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Darrell G. Kirch, M.D.
President

July 7, 2006

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

Attention: CMS–1540–P

Dear Dr. McClellan:

The Association of American Medical Colleges (AAMC) welcomes this opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS or the Agency) proposed rule entitled *"Medicare Program; Inpatient Rehabilitation Facility (IRF) Prospective Payment System for Federal Fiscal Year 2007; Proposed Rule"* 71 Fed. Reg. 28105 (May 15, 2006). The AAMC represents approximately 400 major teaching hospitals and health systems; all 125 accredited U.S. allopathic medical schools; 96 professional and academic societies; and the nation's medical students and residents.

We have serious concerns about the proposed "one time" 2.9 percent cut in the standardized payment amount for federal fiscal year (FFY) 2007 to account for so-called "changes in coding practices that do not reflect real changes in [rehabilitation facilities'] case mix." (71 Fed. Reg. at 28109). The analysis on which the proposed reduction is based utilizes limited and old data. Moreover, the analysis does not take into account recent changes that are affecting IRFs case mix indices, including the effects of the so-called 75 percent rule.

A. Background

In FFY 2006, CMS applied a 1.9 percent payment reduction to the standardized payment amount to account for what the Agency believed were changes in providers' coding practices that resulted in higher PPS payments but were not related to increases in the complexity of the patients treated. The amount of the reduction was based on analyses conducted for CMS by the RAND Corporation (RAND). Using data from 1999 and 2002, RAND found that hospital coding practices were responsible for PPS payment

increases between 1.9 and up to 5.8 percent, but acknowledged that due to data limitations, the 5.8 percent estimate was a "high end estimate." (71 Fed. Reg. at 28123).

Also aware of the limitations of RAND's data analysis CMS decided to implement the low-end 1.9 percent reduction to the standard payment amount, because the Agency wanted to "provide some flexibility to account for the possibility that all or some of the observed changes may have been attributable to factors other than coding changes or could be temporary changes associated with the transition to a new payment system." (ibid.)

B. Proposed 2.9 Percent Payment Reduction

While it is not clear how CMS determined that the payment reduction should be 2.9 percent, CMS seems to rely, at least in part, on the same RAND analysis that was used in determining the 1.9 percent cut for FFY 2006. The Agency augmented the RAND analysis by doing a limited examination of coding trends through 2005. The proposed rule also notes that according to the Medicare Payment Advisory Commission (MedPAC), margins for IRFs increased from 1.5 percent in 2001 to 16.3 percent in 2004. MedPAC analyses also indicate that IRF cost increases in 2003 and 2004 were lower than the corresponding increase in PPS payments, suggesting that the payment increases were due to coding practices, not patient complexity.

C. The 75 Percent Rule and Recent Payment Changes Call Into Question Another Payment Reduction

Several significant changes have occurred since the timeframe that the analyses discussed in the proposed rule were developed. Perhaps most important are the patient mix changes that have occurred, and will continue to occur, as a result of the transition to the "75 percent rule." Under this rule, 75 percent of an IRF's patients must meet one of 13 designated medical conditions in order to be paid under the IRF PPS. Because, for myriad reasons, many IRFs have not met that threshold, it is being phased in. Between July 1, 2004 and June 30, 2005 the threshold was set at 50 percent. For July 1, 2006 through June 30, 2007 the threshold is 60 percent. The 75 percent threshold will not be required until July 1, 2008.

The number and types of patients that will be treated at IRFs will likely significantly change as IRFs transition to the 75 percent threshold. The analyses conducted by RAND, CMS and MedPAC do not appear to have taken into account these case mix changes.

Moreover, CMS implemented a number of significant coding changes in FFY 2006. The impact of these changes on IRF payments is not yet known, raising further questions as to the wisdom of implementing a prospective payment reduction.

In addition to the payment reduction in FFY 2006, CMS implemented a 16 percent "behavioral offset" payment reduction when the IRF PPS was introduced. Implementing a third "one time" adjustment seems at best premature, and more likely redundant and excessive. We urge CMS to withdraw the proposed 2.9 percent reduction.

If you have questions concerning these comments, please contact Karen Fisher (kfisher@aamc.org or 202-862-6140) or Diana Mayes (dmayes@aamc.org or 202-828-0498).

Sincerely,

Darrell G. Kirch

Darrell G. Kirch, M.D.

cc: Robert Dickler, AAMC
Karen Fisher, AAMC
Diana Mayes, AAMC

HAP

THE HOSPITAL & HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA

JUL -7 2006

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July 7, 2006

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

Dear Dr. McClellan:

On behalf of The Hospital & Healthsystem Association of Pennsylvania (HAP)—a statewide membership services organization that advocates for nearly 250 Pennsylvania acute and specialty care, primary care, subacute care, rehabilitation, long-term care, home health, and hospice providers, as well as the patients and communities they serve—we appreciate the opportunity to comment on the fiscal year 2007 proposed rule for the inpatient rehabilitation facility prospective payment system (IRF PPS).

Overall, HAP is concerned that the Centers for Medicare & Medicaid Services (CMS) is again basing its proposals on old data that does not reflect the current environment of IRFs nor the changes in IRF patient population induced by the 75% Rule, modification of local coverage determinations, and other factors. IRFs have experienced several years of extreme liability and changes to the IRF PPS predicated on data reflective of the IRF environment prior to introduction of modifications to the 75% Rule are at best erroneous, and at worst could further erode access to IRF services. With this overarching comment as a backdrop, we offer the following specific comments.

Proposed Negative 2.9 Percent Coding Adjustment

HAP is concerned that CMS does not consider claims data analysis that shows a reduction of 100,000 patients accessing IRF services during the first two years of the phased-in implementation of the 75% Rule in offering the current proposal. This, despite the fact that the reduction of 100,000 patients far exceeds CMS' estimated impact of 7,000 fewer patients that would be seen in IRFs during the first two years of the 75% Rule phase-in. In addition, CMS already accounted for improved coding in fiscal year 2006 with a 1.9 percent across-the-board decrease in Medicare payments to IRFs. The proposal is particularly questionable in light of the fact that CMS is proposing to impose additional adjustments to the IRF PPS based on 1999-2002 data, when the payment system was refined by restructuring and reweighting of the case-mix groups (CMG) in

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fiscal year 2006. Finally, the proposal also overlooks the *16 percent* "behavioral offset" already applied to the payment system when the IRF PPS was initially implemented in January 2002.

Recommendation: HAP strongly urges CMS to withdraw its proposal to implement an additional coding adjustment. HAP recommends that the comprehensive fiscal year 2006 refinement of the CMGs should serve as a new baseline for the IRF PPS. Analysis to justify further coding adjustments must be based on data from after the fiscal year 2006 refinement.

Proposed Changes to the CMG Relative Weights

CMS is proposing to reweight the IRF PPS CMGs to account for proposed changes to the comorbidity codes used to calculate Medicare payments per patient. However, HAP is concerned that CMS is not also recalibrating the weights using the latest available data.

Recommendation: HAP encourages CMS to rerun the recalibration of weights to include not only the proposed new comorbidity codes, but also the latest available data and to issue the recalibrated weights in an interim final rule with opportunity for public review and comment.

Research on Medical Rehabilitation

CMS has expressed its belief that less intensive settings save money for the Medicare program, but there is inadequate research to support this assumption. HAP's Council for Medical Rehabilitation, comprised of chief executive officers of Pennsylvania's rehabilitation hospitals and administrators of Pennsylvania hospital-based rehabilitation units, supports research to validate what their experience tells them: high quality inpatient rehabilitation services can save money in the long-run by optimizing outcomes and supporting patients in their return to independence. Many of our IRFs believe CMS is being "penny-wise and pound-foolish" in restricting access to IRF services and welcome the opportunity to prove their assertion.

Recommendation: HAP urges CMS to provide research funding to test its hypothesis that less intensive settings can save the Medicare program money and not compromise patient outcomes.

Post-Acute Care Demonstration

Particularly in light of our broad membership—which includes not only hospitals, but also home health, rehabilitation, long-term care, hospice, and other providers—HAP supports the post-acute demonstration project authorized by the Deficit Reduction Act of

2005. We support better alignment of the payment system with the clinical characteristics of post-acute patients.

HAP thanks CMS for the opportunity to comment on this proposed rule. Questions may be addressed to Cheri Rinehart, vice president, integrated delivery systems, and staff to the HAP Council for Medical Rehabilitation, at crinehart@haponline.org, or (717) 561-5325.

Sincerely,

Paula A. Bussard

PAULA A. BUSSARD
Senior Vice President
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PAB/dd

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July 7, 2006

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

Dear Dr. McClellan:

On behalf of Southern Indiana Rehab Hospital (SIRH), a 60 bed Inpatient Rehabilitation Facility (IRF) located in New Albany, Indiana, we are submitting our comments on the IRF Prospective Payment System Rule for the Federal Fiscal Year 2007.

SIRH 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; and SectionVI: Revisions to the Classification Criteria Percentage for IRFs.

Section II A: Refinements to the Patient Classification System

SIRH appreciates CMS's efforts to make refinements to the list of comorbidities that are relevant to patients being served in the inpatient rehabilitation. However we disagree with some of the recommendations. SIRH requests that CMS retain the ICD-9 codes listed in Table 2 that are proposed to be deleted in this rule. Many patients with multiple diagnoses have been immobile for extended periods and are susceptible to developing a deep vain thrombosis (DVT) or may have already experienced a DVT and are continuing on their anticoagulation medication. This complicates the patient's ability to participate in their rehabilitation program.

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

While the market basket update of 3.4 percent, which was required by statute, is greatly appreciated, we feel it is not appropriate to implement the 2.9 percent across the board reduction to adjust for coding changes. The implementation of the 75 % rule at the 60 % level has forced Inpatient Rehab Facilities (IRFs) to limit admissions of patients in the orthopedic, pulmonary and many other diagnostic groups and to increase the percentage of

admissions of patients with more co-morbidities who require more resources to complete their recovery process.

CMS continues to utilize data from 1999-2002 as a basis for these decisions. SIRH for sure, and most all other IRFs, in my opinion have changed the way we evaluate patients that are in potential need of inpatient rehabilitation since that period. The rehab industry has always attempted to comply with any changes that CMS has proposed, but quite simply, we believe these recommendations are going to be devastating to the industry, but more significantly, the patients who need our services. In fact, the Med-PAC report on this topic states that IRF margins are and will continue to decline as these changes are implemented.

Additionally, we believe CMS has duplicated a portion of the payment cuts. The 1.9% coding reduction that was implemented in fiscal year 2006 and the proposed 2.9% negative behavior coding reduction appear to be based on the same "behavioral offset".

CMS has already made changes that will impact the ability to care for patients for years to come and SIRH strongly recommends that CMS withdraw the proposed 2.9 % coding reduction.

Section VI: Revisions to the Classification Criteria Percentage for IRFs

SIRH has been providing high quality rehabilitation care for 12 plus years and is proud of the outcomes our patients have achieved as well as the cost effective manner in which those results have occurred.

We recognize the duty CMS has to manage the overall ability of America's healthcare system to meet the needs of all Medicare recipients is unfathomably large. However, we believe the decisions regarding the 75 % rule are based on a system that is 20 years old and have not taken into consideration the changes that have occurred in the American healthcare system during this period that have increased life expectancies. Restricting access to acute rehabilitation services will result in decreases in quality of life.

We respectfully request that you agency give more serious consideration to the negative impact on the lives of our senior citizens before a terrible mistake is made by CMS in order to meet external pressures and time constraints.

Thank you for your consideration.

Sincerely,

Randy L. Napier

President and CEO

Southern Indiana Rehab Hospital

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July 6, 2006

JUL -7 2006

Dr. Mark B. McClellan, M.D., Ph.D.
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Washington, D.C. 20201

ATTN.: CMS-1540-P

Re: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2007; Proposed Rule, Federal Register, Volume 71, No. 93, Monday, May 15, 2006

Dear Dr. McClellan:

On behalf of our approximately 200 member hospitals or health care systems, the Illinois Hospital Association (IHA) is taking this opportunity to formally comment on the proposed rule establishing new policies and payment rates for inpatient rehabilitation services for fiscal year 2007. Accordingly, the Illinois Hospital Association presents the following comments for your consideration:

PROPOSED FY 2007 FEDERAL PROSPECTIVE PAYMENT RATES:

- **Implementation of an across the board reduction of 2.9%:** CMS has proposed an across the board reduction of 2.9% for all CMG payment rates; its rationale for doing so is that coding improvements and not patient acuities, are driving increases in payments under the Inpatient Rehabilitation Facility Prospective Payment System (IRF-PPS). The reduction was the result of CMS' analysis of Patient Assessment Instrument data from 2002 through 2005. In 2006, CMS applied a "one-time" reduction of 1.9% to account for coding changes between 1999 and 2002 that were unrelated to changes in case mix.

The Illinois Hospital Association is concerned that these "one-time" reductions will become annual reductions to the standard payment rate, focusing more on reducing payments than reflecting actual changes in case mix. Providers of rehabilitative services still require fair payments, payments that recognize the effects of inflation on those providers. Reductions to the increase to the standardized payment rate such as the aforementioned 2.9% penalize those providers that have not experienced substantial case mix changes, but yet, do experience the full impact of cost inflation on the costs of the services they do provide.

- **Increase in the fixed loss threshold:** CMS has proposed increasing the outlier loss threshold from $5,129 to $5,609, a 9.4% increase. The agency's rationale is

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that this increase is necessary in order to maintain the outlier dollar pool at 3% of total IRF payments. Because past increases in the outlier thresholds in other Medicare prospective payment systems (i.e., the inpatient acute DRG system) have resulted in unspent outlier funds, the Illinois Hospital Association requests that CMS, as best as possible, re-examine and verify the data used in its determination of the FY 2007 proposed amount.

- **Increase in the add-on for rural facilities:** Maintaining quality patient access to services in rural facilities has long been an objective of not only the Illinois Hospital Association, but of CMS as well. Therefore, to ensure that Medicare residents of rural communities continue to have access to needed healthcare services, **IHA supports an increase in the rural add-on for payments to rural facilities providing rehabilitation services.**

Dr. McClellan, thank you again for the opportunity to comment. The Illinois Hospital Association welcomes the opportunity to work with your agency in the continued development and refinement of the Medicare payment system.

Sincerely,

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CSM 2007:
Combined Sections Meeting
February 14–18, 2007
Boston, Massachusetts

PT 2007:
The Annual Conference & Exposition of the American Physical Therapy Association
June 27–30
Denver, Colorado

July 6, 2006

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Submitted electronically and by hand

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

Dear Dr. McClellan:

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

APTA commends CMS for its efforts to update the prospective payment system to accurately reflect the costs of treatment in the inpatient rehabilitation setting. Although we feel that CMS has made strides in the right direction, there are a few issues that we would like to address that affect the practice of physical therapy.

"Revisions to the Classification Criteria Percentage for IRFs"

As with previous rules, APTA is still very concerned about the implementation of the classification criteria percentage for inpatient rehabilitation facilities, known as the "75% rule". The criterion sets a minimum percentage of the facility's total inpatient population that must meet one of thirteen medical

conditions listed in the regulation in order for the facility to be classified as an IRF. This minimum percentage is known as the "compliance threshold". The FY 2007 proposed rule discusses the revised "75% rule" phase-in implementation as mandated by the Deficit Reduction Act of 2005 (DRA) which extends the full compliance threshold of 75 percent until July 1, 2008. APTA contends that the "75% rule" continues to reduce IRF admissions based on outdated diagnosis-based criteria.

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

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

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

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

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

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

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

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

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

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

For example, a patient with a simple intertrocanteric fracture of the hip and subsequent pinning may not require inpatient rehabilitation. However, a patient with a subcapital fracture of the hip that is not a candidate for an arthroplasty requires up to three months of non-weight bearing status and may be an excellent candidate for inpatient

rehabilitation. In addition, a patient with either type of fracture may have comorbidities including obesity, cardiac and pulmonary problems that will limit the patient's ability to use assistive ambulation aides and seriously decrease their potential to achieve independence in activities of daily living.

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

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

Post Acute Care Demonstration

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

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

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

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

Sincerely,

G. David Mason
Vice President, Government Affairs

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CALIFORNIA
HOSPITAL
ASSOCIATION

Providing Leadership in Health Policy and Advocacy

July 7, 2006

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

Dear Dr. McClellan:

California Hospital Association (CHA), on behalf of its nearly 500 hospital and health system members, respectfully submits comments on proposed changes to the fiscal year (FY) 2007 inpatient rehabilitation facility prospective payment system (IRF PPS).

Among other changes, the Centers for Medicare & Medicaid Services (CMS) proposes providing an inflationary update at the statutorily required market-basket rate of 3.4 percent, a 2.9 percent across-the-board reduction to adjust for coding increases, and several adjustments to the changes made in last year's system refinement that significantly revised the IRF PPS.

CHA is very concerned that the negative 2.9 coding adjustment, as well as other proposals in this rule, is based on substandard and limited analysis of old data that do not reflect the current environment and strongly urges CMS to withdraw it. CHA also urges CMS to update its data and analysis in subsequent rules. CHA's detailed comments follow.

Data-related Concerns

It is inappropriate for CMS to proceed with rulemaking on IRF payment policy using old and irrelevant data, as it did for FY 2006 and again in its FY 2007 proposal. We encourage CMS to adjust its internal protocols to ensure that future rulemaking uses the most recent payment and claims data available. It is unclear why CMS allocates the resources to meet this standard for the inpatient PPS but fails to meet this reasonable and worthwhile goal for other payment systems such as the IRF PPS. For instance, the proposed FY 2007 inpatient PPS rule was based on the May 2004 claims data.

In addition to using the most recent payment and claims data, CMS should publicly disseminate this data along with the paid, current and proposed case-mix groups (CMG) and associated IRF patient-assessment instrument data. This type of data release would be similar to the process

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CMS carries out for the inpatient PPS annual rulemaking. It is a critical step that enables hospitals to develop robust recommendations on how to improve the proposal. Under the current scenario, in which the IRF PPS proposed rule has been published without the provider-identified facility-level impact file, the field faces an analytical handicap that, in the long run, is also a hindrance to CMS, since the resulting analytical limitations prevent stakeholders from developing stronger public comments.

Proposed Changes to the CMG Relative Weights

CMS is proposing to reweight the IRF PPS CMGs to account for proposed changes to the comorbidity codes used to calculate Medicare payments per patient. The agency states that it "propose[s] to update the CMG relative weights for FY 2007 to ensure that they continue to reflect as accurately as possible the costs of treatment for various types of patients in IRFs." Yet CMS also fails to rebase the CMG weights, as it annually does for the diagnosis-related groups of the inpatient PPS, by incorporating the latest claims data. This opportunity has been inappropriately bypassed in this proposed rule and prior IRF PPS updates.

CHA urges CMS to recalibrate the weights to include not only the proposed new comorbidity codes, but also 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 recommend that CMS implement an interim final rule for FY 2007 that is based on more recent data. An interim final rule would enable stakeholders to comment on the revised data and policies for FY 2007.

Proposed 2.9 Percent Coding Reduction

In FY 2006, CMS implemented a 1.9 percent across-the-board payment cut to offset coding increases from 1999 to 2002. RAND Corporation had estimated coding increases ranging from 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 lack of supporting analysis, CHA questions the need for the proposed 2.9 percent cut for FY 2007 and believes it should be withdrawn in the final rule.

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

Questions have recently been raised pertaining to the transition to restructured and rebased CMGs in FY 2006. Early analyses by the Lewin Group and others indicate this transition likely produced a 3 percent decrease in overall case mix — and, subsequently, Medicare payments to

IRFs during FY 2006. The effect of transitioning to the new CMGs was neither discussed nor accounted for in the budget neutrality adjustments in the FY 2006 final rule. This reduction was distinct from the FY 2006 coding-related cut of 1.9 percent. Final analysis of this matter is pending and CHA urges CMS to evaluate this work closely. It would be appropriate for CMS to discuss its findings on this sensitive matter in an interim final rule for FY 2007.

The proposed 2.9 percent cut raises other questions: Why, for example [since there's only one 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? The comprehensive FY 2006 refinement should serve as a new baseline for this payment system. As such, CMS would need further data analysis using information after the refinement to substantiate further reductions.

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

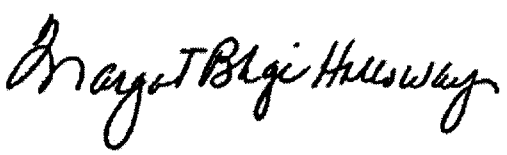
> "account(s) for change in practice patterns due to new incentives in order to maintain a budget neutral payment system. Efficient providers are adept at modifying and adjusting practice patterns to maximize revenues while still maintaining optimum quality of care for the patient. We take this behavior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

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

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

Thank you for the opportunity to provide comments on this proposed rule. If you have any questions or would like to discuss these comments, please contact me at (202) 488-4688 or mholloway@calhospital.org.

Sincerely,



Margot Holloway
Vice President, Federal Regulatory Affairs