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200 First Street SW
Rochester, Minnesota 55905
507-284-2511

July 5, 2006

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

Re: File Code CMS-1540-P

Comments to Proposed Rule 71 FR 28106, Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2007; Proposed Rule

We appreciate the opportunity to provide comments on the proposed changes to the Inpatient Rehabilitation Facility (IPF) that were published in the May 15, 2006 Federal Register.

"Proposed FY 2007 Federal Prospective Payment Rates"

CMS proposes to apply a 2.9 percent reduction in the standard payment amount for FY 2007 to offset the effect of changes in coding that do not reflect real changes in patient acuity. This proposed adjustment is based on estimated data that is several years old which may not represent the current environment. RAND acknowledged limitations in their own data analyses for the two different sets of data used to estimate the 1.9 – 5.8 percent increase in payments attributable to coding.

We urge CMS to provide additional analysis with later, more recent data in order to validate there truly has been a behavior change in coding before implementing a second one-time 2.9 percent coding reduction. We believe analysis should be based on data following the FY 2006 refinements. Because of these reasons, we strongly oppose the proposed implementation of the second one-time only coding adjustment of 2.9 percent.

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Thank you for the opportunity to comment on this proposed rule and for consideration of our comments. If you have any questions, please contact Brenda Mickow at 507-284-1871 or me at 507-284-4627.

Very truly yours,

Ron Grousky/bjm

Ronald W. Grousky
Director, Medicare Strategy Unit

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CRA

Western Alliance for Rehabilitation
California Rehabilitation Association

June 29, 2006

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

To Whom It May Concern:

Please accept these written comments on the Center for Medicare & Medicaid Service's (CMS's) May 15, 2006 Notice of Proposed Final Rule, Amendments to the Inpatient Rehabilitation Facilities Prospective Payment System (IRF PPS), CMS-1540P; 71 FR 28106 et 5eq.

California Rehabilitation Association (CRA), the Western Alliance for Rehabilitation (Western Alliance) and its members respect and support the need to evaluate and refine the Prospective Payment System (PPS) - still in its infancy - and collectively meet the needs of our patients, providers and CMS. We pledge to effectively serve as a CMS partner and thank you for the opportunity to submit constructive comments.

CRA currently represents 39 Inpatient Rehabilitation Facilities (IRFs) in California, and the Western Alliance represents 59 IRFs in the Western United States. Collectively we serve over 29,000 acute inpatient rehabilitation admissions each year, of which more than half are Medicare beneficiaries.

Please note the following areas of concern and recommendations:

Implementation Using Pre-2005 Data in the Current Regulatory Environment
We currently provide extraordinary care to ensure our patients return to maximum mobility and independence, yet we provide services inside an extremely volatile environment due to Fiscal Intermediary (FI) review policies, increased audit activity (including Recovery Audit Contractors in California), and the archaic 75 Percent Rule. Last year we expressed our concerns about making numerous dramatic changes in the payment system, further restricting access to rehabilitation, while our industry is in the infancy of the PPS. Now CMS is proposing additional changes to FY 07 before analyzing 2005-06 IRF PAI data.

From the CRA/Western Alliance Annual Survey[1] we've noted that the average (mean) IRF admissions have decreased from 527/year in 2004 to 504/year in

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2005 (a 4% decrease or 1,357 less patients). According to the Moran Report[2], the actual volume decrease in patients nationwide is more than 59,000. These decreases in care are far beyond what CMS originally forecasted.

As we move forward, the case mix index (CMI) of our member facilities will continue to change, decreasing or completely eliminating care for shorter stay, less costly patients and increasing longer stay, more complex patients. This, paired with closing beds will most definitely result in a change in facilities' cost structure (which MedPAC noted in its recent March report[3]).

By October 1, 2006 when the proposed FY 07 changes become effective, the mandated regulations will apply to a patient and cost environment very different and more volatile from that which CMS has observed. The rehabilitation environment no longer reflects RAND's original research and policy recommendations.

And, the environment will continue to change. For instance, cerebral vascular accident (CVA) or stroke is currently one of the leading causes of death after heart disease and cancer in the United States ([4] Wolf, et al., 1992). It is estimated that 700,000 new strokes occur every year in the United States and about 500,000 of these are first attacks and 200,000 are recurrent strokes ([5]NSA, 2005). Stroke is also one of the leading causes of disability in the United States and at least 50% of the survivors suffer permanent neurologic disability and one third of the survivors undergo a second stroke which further compounds their disability ([6]AHA, 2005; Donnelly, et al., 2004). The incidence of long-term disability increases every year due to the longevity of the aging population ([7]Williams, 2001). About two-thirds of these have mild to moderate impairments; while one-third continue to be severely impaired ([8]University of Massachusetts, 2000).

We recommend, therefore, that CMS delay additional proposed coding reductions under the IRF-PPS until data from FY 2005 through FY 2006 is collected and analyzed; a prudent, appropriate approach.

If CMS does not collect such data and revise its proposals, our comments on the proposed changes follow.

Industry Review of Current Data

Although CMS refers to more recent analysis of data, the industry has not had the same access to the data (other than the RAND reports of 2002 data).

We recommend that CMS provide the industry with access to the 2002, 2003,and 2004 IRF-PAI claims and cost report data. We believe we are partners with CMS in delivering quality healthcare; therefore, our feedback could prove highly valuable, with our on-site day-to-day-experience perspective.

Proposed Tier Comorbidities Changes
By our estimation, the proposed changes in comorbidity tiers increase the conversion factor by $102 per case due to the budget neutrality factor of 10079; however, the industry does not have access to the RAND analysis.

We recommend that CMS provide the industry with access to the recent RAND analysis. Again, as we are in the trenches everyday, and may be able to provide an additional perspective to CMS.

Proposed Changes to the CMG Relative Weights
CMS proposes to update the relative weights based on "a revised analysis of the data used to construct the relative weights for FY 2006" and certain minor discrepancies it found.

We recommend that the industry be given access to the data, as our perspective and feedback are necessary in our mutual quest to provide quality healthcare.

In addition, we recommend that the IRF-PAI Training Manual be revised, incorporating all of the FY 06 and 07 changes.

Proposed Reduction of the Standard Payment Amount to Account for Coding Changes
CMS proposes a one-time adjustment to the standard payment conversion factor (in addition to the 1.9 percent reduction in FY 06) to account for coding changes observed (shift in tiers, comorbidity codes) during the first years of implementation of the IRF PPS and other analyses performed by Medicare Payment Advisory Commission (MedPAC). The current proposal reduces the standard payment amount by 2.9% which will reduce the average nation wide per case payment amount by $383.

We recommend CMS delay a further decrease in the standard conversion factor until more analysis using contemporary data can be completed. The proposed FY 07 change would cause even more volatility in this critical level of the rehabilitation continuum.

Also, we disagree with CMS's conclusions from their analysis. Please consider our alternate conclusions:

- Several factors contributed to lower IRF documented costs in 2002 and 2003 which were not related to change in case mix index.

- Since the implementation of the 75% rule in July, 2004 there has been a considerable change in the cost structure of facilities. There has been a decrease in occupancy and related shift from orthopedic cases to more complex cases, driving up per unit costs; and a slow increase in length of stay.

In fact, MedPAC acknowledged this dynamic during its discussion of the changes in the IRF margins and in Chapter 4 of its March 2005 *Report to Congress*[3]. The staff noted that as a result of the 75% rule, margins will continue to drop precipitously.

Standard Comprehensive Assessment Instrument Integration and Assessments

CMS states, "Section 5008 of the DRA provides a pathway to achieve the goals of the new model by providing for a demonstration on uniform assessment and data collection across different sites of service. We are in the early stages of developing a standard, comprehensive assessment instrument to be completed at hospital discharge and ultimately integrated with PAC assessments. The demonstration will enable us to test the usefulness of this instrument, and analyze cost and outcomes across different PAC sites. The lessons learned from this demonstration will inform efforts to improve the post-acute payment systems. The instrument is intended to cover the population admitted to all PAC settings (SNFs, IRFs, and long-term care hospitals) as well as residential-based PAC (home health agencies, outpatient programs).

We have evaluated existing assessment instruments used by managed care and other insurers. These instruments will form the basis of our efforts to create a hospital discharge assessment tool that may be used in the following ways: to facilitate post-hospital placement decision making; to enhance the safety and quality of care during patient transfers through transmission of core information to a receiving provider; and to provide baseline information for longitudinal follow-up of health and function."

We recommend that a field representative (and we would prefer an AMRPA representative) be included on the advisory groups to contribute in the development of the instrument and subsequent analysis. Further, we recommend CMS provide the rehabilitation industry access to the University of Colorado study.

In conclusion, we want to reiterate our strong belief that the 75 Percent Rule must be modernized to reflect current practice. Access to Inpatient Rehabilitation, SubAcute care, Skilled Nursing and Outpatient Rehabilitation could ideally be driven by medical necessity, nursing needs, medical complexity, medical monitoring, and amount of necessary therapy. We ask that CMS support extending the 60 Percent threshold for additional years, and retain comorbidities when the threshold increases to 75 Percent.

We also ask for CMS' support in funding research that studies the long term cost efficiency and outcome effectiveness of acute rehabilitation and post-acute rehabilitative care.

We thank you for your serious consideration of our comments and look forward to an open dialogue.

Sincerely,

Sean Hutchinson
President and CEO

References

[1] California Rehabilitation Association (CRA) (2005 & 2006). *Annual Medical Rehabilitation Survey*. Sacramento

[2] The Moran Company (2005). *New Estimates of the Impact of Enforcement of the Percent Rule on Inpatient Rehabilitation Volume*

[3] MedPAC (2006) *Report to Congress: Medicare Payment Policy*. Retrieved April 16, 2006 from World Wide Web: http://www.medpac.gov/publications/generic_report_display.cfm?report_type_id=1&sid=2&subid=0

[4] Wolf, PA, Cobb, JL, D'Agostino RB. (1992). Epidemiology of stroke. In: Barnett HJ, Mohr JP, Stein BM, Yatsu, FM eds. Stroke Pathophysiology, Diagnosis and Management. New York, NY: Churchill Livingstone, Inc. 3-27.

[5] National Stroke Association (NSA) (January 2005). National Stroke Association Recurrent Stroke Prevention Guidelines. Retrieved January 16, 2005 from the World Wide Web: www.stroke.org.

[6] American Heart Association (AHA) (2005). *Heart Disease and stroke statistics, 2005 update*. Dallas: AHA; 2003. Retrieved January 2005 from World Wide Web: www.americanheart.org/statistics/stroke.html.

[6] Donnelly, M, Power, M, Russell, M & Fullerton, K (2004). Randomized control trial of an early discharge rehabilitation service: The Belfast stroke trial. *Stroke*, 35: 127-133.

[7] Williams, GR (2001). Incidence and characteristics of total stroke in the United States. *BioMed Central Neurology*. Retrieved January 28, 2005 from the World Wide Web: www.biomedcentral.com/1471-2377/1/2.

[8] University of Massachusetts Medical School & the American Stroke Association (2000). Stroke Curriculum for Medical Students-PILOT text Module 1. Retrieved January 2005 from the World Wide Web: American Stroke Association website.

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Regulatory Affairs
PO Box 43 Mail Route 10105
Minneapolis, MN 55440-0043

ALLINA.
Hospitals & Clinics

July 5, 2006

Mark B. McClellan, M.D., Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1540-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: MEDICARE PROGRAM; INPATIENT REHABILITATION FACILITY PROSPECTIVE PAYMENT SYSTEM FOR FISCAL YEAR 2007, Federal Register, Vol. 71, No. 93, Monday, May 15, 2006; PROPOSED RULE – CMS-1540-P

Dear Dr. McClellan:

On behalf of Allina Hospitals & Clinics (Allina), I appreciate the opportunity to comment on the proposed rule concerning the Inpatient Rehabilitation Facility Prospective Payment System (IRF-PPS). Allina is a family of hospitals, clinics and care services that believes the most valuable asset people can have is their good health. We provide a continuum of care, from disease prevention programs, to technically advanced inpatient and outpatient care, to medical transportation, pharmacy and hospice services. Allina serves communities around Minnesota and in western Wisconsin.

Abbott Northwestern Hospital, our largest hospital, located in Minneapolis, Minnesota is recognized as one of the best hospitals in the country. The Sister Kenny Rehabilitation Institute (SKRI or Sister Kenny) is a center of excellence of Abbott Northwestern Hospital. Sister Elizabeth Kenny established SKRI in 1942 in response to the polio epidemic. Her pioneering principles of muscle rehabilitation became the foundation of modern physical therapy. SKRI comprises two hospital-based inpatient rehab facilities totally 55 beds, two spine centers, 20 outpatient physical therapy clinics, and many other specialty clinics. We treat over 1300 rehab inpatients a year, and more than 70,000 outpatients.

Thank you for this opportunity to present our comments and recommendations. Your efforts to support providers and beneficiaries with this payment structure are recognized. We have reviewed and analyzed the impact of the proposed rule. Our specific feedback on the proposed changes follows.

Proposed FY 2007 Federal Prospective Payment Rates

CMS proposes a one-time adjustment of a 2.9 percent reduction to the proposed standard payment conversion amount for FY 2007. This reduction is in addition to the 1.9% reduction we took in FY2006 for a total adjustment of 4.8percent. Allina opposes this reduction as the arguments in support of it are flawed.

First, CMS cites a RAND study that examined the interaction between case mix and coding changes. RAND used 1999 (pre-PPS) and 2002 (post-PPS) data to derive an estimate that between 1.9 and 5.8 percent of the increase in payments to IRFs was attributable to coding. Allina is concerned about the use of this data to support a decrease in payments as it is prior to the implementation of the 75 percent rule in 2005. In MedPAC's Report to the Congress: Medicare Payment Policy, they state that the number of IRF cases has dropped an estimated 9 to 14 percent since 2005, and that costs per case will rise in 2007 as IRFs spread total costs over fewer patients. Costs and payments are in a vastly different relationship now than for the years analyzed by RAND, which CMS uses to support the proposed 2.9 percent reduction.

Allina does not find persuasive the other two arguments CMS believes to be in support of the proposed reduction. First, it is claimed that the increased number of IRF-PAI forms with the co-morbidity of code 278.02, overweight (after an inadvertent inclusion as part of an update to the GROUPER software) shows that IRFs "...respond more rapidly to coding changes than we initially believed." The increased use of this code is more likely due to 2005 national coding compliance changes. We do not believe that all of these cases can be attributed to the CMS perception that providers may be "gaming the system." We would hope that CMS desires all facilities to accurately reflect the patient's status and costs through their coding.

The other argument CMS makes regarding the proposed 2.9 percent reduction is that the proportion of patients in each of the three higher paying tiers increased each year from 2002 to 2005, in spite of MedPAC's analysis that IRFs' costs "...**suggests** that patient severity was not increasing substantially over this time period." Again, the data relied on by CMS is pre-75 percent rule implementation, and thus ignores MedPAC's own analysis for 2007 showing substantial cost increases. In addition, CMS has not factored out the tier changes because of changes in the patient case-mix group. We would recommend that CMS use data that is more conclusive, than suggestive, in nature before it implements a reduction attributable to changes in coding practices.

We therefore advise CMS to defer a reduction to the standard payment conversion amount until RAND has an opportunity to analyze data that takes into account the true impact of the 75 percent rule since 2005.

Other Issues

Allina supports efforts to enhance the delivery and quality of post-acute care (PAC). We are intrigued by the idea of a "standard, comprehensive assessment instrument to be completed at hospital discharge and ultimately integrated with PAC assessments." We are concerned, however, that without a solid foundation upon which changes to PAC may be built, the resulting system may have the opposite intended effect.

Specifically, per MedPAC's report to Congress, we are concerned that CMS has still not convened an expert panel on the 75 percent rule in spite of the Commission recommending this twice. The report goes on to state:

> "A key issue has been whether diagnoses alone are enough to predict need for IRF-level care. The Government Accountability Office (GAO)(2005) studied the clinical appropriateness of the new 75 percent rule and determined that condition alone was insufficient for identifying appropriate types of patients for inpatient rehabilitation facilities. GAO suggested that additional criteria (such as functional status) be used to identify patients appropriate for IRFs and to classify these facilities, especially since not all patients with a given diagnoses require intensive rehabilitation."

In addition to this, we are aware of the "Workshop to Develop a Research Agenda on Appropriate Settings for Rehabilitation" held on February 14-15, 2005, and sponsored by the National Center for Medical Rehabilitation Research (NCMRR), the National Institute of Child Health and Human Development (NICHD), and the National Institutes of Health. We are concerned that CMS staff has not indicated interest in pursuing collaborative trials with them. This is very disconcerting as the ideas presented in the Summary Report of the workshop (found on-line at: http://www.nichd.nih.gov/about/ncmrr/workshop-dev-research-agenda.pdf) are aimed at data-driven questions around PAC that would, among other things, operationally standardize, and hence improve, treatment delivered PAC.

We are concerned that CMS is "jumping the gun" by failing to first address these substantive issues on diagnosis versus function in relation to IRF accessibility, and that the sincerity of CMS' desire to improve PAC could be readily demonstrated by collaboration with the trials suggested above.

We therefore recommend that CMS first pursue collaborative trials with NCMRR and NICHD per their request before further exploration of a standardized assessment instrument completed at hospital discharge.

We also recommend that CMS convene a national expert panel represented by stakeholders across the PAC for their input in the eventual development of such an instrument.

Proposed Revisions to the Classification Criteria Percentage for IRFs

We are concerned that CMS is committed to the full implementation of the 75 percent rule in the absence of an expert panel, as recommended by MedPAC, that would reach consensus on diagnoses to be included in the rule, as well as clinical criteria for patients within the respective diagnoses.

Specifically, we are concerned about the proposal that co-morbidities that meet the criteria as specified in §412.23(b)(2)(i) will not be used to determine the compliance threshold for cost reporting periods beginning on or after July 1, 2008. When CMS began to enforce the 75 percent rule, in addition to the use of Impairment Group Codes (ICGs) to determine compliance, CMS also gave an extensive list of co-morbidities that would count toward compliance regardless of the ICG. However, it also gave a list of etiologic diagnoses that would exclude counting toward compliance *in spite of* compliance based on the ICG. This will impact Sister Kenny in that we have treated many patients with spinal stenosis as an etiologic diagnosis. Not only has CMS not given any clinical, research-based reason for this exclusion, but it is now proposing to eliminate qualifying co-morbidities while retaining disqualifying ones. This approach is not only biased but without basis in factual support.

We therefore recommend that CMS delay its proposed discontinued use of co-morbidities to determine the compliance threshold for cost reporting periods beginning on or after July 1, 2008 until it first convenes an expert panel per MedPAC's recommendation, and pursues collaborative trials with NCMRR and NICHD, per above.

Thank you for your consideration of our comments on the proposed rule. If you have any questions about our comments please feel free to contact me at (612) 262-4912. We look forward to your response in the final rule.

Sincerely,

Nancy G Payne

Nancy G. Payne, RN
Director Regulatory Affairs

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TEXAS HEALTH RESOURCES

July 6, 2006

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

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

Dear Dr. McClellan:

On behalf of Texas Health Resources (THR) and its 13 faith-based, nonprofit community hospitals throughout North Texas, including Harris Methodist Hospitals, Arlington Memorial Hospital and Presbyterian Healthcare System, we appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed rule on the fiscal year 2007 Medicare Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) published in the May 15, 2006 *Federal Register*. Given the current instability faced by IRFs due to the "75% Rule," certain local coverage determinations (LCDs) and the fiscal year 2006 1.9 percent overall reduction in Medicare payments, THR strongly urges CMS to withdraw the proposed negative 2.9 percent coding adjustment and to delay further implementation of the 75% Rule phase-in.

CMS proposes providing the 2.9 percent overall reduction to adjust for coding increases as well as an inflationary update at the statutorily required market-basket rate of 3.4 percent, among other changes. Again, THR urges CMS to withdraw the negative 2.9 percent coding adjustment, which is based on limited analysis of outdated information that does not accurately reflect the recent significant revisions to the IRF PPS system.

The proposed rule, by using data from 1999 through 2004, specifically does not take into consideration the negative impact caused by the phase-in of the 75% Rule, which began in July 2004. According to the Moran Company's June 2006 report on the impact of the 75% Rule, 37,000 fewer patients were treated by IRFs during the first year of implementation of the 75% Rule (under a 50 percent threshold from July 2004 through June 2005). The Moran Company also estimates that during the second year of implementation of the 75% Rule (under a 60 percent threshold from July 2005 through June 2006) roughly 62,000 fewer patients will have accessed IRFs. The combined reduction of approximately 100,000 patients accessing IRFs in the first two years of the 75% Rule phase-in is not taken into account in the proposed rule, and the figure far exceeds CMS' estimate that only 7,000 fewer patients would be treated by IRFs during this same time frame.

Case mix and cost structure must also be revisited in light of changes made since 2004. Both the Medicare Payment Advisory Commission and the Moran Company's analysis have determined that the overall case mix in IRFs has changed significantly since 2004 in response to the 75% Rule. The percentage of joint-replacement cases is declining and the percentage of stroke cases is increasing—resulting in a higher overall case mix. The average length of stay and cost per case for IRFs has also increased as a result of this pattern and differs greatly from the conditions that existed during the period of focus in the proposed rule (1999 through 2003).

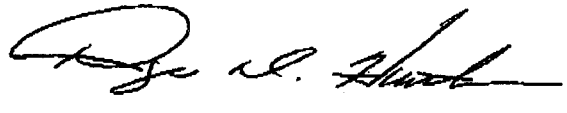
THR respectfully requests that CMS update its data and analysis in future rules. CMS should use the most recent payment and claims data and publicly disseminate the information along with paid, current and proposed case-mix groups and associated IRF patient-assessment data (as is the case with the annual rulemaking for the inpatient PPS).

CMS also proposes 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. But CMS fails to rebase the CMG weights, as it does annually for the diagnosis-related groups (DRG) of the inpatient PPS by incorporating the most current claims data. THR does not believe that CMS should impose further negative adjustments to the IRF PPS based on outdated data when the payment system was refined by restructuring and reweighting the CMGs in fiscal year 2006. This comprehensive fiscal year 2006 refinement should serve as the new baseline for this payment system, and analysis using information after the refinement would be needed to substantiate further reductions. As such, THR urges CMS to rerun the recalibration of the weights so that it includes not only the proposed new comorbidity codes, but also uses the latest available data. CMS could then issue the resulting changes in an interim final rule for fiscal year 2007.

CMS has also failed to take into consideration 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 fiscal year 2006 and the proposed negative 2.9 percent coding adjustment for fiscal year 2007 are redundant with the original behavioral offset. In short, CMS has already made more than enough downward adjustments with the implementation of the IRF PPS and the fiscal year 2006 refinement. IRF case mix, average length of stay and costs per stay are increasing. As such, THR strongly urges CMS to withdraw the proposed negative 2.9 percent coding adjustment and to delay further implementation of the 75% Rule phase-in.

Again, thank you for the opportunity to share our comments. We look forward to working with CMS to resolve these issues and concerns. If we can provide you or your staff with additional information, please do not hesitate to contact David Tesmer, Senior Vice President of Advocacy and Community Benefit, at 817-462-7937 or by e-mail at DavidTesmer@TexasHealth.org.

Sincerely,



Douglas D. Hawthorne, FACHE
President and CEO
Texas Health Resources