : Other Association

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. Michael Hill

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Organization : New Hampshire Hospital Association

Category : Other Association

Issue Areas/Comments

GENERAL

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"see attachment"

CMS-1540-P2-27-Attach-1.DOC

New Hampshire Hospital Association

July 6, 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:

On behalf of our 28 acute care hospitals and rehabilitation hospitals New Hampshire Hospital Association (NHHA) appreciates the opportunity to comment on the fiscal year (FY) 2007 proposed rule for the inpatient rehabilitation facility prospective payment system (IRF PPS).

We want to alert CMS to the disproportionately negative impact on New Hampshire facilities 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 New Hampshire facility's ability to serve Medicare beneficiaries, and believe that the implementation of the FY 2007 proposed rule will further decrease the wage index for the New Hampshire facilities. **We urge CMS to address this negative impact in 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

The significant impact of the transition to the CBSA-based wage index areas on New Hampshire facilities 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 #	Propose d 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.

We 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.

Proposed 2.9 Percent Coding Reduction

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 NHHA**

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.

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 in June 2006 on the impact of the 75% Rule, "Utilization Trends in Inpatient Rehabilitation: Update through QI 2006", 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 NHHA strongly urges CMS to withdraw the proposed 2.9 percent coding reduction.**

We thank CMS for the opportunity to comment on the proposed rule. Please address any comments or questions to me or Paula Minnehan, VP, finance and rural hospitals, at 603-225-0900 or pminnehan@nhha.org.

Sincerely,

Michael Hill, President

Submitter : Dr. Carl Granger

Date: 07/06/2006

Organization : Uniform Data System for Medical Rehabilitation

Category : Other

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1540-P2-28-Attach-1.DOC

The Functional Assessment Specialists

Uniform Data System for Medical Rehabilitation

Telephone
716.817.7800

Fax
716.568.0037

E-mail
info@udsmr.org

Web site
www.udsmr.org

Suite 300
270 Northpointe Parkway
Amherst, NY 14228

July 6, 2006

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

Re: 42 CFR Part 412; [CMS-1540-P] RIN 0938-AO16: Medicare Program: Inpatient Rehabilitation Facility Prospective Payment System for FY 2007

Dear Dr. McClellan:

We are writing now to comment on the May 15, 2006, publication of the Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2007: Proposed Rule.

The Uniform Data System for Medical Rehabilitation (UDSMR) has, for the past 19 years, provided rehabilitation facilities with education, training, outcome/QI reporting, and national benchmarks. Annually, more than 865 inpatient rehabilitation facilities (IRFs) voluntarily use our services to improve the efficiency, effectiveness, and quality of their care. As such, UDSMR is the world's largest government-independent repository of rehabilitation outcomes and IRF-PAI data. Because of our longstanding leadership position in the industry, we have been recognized as objective evaluators of the data that is used to measure the outcomes and quality of inpatient rehabilitation. Therefore, industry associations, research groups, and others regularly call upon us to provide unbiased, factual information about trends and outcomes information in the United States.

Given that UDSMR houses and continually analyzes this large inpatient rehabilitation database for random and special cause variation, and that UDSMR has the clinical expertise to evaluate the impact of external factors on IRF case characteristics and treatment outcomes, we are compelled to express our assessment of the potential impact this proposed rule may have on these IRFs and the patients they serve. We trust that our comments will be given serious consideration by the Centers for Medicare and Medicaid Services and will provide cause for reconsideration of the proposal to further reduce payment to IRFs by 2.9 percent in FY 2007. UDSMR believes the matter warrants a reexamination of the assumptions put forth to support the proposed reduction in payment, and we stand prepared to offer our analytical assistance and data to further explore the real root cause (or causes) of increased severity of patients treated in IRFs subsequent to the implementation of the PPS in 2002. Our comments are organized by section as identified in the proposed rule.

I. Background

In the "Background" section of the proposed rule, the FY 2006 final rule (70 FR 47880, 47904) is referenced in relation to implementation of "...a payment adjustment to account for changes to coding that did not reflect real changes in case mix." The adjustment was a 1.9 percent reduction in the standard payment amount and was based on data from 1999 (pre-PPS) and 2002 (first year under PPS). CMS's contractor calculated that the "real change" in IRFs' case mix ranged from -2.4 percent to 1.5 percent and attributed the remaining change in IRF payments (estimated at between 1.9 percent and 5.8 percent) to coding changes. We raise this issue at this point, not to challenge the measurable increase in IRF case mix index from 1999 to the implementation of PPS in 2002 and through 2005, but to question the rationale for determining the underlying causes of the coding changes and the agency's corrective actions taken based on this rationale.

We will address this issue in more detail in section III.

University at Buffalo
The State University of New York

II. Refinements to the Patient Classification System

We applaud the agency for eliminating the ICD-9-CM ***category codes*** from the IRF grouper. This decision will provide more clarity and accuracy in coding.

At the same time, we restate our objection to the implementation of the ***weighted motor index score*** portion of the CMG assignment in the FY 2006 final rule (70 FR 47880, 47904). The reasons for our continued objection are the same as in our comment letter to the final rule (dated July 11, 2005, as attached). In addition, the new CMGs are no longer groupings of like severity patients with like "needs for assistance" as measured by the FIM™ instrument, but rather categories based on an attempt to group patients around cost. This grouping around cost employs weightings that are not specific to the impairment groups. Thus, much of the accuracy and the effectiveness of the FIM™ instrument is lost or distorted from its original purpose as a meaningful measure of a patient's need for assistance from another person (burden of care). Also, we have watched providers and the industry struggle to monitor their clinical and fiscal performance, as well as the performance of the payment system over time, in the face of such drastic change to the classification system.

III. Proposed FY 2007 Federal Prospective Payment Rates

The proposed rule states that the agency believes that a large portion of the increase in Medicare payments under the IRF PPS can be attributed to changes in provider coding practices that do not reflect real changes in case mix. As such, the agency proposes applying a one-time adjustment consisting of a 2.9 percent reduction to the proposed standard payment amount for FY 2007. This proposed adjustment would be in addition to the 1.9 percent reduction implemented for FY 2006.

We understand CMS's responsibility for fiscal oversight of the IRF PPS, and we applaud its efforts to monitor and analyze IRF payment and utilization practices. We also agree that there have been measurable and real increases in severity of IRF cases from 1999 to 2002 as evidenced by the data from our database, which is presented in table 1.

Table 1: Admission Relative Weight 1999 and 2002 (FY 2002 Grouper).

	Admission Relative Weight FY 2002 Grouper		
	1999	2002	% Difference
Excluding Tiered CCs	1.01	1.05	3.87%
Including Tiered CCs	1.02	1.09	6.74%
% Difference	1.53%	4.33%	

CC = Complications and comorbid conditions

We disagree with the agency regarding its assessment of the extent to which the CMI increase is due to providers' coding changes rather than real patient severity. Additionally, we would like to draw your attention to the fact that a portion of the increase is due to a variety of confounding factors induced, in part, by CMS's rulings.

We believe that many contributing factors are having an impact on the rising case mix index, including:

1. **The years of data upon which the analysis was performed (1999 and 2002).** During 1999, collection of FIM™ data by the field was entirely voluntary, and we question the accuracy and diligence applied to the collection and recording of ICD-9-CM codes. These codes were not required at the time, having more to do with ancillary costs than clinical healthcare outcomes. With the implementation of the IRF PPS in 2002, facilities were given incentives to be both diligent and accurate in collecting these codes as complications and cormorbid conditions. Table 2 (next page) shows the distribution of cases by year and tier. This shift in tier distribution could be perceived as coding changes that do not reflect real case mix. Given the differences between the two years, we believe that some of the observed change reflects real, improved ascertainment and documentation of case conditions, not artificial upcoding.

Table 2: Variation in Tiered Comorbidity Distribution

	1999	2002
Tier	%	%
0 (no tier)	89.7	74.0
1 (highest tier)	0.2	1.9
2 (mid tier)	3.6	9.1
3 (lowest tier)	6.4	14.9

2. **CMS changes to the FIM™ rating system during the implementation of the IRF PPS (IRF-PAI).** The nature of those changes included the introduction of the use of "0" for items not rated (these items are re-coded to 1 for grouper purposes, and this code is not allowed for bowel and bladder), the introduction of function modifiers, and changes to assessment time frames and look-back periods, all of which have had the effect of depressing the post-PPS FIM™ ratings. It follows that any global reduction in FIM™ ratings translates into a CMG distribution shift in each rehabilitation impairment category (RIC) and a concomitant increase in case mix index. Table 3 shows the consistent reduction in average admission FIM™ rating for every RIC between years 1999, 2002, and 2005. It is our contention that most of the apparent reduction in FIM™ ratings and associated increase in case mix index between 1999 and 2002 are due to the changes listed above and should have been predicted in the original modeling efforts. We also suspect that much of the continued decrease in admission ratings between 2002 and 2005 is due to the enforcement of the 75% rule, combined with enhanced scrutiny of cases for medical necessity.

Table3: Decline in Average Total FIM™ Rating at Admission

		Admission Total FIM™ Rating by Year		
Rehabilitation Impairment Category (RIC)		1999	2002	2005
Total Medicare Cases	**N**	**218,745**	**345,245**	**313,013**
ALL RICs	**Avg.**	**73.0**	**69.2**	**64.6**
Stroke	Avg.	62.0	58.1	55.3
Traumatic Brain Dysfunction	Avg.	60.0	57.7	55.2
Non-Traumatic Brain Dysfunction	Avg.	62.4	59.4	57.4
Traumatic Spinal Cord Dysfunction	Avg.	64.6	60.8	57.9
Non-Traumatic Spinal Cord Dysfunction	Avg.	74.6	71.1	66.5
Neurological Conditions	Avg.	70.9	66.6	63.2
Lower Extremity Fracture	Avg.	72.4	65.6	61.8
Lower Extremity Joint Replacement	Avg.	82.8	78.9	74.8
Other Orthopedic Conditions	Avg.	76.3	70.0	65.9
Lower Extremity Amputation	Avg.	75.6	70.6	66.7
Other Amputation	Avg.	77.6	71.5	67.2
Osteoarthritis	Avg.	78.4	71.8	66.5
Rheumatoid and Other Arthritis	Avg.	76.2	71.1	65.9
Cardiac Conditions	Avg.	79.4	73.0	68.5
Pulmonary Disorders	Avg.	79.9	74.1	69.7
Pain Syndromes	Avg.	79.8	75.1	70.5
Major Multiple Trauma w/o TBI, SCI	Avg.	71.0	65.5	61.4
Major Multiple Trauma with TBI, SCI	Avg.	60.7	54.1	52.5
Guillain-Barré Syndrome	Avg.	72.3	65.6	62.9
Miscellaneous	Avg.	73.5	68.6	65.2
Burns	Avg.	67.1	63.7	61.8

3. **Impact of the enforcement of the 75% rule and the scrutiny of medical necessity having the effect of driving the lower-severity (low-CMI) cases out of the IRFs.** The data in 1999 and 2002 do not necessarily reflect current practice patterns, which have been greatly influenced by these two constraining factors. Table 4 shows the change in distribution of cases by RIC between 1999 and 2005. Although the change in RIC case mix from 1999 to 2002 is not sufficient to be a major factor causing increase in severity, the shift in distribution between 2002 and 2005 data is a clear indication of how extrinsic actions can influence case mix index by leading toward selection of lower-functioning (higher-severity) types of cases. Extrinsic forces leading to a reduction in proportion of lower relative weight cases (i.e., joint replacements, mild strokes, pain syndrome, cardiac conditions, and pulmonary disorders) has led to higher proportions of the more severe RICs (i.e., brain injury, non-traumatic spinal cord, neurologic conditions, and lower extremity fractures), and hence a higher CMI.

Table 4: Case Distribution by RIC and Year

		Discharge Year		
Rehabilitation Impairment Category (RIC)		1999	2002	2005
Total (n = Medicare cases)		218,745	345,245	313,013
Stroke	%	22.6	17.2	18.7
Traumatic Brain Dysfunction	%	1.3	1.3	2.0
Non-Traumatic Brain Dysfunction	%	2.3	2.0	3.1
Traumatic Spinal Cord Dysfunction	%	0.6	0.6	0.6
Non-Traumatic Spinal Cord Dysfunction	%	3.4	3.3	3.7
Neurological Conditions	%	4.3	4.2	6.2
Lower Extremity Fracture	%	11.6	11.8	14.9
Lower Extremity Joint Replacement	%	21.1	23.8	21.1
Other Orthopaedic Conditions	%	4.7	5.1	5.5
Lower Extremity Amputation	%	3.5	2.7	2.8
Other Amputation	%	0.4	0.3	0.2
Osteoarthritis	%	1.9	2.0	0.9
Rheumatoid and Other Arthritis	%	0.8	1.0	0.7
Cardiac Conditions	%	4.4	6.1	4.3
Pulmonary Disorders	%	2.3	2.5	1.6
Pain Syndromes	%	1.4	2.3	1.6
Major Multiple Trauma w/o TBI, SCI	%	0.9	1.1	1.1
Major Multiple Trauma with TBI, SCI	%	0.1	0.2	0.3
Guillain-Barré Syndrome	%	0.2	0.1	0.2
Miscellaneous	%	12.0	12.4	10.5
Burns	%	0.1	0.1	0.1

Given the above comments and questions about the true state of IRF patient severity, we recommend that CMS defer implementation of any reduction to the standard payment amount until further analysis on root causes can be accomplished. We find it hard to believe that our 865 subscribing provider facilities have consistently and/or collaboratively altered their coding patterns in reaction to the PPS. We also believe that many of the changes identified in the data are reflective of changes in the system and the types and severity of patients served, not artificial coding changes. We would welcome an opportunity to work with the agency to establish the real sources of CMI increase and to make a valid determination if they support a reduction in IRF payment.

IV. Other Issues

We request that CMS provide some clarification on the teaching status of a facility that converts from a long-term care hospital (LTCH) to an inpatient rehabilitation facility (IRF). If a current LTCH with teaching status decides to convert to an IRF, do they need to re-apply for the teaching status?

The proposed rule cites a demonstration on uniform assessment and data collection across different sites of service in post-acute care. UDSMR has more than 20 years of functional assessment experience and research in post-acute care. Additionally, we have hundreds of customers and data from all the post-acute care "silos" that could help the agency in defining such a demonstration. UDSMR also has an acute care discharge screening/planning tool that is based on the FIM™ instrument; this tool could be a valuable part of such an effort. We would very much like to participate in the demonstration project and look forward to further discussing this with the agency.

In closing, we are grateful for the opportunity to provide comments to the Secretary on the proposed rule. We welcome the opportunity to work with the government to provide unbiased research regarding the impact of federal regulation on IRFs. If there are any questions about these comments, or if further information is needed, please feel free to contact us at (716) 817-7800.

Sincerely,

Carl V. Granger

Carl V. Granger, M.D.
Executive Director, UDSMR

CC: The Honorable Michael O. Leavitt; Secretary
U.S. Department of Health and Human Services

Leslie V. Norwalk, Esq.; CMS Deputy Administrator

Submitter : **Dr. Bruce Stelmack** **Date: 07/07/2006**

Organization : **Carilion Health System**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

In patient rehab for severe medical debilitation of acute illness or injuries must be added to the "75% rule" as this is a growing need in my practice and many patients are relugated to nursing homes that could otherwise go home after rehab, but can not be admitted due to the 75% rule.

Also, the 50% requirement of Medicare patients on a Rehab Unit,to avoid Audit needs to be lowered for Level One Trauma Centers where we see a large number of young trauma patients, making our Medicare population low at times.

Thanks

Submitter : Ms. Carol Ormay **Date:** 07/07/2006

Organization : Kentucky Hospital Association

Category : Health Care Professional or Association

Issue Areas/Comments

Proposed Changes to the CMG Relative Weights

Proposed Changes to the CMG Relative Weights

CMS is proposing to reweight the IRF PPS CMGs 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. Kentucky s IRFs 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.

Submitter : **Ms. Carol Ormay** **Date: 07/07/2006**

Organization : **Kentucky Hospital Association**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Attachment

Other Issues

Other Issues

Other Issues - Research on Medical Rehabilitation

When trying to implement the 75% Rule CMS stumbled across a number of questions which remain unanswered. Because the long-term care industry and IRFs measure patient outcomes differently, there is no accurate method of comparing outcomes and determining actual costs. Kentucky s IRFs were pleased to see an emphasis on creating a more seamless system of post acute care in Section V of the proposed rule. We would urge CMS to do the following in order to move forward in creating this seamless system of post acute care:

1. Involve actual rehabilitation providers in the development and implementation of any research designed to measure the effectiveness of the post acute settings

2. CMS needs to provide funding and support for studies that rehabilitation providers are currently undertaking

3. Kentucky IRFs are especially concerned about the exclusion of cardio-pulmonary and cancer patients from the CMS 13 and are launching their own research studies. We would also volunteer our facilities for a CMS pilot study on the effectiveness of inpatient rehabilitation for these patients

4. Kentucky IRFs are willing to work with CMS to conduct a study of appropriate post acute care delivery

Proposed Changes to the CMG Relative Weights

Proposed Changes to the CMG Relative Weights

CMS is proposing to reweight the IRF PPS CMGs 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. Kentucky s IRFs 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 FY 2007 Federal Prospective Payment Rates

Proposed FY 2007 Federal Prospective Payment Rates

Proposed -2.9 Percent Coding Adjustment

While Kentucky IRFs appreciate the statutorily required market basket update of 3.4 percent, we are extremely concerned about the 2.9 percent across the board reduction to adjust for coding changes. Kentucky s IRFs feel that payment increases the Centers for Medicare and Medicaid Services are adjusting for are an effect of the implementation of the 75% Rule, not upcoding or more aggressive coding on the part of the hospitals to replace lost revenues. The implementation of the 75% Rule, even with its current freeze at 60 percent, has caused IRFs to shift their patient mix from hip and knee replacement patients with few or no comorbidities to higher paying, complex patients with multiple comorbidities. Implementing a -2.9 coding adjustment without taking into consideration the admission modifications hospitals have had to make to meet the 75% rule simply punishes hospitals for meeting CMS requirements.

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 case-mix groups (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 Kentucky Hospital Association and Kentucky s IRFs strongly urge CMS to withdraw the proposed 2.9 percent coding reduction.

Proposed Revisions to the Classification Criteria

Proposed Revisions to the Classification Criteria Percentage for IRFs

Deletion of DVT Codes

Kentucky s IRFs are questioning the rationale for deleting codes of 453.40, 453.41 and 453.42 (deep venous thrombosis), which were just added last year. When a person develops a deep venous thrombosis or is suspected to have developed one, the physician usually orders a venous Doppler ultrasound and puts the patient on bedrest until the results of the test are back. This limits the patient s ability to participate in therapy. If there is a thrombosis, then the appropriate medication must be started, lab tests run and the patient started back on a full therapy schedule when appropriate. This increases the length of stay for that patient as well as increased costs and use of resources. CMS comments in the Federal Register note that the DVT codes are being eliminate because they were inadvertently added. Deep venous thromboses are commonly seen in many IRFs and we would recommend that further study be undertaken before these codes are eliminated.

Submitter : Mr. Don Sipes **Date:** 07/07/2006

Organization : Saint Luke's Northland Hospital - Smithville

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1540-P2-32-Attach-1.DOC

Saint Luke's
Health System
saintlukeshealthsystem.org

July 6, 2006

Mark McClellan, M.D., Ph.D.
Administrator, Centers for Medicare & Medicaid Services
ATTN: CMS-1540-P
Room 445-G
Hubert 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 the inpatient rehabilitation unit at Saint Luke's Northland Hospital – Smithville Campus (SLN-Smithville) of Saint Luke's Health System in the Kansas City region, I write to you to comment on the proposed rule mentioned above. SLN-Smithville includes an inpatient rehabilitation unit within the hospital that has been adversely affected by the changes to inpatient rehabilitation facilities (IRFs) over the last few years, and will continue to be negatively impacted by the proposed rule.

We concur with the comment letter submitted by Rick Pollack of the American Hospital Association, and ask CMS to **withdraw the negative 2.9 percent coding adjustment**. It appears that the proposed negative adjustment, along with the other proposed changes in this rule, is based on old data that does not affect the current inpatient rehabilitation environment. Specifically, the phase in of the "75% Rule" began in July, 2004, yet the data used in the proposed rule is almost entirely from 1999 through 2004, prior to implementation of the 75% Rule, and does not reflect the realities faced by IRFs today.

The proposed rule also fails to recognize the IRF environment has worsened further in recent months because of local coverage determinations (LCDs). Specifically, the LCD being enforced by Mutual of Omaha, our fiscal intermediary, and the subsequent probe audits performed are contrary to the rules promulgated by CMS. An example of this is cases that are clearly within the 75% Rule qualifying conditions, yet Mutual of Omaha is denying payment.

Because of the current instability facing IRFs due to the 75% Rule, LCDs and the FY 2006 across-the-board cut, we believe it is inappropriate for CMS to create further volatility by implementing another 2.9 % cut in reimbursement. We strongly urge CMS to withdraw the negative 2.9% coding adjustment, update its analyses so they reflect the

current reality facing patients, physicians, and IRFs; and study the current medical rehabilitation environment.

Thank you for the opportunity to comment on the proposed rule, CMS-1540-P. Should you have any questions, please do not hesitate to contact me, or Jodi Faustlin, Government Affairs Manager for Saint Luke's Health System, at 816-932-8160, or rfaustlin@saint-lukes.org.

Sincerely,

Don Sipes
CEO, Saint Luke's Northland – Smithville
601 S. 169 Highway
Smithville, MO 64089
And
Vice President, Regional Services
Saint Luke's Health System

Submitter : **Mr. Dan Rode** **Date: 07/07/2006**

Organization : **American Health Information Managment Association**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1540-P2-33-Attach-1.DOC

AHIMA
American Health Information Management Association

July 5, 2006

Mark McClellan, MD, PhD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: **CMS-1540-P**
PO Box 8012
Baltimore, Maryland 21244-8012

Dear Dr. McClellan:

The purpose of this letter is to comment on the Centers for Medicare & Medicaid Services' (CMS') proposed changes to the Medicare Inpatient Rehabilitation Facility Prospective Payment Systems (IRF-PPS) and fiscal year 2007 Rates, as published in the May 15, 2006 *Federal Register* (CMS-1540-P).

AHIMA is a professional association representing more than 50,000 health information management (HIM) professionals who work throughout the healthcare industry and whose work is closely engaged with the diagnoses and procedure classification systems that serve to create the diagnoses related groups discussed in this proposed rule. As part of our effort to promote consistent coding practices, AHIMA is one of the Cooperating Parties, along with CMS, the Department of Health and Human Services' (HHS) National Center for Health Statistics (NCHS), and the American Hospital Association (AHA). The Cooperating Parties oversee correct coding rules associated with the *International Classification of Diseases Ninth Revision, Clinical Modification* (ICD-9-CM).

II: Refinements to the Patient Classification System

II-A – Proposed Changes to the Existing List of Tier Comorbidities (71FR28110)

AHIMA fully supports CMS' proposal to revise the tier comorbidity list in the IRF GROUPER for FY 2007 to ensure that the list appropriately reflects current ICD-9-CM national coding guidelines. We also support the proposal to remove the category codes from the tier comorbidities in the IRF GROUPER because it is not appropriate to report a three-digit category code when the code is subdivided at the fourth and fifth digit level. We appreciate CMS' commitment to ensuring the IRF GROUPER is updated to reflect annual ICD-9-CM code revisions according to the effective date of these changes and that coding

1730 M Street, NW, Suite 409, Washington, IL 20036
phone (202) 659-9440 · *fax* (202) 659-9422 · www.ahima.org

policies under the IRF-PPS are consistent with the *ICD-9-CM Official Guidelines for Coding and Reporting*. **We recommend that CMS work with the Medicare contractors to ensure that they, too, support compliance with the *ICD-9-CM Official Guidelines for Coding and Reporting*, as our members have reported instances of contractor-initiated policies or requirements that violate the national coding rules and guidelines.**

III: Proposed FY 2007 Federal Prospective Payment Rates

III-A – Proposed Reduction of the Standard Payment Amount to Account for Coding Changes (71FR28122)

CMS indicated that the rapid increases in IRF payments are likely attributable to coding increases that do not reflect real changes in case mix. A dramatic increase in the reporting of code 278.02 during the first quarter of 2006 was used as an example. We would like to point out that this code is a new code that only became effective October 1, 2005. **Therefore, code 278.02 could not have been reported between January 2002 and October 1, 2005.** The eight IRF-PAI forms on which this code was reported between January 2002 and October 2005 were undoubtedly all from October 2005. AHIMA does not agree with CMS' conclusion that the increased use of this code reflects changes in the payment structure. Rather, the increased use of this code in 2006 reflects the fact that it is a new code.

To achieve accurate and complete coded data and health information that supports this country's healthcare services, research, and other purposes for which coded data are used, healthcare providers, health plans and other organizations must uniformly subscribe to the same coding guidelines and practices, regardless of the level or site of healthcare service, or the method of reimbursement. Healthcare providers are expected to adhere to the *ICD-9-CM Official Guidelines for Coding and Reporting*, which provide direction for reporting diagnoses without regard to the reimbursement impact. Per AHIMA's Standards for Ethical Coding, coding professionals are expected to support the importance of accurate, complete, and consistent coding practices for the production of quality healthcare data. Further, diagnoses or procedures should not be inappropriately included or excluded [from external reporting] because payment or insurance policy coverage requirements will be affected. Since reimbursement policies can change, and reimbursement policies vary from payer to payer, it is essential for the quality and integrity of our healthcare data that coding practices be uniform and comply with the official coding rules and guidelines, regardless of the reimbursement impact.

V: Other Issues

AHIMA supports creation of a new Medicare reimbursement model characterized by more consistent payments for the same type of care across different sites of service and collection of uniform clinical assessment information to support quality and discharge planning functions. The current situation of disparate reimbursement systems for different types of post-acute care providers has contributed to the lack of uniformity in coding practices across healthcare settings and has resulted in a degradation of the quality and comparability of US healthcare data.

Many HIM professionals work for healthcare systems that encompass more than one type of post-acute care provider, and they struggle to deal with the complex and variable reimbursement systems and reporting requirements. As the US pursues the goal of a nationwide health information network (NHIN),

seamless care and the ability to collect and analyze comparable healthcare data across provider settings have become increasingly important. In addition to improving the quality of healthcare data used to develop and refine reimbursement systems, measure quality, set health policy, track public health, conduct research, and monitor resource utilization, consistent data reporting requirements across settings would facilitate the development of more effective fraud management programs.

AHIMA welcomes CMS' ongoing support for the use of health information technology (HIT) as a means to significantly improve the quality, safety, and efficiency of healthcare. The adoption of uniform standards for the electronic health records (EHR) will permit the submission of standard reporting of secondary data, such as quality monitoring data. Quality reporting should be a byproduct of a well designed EHR, and CMS must be clear that it is the EHR architecture that will convert the primary data of the EHR into the secondary data for reporting such as for quality monitoring data. It is inappropriate to suggest building monitoring measures into the EHR (primary data) itself – clinicians should not be forced to chart to these external measures that could change over time. National uniform standards for the EHR should be in place to ensure proper charting or documentation requirements will produce primary data that can be combined to produce the secondary data needed for quality monitoring, public health reporting, biosurveillance, reimbursement and so forth, as well as for development of internal point-of-care decision support.

Regarding the role of HIT in a value-based purchasing program, uniform data content standards will therefore be crucial to the development of such a program. A standard EHR will facilitate the process for automated data transmission, and EHR vendors will be more apt to incorporate measurement reporting capabilities into EHR products if measure specifications were standardized across all provider segments of the industry. This would streamline the hospital data submission procedures and provide the ability for providers to view real-time measurement results to initiate their own improvement interventions in a timelier manner. CMS must keep in mind and play a collaborative role in the development of a NHIN, data, standards, and uniform quality measures. In this era, it is inappropriate to have disparate systems for the collection of data meant to accomplish among other goals improved quality and uniform collection of data for value based purchasing. .

Conclusion

AHIMA agrees that uniform adoption of a standard EHR will significantly improve clinical care and has the potential to provide good secondary data for a variety of purposes including quality measurement and monitoring. AHIMA is an active developer and promoter of the standard EHR and AHIMA and its 50,000 HIM professionals want to see the standard EHR succeed. We look forward to the day when secondary data, whether it is being produced for quality measurement, public health reporting, or reimbursement accurately portrays the diagnoses, severity, and services or procedures provided.

AHIMA stands ready to work with CMS and the healthcare industry to promote consistent coding practices by both providers and payers in order to improve the quality and comparability of healthcare data so that it can reliably support quality measurement, reimbursement, research, and other purposes.

AHIMA appreciates the opportunity to comment on the proposed modifications to the Medicare Inpatient Rehabilitation Facility PPS for fiscal year 2007. If AHIMA can provide any further information, or if there are any questions or concerns in regard to this letter and its recommendations, please contact Sue

Bowman, RHIA, CCS, AHIMA's director of coding policy and compliance at (312) 233-1115 or sue.bowman@ahima.org, or myself at (202) 659-9440 or dan.rode@ahima.org.

Sincerely,

Dan Rode, MBA, FHFMA
Vice President, Policy and Government Relations

cc: Sue Bowman, RHIA, CCS

Submitter : Mr. David McClure **Date:** 07/07/2006

Organization : Tennessee Hospital Association

Category : Other Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1540-P2-34-Attach-1.DOC

July 7, 2006

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 CMS-1540-P.

Dear Sirs:

The Tennessee Hospital Association (THA), on behalf of our over 200 healthcare facilities, including hospitals, home care agencies, nursing homes, and health-related agencies and businesses, and over 2,000 employees of member healthcare institutions, such as administrators, board members, nurses and many other health professionals, appreciates the opportunity to submit comments 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 THA strongly urges CMS to withdraw the negative 2.9 percent coding adjustment. CMS proposes this coding adjustment without providing statistically valid analysis of the 1.9 percent coding adjustment imposed with the FY2006 rule. 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 THA 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 Riverbend, Mutual of Omaha and Tri-Span fiscal intermediaries (FIs).

The 75% Rule by itself may not have led to IRF closures. However, its impact in combination with the LCD enforcement has already produced severe financial burdens

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 re-weight 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 re-weighting 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 THA 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 THA is supportive of the post-acute care demonstration authorized by the *Deficit Reduction Act of 2005*. 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 David McClure, THA vice president of finance, at 800-258-9541 or dmcclure@tha.com.

Sincerely,

Craig Becker, FACHE
President

cc: Rick Pollack, AHA, Executive Vice President

Submitter : **Mr. Edward Coyle** **Date: 07/07/2006**

Organization : **Mercy Health System**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1540-P2-35-Attach-1.DOC

Mercy
Health System

July 7, 2006

The Honorable Mark B. McClellan, MD
Administrator
Center for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1540-P; P.O. Box 8012
Baltimore, MD 21244-8012

RE: CMS-1540-P – Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2007; Proposed Rule (71 Federal Register 28106)

Dear Administrator McClellan:

Thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule for changes to the inpatient rehabilitation facility prospective payment system, published May 15, 2006 in the Federal Register. I am the Director of Revenue and Reimbursement for Mercy Health System.

Section III.A. Proposed FY 2007 Federal Prospective Payment Rates:
CMS has proposed to apply a one-time adjustment of (2.9%) reduction as a behavioral offset to the proposed standard payment amount for FY 2007, after applying the market basket increase of 3.4%, for a net increase of 0.5%. In support of this reduction CMS cites pre- and post- PPS comparisons of 2002 patient data vs. 1999 data of resource needs and an increase in joint replacements, as well as a shift from 2002 to 2005 to higher paying comorbidities. CMS should delay this 2.9% behavioral offset until they gather and analyze more recent data from claims after the 75% rule enforcement moratorium was lifted, cost reporting periods beginning on or after July 1, 2004. CMS is basing its conclusion that a further 2.9% behavioral offset is required on old data that is inapplicable to current IRF practices. Since 2004 every Rehab unit has had to re-evaluate its admission criteria to ensure compliance the 50% transitional threshold of the 75% rule, under the CMS *"clarified"* List of Medical Conditions, which no longer allows simple joint replacements to qualify. What CMS points to as evidence of coding changes in 2002 - 2005 data shift in comorbidity tiers could alternately be interpreted as evidence of the shift in admission practices to ensure compliance with the 75% rule by Rehab hospitals. This change in admission criteria/practices to the higher acuity cases would also be a result of CMS clarifying that simple hip replacements do not qualify for the 75% rule. Also, the change in admission practices to higher acuity cases will most likely decrease some of the high margins CMS is pointing out where the Medicare payments far exceeds the Rehab costs. I strongly suggest that CMS should delay this (2.9%) behavioral offset until they gather and analyze more recent data from claims after the 75% rule enforcement moratorium was lifted.

Mercy
Health System

Should CMS choose to ignore the multitude of comments I am sure they will receive asking for a delay in the above referenced 2.9% behavioral offset, I would like to comment on the basis for the 2.9% reduction. The 2.9% one-time adjustment is based on patient data from a period prior to the end of the 75% rule enforcement moratorium, and therefore is an arbitrary percentage, with no relationship to the current practices it seeks to influence. If CMS insists on pursuing a one-time adjustment in the FY 2007 final rule, it should be based solely on data from cost reporting periods beginning on or after July 1, 2004, the first period of 75% rule enforcement. That data will surely show a decrease in joint replacements, as opposed to the 22% increase in joint replacements CMS cites in the RAND study from 1999 to 2002 (pre- and post- PPS). This would be the result of CMS' clarification in the final rule of May 7, 2004 that:

"Knee or hip joint replacement, or both, during an acute hospitalization immediately preceding the inpatient rehabilitation stay and also meets one or more of the following specific criteria: a. The patient underwent bilateral knee or bilateral hip joint replacement surgery during the acute hospital admission immediately preceding the IRF admission. b. The patient is extremely obese with a Body Mass Index of at least 50 at the time of admission to the IRF. c. The patient is age 85 or older at the time of admission to the IRF."

CMS should take the time to evaluate the data they are relying on in the context of recent industry changes before proceeding with this 2.9% decrease.

Section V. Other Issues:

The DRA §5008 provides for a demonstration on uniform assessment and data collection across different sites of service. CMS states in the proposed rule that they are in the early stages of developing a standard, comprehensive, assessment instrument to be completed at hospital discharge, to be integrated with post-acute care (PAC) assessments. One of the stated uses would be to "facilitate post-hospital placement decision making". I read this as an attempt to take patient care decision making out of the hands of the patient's physician. Although there are not a lot of details yet on how this instrument will develop, CMS should take great care not to pigeon-hole patients into forms and charts, and leave the ultimate care decisions up to the physician in consultation with the patient.

Another objective of this model is to have "more consistent payment for the same type of care across different sites of service." CMS should bear in mind that physicians choose different sites of service for their patients based on multiple factors of patient need and level of care available at each site. These different sites of service have different staffing level requirements, and fixed and overhead cost structures. To ensure that physicians/patients continue to have these options available, the Medicare payment formula needs to weigh site of service into the payment rate analysis.

Another concern with CMS's objective to have "more consistent payment" is whether or not they would be exceeding their Congressional authority. Chapter 3 of The BBA of 1997 required the Secretary to establish the Rehab PPS system in a budget neutral manner, where payments from 2001 through 2004 would equal 98% of the amount that would have been paid had PPS not been

Mercy
Health System

enacted. To eliminate the "provider-oriented 'silos' to create a more seamless system for payment" might violate the Congressional intent that these IRFs, LTCHs, SNFs, and HHAs PPS systems have a basis related to the approximate payment levels when they were cost reimbursed.

Thank you for your review and consideration of these comments. If you have any questions, please feel free to call me at (610) 567-5563.

Very Truly Yours,

Edward J. Coyle
Director, Revenue & Reimbursement

Submitter : **Date: 07/07/2006**

Organization :

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1540-P2-36-Attach-1.PDF

CATHOLIC HEALTH EAST

CORPORATE OFFICE

14 Campus Boulevard, Suite 300
Newtown Square, PA 19073-3277
www.che.org
(610) 355-2000 (610) 355-2050 fax

July 7, 2006

The Honorable Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS –1540 – P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: CMS-1540-P – Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for FY 2007; Proposed Rule *(71 Federal Register 28106).*

Dear Administrator McClellan:

On behalf of Catholic Health East, I would like to thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) proposed rule, published May 15, 2006 in the *Federal Register*. I am the Vice President of Advocacy and Government Relations for Catholic Health East.

Catholic Health East (CHE) is a multi-institutional, Catholic health system with facilities in 11 eastern states from Maine to Florida. CHE is comprised of 33 acute care hospitals, 4 long term acute care hospitals, 41 free-standing and hospital-based long term care facilities, 13 assisted living facilities, five continuing care retirement communities, eight behavioral health facilities and rehabilitation facilities, 32 home health/hospice agencies, and numerous ambulatory and community-based health services.

Proposed FY 2007 Federal Prospective Payment Rates

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

In this proposed rule, CMS is announcing its plan to reduce the standard payment amount for inpatient rehabilitation facilities (IRFs) by 2.9 percent to address the increase in Medicare payments under the IRF PPS, which CMS believes is attributed to changes in provider coding practices that do not reflect real changes in case mix. This reduction

would be in addition to the 1.9 percent reduction in the standard payment amount CMS implemented for FY 2006, resulting in a combined reduction of 4.8 percent. CMS offers the following justifications for reducing the standard payment amount by 2.9 percent:

- A review of IRF patients' acute care hospital records "found little evidence that the patients admitted to IRFs in 2002 had higher resource needs than the patients admitted in 1999."
- A 16 percent decrease in stroke cases and a corresponding 22 percent increase in joint replacement cases from 1999 to 2002 resulted in lower overall patient acuity.
- Medicare margin data indicates that IRF costs from 2001 through 2004 were substantially below Medicare payments.
- IRF patient assessment data from 2002 through 2005 indicates a shift from the lowest to the higher-paying comorbidity tiers.

In the proposed rule, CMS is using data from 1999 to 2004 to examine differences over time in patient resource needs, case mix and IRF Medicare margins. CMS then draws generalized conclusions from this data about current coding practices of inpatient rehabilitation providers. CHE is apprehensive that the differences CMS may see in data from 1999 to 2004 have no bearing on the current behavior of IRFs because of significant policy changes that have occurred between 1999 and 2004 and changes that have been implemented since 2004, specifically the phase-in of the "75 percent rule.[1]" In 2002, CMS suspended enforcement of the 75 percent rule because it was concerned that the rule was not uniformly implemented across the nation.[2] CMS did not reinstate enforcement of the 75 percent rule until 2004, at which time it also modified the rule by expanding the qualifying medical condition to 13 and by slowly phasing-in the qualifying threshold over several years. In short, CMS is concluding that the coding practices it sees in data from a time when there was either no enforcement or disparate enforcement of the 75 percent rule is indicative of current coding practices under the phase-in of the 75 percent rule such that it can justify reducing payments to IRFs by 2.9 percent.

Given that the 75 percent rule is designed to ensure that IRFs are only treating those patients that require intensive rehabilitation services that cannot be provided in less costly facilities, it is possible that the 75 percent rule is correcting for the coding practices that CMS sees in the data from 1999 to 2004 and there is no need for further reductions to the standard payment amount. In fact, CMS has noted "Medicare admissions for musculoskeletal conditions (e.g. single joint replacements) and medical conditions (e.g., pain, pulmonary, miscellaneous, etc.) increased rapidly prior to and during the period of IRF PPS implementation and suspension of the 75 percent rule. Once monitoring procedures were reinstituted using the updated 75 percent rule, Medicare admissions for these conditions have appropriately decreased. Admissions for nervous system and brain

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[1] When CMS instituted the Acute Inpatient Prospective Payment System (IPPS) in 1983, it created the "75 percent rule" to define which health care facilities would be excluded from payment under the IPPS as inpatient rehabilitation facilities. At that time, the 75 percent rule required that 75 percent of an IRF's patient population be diagnosed with one or more of 10 specified medical conditions, thus ensuring that IRFs were primarily involved in providing intensive rehabilitation services to patients that could not be served in other, less intensive rehabilitation settings.

[2] Tom Hoyer, Director, Chronic Policy Group, CMS Open Hospital Forum (May 8, 2002).

conditions, which are generally assumed to require intensive rehabilitation, decreased prior to and during this same period. Admission for these complex conditions are now appropriately increasing."[3] By CMS' own account, recent data shows the reintroduction and enforcement of the 75 percent rule provided the policy change that would require IRFs to treat patients with high acuity who have high resource needs.

According to our internal information, IRF patient admissions are mirroring the same trend in admissions that CMS indicates it is seeing in recent data, that is significant decreases in admissions for joint replacements and increases in admissions for strokes. Our own experience is also suggesting that the phase-in of the 75 percent rule is having the desired impact on patient case mix, and this is while the threshold has been at 60 percent. Further reductions are expected as the phase-in continues and the threshold moves to 65 percent and then finally to 75 percent. In addition, currently IRFs can count patients who are not diagnosed with one of the 13 conditions but who have a comorbidity that falls within one of those 13 conditions toward the compliance threshold. However, once the threshold has reached 75 percent, IRFs may no longer count those patients toward meeting the compliance threshold, thus adding toward the anticipated further increase in patient case-mix.

This proposed 2.9 percent standard payment reduction eliminates almost the entire 3.4 percent market basket increase that CMS is proposing to give IRFs for FY 2007. Without proper market basket increases, IRFs payment will not be increasing with the cost of inflation. Inadequate inflationary increases in IRF payments combined with the phase in of the 75 percent rule, which requires that IRFs treat higher cost patients, will make it difficult for IRFs to cover the cost of providing care. Unless IRFs can cover the cost of care, access to intensive rehabilitation care could be compromised.

CHE strongly urges CMS to withdraw the 2.9 percent standard payment reduction. If the 75 percent rule is providing the necessary policy changes to improve the coding practices of practitioners, then there is no need for any further reductions to the standard payment amount and implementing any could be detrimental to inpatient rehabilitation facilities.

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 goups and associated IRF patient-assessment instrument data, as they do with annual rulemaking for the inpatient PPS.

Appropriate Adjustment to Account for Coding Changes
Although CMS stated that the 4.8 percent total reduction to the standard amount (proposed 2.9 percent for FY 2007 layered on top of the 1.9 percent reduction from FY 2006) still falls within the range that RAND had calculated to be attributable to provider coding practices, they did not indicate how they arrived at the 2.9 percent reduction for FY 2007. In the proposed rule, CMS specifically requests comments on the

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[3] *Inpatient Rehabilitation Facility Prospective Payment System and the 75 Percent Rule, at* http://www.cms.hhs.gov/InpatientRehabFacPPS/Downloads/OLSumIRFPPS_75pcrule.pdf.

appropriateness of a 2.9 percent and whether there was a more appropriate percentage by which to reduce the standard payment amount. It is difficult to provide comments on this as we would need to know the impact of the phase in of the 75 percent rule on provider coding practices and Medicare reimbursements. Without that information, any suggestions as to what percentage to decrease the standard payment amount would be arbitrary at best.

Therefore, as stated previously, CHE strongly urges CMS to withdraw the 2.9 percent reduction to the standard payment amount. If the 75 percent rule is providing the necessary policy changes to improve the coding practices of practitioners, then there is no need for any further reductions to the standard payment amount and implementing any could be detrimental to inpatient rehabilitation facilities. In the event that CMS goes forward with a reduction to the standard payment amount, CHE requests CMS provide a basis for the reduction amount they have chosen.

Proposed Changes to the CMG Relative Weights

CMS is proposing to reweight the IRF PPS case-mix groups (CMGs) 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. CHE supports AHA's position to **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.**

High-Cost Outliers Under the IRF PPS

CMS is proposing to adjust the outlier threshold amount from $5,129 for FY 2006 to $5,609 for FY 2007. CMS explains that they are adjusting the outlier threshold to set estimated outlier payments equal to 3 percent of total estimated aggregate IRF payment for FY 2007, and in their calculations for updating the outlier threshold, they have included the effect the proposed 2.9 percent reduction to the standard amount will have on the number of cases that would qualify as outliers. While CMS did consider the proposed 2.9 percent reduction to the standard payment amount, it is not clear whether they also considered the impact the phase in of the 75 percent rule could have on the number of high cost outliers. Additionally, in the IRF PPS FY 2006 Final Rule, CMS stated that its data has shown that cost to charge ratios have been falling since the implementation of the IRF PPS. In the current proposed rule, it is unclear whether CMS is continuing to see that decrease in cost to charge ratios, which if they are would also impact the number of outlier cases. Finally, CMS did not include in the proposed rule its most recent data on whether outlier payments did indeed account for 3 percent of aggregate payments under the IRF PPS, which is helpful to estimate whether the proposed outlier threshold is appropriate to meet the 3 percent of estimated aggregate

payments. **CHE urges CMS to consider all possible factors that could impact the number of high cost outliers to ensure that estimated outlier payments equal 3 percent of total estimated aggregate IRF payments.**

Thank you for your review and consideration of these comments.

Sincerely,

Ken Becker
V.P. Advocacy & Government Relations

Submitter : Ms. Catherine Devaney **Date:** 07/07/2006

Organization : Healthsouth Rehabilitation Hospital of Concord, NH

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1540-P2-37-Attach-1.DOC

HealthSouth Rehabilitation Hospital
of Concord, New Hampshire
254 Pleasant Street
Concord, NH 03301

VIA ELECTRONIC MAIL

July 7, 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 this rule will have on HealthSouth Rehabilitation Hospital of Concord, New Hampshire 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

HealthSouth Rehabilitation Hospital of Concord, New Hampshire is a 50-bed free standing rehabilitation hospital. We have been in operation for 13 years. We offer comprehensive inpatient acute rehabilitation services in a state with no LTAC providers. Patients referred to us are increasingly complex and require intensive medical services in addition to rehabilitation nursing; physical, occupational and speech therapy; respiratory therapy; case management services, etc. Given the shortage of nursing and therapy staffing our wages have increased with other New England providers over the past three years.

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 respectfully request that CMS extend the blended rate for one additional year for IRFs that would otherwise endure an eight percent or greater wage index reduction in the final rule. 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,

Catherine Devaney
Administrator

July 7, 2006

Mark B. McClellan, M.D., Ph.D.
Administrator
The Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention CMS-1540-P
P.O. Box 8011
Baltimore, MD 21244-1850

RE: [CMS-1540-P], Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2007.

Dear Administrator McClellan:

Owensboro Medical Health System (OMHS) of Owensboro, Kentucky appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule which establishes new policies and payment rates for inpatient rehabilitation services for fiscal year (FY) 2007.

Proposed FY 2007 Federal Prospective Payment Rates

CMS proposes to apply a one-time adjustment consisting of a 2.9% reduction to the proposed standard payment amount for FY 2007, which would be in addition to the 1.9% adjustment implemented for FY 2006. Also, CMS estimates the increase in payments during 1999-2002 to be between 1.9% and 5.8% due to changes in coding practices not associated with increased patient acuity. The following analyses were referred to by CMS to support the proposed rule:

- After reviewing acute care hospital records of IRF patients', CMS "found little evidence that the patients admitted to IRFs in 2002 had higher resource needs (that is, more impairments, lower functioning, or more comorbidities) than those admitted in 1999."
- Overall lower patient acuity was the result of a simultaneous 16% decrease in stroke cases and 22% increase in joint replacement cases from 1999 through 2002.
- Medicare payments were significantly higher than Medicare margin data of IRF costs from 2001 through 2004.

OMHS is concerned about this provision of the proposed rule given the impact of the 75% Rule phase-in and the scenarios in which IRFs faced lower costs and a decreasing case mix index no longer exist to support the proposed adjustment. This provision uses dated information that is no longer applicable to the patient base that IRFs are currently seeing. We also question further refinement of a system that had CMGs re-weighted in FY 2006. It is not clear to us why analysis of old data is the most appropriate way to adjust a system that was just adjusted a year ago. We ask that CMS withdraw the negative 2.9% coding adjustment.

Please feel free to contact me at (270) 688-2855 or Rranallo@omhs.org if you have any questions or if you need additional information.

Sincerely,

Russ Ranallo
Vice President of Financial Services

Submitter : Mr. Russ Ranallo **Date:** 07/07/2006

Organization : Owensboro Medical Health System

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1540-P2-38-Attach-1.DOC

July 7, 2006

Mark B. McClellan, M.D., Ph.D.
Administrator
The Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention CMS-1540-P
P.O. Box 8011
Baltimore, MD 21244-1850

RE: [CMS-1540-P], Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2007.

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OMHS is concerned about this provision of the proposed rule given the impact of the 75% Rule phase-in and the scenarios in which IRFs faced lower costs and a decreasing case mix index no longer exist to support the proposed adjustment. This provision uses dated information that is no longer applicable to the patient base that IRFs are currently seeing. We also question further refinement of a system that had CMGs re-weighted in FY 2006. It is not clear to us why analysis of old data is the most appropriate way to adjust a system that was just adjusted a year ago. We ask that CMS withdraw the negative 2.9% coding adjustment.

Please feel free to contact me at (270) 688-2855 or Rranallo@omhs.org if you have any questions or if you need additional information.

Sincerely,

Russ Ranallo
Vice President of Financial Services

Submitter : Mr. Robert Reske

Date: 07/07/2006

Organization : The University of Michigan Health System

Category : Hospital

Issue Areas/Comments

Proposed FY 2007 Federal Prospective Payment Rates

Proposed FY 2007 Federal Prospective Payment Rates

See Attachment

CMS-1540-P2-39-Attach-1.DOC

University of Michigan
Hospitals and
Health Centers

Accounting and Reimbursement Services
2500 Green Rd. Suite 100
Ann Arbor, Michigan 48105-1500
734-647-3321

Mark McClellan, M.D., PhD, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention CMS-1540-P
P.O. Box 8012
Baltimore, MD 21244-8012

July 7, 2006

RE: Medicare Program; Inpatient Rehabilitation Facility
Prospective Payment System for Federal Fiscal Year 2007
FY 2007 Proposed Rule
Federal Register Dated May 15, 2006

Dear Dr. McClellan:

The University of Michigan Health System (UMHS) appreciates the opportunity to comment on the proposed rule for inpatient rehabilitation facility PPS (IRF PPS).

Proposed FY 2007 Federal Prospective Payment Rates

CMS states in the proposed rule that based on its analysis "a large portion of the increase in Medicare payments under the IRF PPS can be attributed to changes in provider coding practices that do not reflect real changes in case mix". CMS goes on to propose to apply a one-time adjustment consisting of a 2.9% reduction to the FY 2007 standard payment amount. UMHS notes that the CMS' conclusion is based on historical data that has been the basis for the FY 2006 1.9% across-the-board payment reduction. As a result of using the historical data for both the 1.9% reduction implemented in FY 2006 and the proposed 2.9% coding adjustment for FY 2007, the combined reduction is redundant.

UMHS notes that the CMS analysis for the 2.9% IRF PPS rate reduction is based on 2004 claims data. Yet for developing the FY 2007 Inpatient Prospective Payment System rates 2005 claims data was utilized.

In addition, the CMS analysis does not reference the current increase in provider case mix, length of stay and cost per case resulting from an increase in the treatment of stroke cases noted by the Medicare Payment Advisory Commission's analysis in March 2006. Therefore the UMHS believes that there are offsetting factors to the proposed 2.9% payment reduction that CMS has not considered. CMS should not implement an adjustment for coding improvements that inappropriately reduces payments without

completing an analysis that differentiates between changes in coding practice and current changes in patient characteristics.

UMHS recommends that CMS perform additional analysis, prior to issuing the final rule, to verify that the FY 2007 2.9% coding related payment reduction does not duplicate the FY 2006 1.9% reduction that has already been implemented.

Other Issues

Section 5008 of the Deficit Reduction Act of 2005 provides for a demonstration project to be conducted to develop a common post-acute care assessment instrument for use in all post-acute settings. The demonstration project will be conducted over a three year period beginning January 1, 2008 and is expected to result in more consistent payments for the same type of care across different sites of service. The post-acute care assessment instrument is intended to collect clinical information in a uniform manner to support quality care and discharge planning functions.

UMHS is supportive of the post-acute care demonstration project and its objective to create a more seamless system for delivery of post–acute care. CMS noted in its FY 2006 proposed rule, rehabilitation facilities with larger teaching programs generally treat more costly patient populations than the patients treated by home health agencies, skilled nursing facilities and long- term care hospitals.

UMHS recommends that CMS include an adequate representation of rehabilitation facilities that have graduate medical education programs in order to develop an assessment instrument that identifies the medical needs of these more costly patients. In addition, as noted above, the post-acute care demonstration project conclusions should be based on current claims data.

Thank you for the opportunity to respond to the Proposed Rule. If you have any questions about these comments or desire additional information, please call me at (734) 647-2579.

Cordially,

Robert Reske, Manager
Accounting and Reimbursement Services
University of Michigan Health System

Submitter : Ms. Cecelia Wu

Date: 07/07/2006

Organization : Partners Healthcare System

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1540-P2-40-Attach-1.DOC

Mark B. McClellan, MD, PhD, Administrator, CMS
Comments to FY 07 Proposed Inpatient Rehabilitation Facilities Rule, July 7, 2006

Electronically

July 7, 2006

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 443-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Attention: CMS-1540-P

Dear Dr. McClellan:

Partners HealthCare System, Inc. is pleased to comment on the Proposed Rule for the Medicare Program: Changes to the Inpatient Rehabilitation Facilities Prospective Payment Systems and Fiscal Year 2007 Rates, as published in the May 15, 2006 Federal Register, on behalf of its member inpatient rehabilitation facilities:

Institution	Provider Number
Rehabilitation Hospital of the Cape and Islands	223032
Spaulding Rehabilitation Hospital	222035[1]

Proposed FY 2007 Federal Prospective Payment Rates

For the second consecutive rate year CMS is proposing a one-time adjustment to the standard payment amount to account for coding charges observed during the first years of the implementation of IRF PPS. The proposed adjustment is a reduction of 2.9% -- a number based on the same RAND study that generated the basis for last rate year's one-time adjustment.

In the proposed FY2006 IRF payment rule CMS writes:

> "for FY2006, we are proposing to reduce the standard payment amount by the lowest amount (1.9%) attributable to coding changes. We believe this approach, which is supported by RAND's analysis of the data, would adequately adjust for

[1] As of October 2006, Spaulding Rehabilitation Hospital will become an IRF provider. IRF provider number is currently pending. (Provider number 222035 is the current LTCH provider number.)

> the increased payments to IRFs caused by purely coding changes, but would still provide the flexibility to account for the possibility that some of the observed changes in case mix may be attributed to other than coding changes. Furthermore, we chose the amount of the proposed reduction in the standard payment amount in order to recognize that IRFs' current cost structures may be changing as they strive to comply with other recent Medicare policy changes, such as the criteria for IRF classification commonly known as the "75 percent rule."

Partners agrees with CMS that the one-time adjustment of –1.9% due to coding changes, implemented in the FY2006 final rule, was adequate to address the changes in coding practice in the first 3 years of IRF-PPS implementation. Thereby, we caution that the proposed one-time adjustment based on the same data as the prior year's adjustment, a total of –4.8% reduction due to coding, may be a gross overstatement of casemix changes due to coding. ***If CMS believes it necessary to implement, yet, another one-time adjustment due to coding changes, we believe the adjustment should address the PPS years after the first 3 years, and a new study based on data of the appropriate period is required to discern the correct adjustment amount.***

We agree that CMS' payment policy must consider the stability of the IRF providers amidst other Medicare policy changes, such as the "75 percent rule" and the CMG refinement. (American Medical Rehabilitation Providers Association states, in their comment letter to FY07 IRF-PPS proposed rule, that the impact of FY2006 CMG refinement was –2.7% and was not implemented in a budget neutral manner.) We commend CMS for taking these drastic changes into consideration in the last rule making, and we hope CMS will consider these factors again in preparation for the FY2007 final rule.

For the reasons described above, we strongly urge CMS to withdraw the 2.9% reduction due to coding changes.

On behalf of the current and future inpatient rehabilitation providers of Partners HealthCare System, I thank you for the opportunity to comment on this proposed rule. Please feel free to contact Cecelia Wu by phone (617-726-5449) or email (**cwu4@partners.org**) should you or your staff have any questions or would like more information.

Sincerely,

Anthony Santangelo
Corporate Manager of Government Revenue
Partners Healthcare System