Submitter : Mrs. Mary Whitbread

Date: 07/07/2006

Organization : Henry Ford Health System

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1540-P2-41-Attach-1.DOC

Mary Whitbread, Corporate Reimbursement
One Ford Place, 5F
Detroit, MI 48202
Office (313) 874-9533
Fax (313) 876-9220

SUBMITTED ELECTRONICALLY

July 7, 2006

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

Re: CMS-1540-P – Medicare Program; Proposed Changes to the Inpatient Rehabilitation Facility Prospective Payment System for FY 2007; May 15, 2006 *Federal Register*

Dear Dr. McClellan:

On behalf Henry Ford Health System (HFHS), we appreciate the opportunity to provide comments on the proposed rule for the FY 2007 Inpatient Rehabilitation Facility Prospective Payment System published in the May 15, 2006 *Federal Register.* HFHS owns and operates an Inpatient Rehab Unit at Henry Ford Wyandotte Hospital and Henry Ford BiCounty Hospital.

Proposed Reduction for Coding Changes
CMS proposes to reduce the standard payment conversion factor by 2.9%. To support the proposal CMS cites MedPAC's analysis regarding margins, a shift in the use of higher paying tiers since the inception of the IRF PPS and alleged facility coding practices based on a code that didn't exist prior to October 2005. HFHS does not support the proposed 2.9% reduction to the standard payment conversion factor and recommends for reasons stated below that it add back the reduction in the case mix weights that occurred in moving to the FY 2006 CMGs. We strongly disagree with CMS's conclusions for the following reasons.

1. Medicare Payment Advisory Commission (MedPAC) Reports
MedPAC expects IRF's cost per case to rise in 2007 as facilities have fewer patients across which to spread their costs. The result is that payments will be much closer to costs as facilities' costs increase. While facilities are expected to work diligently to reduce costs, MedPAC observes they may not be able to completely adjust their direct patient care costs to reflect the reduced volume.
MedPAC staff was quite clear on these points during presentation and discussion before the Commission in December. In the transcript on page 139, the staff assumed that discharges will fall by 29 percent and "75 percent of overhead costs and 10 percent of

data. HFHS understands also that for the IRF PPS, CMS used the most recently audited cost reports. For the IPPS it uses the most current cost report be it as submitted, final settled or reopened. Therefore, the cost reports for the IPPS are more current than those used for the IRF PPS. HFHS recommends that CMS use the same more current cost reporting data to determine the IRF PPS wage index as is used in the IPPS.

3. HFHS also notes that acute hospitals under the IPPS have two other adjustments to their wage index available to them. First, they can avail themselves of the rural wage index in the state if the hospital's wage index will be lower than the rural wage index. This change was enacted in Section 4410 of the Balanced Budget Act of 1997 (P.L. 105-33). Second, IPPS hospitals can apply, pursuant to Section 6003(h) of the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239), to change their designations from rural to urban, rural to rural or urban to urban if they meet certain criteria and make an application to the Medicare Geographic Classification Review Board.

HFHS believes these alternatives should be available to IRFs as well. IRFs compete for personnel, and frequently personnel such as nurses and therapists work in the same area as acute hospitals. HFHS recommends that CMS meet with the IRF field to discuss such changes, while acknowledging that such policy changes may require legislative action.

75% Rule Regulations p. 28135

In the proposed rule, CMS states that it is conforming the 75% Rule regulation, 42 CFR 412.23(b)(2), to the changes made in Section 5005 of the Deficit Reduction Act of 2005 (P.L. 109-171).

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. **CMS needs to recognize the significance changes the 75% rule phase-in is having on IRFs.**

Proposed Changes to the CMS Relative Weights, p. 28114

HFHS evaluated the proposed changes to CMG weights and changes in the lengths of stay. HFHS supports the proposed changes to the weights.

However, HFHS reiterates its concerns that these weights are based on 2002-2003 data when case mix is going up as described below. **HFHS recommends CMS examine the 2005-2006 data before making any final changes.**

Conclusion

Thank you for you review of this submission. We would be pleased to work with CMS on any of the issues discussed above. If you have any questions concerning these comments please contact me at (313) 874-9533 or via email at mwhitbr1@hfhs.org.

Sincerely,

Mary Whitbread
V.P. Reimbursement & Managed Care Contracting

Submitter : Dr. Anne Deutsch

Date: 07/07/2006

Organization : Rehabilitation Institute of Chicago

Category : Nurse

Issue Areas/Comments

Other Issues

Other Issues

1) Access to IRF care for patients with stroke
2) conversions of LTCHs to IRFs

CMS-1540-P2-42-Attach-1.DOC

CMS-1540-P2-42-Attach-2.DOC

Rehabilitation Institute *of* Chicago
Center for Rehabilitation
Outcomes Research

Anne Deutsch
Clinical Research Scientist

345 E. Superior Street
Chicago, Illinois 60611
312.238.2809 telephone
312.238.4572 fax
a-deutsch@northwestern.edu

July 7, 2006

Centers for Medicare and Medicaid Services
Department of Health & Human Services
Attention – CMS-1540-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Proposed Rule: Inpatient Rehabilitation Facility Prospective Payment System for Fiscal Year 2007; 42 CFR, part 412; May 15, 2006

Dear Sir/Madam:

We are writing in response to the Proposed Rules and Regulations for Medicare Program; Prospective Payment System for Inpatient Rehabilitation Facilities (42 CFR, part 412), published in the Federal Register on May 15, 2006; volume 71, number 93, pages 28106 to 28165 requesting public comments by July 7th, 2006.

On page 28123, you request comments regarding possible changes in access to IRF care for patients with stroke based on a study that suggested reduced access to IRF care for patients with stroke following the implementation of the IRF-PPS.

The Center for Rehabilitation Outcomes Research at the Rehabilitation Institute of Chicago is funded by the National Institute on Disability and Rehabilitation Research to conduct several studies of post-acute care rehabilitation access, service organization and outcomes. Our research project "Early Impact of the Inpatient Rehabilitation Facility Prospective Payment System" provided the opportunity to analyze data from 411 IRFs (approximately 38% of IRFs existing in 1998) that submitted data to the Uniform Data System for Medical Rehabilitation for each of the years 1998 to 2003. As shown in the table below, the number of first admission Medicare fee-for-service beneficiaries with stroke admitted to the 411 IRFs varied less than 6.5 percent over the 6 years, and does not appear to decrease with the implementation of the IRF-PPS in 2002.

Data from the Medicare and Medicaid Statistical Supplements for the years 2001 to 2005 showed that the number of patients with a diagnosis of cerebrovascular accident discharged from short stay hospitals for the years 1999 through 2003 varied less than 4 percent over the 5 years. Together, these data suggest that access to IRF care for patients with stroke did not decrease with the implementation of the IRF-PPS among the 411 IRFs.

We agree that patients with stroke should be treated in IRFs rather than less intensive rehabilitation setting, such as skilled nursing facilities. Our recent publication compared

the outcomes of patients with stroke receiving post-acute rehabilitation care in IRFs and SNFs; the results support the conclusions that most patients with stroke should be treated in IRFs rather than rehabilitation SNFs due to the superior outcomes. (Deutsch A, Granger CV, Heinemann AW, Fiedler RC, DeJong G, Kane RL, Ottenbacher KJ, Naughton JP, Trevisan M. Post-stroke rehabilitation: Outcomes and reimbursement of inpatient rehabilitation facilities and subacute rehabilitation programs. *Stroke*, 37;1477-1482.)

Patients with Stroke, 1998 to 2003.

Criteria	1998	1999	2000	2001	2002	2003
Number of first admission IRF patients with stroke with Medicare fee-for-service as primary payer for 411 IRFs	31,331	30,779	29,898	28,858	30,721	31,152
Number of Medicare beneficiaries discharged from short stay hospitals with diagnosis of cerebrovascular accident (CVA)	Not available	608,430	604,775	612,380	609,070	588,890
Percent of Medicare beneficiaries with CVA (as reported in the statistical supplement) admitted to the 411 IRFs	-	5.1%	4.9%	4.7%	5.0%	5.3%

We also have a question about long-term care hospitals (LTCHs) that convert to be IRFs. If an LTCH is a teaching facility and converts to be an IRF, will the facility be recognized as a teaching facility for purposes of the IRF-PPS immediately?

We appreciate the opportunity to comment on the proposed rule. Please feel free to contact us should you have any questions.

Sincerely,

Anne Deutsch, RN, PhD, CRRN
Clinical Research Scientist, Rehabilitation Institute of Chicago

Allen W. Heinemann, PhD, ABPP
Director, Center for Rehabilitation Outcomes Research

Trudy R. Mallinson, PhD, OTR/L
Associate Director, Center for Rehabilitation Outcomes Research

Carl V. Granger, MD
Director, Uniform Data System for Medical Rehabilitation

Kenneth J. Ottenbacher, PhD, OTR
University of Texas Medical Branch at Galveston

Rehabilitation Institute *of* Chicago
Center for Rehabilitation
Outcomes Research

Anne Deutsch
Clinical Research Scientist

345 E. Superior Street
Chicago, Illinois 60611
312-238-2816 telephone
312-238-4572 fax
a-deutsch@northwestern.edu

July 7, 2006

Centers for Medicare and Medicaid Services
Department of Health & Human Services
Attention – CMS-1540-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Proposed Rule: Inpatient Rehabilitation Facility Prospective Payment System for Fiscal Year 2007; 42 CFR, part 412; May 15, 2006

Dear Sir/Madam:

We are writing in response to the Proposed Rules and Regulations for Medicare Program; Prospective Payment System for Inpatient Rehabilitation Facilities (42 CFR, part 412), published in the Federal Register on May 15, 2006; volume 71, number 93, pages 28106 to 28165 requesting public comments by July 7th, 2006.

On page 28123, you request comments regarding possible changes in access to IRF care for patients with stroke based on a study that suggested reduced access to IRF care for patients with stroke following the implementation of the IRF-PPS.

The Center for Rehabilitation Outcomes Research at the Rehabilitation Institute of Chicago is funded by the National Institute on Disability and Rehabilitation Research to conduct several studies of post-acute care rehabilitation access, service organization and outcomes. Our research project "Early Impact of the Inpatient Rehabilitation Facility Prospective Payment System" provided the opportunity to analyze data from 411 IRFs (approximately 38% of IRFs existing in 1998) that submitted data to the Uniform Data System for Medical Rehabilitation for each of the years 1998 to 2003. As shown in the table below, the number of first admission Medicare fee-for-service beneficiaries with stroke admitted to the 411 IRFs varied less than 6.5 percent over the 6 years, and does not appear to decrease with the implementation of the IRF-PPS in 2002.

Data from the Medicare and Medicaid Statistical Supplements for the years 2001 to 2005 showed that the number of patients with a diagnosis of cerebrovascular accident discharged from short stay hospitals for the years 1999 through 2003 varied less than 4 percent over the 5 years. Together, these data suggest that access to IRF care for patients with stroke did not decrease with the implementation of the IRF-PPS among the 411 IRFs.

We agree that patients with stroke should be treated in IRFs rather than less intensive rehabilitation setting, such as skilled nursing facilities. Our recent publication compared

the outcomes of patients with stroke receiving post-acute rehabilitation care in IRFs and SNFs; the results support the conclusions that most patients with stroke should be treated in IRFs rather than rehabilitation SNFs due to the superior outcomes. (Deutsch A, Granger CV, Heinemann AW, Fiedler RC, DeJong G, Kane RL, Ottenbacher KJ, Naughton JP, Trevisan M. Post-stroke rehabilitation: Outcomes and reimbursement of inpatient rehabilitation facilities and subacute rehabilitation programs. *Stroke*, 37;1477-1482.)

Patients with Stroke, 1998 to 2003.

Criteria	1998	1999	2000	2001	2002	2003
Number of first admission IRF patients with stroke with Medicare fee-for-service as primary payer for 411 IRFs	31,331	30,779	29,898	28,858	30,721	31,152
Number of Medicare beneficiaries discharged from short stay hospitals with diagnosis of cerebrovascular accident (CVA)	Not available	608,430	604,775	612,380	609,070	588,890
Percent of Medicare beneficiaries with CVA (as reported in the statistical supplement) admitted to the 411 IRFs	-	5.1%	4.9%	4.7%	5.0%	5.3%

We also have a question about long-term care hospitals (LTCHs) that convert to be IRFs. If an LTCH is a teaching facility and converts to be an IRF, will the facility be recognized as a teaching facility for purposes of the IRF-PPS immediately?

We appreciate the opportunity to comment on the proposed rule. Please feel free to contact us should you have any questions.

Sincerely,

Anne Deutsch, RN, PhD, CRRN
Clinical Research Scientist, Rehabilitation Institute of Chicago

Allen W. Heinemann, PhD, ABPP
Director, Center for Rehabilitation Outcomes Research

Trudy R. Mallinson, PhD, OTR/L
Associate Director, Center for Rehabilitation Outcomes Research

Carl V. Granger, MD
Director, Uniform Data System for Medical Rehabilitation

Kenneth J. Ottenbacher, PhD, OTR
University of Texas Medical Branch at Galveston

Submitter : **Ms. Joanne Berryman** **Date: 07/07/2006**

Organization : **Frazier Rehab Institute**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1540-P2-43-Attach-1.DOC

CMS-1540-P2-43-Attach-2.DOC

July 7, 2006

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

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

Dear Dr. McClellan:

On behalf of Frazier Rehabilitation Institute, a 135 bed Inpatient Rehabilitation Facility (IRF) located in Louisville, Kentucky, we are submitting our comments on the IRF Prospective Payment System Rule for the Federal Fiscal Year 2007.

Frazier appreciates the opportunity to comment on the fiscal year 2007 proposed rule for the inpatient rehabilitation facility prospective payment system. Our comments are directed at Section IIA: Refinements to the Patient Classification System, Section III A: Proposed Reduction of the Standard Payment Amount to Account for Coding Changes; V: Other Issues; and SectionVI: Revisions to the Classification Criteria Percentage for IRFs.

Section II A: Refinements to the Patient Classification System

Frazier supports CMS's efforts to make refinements to the list of comorbidities that are relevant to patients being served in the inpatient rehabilitation setting yet Frazier disagrees with a few of these recommendations. Patients with multiple diagnoses including neurological deficits, orthopedic conditions or trauma can develop deep vein thrombosis (DVT). Most patients receiving inpatient rehabilitation have incurred immobilization due to their primary diagnosis and are at risk of developing a DVT due to their immobilization. Other patients may be continuing on anticoagulation medication upon admission for a DVT not fully resolved. Obviously, this complication must be addressed in order for the patient to fully participate in their rehabilitation program. Additionally, hypoxemia is frequently found as a complication in our pulmonary population. Frazier strongly urges CMS to retain the 5 – ICD-9 codes on comorbid conditions listed in Table 2.

Section III A: Proposed Reduction of the Standard Payment Amount to Account for Coding Changes

While Frazier appreciates the statutorily required market basket update of 3.4 percent, we are concerned about the 2.9 percent across the board reduction to adjust for coding changes. The implementation of the 75% Rule, even with its current freeze at 60%, has shifted IRF's patient mix from orthopedic conditions (which no longer qualify) to more complex and higher cost patients, with multiple comorbidities. To ignore the impact of this policy change on case-mix is a mistake.

Additionally, justification for this adjustment is not based on new evidence, additional data, or further analysis beyond the 2004 Rand Report, TR-213. Though the agency stated in the 2006 final rule (70 FR 47880, 47906) that it "would continue to review the need for any further reduction in the standard payment amount in subsequent years", and though it claims in this year's proposed rule to "have conducted detailed analyses of IRF payment and utilization practices," there is only reference to one comorbidity tiering analysis in the March, 2006 MedPAC Report to Congress. Specifically, to cite the MedPAC report as a basis for a 2.9% reduction because of coding improvements is unsubstantiated. The actual MedPAC conclusion states, "Higher (IRF) spending was due *primarily* to a *combination* of payment updates and case-mix changes that *may* have been at least *partly* due to coding improvement" (italics added). This is a nuanced and heavily qualified statement upon which to base an adjustment that, together with last year's, adjustment equals (-4.8%).

Citation of Medicare margins from the MedPAC report without reference to the precipitous margin decline estimate on the same page is inconclusive. Additionally, CMS' use of costs as a surrogate for case-mix is logically and statistically unjustified and is not supported by the authors of the MedPAC report.

The proposed 2.9 percent cut raises antother question: Should CMS impose further adjustments to the IRF PPS based on data from 1999 through 2002 when the payment system was refined by restructuring and reweighting of the CMGs in FY 2006? We believe that the comprehensive FY 2006 refinement should serve as a new baseline for this payment system.

Furthermore, we believe that CMS has overlooked the 16 percent behavioral offset already applied to the payment system when the IRF PPS was initially implemented in January 2002. As noted by 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 extraordinary 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.*** Frazier strongly urges CMS to withdraw the proposed 2.9 percent coding reduction.

Section V. Other Issues:

With the implementation of the 75% Rule, CMS identifies 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 to achieve outcomes. Frazier is pleased to see an emphasis on creating a more seamless system of post acute care (PAC) in Section V of the proposed rule. We urge CMS to do the following in order to move forward in creating this seamless system of post acute care:

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

2. Provide funding and support for studies that rehabilitation providers are currently undertaking

Frazier is especially concerned about the exclusion of cardio-pulmonary and cancer patients from the "CMS 13" and is launching our research studies to demonstrate quality outcomes for these patients. Frazier will volunteer its facilities for a CMS pilot study on the effectiveness of inpatient rehabilitation for these patients. Additionally, Frazier is willing to work with CMS to conduct a study of appropriate post acute care delivery

Frazier appreciates the opportunity to comment on this section of the proposed rule and would again like to stress its willingness to work together on a pilot study on post acute care in general and a specific outcome study focused on cardio-pulmonary and cancer patients in inpatient rehabilitation.

SectionVI: Revisions to the Classification Criteria Percentage for IRFs.

Implementation and enforcement of the 75% rule is an outdated approach to the amelioration of the perceived problems of costs, excessive utilization, and IRF facility growth. Unfortunately, it was conceived within a regulatory framework based on a twenty year old, broad statutory definition of an inpatient rehabilitation facility. That facility classification was part of the "carve out" of certain hospital categories to be exempt from the prospective payment system for acute care hospitals, which was mandated in 1983.

Of issue to most IRFs is the narrowness of the thirteen "conditions", the arbitrary nature of the 75% compliance threshold, and the transitional use of comorbidities for compliance. It appears that over the last decade many segments of the PAC continuum have been provided payment, reimbursement, and classification policies that expand

potential patient populations, while only IRFs have had their patient populations circumscribed by policy. Separate policies, payments and classification systems cover the post acute care continuum. The result is a silo system that is not patient centered, does not consistently measure outcomes, limits standards for care appropriately performed in one or another setting, and is susceptible to industry manipulation of the political process.

Frazier Rehab Institute is a proud provider of services to Medicare beneficiaries. We believe strongly in the practice of evidence-based medicine. But we also believe that evidence, data, and objective thought should be the basis of payment, classification, and patient assessment systems in all PAC settings. Frazier strongly urges CMS to modernize the "75% Rule" by adding cardiac, pulmonary and oncological conditions to qualify towards the compliance with this regulation. Additionally, Frazier urges CMS to retain the use of comorbid conditions as evidence of an institutions compliance with the 75% Rule beyond July 1, 2008.

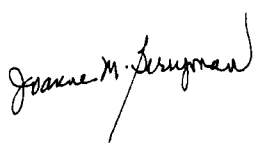
Summary:

In closing, Frazier again appreciates the opportunity to submit these comments on the IRF Proposed Rule.

- Frazier urges CMS to not delete the ICD- 9 Codes listed in table 2
- Frazier urges CMS to withdraw the proposed 2.9% reduction in payment.
- Frazier supports research activities concerning appropriate patient placement in post acute care settings and would like to participate in these activities.
- Frazier urges CMS to continue to update the "75% Rule, to include cardiac, pulmonary and cancer as qualifying conditions and retain use of comorbid conditions for meeting compliance beyond July 1, 2008.

Please address any comments to me or Ms. Jean M. Russell, Vice President of Operations at 502-582-7480 or jean.russell@jhsmh.org.

Sincerely,



Joanne Berryman
Senior Vice President
Jewish Hospital & St. Mary's HealthCare
Frazier Rehab Institute
joanne.berryman@jhsmh.org

July 7, 2006

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

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

Dear Dr. McClellan:

On behalf of Frazier Rehabilitation Institute, a 135 bed Inpatient Rehabilitation Facility (IRF) located in Louisville, Kentucky, we are submitting our comments on the IRF Prospective Payment System Rule for the Federal Fiscal Year 2007.

Frazier appreciates the opportunity to comment on the fiscal year 2007 proposed rule for the inpatient rehabilitation facility prospective payment system. Our comments are directed at Section IIA: Refinements to the Patient Classification System, Section III A: Proposed Reduction of the Standard Payment Amount to Account for Coding Changes; V: Other Issues; and SectionVI: Revisions to the Classification Criteria Percentage for IRFs.

Section II A: Refinements to the Patient Classification System

Frazier supports CMS's efforts to make refinements to the list of comorbidities that are relevant to patients being served in the inpatient rehabilitation setting yet Frazier disagrees with a few of these recommendations. Patients with multiple diagnoses including neurological deficits, orthopedic conditions or trauma can develop deep vein thrombosis (DVT). Most patients receiving inpatient rehabilitation have incurred immobilization due to their primary diagnosis and are at risk of developing a DVT due to their immobilization. Other patients may be continuing on anticoagulation medication upon admission for a DVT not fully resolved. Obviously, this complication must be addressed in order for the patient to fully participate in their rehabilitation program. Additionally, hypoxemia is frequently found as a complication in our pulmonary population. Frazier strongly urges CMS to retain the 5 – ICD-9 codes on comorbid conditions listed in Table 2.

Section III A: Proposed Reduction of the Standard Payment Amount to Account for Coding Changes

While Frazier appreciates the statutorily required market basket update of 3.4 percent, we are concerned about the 2.9 percent across the board reduction to adjust for coding changes. The implementation of the 75% Rule, even with its current freeze at 60%, has shifted IRF's patient mix from orthopedic conditions (which no longer qualify) to more complex and higher cost patients, with multiple comorbidities. To ignore the impact of this policy change on case-mix is a mistake.

Additionally, justification for this adjustment is not based on new evidence, additional data, or further analysis beyond the 2004 Rand Report, TR-213. Though the agency stated in the 2006 final rule (70 FR 47880, 47906) that it "would continue to review the need for any further reduction in the standard payment amount in subsequent years", and though it claims in this year's proposed rule to "have conducted detailed analyses of IRF payment and utilization practices," there is only reference to one comorbidity tiering analysis in the March, 2006 MedPAC Report to Congress. Specifically, to cite the MedPAC report as a basis for a 2.9% reduction because of coding improvements is unsubstantiated. The actual MedPAC conclusion states, "Higher (IRF) spending was due *primarily* to a *combination* of payment updates and case-mix changes that *may* have been at least *partly* due to coding improvement" (italics added). This is a nuanced and heavily qualified statement upon which to base an adjustment that, together with last year's, adjustment equals (-4.8%).

Citation of Medicare margins from the MedPAC report without reference to the precipitous margin decline estimate on the same page is inconclusive. Additionally, CMS' use of <u>costs</u> as a surrogate for <u>case-mix</u> is logically and statistically unjustified and is not supported by the authors of the MedPAC report.

The proposed 2.9 percent cut raises antother question: Should CMS impose further adjustments to the IRF PPS based on data from 1999 through 2002 when the payment system was refined by restructuring and reweighting of the CMGs in FY 2006? We believe that the comprehensive FY 2006 refinement should serve as a new baseline for this payment system.

Furthermore, we believe that CMS has overlooked the 16 percent behavioral offset already applied to the payment system when the IRF PPS was initially implemented in January 2002. As noted by 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 extraordinary 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.*** Frazier strongly urges CMS to withdraw the proposed 2.9 percent coding reduction.

Section V. Other Issues:

With the implementation of the 75% Rule, CMS identifies 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 to achieve outcomes. Frazier is pleased to see an emphasis on creating a more seamless system of post acute care (PAC) in Section V of the proposed rule. We urge CMS to do the following in order to move forward in creating this seamless system of post acute care:

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

2. Provide funding and support for studies that rehabilitation providers are currently undertaking

Frazier is especially concerned about the exclusion of cardio-pulmonary and cancer patients from the "CMS 13" and is launching our research studies to demonstrate quality outcomes for these patients. Frazier will volunteer its facilities for a CMS pilot study on the effectiveness of inpatient rehabilitation for these patients. Additionally, Frazier is willing to work with CMS to conduct a study of appropriate post acute care delivery

Frazier appreciates the opportunity to comment on this section of the proposed rule and would again like to stress its willingness to work together on a pilot study on post acute care in general and a specific outcome study focused on cardio-pulmonary and cancer patients in inpatient rehabilitation.

SectionVI: Revisions to the Classification Criteria Percentage for IRFs.

Implementation and enforcement of the 75% rule is an outdated approach to the amelioration of the perceived problems of costs, excessive utilization, and IRF facility growth. Unfortunately, it was conceived within a regulatory framework based on a twenty year old, broad statutory definition of an inpatient rehabilitation facility. That facility classification was part of the "carve out" of certain hospital categories to be exempt from the prospective payment system for acute care hospitals, which was mandated in 1983.

Of issue to most IRFs is the narrowness of the thirteen "conditions", the arbitrary nature of the 75% compliance threshold, and the transitional use of comorbidities for compliance. It appears that over the last decade many segments of the PAC continuum have been provided payment, reimbursement, and classification policies that expand

potential patient populations, while only IRFs have had their patient populations circumscribed by policy. Separate policies, payments and classification systems cover the post acute care continuum. The result is a silo system that is not patient centered, does not consistently measure outcomes, limits standards for care appropriately performed in one or another setting, and is susceptible to industry manipulation of the political process.

Frazier Rehab Institute is a proud provider of services to Medicare beneficiaries. We believe strongly in the practice of evidence-based medicine. But we also believe that evidence, data, and objective thought should be the basis of payment, classification, and patient assessment systems in all PAC settings. Frazier strongly urges CMS to modernize the "75% Rule" by adding cardiac, pulmonary and oncological conditions to qualify towards the compliance with this regulation. Additionally, Frazier urges CMS to retain the use of comorbid conditions as evidence of an institutions compliance with the 75% Rule beyond July 1, 2008.

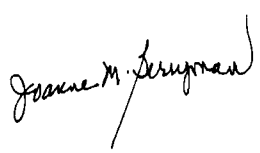
Summary:

In closing, Frazier again appreciates the opportunity to submit these comments on the IRF Proposed Rule.

- Frazier urges CMS to not delete the ICD- 9 Codes listed in table 2
- Frazier urges CMS to withdraw the proposed 2.9% reduction in payment.
- Frazier supports research activities concerning appropriate patient placement in post acute care settings and would like to participate in these activities.
- Frazier urges CMS to continue to update the "75% Rule, to include cardiac, pulmonary and cancer as qualifying conditions and retain use of comorbid conditions for meeting compliance beyond July 1, 2008.

Please address any comments to me or Ms. Jean M. Russell, Vice President of Operations at 502-582-7480 or jean.russell@jhsmh.org.

Sincerely,



Joanne Berryman
Senior Vice President
Jewish Hospital & St. Mary's HealthCare
Frazier Rehab Institute
joanne.berryman@jhsmh.org

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

Organization :

Category : **Health Care Professional or 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 : Ms. Kay Marsyla **Date:** 07/07/2006

Organization : Mercy General Health Partners

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

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

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

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

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

Organization :

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1540-P2-46-Attach-1.DOC

TRINITY HEALTH
Novi, Michigan

July 7, 2006

West Michigan Finance
Shared Services
1820 44th Street
Kentwood, MI 49508

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

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

Dear Dr. McClellan:

Mercy General Health Partners (MGHP) appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services regarding the fiscal year (FY) 2007 proposed rule for the inpatient rehabilitation facility prospective payment system (IRF PPS).

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

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

In addition to overlooking the impact of the 75 Percent Rule, the proposed rule also fails to recognize that the IRF environment has worsened further in recent months due to the negative impact

of several local coverage determinations (LCDs), by some fiscal intermediaries (FIs). Medical necessity reviews are being conducted by these and other FIs on both a pre-payment and post-payment basis.

As a single factor, the 75 Percent Rule has not resulted in IRF closures. However, in combination with the LCD enforcement, the 75 Percent Rule has already resulted in facility closures in 2006, with more pending. Given the current instability facing IRFs due to the 75 Percent Rule, LCDs and the FY 2006 1.9 percent across-the-board cut, it is inappropriate for the CMS to create further volatility. Therefore, MGHP urges the CMS to:

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

Data-related Concerns

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

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

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

Proposed Changes to the CMG Relative Weights

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

Research on Medical Rehabilitation

Whether overall Medicare savings have or will be achieved by the significant reduction in IRF cases due to the 75% Rule remains unknown. The CMS has taken a position that less-intensive settings are an overall value for the Medicare program, especially for joint-replacement patients, but this

position has not yet been scientifically reviewed. The work done by the Government Accountability Office and the National Institutes of Health on the 75 Percent Rule was helpful for identifying what further analysis is needed in order to modernize the 75 Percent Rule, more clearly define the role of IRFs relative to other post-acute care providers and better understand the cost effectiveness of IRFs and other post-acute providers. The IRF field is proactively stepping forward to help fill the void in the medical literature on comparative analysis of medical rehabilitation costs and outcomes. MGHP believes that the CMS should strongly support these efforts by providing project funding and issuing thoughtful regulatory changes that recognize the need to provide stability in the IRF environment while research is conducted.

Post-acute Care Demonstration

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

Again, MGHP appreciates the opportunity to provide comments to the CMS regarding this proposed rule. Please contact me if you have any questions or require additional information at 616-643-3569 or via email at marsylkp@trinity-health.org.

Sincerely,

Kay Marsyla, CHFP
Sr. Reimbursement Specialist
Trinity Health West MI
Finance Shared Services

Submitter : **Mr. Richard Meiers** **Date: 07/07/2006**

Organization : **Healthcare Association of Hawaii**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Proposed FY 2007 Federal Prospective Payment Rates

Proposed FY 2007 Federal Prospective Payment Rates

The 2.9 percent coding adjustment and other proposals in this rule are based on substandard and limited analysis of obsolete data that do not reflect the current environment. As such, the data and the coding adjustment fail to account for serious environmental challenges that are currently facing IRFs. We urge CMS to update its data and analysis in subsequent rules.

CMS-1540-P2-47-Attach-1.PDF

HAH
Healthcare Association
of Hawaii

July 7, 2006

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

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

Dear Dr. McClellan:

On behalf of the Healthcare Association of Hawaii, I appreciate this opportunity to comment on the fiscal year 2007 proposed rule for the inpatient rehabilitation facility prospective payment system (IRF PPS).

The proposal by the Centers for Medicare & Medicaid Services (CMS) includes, among other things, a 2.9 percent across-the-board reduction to adjust for coding increases. The Healthcare Association of Hawaii strongly urges CMS to withdraw this 2.9 percent coding adjustment reduction.

The 2.9 percent coding adjustment and other proposals in this rule are based on substandard and limited analysis of obsolete data that do not reflect the current environment. As such, the data and the coding adjustment fail to account for serious environmental challenges that are currently facing IRFs. We urge CMS to update its data and analysis in subsequent rules.

Thank you for the opportunity to comment on this proposed rule. Should you have any questions, please contact me at (808) 521-8961.

Sincerely,

Richard E. Meiers
RICHARD E. MEIERS
President and CEO

REM/lth

732 Ward Avenue Suite 130 Honolulu, Hawaii 96814-2126 808/521-8961 FAX 808/599-2879

Submitter : **Mrs. Sybil Paulson** **Date: 07/07/2006**

Organization : **North Oaks Rehabilitation Hospital**

Category : **Hospital**

Issue Areas/Comments

Other Issues

Other Issues

It is inappropriate for CMS to proceed with rulemaking on IRF payment policy using old and irrelevant data, as it did for FY 2006 and again in its FY 2007 proposal. We encourage CMS to adjust its internal protocols to ensure that future rulemaking uses the most recent payment and claims data available. In addition to using the most recent payment and claims data, CMS should publicly disseminate this data along with the paid, current and proposed case-mix groups and associated IRF patient-assessment instrument data.

Sybil Paulson, RN
Administrator and Operations Officer
North Oaks Rehabilitation Hospital

Proposed Changes to the CMG Relative Weights

Proposed Changes to the CMG Relative Weights

We urge CMS to rerun the recalibration of the weights so that it includes not only the proposed new comorbidity codes, but also utilizes the latest available data, rather than using the same 2002 and 2003 data used for the FY 2006 proposed and final rules. Given the need for more recent data to substantiate changes for FY 2007, we urge CMS to implement an interim final rule for FY 2007 that is based on more recent data. An interim final rule would enable stakeholders to comment on the revised data and policies for FY 2007.

Sybil Paulson, RN
Administrator and Operations Officer
North Oaks Rehabilitation Hospital

Proposed FY 2007 Federal Prospective Payment Rates

Proposed FY 2007 Federal Prospective Payment Rates

The proposed rule is almost entirely based on data from 1999 through 2004. The combined impact of these analyses a reduction of 60,000 patients accessing IRFs in the first two years of the 75% Rule phase-in appears to be entirely overlooked in this proposed rule. We urge CMS to withdraw the negative 2.9 percent coding adjustment; update its analyses so that they reflect the current reality facing patients, referring physicians and IRFs; and study the current medical rehabilitation environment.

RAND Corporation had estimated coding increases ranging from an increase of 1.9 percent to 5.8 percent. However, RAND questioned the accuracy of its own coding analysis, and CMS acknowledged the inconclusive finding in setting the reduction at the low end of the range in the FY 2006 rule. Given the shaky analytical foundation and lack of further work showing the need, the proposed 2.9 percent cut should be withdrawn in the final rule.

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. 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.

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 Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS). We are very concerned that the -2.9 percent coding adjustment and other proposals in this rule are based on substandard and limited analysis of old data that do not reflect the current environment. We urge CMS to update its data and analysis in subsequent rules.

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. North Oaks Rehabilitation Hospital strongly urges CMS to withdraw the proposed 2.9 percent coding reduction.

Sybil Paulson, RN
Administrator and Operations Officer
North Oaks Rehabilitation Hospital

Regulatory Impact Analysis

Regulatory Impact Analysis

Although the need for inpatient rehabilitation therapy has increased in our community due to the post-Katrina population surge, our census continues to decline as

restrictions are increased. Each day, our hospital administrators re-calculate the percentage of current patients who meet the mandated criteria in order to determine how many new patients can be accepted. If a community member happens to come in on a day when the percentage is not favorable, he/she must be turned away. Because of a lack of other facilities in the local area that do intensive rehabilitation therapy, many of these patients must resort to home health care which is not comparable to the necessary intensive therapy they could have received in our Comprehensive Medical Rehabilitation Unit. The critical window of opportunity for maximum rehabilitation efforts may have passed. These are real people with real needs who are being denied access to care that is readily available through our facility simply because the percentage did not work in their favor that day.

Sybil Paulson, RN
Administrator and Operations Officer
North Oaks Rehabilitation Hospital

Submitter : **Ms. Patricia Henry** **Date: 07/07/2006**

Organization : **RehabCare Group, Inc.**

Category : **Health Care Industry**

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Please see the attached Adobe file for the complete comment.

CMS-1540-P2-49-Attach-1.PDF

July 6, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1540-P
P.O. Box 8012
Baltimore, MD 21244-8012

By e-mail

Submitted at http://www.cms.hhs.gov/erulemaking

Dear Dr. McClellan:

RehabCare Group Inc. ("RehabCare") is a publicly owned company that manages inpatient rehabilitation units in hospitals and self operates its own inpatient rehabilitation hospitals. RehabCare appreciates the opportunity to provide comments in response to the Inpatient Rehabilitation Facility Prospective Payment System for FY 2007; Proposed Rule, as published in the Federal Register on May 15, 2006. We respectfully submit these comments.

I. Refinements to the Patient Classification System

Proposed Changes to the Existing List of Tier Comorbidities

We agree with the goal of ensuring that IRF PPS payments better reflect the costs of care in IRF's.

Proposed Changes to the CMG Relative Weights

We agree with the goal of ensuring that IRF PPS payments better reflect the costs of care in IRF's.

II. Proposed FY 2007 Federal Prospective Payment Rates

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

We are concerned about the 2.9% downward adjustment that CMS has proposed to eliminate the impact of coding changes. In particular, we are concerned that the underlying methodology continues to neglect to recognize certain changes that occurred between 1999 and 2003. For instance, one of the key assumptions in the analysis is that changes in patient coding and diagnoses in rehab facilities should be similarly reflected in the patients' preceding acute med/surg stay. We don't necessarily disagree with this assumption; however it does not consider potential changes in the med/surg length of stay preceding admission to acute rehab. We believe that a decline in med/surg length of stay preceding admission to acute rehab could have affected caregivers' abilities to fully

diagnose patients prior to their acute rehab stay. We believe these patients may now be more fully diagnosed in the acute rehab setting.

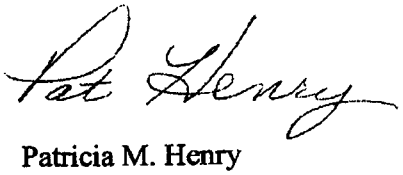
We are also concerned that the 2.9% reduction fails to recognize the difficulties facilities are facing as they transition through the 75% Rule. This reduction combines with the 2006 fiscal year standard payment reduction of 1.9%, previous changes to CMG relative weights, and the 75% Rule, applying pressure to the viability of inpatient rehabilitation units. As facilities are forced to restrict access due to the revised 75/25 percent rule, they become less efficient. As labor costs, administrative costs, and occupancy costs are spread across fewer patients, it is logical to expect that costs per discharge will increase significantly. We are concerned that these further reductions in reimbursement will further threaten the viability of acute rehabilitation in these facilities.

III. Other Issues

RehabCare welcomes the development of a more seamless system for payment and delivery of post-acute care services. In addition to our experience in acute rehabilitation, we provide therapy in numerous med/surg, outpatient, home health, skilled nursing, and LTACH settings. We would welcome the opportunity to work with CMS to assess the relative advantages and disadvantages of assessment instruments and payment methodologies affecting post-acute care sites, as well as the efficacy of care among these settings.

We thank you for the opportunity to comment on the proposed IRF PPS rule and welcome the opportunity to provide any further input that you wish on inpatient rehabilitation services. Should you have any questions, please contact me at (314) 659-2100.

Very Truly Yours,



Patricia M. Henry
Executive Vice President
RehabCare Group, Inc.

Submitter : **Mr. Stephen Harwell** **Date: 07/07/2006**

Organization : **Healthcare Association of New York State**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1540-P2-50-Attach-1.DOC

Healthcare Association
of New York State

July 7, 2006

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

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

Dear Dr. McClellan:

The Healthcare Association of New York State (HANYS), on behalf of our more than 550 hospitals, nursing homes, home health agencies, and other health care providers, welcomes the opportunity to comment on the proposed rule related to the federal fiscal year (FFY) 2007 Prospective Payment System (PPS) for Inpatient Rehabilitation Facilities (IRFs).

Proposed FFY 2007 Federal Prospective Payment Rates

Reduction to the Standard Payment Rate

In FFY 2006, the Centers for Medicare and Medicaid Services (CMS) applied a "one-time" 1.9% reduction to the standard payment rate for what were determined to be coding changes between 1999 and 2002 that did not reflect real changes in case mix. This reduction was based on an analysis by the RAND Corporation that estimated case-mix changes due to coding changes had increased IRF PPS payments by a range of 1.9% to 5.8%. In the FFY 2007 proposed rule, CMS proposes another reduction to the standard payment rate of 2.9%. CMS based this reduction on profit margins as reported by Medicare Payment Advisory Commission (MedPAC) and analysis by CMS of IRF Patient Assessment Instrument data.

75% Rule

HANYS is concerned that continued behavioral offsets by CMS (1.9% in FFY 2006 and proposed 2.9% in FFY 2007) do not take into account current conditions and treatment patterns of facilities as they adapt to implementation of the "75% rule." To meet the standards of the 75% rule, it has been necessary for facilities to change their admission patterns. This makes any attempt to differentiate patient severity changes from coding changes problematic. As noted in the American Hospital Association's (AHA) comments to CMS, 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.

Reduction of IRF Admissions

HANYS echoes AHA's comments regarding the Moran Company's June 2006 report on the impact of the 75% rule, *Utilization Trends in Inpatient Rehabilitation: Update through QI 2006.* This report estimates that approximately 37,000 fewer patients were treated by IRFs during the first year of the 75% rule implementation (with a 50% 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 (with a 60% threshold from July 2005 through June 2006) about 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 the 75% rule phase-in.

Changes to the Patient Classification System

In FFY 2006, CMS overhauled the IRF patient classification system. Although CMS kept the same basic structure to the payment system, substantial modifications were made to the case-mix groups (CMGs), tier comorbidities, and relative weights—causing a significant redistributive effect among IRFs. The CMG revisions attempted to reduce payments for cases with reported comorbidities that the CMS analysis determined to be overpaid compared to actual costs. CMS justified these revisions based on the belief that ". . . the IRF PPS led to substantial changes in coding of comorbidities between 1999 (pre-implementation of the IRF PPS) and 2003 (post-implementation of the IRF PPS)." Therefore, the revision to the patient classification system combined with the 1.9% reduction to the standard rate essentially adjusted twice for the same coding changes. HANYS believes that the CMG revisions of FFY 2006 and proposed modifications for FFY 2007—based on specific codes that were identified as problems by a systematic analysis—are more equitable than across-the-board rate reductions based on circumstantial evidence. We encourage CMS to analyze the impact that the revised patient classification system has had on IRF payments before imposing another across-the-board standard rate reduction.

HANYS believes that CMS should not apply another behavioral offset that could inappropriately reduce payments without proper analysis of how all of the factors discussed above (75% rule, reduced IRF admissions, and the recent changes to the patient classification system) are currently interacting and, in turn, how these changes are affecting the IRF payment system overall.

Additionally, in the FFY 2006 proposed rule, CMS noted that while the RAND analysis could determine the total change in case mix, it was not able to precisely measure the amount of the total change that is real and the amount that is due to coding. Instead, RAND used indirect evidence to estimate that somewhere between 1.9% and 5.8% of the case-mix change experienced in IRFs might be attributed to coding changes.

In this proposed rule, the 2.9% reduction combined with the FFY 2006 reduction of 1.9% equates to a total 4.8% reduction to the IRF PPS that CMS states *". . . is well within the range of RAND's estimates of the effects of coding changes on IRF PPS payments, we continue to believe that we are still providing flexibility to account for the possibility that some of the observed changes may be attributable to factors other than coding changes."*

Although CMS states that it is ". . . *still providing flexibility to account for the possibility that some of the observed changes may be attributable to factors other than coding changes*," the proposed 2.9% reduction combined with the FFY 2006 reduction of 1.9% will put the total reduction to the standard rate at the upper end of RAND's estimated range, that is admittedly based on indirect evidence. HANYS believes that any further across-the-board reductions must be based on hard, data-related evidence, rather than indirect reduction ranges.

We urge CMS to eliminate the proposed reduction for coding changes from the final rule. Most IRFs are currently facing substantial obstacles and disruptions as they attempt to adapt to the requirements of the 75% rule. CMS should not add to the burden by implementing an across-the-board reduction based on data that do not reflect current IRF admission practices.

Marketbasket Update for FFY 2007

The rehabilitation, psychiatric, long-term care (RPL) marketbasket update is based on a "marketbasket" factor that is intended to reflect the average change in the price of goods and services these facilities purchase to furnish rehabilitation, psychiatric, and long-term care. CMS contracts with Global Insight, Inc. for marketbasket projections and its projection for FFY 2007 is 3.4%. We believe this projection significantly underestimates the inflation pressure that hospitals face in serving Medicare beneficiaries.

Global Insight's projections have proven to be unsatisfactory. After several years of consistent under-projections, HANYS and the allied associations challenged the reliability of its projection methodology last year. In response, CMS worked with Global Insight and revised its projection methodology, increasing the 2006 RPL projection from 3.1% in the proposed rule to 3.6% for the final rule. Even with this increase, it still is short of Global Insight's latest 2006 forecasted marketbasket increase of 3.8%.

We believe that Global Insight's projection methodology has a built-in bias of under-projecting during a period when the overall economy is transitioning from a high growth and low inflation era to a low growth and high inflation period. During a transition period, the normal projection methodologies that use the extrapolation of historical data tend to have larger projection variances. Adjustments need to be made to correct for these systematic projection biases during the time of major business cycle reversals. Traditionally, CMS does not correct for marketbasket projection errors in subsequent years' payment rates. This policy may be warranted during stable economic conditions. However, this policy can introduce significant overpayments or shortfalls during the period of major changes in economic trends.

General inflation indicators such as the Consumer Price Index and the Gross Domestic Product Implicit Price Deflator have both demonstrated that the inflation rate bottomed out in 2002. Both indicated that inflation rates moved higher in 2003, 2004, and 2005. The failure to capture the impact of this trend reversal may be the key factor of CMS' consistent under-projection of the RPL marketbasket index during these years. The following table provides the CMS projection errors for these years.

	FFY 2003	FFY 2004	FFY 2005
Actual Cost Increase (RPL marketbasket)	3.8%	3.6%	3.7%
Projected Cost Increase	3.0%	3.2%	3.1%
Projection Shortfall	-0.8%	-0.4%	-0.6%

Many Federal Reserve Board Governors have recently expressed worries about continued high inflation.

HANYS is concerned about the major hospital payment shortfalls from 2003 to 2006 and the potential of continued shortfalls in 2007 and beyond. We request that CMS either include an adjustment in its projection methodology to correct for this systematic bias, or adjust for projection errors in its subsequent years' payment rates.

Data-Related Concerns

HANYS joins AHA in encouraging CMS to 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 CMS does with annual rulemaking for the Inpatient PPS.

Public dissemination of case-level and provider characteristic information allows for data-based analysis, comments, and recommendations from the provider community. HANYS

encourages the dissemination of this type of information for all of the PPS systems including the IRF PPS.

Other Issues

Post-Acute Care Demonstration of a Uniform Assessment and Data Collection Tool
Section 5008 of the DRA provides for a demonstration on uniform assessment and data collection across different sites of service.

HANYS supports a demonstration conducted on the use of a uniform assessment and data collection tool across different sites of service, with the inclusion of some critical features.

A uniform assessment tool has been impossible to achieve to date due to the different levels of care and their current assessment tools, the incompatible clinical terminology used, and the lack of integration between settings and systems. HANYS is also very concerned that adding the completion of another document at the point of hospital discharge will cause undo hospital backlogs of patients and delays in transitioning them to post-acute settings. However, HANYS believes that a uniform assessment tool that is electronic and accessible to all users can eliminate unnecessary duplication and provider burden, improve patient safety, and assist with some aspects of discharge planning.

HANYS believes that the demonstration of such a tool should include electronic data entry and the exchange of patient assessment data that can be integrated electronically between settings and accessed by all users. Assessment data elements should be universally defined for all settings and hospital discharge data should be electronically available to post-acute providers in a manner that preserves and protects patient confidentiality. This would be most useful for post-acute providers, who would be able to receive uniform patient assessment data for their pre-discharge evaluation of the appropriateness of potential admissions.

Discharge placement recommendations are made by professionals who collect and consider a wealth of patient assessment information. Two clinicians who collect the same data about a patient c an m ake t wo d ifferent dis charge r ecommendations a fter c onsidering o ther v ariables. Such variables include the characteristics of a patient's social and family supports, the patient's emotional stability, and his or her determination to get well. Discharge planners incorporate these additional, often intuitive components into the guidance they give to patients and their families to assist their decision making about discharge planning.

HANYS believes that, to the extent possible, the uniform assessment and data collection tool should capture these other important variables.

As part of the demonstration, we urge CMS to allow clinicians currently practiced in making post-acute rehabilitation placement decisions to review and critique discharge placement decisions generated by the use of the uniform tool. This evaluation could be used to determine how well the tool captures the full breadth of information and variables used for making discharge planning decisions. Clinicians may also be helpful in identifying ways to improve the tool.

HANYS agrees with CMS that it is advantageous for consumers to have "a more seamless system for payment and delivery of post-acute care (PAC) under Medicare." However, HANYS believes that the challenge for CMS is not to provide "more consistent payments for the same type of care," but to pay for services to patients that are received in the most appropriate setting to their care needs. The Medicare conditions of payment mandate different levels of rehabilitative care based on the intensity of therapy, the skill mix of the clinicians, and the ancillary resources necessary to support this higher level of care.

Specifically for institutionalized rehabilitation, there are significant differences between the rehabilitation care and services a patient receives in a skilled nursing facility (SNF) versus an IRF. The combination and hours of therapy services that must be delivered each day, the presence of a rehabilitative nurse and physiatrist, and the amount of available onsite medical supervision are all components that differentiate an IRF from an SNF level of rehabilitation. It is also true that not all patients discharged from a hospital need intense IRF rehabilitation. Rehabilitation at a lesser level of intensity and delivered by a different skill mix of professionals can happen in a nursing home or via home care. However, for patients who are appropriate for an IRF admission, an IRF can produce significantly better patient outcomes, more quickly than the other settings, and frequently at less cost to Medicare.

A recent study conducted by The Burke Rehabilitation Hospital and published in the January 2006 edition of the *American Journal of Physical Medicine and Rehabilitation* compared the length of stay (LOS) and functional ambulation status at discharge for patients in 2004 who were matched by a number of characteristics including age, gender, operative diagnosis (single hip or knee joint replacement), and functional ambulation. The study compared LOS, discharge location, discharge ambulation status, and hospital readmissions for the population in the study.

The mean LOS for IRF patients in this study was 10.3 days while it was 20.0 days for their SNF cohort. A higher percentage of IRF patients were discharged directly to home (89.5%) than went home from the SNF (79.1%). The discharge ambulation status of IRF patients was measured higher by the Functional Independence Measure system than the SNF group, the IRF group on average ambulated further, and without the assistance of a walker. In addition, it was noted that readmissions back to the acute hospital occurred in 6.9% of the SNF discharges versus only 3.4% of the IRF discharges. Although the SNF setting pays a lower rate than the IRF setting,

longer LOS in the less intense SNF setting can result in comparable cost to CMS. This does not factor in the additional costs of home rehabilitation needed for 75% of the SNF discharges; only 41.2% of the IRF discharges needed home care rehabilitation. The analysis also does not measure the differences in the quality of life ultimately experienced by the two populations.

HANYS' believes that more scientific study must be done to not only properly identify the clinical conditions that are appropriate for an IRF level of care, but also to quantify the differences in patient outcomes and quality of life following intense rehabilitation as compared to rehabilitation delivered in other settings. We agree with the Burke study that ". . . further research is needed to identify the patient characteristics that influence outcome . . ." and that ". . . it is critically important to determine more rigorously the appropriate level of care for a given patient and to match that level with a site of care capable of delivering it."

The method used to determine which patients are appropriate for what level of rehabilitation combines the collection of data elements about a patient combined with an equally important professional's judgment about the social and emotional characteristics of a patient and his or her support system.

The Burke study points out that ". . . the absence of a uniform assessment tool for functional status and of a comparable resource utilization tool is widely recognized as a major hindrance . . ." to site comparisons and to determining the appropriate level and setting of PAC. The lack of a uniform tool makes it difficult for providers to transition patients expeditiously throughout the continuum of care. It causes hours of duplicative work by staff in collecting assessment information; forces consumers to answer the same questions repeatedly; and diverts caregivers from their most important duty of delivering care, to that of filling out forms.

HANYS agrees that there has been a significant evolution in the delivery of PAC health services. Unfortunately, this evolution has not occurred universally and has not resulted in uniformity of services and quality of care being available in all types of post-acute settings. Given this reality, the Medicare conditions of payment that govern the different levels of PAC services offer only a uniform minimum standard of care for each provider category in the continuum. While a uniform set of patient data elements provides a baseline of information that can be used to help identify settings of care that seem compatible with patient needs, the art of successful discharge planning still requires the use of judgment and intuition in evaluating the facts and patient data available to guide patients and families about these important decisions.

Please contact Stephen Harwell, Director, Economic Analyses, at (518) 431-7777 or at sharwell@hanys.org if you have any questions.

Sincerely,

Ju-Ming Chang
Vice President, Economics, Finance, and Information

JC:do

Submitter : Mr. Kerry Gillihan **Date:** 07/07/2006

Organization : Cardinal Hill Healthcare System

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-1540-P2-51-Attach-1.DOC

CMS-1540-P2-51-Attach-2.DOC

July 7, 2006

Mark McClellan, MD, Ph.D.
Administrator, Center for Medicare &
Medicaid Services
Department of Health & Human Services
PO Box 8012
Baltimore, MD 20244-8012

Attn: CMS – 1540-P

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

Dear Dr. McClellan,

Cardinal Hill Rehabilitation Hospital is a non-profit 108-bed freestanding acute rehabilitation facility serving adults and children from throughout the Commonwealth of Kentucky in one of our inpatient rehabilitation programs. In calendar year 2005, we served 2469 patients. Physicians count on us to provide a high quality program to their patients so that the patient may return to an independent lifestyle after a life-changing, illness or injury. 84% of our patients are discharged home. We have worked very hard to adjust to the many changes in the IRF-PPS since its inception. Our ability to continue to meet the needs of patients referred for services is a daily challenge due to the frequently changing regulations concerning payment and IRF classification imposed by CMS.

The proposed rule presents additional challenges to providing rehabilitation services that will enable our patients to become less dependent on the Medicare system by learning to become functional in the home setting and manage their own healthcare needs. We respectfully urge CMS to reconsider the following areas in the proposed rule:

Proposed FY 2007 Federal prospective Payment Dates

The content of the proposed rule contains significant discussion of alleged "changes in coding practice" by IRF's, resulting in increased reimbursement to IRFs. It is quite apparent that CMS considers IRFs to be utilizing inappropriate coding practices to maximize reimbursement. The reality for our facility is that our coding practices accurately reflect a change in case-mix of patients imposed by the re-implementation of the 75% Rule. We have been forced to replace joint replacement patients with other patients who fit into the 13 diagnoses now

considered by CMS to be appropriate for admission to an IRF. In our facility, the increases have been primarily in patients with stroke and brain injury diagnoses. These types of patients frequently present with complications and co-morbidities requiring additional resources, primarily increased diagnostics and medications. The medical necessity requirements of the LCDs have also required IRFs to admit patients with increased medical needs. The proposed –2.9% reduction in payment is premature and should be withdrawn from consideration pending evaluation of patient data post implementation of the 75% rule and medical necessity requirements. This will allow IRFs to serve the very population considered appropriate for admission to IRFs and be adequately reimbursed for the increased resources required to provide an acceptable level of care. Failure to do so may jeopardize access to care for the very patients that CMS has determined are appropriate for IRF services.

Proposed changes to CMS relative weights and tiers

In the September 30, 2005 IRF-PPS Final Rule, very significant changes were made to the CMGs and relative weights used in the IRF-PPS. It is too soon to make additional changes to this system, as new data has not been taken into consideration in these additional changes. While an increase in 65.7% of relative weights is appreciated, it would seem prudent to hold on changing any relative weights until new data can be evaluated. We urge CMS to rerun the calibration of the relative weights so that it includes not only the new co-morbidity codes, but also utilizes the latest available data, rather than using the same data from 2002 & 2003, that was used for the FY 2006 proposed and final rules. We urge CMS to issue any changes to CMGs at a later date, as an interim final rule in 2007.

Proposed Budget neutrality factor methodology for FY 2007

We appreciate the continuation of the LIP factor and teaching status factor. Facilities, which care for a higher percentage of low-income patients, do incur increased costs, which have been taken into account with the LIP factor implemented subsequent to the 2006 Final Rule.

Other Issues

In this proposed rule, CMS references a Post Acute Care Reform Demonstration Program, which will involve use of a discharge assessment tool by the acute care facility on the day of discharge, to determine the appropriate discharge placement for a Medicare patient needing post-acute care services. The use of such an instrument will pose a multitude of problems for Medicare recipients and their caregivers, and for providers. Post acute care providers are required to prepare for the admission of a patient by assessing the patient prior to admission to post acute care, and to determine that the patient meets qualification criteria for admission to those post acute settings. Acute care providers are not properly staffed to comprehensively assess a patient for post acute care

placement, and the patient and families need time to prepare for the transfer of a patient to another setting. IRFs and other post acute care providers are staffed to assess a patient, are required by CMS to assess the patient, and are capable of utilizing a common assessment instrument during a patient's acute care stay which assists with determining the proper post-acute care placement. CMS is urged to involve post acute care providers with various levels of post-acute care services in the development and implementation of the demonstrative project. Cardinal Hill Rehabilitation Hospital would welcome the opportunity to participate in such a demonstration project, as we offer all levels of post-acute care. We work very diligently to place the patient into the most appropriate and least costly level of care and adhere to Medicare requirements for admission.

Healthcare information initiatives and the use of health information technology

We recognize that CMS is committed to public disclosure of quality indicators for each level of healthcare, for which Medicare reimburses services. We urge CMS to assure that quality indicators chosen for reporting in IRFs will be appropriate to the IRF setting and be based on data, which is valid and reliable pursuant to a standardized scoring system.

We also recognize the value that health information technology can provide to CMS and to Medicare recipients. However, such technology is very costly, and is currently not appropriate to the specialized programs provided in rehabilitation. CMS is urged to acknowledge the cost of implementing a healthcare information technology program in the future and must adjust payments to providers to enable them to purchase the technology required.

We appreciate the opportunity to comment on this proposed rule. We urge CMS to seriously reconsider the significant changes to payments proposed, in order to allow IRFs to fully implement the changes from the Final Rule, the 75% Rule, and medical necessity requirements in the Local Coverage Determinations.

Sincerely,

Kerry G. Gillihan
President/CEO

BAM/plp

Submitter : **Mr. Steven Johnson** **Date: 07/07/2006**

Organization : **SSM Rehab**

Category : **Health Care Provider/Association**

Issue Areas/Comments

Proposed FY 2007 Federal Prospective Payment Rates

Proposed FY 2007 Federal Prospective Payment Rates

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services
Attention: CMS-1540-P
P.O. Box 8010
Baltimore, MD 21244-8010

Ref: CMS 1540-P
Inpatient Rehabilitation Facility Prospective Payment System for FY 2007, Proposed Rule

Dear Dr. McClellan,

As president of a not-for-profit rehabilitation hospital in St. Louis, Missouri, I am writing this letter to share my comments on the FY 2007 IRF PPS Proposed Rule.

SSM Rehab provides inpatient rehabilitation to more than 2,700 individuals recovering from traumatic injuries and illnesses each year. Until recently, we operated 132 beds at four acute hospital locations in the St. Louis region. In April 2006 we made the difficult decision to close two of those units as a direct result of CMS implementation of a new definition of medical necessity imposed by our Fiscal Intermediary, Mutual of Omaha. When Mutual applied this new definition to SSM Rehab, our patient volume dropped by a very significant 25 percent, a rate we certainly had not anticipated. Not only were we forced to reduce our number of beds and close two units, but we have had to turn away patients who we strongly feel need the level of medical rehabilitation that only an inpatient rehabilitation facility can provide.

On behalf of SSM Rehab, I want to share with you a number of concerns with the FY 2007 IRF PPS proposed rule.

First, the proposed rule would make significant changes to IRF reimbursement based on data collected before implementation of the 75% rule. Our own experience is the perfect example of the drastic impact the 75% rule already has had on inpatient rehabilitation facilities. We agree with other medical rehabilitation providers in recommending that CMS compile current data and analyze that -- data that actually reflects the current realities of the industry -- before moving forward with refinements to the rule. In the interim, we urge CMS to issue an interim rule or notice of an update.

We also have concerns about CMS failing to define appropriate care for patients currently being denied care by IRFs. CMS infers that patients previously served through IRFs who are now being denied this level of care are able to receive appropriate care in lower cost settings, primarily skilled nursing facilities (SNFs); yet, CMS does not define what appropriate care means. Further, it is not apparent that CMS has investigated whether these numerous patients once served in IRFs are obtaining reasonable outcomes in less intensive settings. Nor is it apparent that CMS has investigated or shown that that the cost of being served in those settings is really less than would have been incurred in an IRF setting, given the typical disparity in length of stay between those settings (SNF = 2-3 times the typical LOS for same condition when compared with IRF).

Another impact of the 75% rule that has been particularly problematic and grossly underestimated is how it has affected case mix for IRFs. Inpatient rehabilitation facilities are now forced to turn away patients who generally have a lower case mix weight and instead, have to depend more on admissions of patients with a higher case mix weight. The result is a rise in the cost per patient; yet, payments are not increasing at the same rate. The IRF PPS proposed rule does not take into consideration payment and cost differentials when making recommendations for refinements to the system.

We are appropriately concerned about the future state of inpatient rehabilitation facilities and our ability to care for the individuals who need this level of medical rehabilitation. We appreciate the opportunity to comment on the proposed rule and are hopeful that the Department of Health and Human Services and CMS will take these comments into consideration to refine and improve the IRF-PPS.

Sincerely,
Steven P. Johnson
President, SSM Rehab

Submitter : Ms. Crystal Estabrook **Date:** 07/07/2006

Organization : Iowa Health - Des Moines

Category : Hospital

Issue Areas/Comments

Proposed FY 2007 Federal Prospective Payment Rates

Proposed FY 2007 Federal Prospective Payment Rates

See attached file for comment.

CMS-1540-P2-53-Attach-1.DOC

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services

Attention: CMS 1540-P

Dear Administrator McClellan:

Iowa Health – Des Moines welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' proposed rule entitled "Medicare Program: Inpatient Rehabilitation Facility Prospective Payment System for FY 2007: Proposed Rule (71 Federal Register 28106)." Below are the comments that Iowa Health – Des Moines would like to address:

Proposed FY 2007 Federal Prospective Payment Rates

Iowa Health - Des Moines strongly disagrees with the proposal to reduce the Inpatient Rehabilitation Facility (IRF) payment rates by 2.9 percent for the 2007 FY as the impact of the reduction would be detrimental to the IRF unit.

Concerns regarding the proposed changes include:

- Payment policy changes in the IRF PPS cannot be considered exclusive of the impact of the 75 Percent Rule. Iowa Health – Des Moines more focused on complying with the 75 Percent Rule have implemented edit checks in order to monitor compliance. CMS should see changes in the case-mix indices in the future.
- CMS has used data for the analysis provided in the proposed rule from 1999 through 2002. The analysis contains fiscal years prior to the implementation of PPS and the 75 Percent Rule for the rehab facilities. For more accurate analysis, CMS should abstain from implementing the rate reduction and complete an analysis using more current claim data.
- CMS has recently implemented policy changes that would effect the payments to the rehab facility. The policy changes include: the FY 2006 case-mix group (CMG) modifications, tiered comorbidities, and relative weight changes.

Iowa Health – Des Moines recommends that CMS withdrawal the proposal to reduce the IRF Payment Rate and allow sufficient time to fully review the impact of the existing policy changes and the impact of compliance with the 75 Percent Rule to the IRF reimbursement system.

Sincerely,

Crystal Estabrook
Reimbursement Manager
Iowa Health – Des Moines

Submitter : **Mrs. Debbie Nelson** **Date: 07/07/2006**

Organization : **Baptist Hospital East**

Category : **Hospital**

Issue Areas/Comments

Other Issues

Other Issues

Proposed -2.9% coding adjustment
I am extremely concern about the reduction to adjust for coding changes. It is my belief and experience that payment increases related to coding is a direct result of the aggressive application and implemntaiton of the 75% rule, not the implied upcoding or aggressive coding to replace lost revenues. The implementation of the 75% rule has caused a shift in patient mix from hip and knee replacements with few or no comorbidities to higher paying, complex patients with multiple comorbidities. Implementing this adjsutment without consideration of the admission changes related to the 75% rule, punishes hospitals for meeting CMS requirements.

Deletion of DVT codes
I question the rationale for deleting codes 453.40, 453.41, and 453.42(deep vein thrombosis)which were just added last yr. When a person develops a DVT or is suspected to have developed one, typically a venous doppler ultrasound is ordered and the patient is put on bedrest until the test results come back. If the test is positive for DVT, appropriate medication must be started, lab tests run, and the patient is started back on full therapy when appropriate. This increases length of stay for that patient as well as increased costs and use of resources. The typical Rehab patient is at risk for DVTs and would recommend further study be done before these codes are eliminated.

Research on Medical Rehab and seamless system of post acute care
I would urge the following:
- involve actual rehab providers in the development and implementation of any research designed to measure the effectiveness of the post acute settings.
-CMS needs to provide funding and support for studies that rehabilitaiotn providers are currently undertaking.

In addition, as long as CMS continues to hold IRFs to a percentage rule of diagnoses, the percentage need not be raised beyond 60%. With all due respect, the continued application of this rule is far beyond the criteria for any other level of care and should be eliminated. Instead, the utilization and application of the acute medical rehab criteria teases out those not appropriate for Rehab without application of the rule.

I appreicate yuor condiseraiotn of these comments.

Proposed Changes to the CMG Relative Weights

Proposed Changes to the CMG Relative Weights

Respectfully ask that CMS rerun the recalibraiton of the weights so that it includes no only the proposed new comorbidity codes, but also utilizes the latest available data, rather than using the same 2002 & 2003 data used for the FY 2006 proposed and final rules. Given the need for more recent data to substantiate changes for FY 2007, I urge CMS to implement an interim final rule for FY 2007 that is based on more recent data. An interim rule would enable stakeholders to comment on the revised data and policies for FY 2007.