

Submitter : Mr. Ingo Angermeier
Organization : Spartanburg Regional Healthcare System
Category : Health Care Professional or Association

Date: 05/19/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Submitter : Mr. Mark Hyder
Organization : Mountain Land Rehabilitation
Category : Physical Therapist

Date: 05/19/2005

Issue Areas/Comments

Issue

Response to Comments

It has come to my attention that there is serious discussion of eliminating the 'Grace Days' for the 5-day MDS for Medicare Part A patients. I feel that this will eliminate the patients' rights to seek the appropriate level of treatment. The CMS criteria asks for 7 days worth of information on the current MDS. By allowing only 5 days to collect information, using a 7-day standard, the system would literally rob the patients of a fair assessment period. This change would also assume that a newly-transferred resident is appropriate for evaluation by skilled rehabilitation after an exhausting, and often late-day, transfer.

I understand the need for fiscal responsibility and management. But, in a system that was introduced as placing the patients' needs at the forefront of RUG categorization, you are eliminating the opportunity for fair categorization. If 7 days of information is required, then there should be at least 7 days in which information can be collected. In my opinion, the current assessment period and additional grace days is appropriate for the fragile, medically complex patients that require skilled rehabilitation intervention.

Submitter : Ms. Elizabeth Henson
Organization : Rehabilitation Nurses
Category : Nurse

Date: 05/20/2005

Issue Areas/Comments

Background

Background

Page 22- "As the differentiation among provider types (such as SNFS and IRFs) becomes less pronounced.

Issue

Response to Comments

If you actually experience acute inpatient rehab and then SNF care, you become aware of the BIG difference in care and rehabilitation. Please consider asking patients about that difference.

Provisions of the Proposed Rule

page 77-proposed optimal weights

Please review nursing research related to why patients go to nursing homes. The reason most cited is incontinence. The average optimal weight for bowel and bladder should be at least 1.

Date: 05/20/2005

Submitter : Mrs. Linda Elliott
Organization : Shannon Medical Center
Category : Hospital
Issue Areas/Comments

GENERAL

GENERAL

scc attachment

CMS-1290-P-4-Attach-1.DOC

TO: Department of Health and Human Services
Centers for Medicare & Medicaid Services
RE: 42 CFR Part 412
(CMS – 1290 – P)
RIN 0938 –An43
Medicare Program; Inpatient Rehabilitation Facility
Prospective Payment System for FY 2006

TABLE 3 – Inpatient Rehabilitation Facilities with Corresponding State and County Location;
Current Labor Market Area
Designation; and Proposed New CBSA-Based Labor Market Area Designation. Page 383

In the table below an error has occurred.

FY 06	FY 06	SSA
Provider Number	Provider Name	State & SSA
MSA	CBSA	County Code
Code	Code	
45T571	should be	SHANNON WEST TEXAS MEDICAL HOSPITAL 39530
7200	41660	
	not	Sharon Regional Health System

The name is incorrect---the correct name is showing in the line above.

Provider Number	Provider Name	SSA State and County Code	FY 06 MSA Code	FY 06 CBSA Code
10001	AMERICAN MEDICAL CENTER	01000	0000	0000
10002	AMERICAN MEDICAL CENTER	01000	0000	0000
10003	AMERICAN MEDICAL CENTER	01000	0000	0000
10004	AMERICAN MEDICAL CENTER	01000	0000	0000
10005	AMERICAN MEDICAL CENTER	01000	0000	0000
10006	AMERICAN MEDICAL CENTER	01000	0000	0000
10007	AMERICAN MEDICAL CENTER	01000	0000	0000
10008	AMERICAN MEDICAL CENTER	01000	0000	0000
10009	AMERICAN MEDICAL CENTER	01000	0000	0000
10010	AMERICAN MEDICAL CENTER	01000	0000	0000
10011	AMERICAN MEDICAL CENTER	01000	0000	0000
10012	AMERICAN MEDICAL CENTER	01000	0000	0000
10013	AMERICAN MEDICAL CENTER	01000	0000	0000
10014	AMERICAN MEDICAL CENTER	01000	0000	0000
10015	AMERICAN MEDICAL CENTER	01000	0000	0000
10016	AMERICAN MEDICAL CENTER	01000	0000	0000
10017	AMERICAN MEDICAL CENTER	01000	0000	0000
10018	AMERICAN MEDICAL CENTER	01000	0000	0000
10019	AMERICAN MEDICAL CENTER	01000	0000	0000
10020	AMERICAN MEDICAL CENTER	01000	0000	0000
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10026	AMERICAN MEDICAL CENTER	01000	0000	0000
10027	AMERICAN MEDICAL CENTER	01000	0000	0000
10028	AMERICAN MEDICAL CENTER	01000	0000	0000
10029	AMERICAN MEDICAL CENTER	01000	0000	0000
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10035	AMERICAN MEDICAL CENTER	01000	0000	0000
10036	AMERICAN MEDICAL CENTER	01000	0000	0000
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10044	AMERICAN MEDICAL CENTER	01000	0000	0000
10045	AMERICAN MEDICAL CENTER	01000	0000	0000
10046	AMERICAN MEDICAL CENTER	01000	0000	0000
10047	AMERICAN MEDICAL CENTER	01000	0000	0000
10048	AMERICAN MEDICAL CENTER	01000	0000	0000
10049	AMERICAN MEDICAL CENTER	01000	0000	0000
10050	AMERICAN MEDICAL CENTER	01000	0000	0000

Submitter : Ms. Mary Spence
Organization : Phoebe Putney Memorial Hospital
Category : Nurse

Date: 05/23/2005

Issue Areas/Comments

Background

Background

Inpatient Rehabilitation Facility PPS for FY 2006: Table 3, Inpatient rehabilitation facilities with corresponding state and county location: current labor market area designation, and proposed new CBSA-based labor market area designation, page 377.

GENERAL

GENERAL

This is not a comment on the proposed changes directly, but thought you should know that the name and ID numbers of two hospitals have been transposed. On page 377, table 3 Phoebe Putney and Phoenix Baptist Hospital have been transposed, so that each facility is listed with the Provider number, SSA state and count code, FY 06 MSA code and CBSA code of the other facility. Thank you.

Submitter :

Date: 05/24/2005

Organization :

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

There are errors in Table 3. The correct provider number for McKay-Dee Hospital is 46T004. Its FY 2006 MSA Code is 7160 and its FY 2006 CBSA Code is 36260. In addition, the correct provider number for Utah Valley Regional Medical Center is 46T001. Its FY 2006 MSA code is 6520 and its FY 2006 CBSA Code is 39340.

Submitter : Ms. Anne Woodson
Organization : Sharp HealthCare
Category : Hospital

Date: 05/31/2005

Issue Areas/Comments

GENERAL

GENERAL

The data in Table 3 (Inpatient Rehabilitation Facilities with Corresponding State and County Location; Current Labor Market Area Designation; and Proposed New CBSA-Based Labor Market Designation) appears to be incorrect as it relates to our hospital.

Sharp Memorial Rehabilitation Center is Provider #05-T100; SSA #49430; MSA #7320 and CBSA #41740. It is not provider #39-T211; SSA #05470, MSA #7610 or CBSA #49660. The correct data appears on the line below, corresponding to another hospital name.

Submitter : Ms. Sue Moriwaki
Organization : Rehabilitation Hospital of the Pacific
Category : Hospital

Date: 05/31/2005

Issue Areas/Comments

Issue

Proposed FY 2006 Federal Prospective Payment Rates

The provider number, MSA and CBSA codes on Table 3 for "Rehabilitation Hospital of the Pacific" (REHAB) are incorrect. The provider number shows "313036", however our provider number is 123025. The MSA code for Honolulu, Hawaii according to Table 1A is 3320, but on Table 3, it shows REHAB's MSA code to be 8760. The CBSA code for Honolulu, Hawaii is 26180 on Table 2A, but on Table 3, it shows REHAB's CBSA code to be 47220.

It appears that the facility listed below REHAB on Table 3, "Rehabilitation Hospital of Tinton Falls" is listed with our provider number and the MSA and CBSA codes for Honolulu, Hawaii. REHAB appears to have the MSA and CBSA codes for Vineland, New Jersey, the location of the facility listed above us on Table 3, "Rehabilitation Hospital of South Jersey".

Submitter : Ms. Kimberly Rzomp
Organization : Chambersburg Hospital
Category : Health Care Industry

Date: 06/07/2005

Issue Areas/Comments

GENERAL

GENERAL

Page 30310 Federal Register has an incorrect Provider Number for Chambersburg Hospital. Our provider number is 39T151, not 45T035.

Submitter : Mr. James stansel
Organization : Mr. James stansel
Category : Individual

Date: 06/09/2005

Issue Areas/Comments

Background

Background

This must be taken care of now, not later

Regulatory Impact Statement

Regulatory Impact Statement

This must be taken care of now, not later

Submitter :

Date: 07/13/2005

Organization : Medicare Payment Advisory Commission

Category : Federal Government

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1290-P-13-Attach-1.PDF



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Glenn M. Hackbarth, J.D., Chairman
Robert D. Reischauer, Ph.D., Vice Chairman
Mark E. Miller, Ph.D., Executive Director

July 13, 2005

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

Re: File code CMS-1290-P

Dear Dr. McClellan:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule entitled *Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for FY 2006*, Federal Register, Vol. 70, No. 100, p. 30188 (May 25, 2005). We appreciate your staff's work on this prospective payment system (PPS), particularly given the competing demands on the agency. We have two comments: One is related to the need for CMS to be transparent in its rules and software used for determining whether inpatient rehabilitation facilities (IRFs) are in compliance with the 75 percent rule and one is related to the need for CMS to be consistent in implementing the new labor market areas.

Transparency on IRFs' compliance with the 75 percent rule

Both IRFs and CMS share responsibility for compliance. CMS must have clear, transparent rules and IRFs must follow them. Therefore, CMS needs to make the computer software used to determine compliance transparent and available to interested parties. To assist fiscal intermediaries in their determinations of compliance, the Iowa Foundation for Medical Care, under contract with CMS, created a computer software program called CASPER. CASPER uses ICD-9 codes from IRF patient assessment instruments with an algorithm to determine compliance. Having the CASPER software available to IRFs for their own use makes it fairer if a facility is found out of compliance with the 75 percent rule.

Consistency in implementing new labor market areas

CMS proposed a transition to new labor market areas for hospitals, but did not propose a similar transition for IRFs. Providers should be treated equitably so we support a change in areas. However, large payment changes should be phased in over time so IRFs should be treated consistently with acute hospitals. Phasing in the new labor market areas would allow IRFs to transition to the new wage level, minimizing large disruptions in payments. The phase in should be budget neutral.

Mark McClellan
Administrator
Page 2

If you have any questions or require clarification of our comments, please feel free to contact Mark Miller, MedPAC's Executive Director.

Sincerely,

A handwritten signature in black ink, appearing to read "Glenn M. Hackbarth". The signature is fluid and cursive, with a prominent initial "G" and "H".

Glenn M. Hackbarth
Chairman

Submitter :

Date: 07/14/2005

Organization : American Health Information Management Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1290-P-14-Attach-1.DOC



American Health Information
Management Association®

July 13, 2005

Mark McClellan, MD, PhD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1290-P
PO Box 8010
Baltimore, Maryland 21244-8010

Dear Dr. McClellan:

The purpose of this letter is to comment on the Centers for Medicare & Medicaid Services' (CMS') proposed changes to the Medicare Prospective Payment System (PPS) for Inpatient Rehabilitation Facilities (IRFs) for fiscal year 2006, as published in the May 25, 2005 *Federal Register*. The American Health Information Management Association (AHIMA) is a professional association representing 50,000 educated health information management (HIM) professionals who work throughout the healthcare industry. HIM professionals serve the healthcare industry and the public by managing, analyzing, and utilizing data and records vital for patient care and making it accessible to healthcare providers and appropriate researchers when it is needed most.

Managing the records for health care has been a role for HIM professionals for over seventy-five years, and AHIMA members are now working diligently to ensure that we soon have standard, interoperable electronic health records to improve the quality and safety of patient care. Currently we are working on a variety of projects with the Health Level Seven (HL7), the Office of the Coordinator for Health Information Technology (ONCHIT), and other groups to ensure that in the future electronic health records (EHRs) will provide the same complete and accurate record, only in an environment that will permit better health and safety than in the paper environment.

I: Background

I-D: Quality of Care in IRFs (70FR30191)

We fully support CMS' efforts to promote and improve the continuity and quality of healthcare through the use of interoperable electronic health record (EHR) systems and standardized data. Moving from

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paper-based records and systems to electronic health records and systems offers significant benefits to the healthcare consumer, provider and payer such as reduction in medical errors, improved use of resources, accelerated diffusion of knowledge, and increased consumer involvement in their care. Post-acute care providers, like the rest of the health care community, face significant challenges in moving towards an EHR. In addition to the daunting challenges posed by technical obstacles, fiscal resources and staff capacity to implement and maintain fully electronic health records are huge hurdles in an industry known for reimbursement and staffing issues. In addition to using electronic information exchange to improve communication between hospitals and IRFs, we believe it is also important to include physician practices in this process. Federal incentives are needed to accelerate the adoption of interoperable electronic health records and achieve the goals of improved quality, safety, and coordination among healthcare providers.

II-B: Proposed Refinements to the Patient Classification System – Proposed Changes to the Existing List of Tier Comorbidities

II-B-1: Proposed Changes to Remove Codes That Are Not Positively Related to Treatment Costs (70FR30194)

Code V46.1 is listed in the proposed list of codes to be removed from the tier list (Table 1 on page 30195). Since this code is a subcategory, is the intent to remove both codes in this subcategory, V46.11 (Dependence on respirator, status) and V46.12 (Encounter for respirator dependence during power failure), or just one of these codes?

Also in the proposed list of codes to be removed from the tier list, the “Condition” column designates code 356.4, idiopathic progressive polyneuropathy, as a type of meningitis and encephalitis. However, code 356.4 does not describe a condition that is related to meningitis or encephalitis. Is the “Condition” column incorrect, or is the wrong code listed in the table?

Why aren't ICD-9-CM codes 250.91 and 250.92 listed in Table 1? It is not clear why all of the 250.9x codes wouldn't be removed from the tier list, rather than just codes 250.90 and 250.93. Code 250.90 represents type II or unspecified type, not stated as uncontrolled, and code 250.93 represents type I, uncontrolled. It would seem as though the counterparts to these codes (type I, not stated as uncontrolled and type II or unspecified type, uncontrolled) should be listed as well.

Also, codes 250.90 and 250.93 are described in this table as “non-renal complications of diabetes.” These codes actually describe diabetes with unspecified complications, meaning that it is known the patient has a diabetic complication, but the specific type of complication is unknown. Since the type of complication is not specified, the complication could be renal or non-renal. Codes 250.90-250.93 are very infrequently used, since the medical record documentation doesn't generally indicate that the patient has a diabetic complication without identifying the type. If diabetes is documented and there is no mention of any complication whatsoever, the correct codes would be 250.00-250.03.

We are concerned about the proposed removal of the codes for status amputation (V49.75, V49.76, V49.7) from the tier list. If an amputee fractures a hip, his amputation status significantly complicates his

care and thus impacts treatment cost. While some of this complexity may be picked up by other data elements, the patient's amputation status helps to more fully explain the higher cost of care.

Conclusion

We appreciate the opportunity to comment on the proposed modifications to the Medicare IRF PPS program for fiscal year 2006. If AHIMA can provide any further information, or if there are any questions or concerns with regard to this letter and its recommendations, please contact either Sue Bowman, RHIA, CCS, AHIMA's director of coding policy and compliance at (312) 233-1115 or sue.bowman@ahima.org, or myself at (202) 659-9440 or dan.rode@ahima.org.

Sincerely,

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

cc: Sue Bowman, RHIA, CCS

Submitter : Ms. Heather Olson
Organization : Iowa Hospital Association
Category : Health Care Professional or Association

Date: 07/14/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1290-P-15-Attach-1.WPD

I O W A H O S P I T A L A S S O C I A T I O N

July 18, 2005

The Honorable Dr. Mark McClellan
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention CMS -1290-P P.O. Box 8016
Baltimore, MD 21244-8010

Ref: CMS 1290-P Medicare Program: Inpatient Rehabilitation Facility Prospective Payment System for FY 2006: Proposed Rule (69 *Federal Register* 30188).

Dear Dr. McClellan,

On behalf of the 11 Iowa hospitals with an Inpatient Rehabilitation Facility (IRF) distinct part unit (DPU), the Iowa Hospital Association (IHA) is pleased to take this opportunity to provide comments on the Centers for Medicare & Medicaid Services (CMS) proposed rule for the FY 2006 IRF prospective payment system (PPS) published in the May 25, 2005 *Federal Register*. Although the system calls for a market basket update of 3.1 percent, this rule proposes many adjustments that will result in a **reduction of 2.3 percent** from the FY 2005 standard payment rate. The following are IHA's comments.

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

The IRF PPS is a very new reimbursement system with its initial implementation not occurring until 2002. As the IRF PPS moves forward to its fourth year, CMS is proposing to make a 1.9 percent reduction to the base rate. The argument CMS provides for this reduction is due to changes in coding of IRF services resulting in a change in case-mix. IHA disagrees with the premise of reducing payments due to increased accuracy in coding for services in a case-mix classification reimbursement system that more closely ties payment to the cost incurred in delivering care. Until implementation of the IRF PPS there was very little education provided to IRFs and medical review of IRF claims was almost non-existent. Only recently have Medicare contractors begun reviewing medical records at IRFs and providing education on what needs to be documented in the medical record and subsequently coded.

Rather than making an across-the-board reduction in the base rate, CMS should continue to work with its contractors to develop and support educational efforts. Policy changes should not be made when proper education has not been provided. Through education and medical reviews, Medicare contractors and CMS will have better knowledge of the content in the medical record and can then verify correct coding. Further, coding of Medicare claims is conducted on an individual facility basis and therefore any corrections must be on an

individual facility level. IRFs should not be penalized for not knowing the expectations from the Medicare program because they were never provided to them.

IHA also refutes CMS' theory that IRFs now have an incentive to admit more costly cases as the payment is tied to diagnosis codes and the more medically complex a patient is, the higher reimbursement the IRF will receive. First, a case-mix classification system is designed to tie payment to the complexity of the patient. If IRFs are treating a more acute patient mix, the reimbursement system should provide adequate compensation for more costly cases. Second, by enforcing the "75 percent rule", many of the less costly and less complex patients will not be in one of the categories that would qualify to meet the 75 percent rule requirements. The 75 percent rule has been in effect for 22 years however, the current payment system and review procedures for IRFs just recently went into effect. Third, CMS has failed to provide adequate training and education to IRFs on documentation and coding of the medical record until very recently. Finally, CMS has not considered changes in the delivery of inpatient rehabilitation care as evidenced by its refusal to redefine the criteria encased in the 75 percent rule policy. Medicare patients are living longer today than was expected in 1983, and are surviving longer with conditions they may not have survived in earlier years. Very minor changes have been made to this policy recently, yet those changes do not adequately recognize the delivery of inpatient rehabilitation and the value this care provides to the quality of life for Medicare beneficiaries.

IHA would also like to take this opportunity to comment that CMS is over-stepping its authority by applying the 75 percent rule to the entire patient volume of IRFs. CMS uses data from Medicare beneficiaries that have received care in an IRF to make a presumption that the entire IRF patient population meets the 75 percent criteria. Employers, private health plans, and finally, patients, have the right to choose what they will and will not pay for. CMS should not be setting policy for services for which it does not provide payment.

Proposed Changes to Move Dialysis to Tier One

IHA is supportive of the proposal to move dialysis to comorbidity tier one to better recognize the resources necessary to provide care and rehabilitation to these frail patients.

Moving Comorbidity Codes Based on Marginal Cost

IHA disagrees with the premise CMS is basing its argument on to move certain comorbidity codes to alternate tier assignments due to the presence of up-coding for higher payment. More accurate coding should be expected as a result of implementing a reimbursement system based on the acuity of the patient. Further, health information managers have standard coding guidelines by which they determine the most appropriate codes to assign based on the documentation contained within the medical record. Until concrete evidence of up-coding is in hand, there should be no policy changes. This evidence can be determined through medical reviews and, if up-coding is found, it should be corrected on an individual provider level as opposed to a policy change.

IHA requests CMS provide a detailed response in the final rule on the impact all the proposals in this to change the current patient classification system may have on the 75 percent rule.

Labor-Related Share

IHA opposes the proposal to increase the labor-related share as there is no precedent set to change the percentage. There is precedent however, to lower the labor-related share for inpatient services in section 403 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). While IRFs do rely on more staff services, the labor share is already high at 72.359 percent. This rule proposes to make numerous changes to the IRF PPS that will have a negative impact on Iowa IRFs. All wage indices for Iowa IRFs are below 1.0 which will result in further payment cuts

from the Medicare program. This proposal will unfairly shift reimbursement to areas with higher wage indices. Though IHA supports the proposal to adopt the Core Based Statistical Areas (CBSA) in defining its labor markets in FY 2006, it will have a substantial redistributive effect of Medicare reimbursement. **Until CMS develops an IRF-specific wage index, no changes should be made to the labor-related share based on data from a different type of provider. IHA urges the agency to withdraw this proposal and wait until more research is completed and use IRF-specific data to determine whether it is necessary or appropriate to increase the labor-related share.**

Wage Index

IHA supports the adoption of the CBSAs as well as the development of an IRF-specific wage index. **IHA urges CMS to begin developing instructions for the collection of IRF data in conjunction with the provider community.** Implementing an IRF-specific wage index would allow CMS to establish geographic reclassification criteria for IRFs and would better recognize the employment mix among labor markets. An IRF wage index would also more appropriately distribute Medicare payments nationwide.

Low-Income Patient Adjustment

IHA supports the proposal to increase the low-income patient adjustment from 4.7 percent to 6.2 percent. IRF stays can be costly to already financially strapped Medicare beneficiaries and this proposal will help off-set some of the uncompensated care Iowa IRFs provide.

Rural Location Adjustment

IHA supports the proposal to increase the add-on payment for rural IRFs to recognize the higher cost of providing these services in rural Iowa and to ensure access to inpatient rehabilitation care for Medicare beneficiaries. The MMA allows Critical Access Hospitals to have a ten-bed IRF DPU. By enhancing the add-on payment to better recognize the cost of rural IRF care, more hospitals may be interested in opening an IRF which would lead to improved access to care.

While IHA is generally supportive of rural payment adjustments, IHA questions the likelihood that IRFs will be established in rural Iowa and the corresponding impact on urban IRFs given the distributive effect of this provision. Should Iowa hospitals determine to open an IRF the reimbursement should support the costs of providing these services.

Teaching Status Adjustment

This rule proposes to adopt a teaching status adjustment to recognize the higher costs incurred with caring for Medicare patients in teaching facilities than non-teaching facilities. The rule also asks for comment on the appropriateness of formulating policy with only one year of data. While IHA supports a teaching adjustment it does not support creating policy with only one year of data. IHA urges CMS to collect one more year of data and revisit this proposal in the FY 2007 proposed rule.

Cost Outliers

CMS is proposing to lower the outlier threshold from the current \$11,211 to \$4,911 above the standard payment amount to maintain total outlier payments at 3 percent of total IRF PPS payments. CMS states that upon implementation of the IRF PPS the overall cost-to-charge ratios (CCR) in IRFs has been on the decline. As a result, the 3 percent of total outlier payments were not distributed to IRFs in FY 2005.

IHA supports lowering the threshold to \$4,911. However, IHA also asks CMS to disclose the estimated amount of unused outlier dollars and the agency's plan to ensure those funds be returned to the IRF PPS to help off-set some of the payment adjustments incorporated into this rule.

Quality of Care in IRFs

As CMS expands its efforts to reward high quality care in the IRF setting, IHA urges the agency to take this opportunity to include measuring the quality of care provided to Medicare beneficiaries that do not fall into one of the 13 categories to meet the 75 percent rule criteria. The agency also wishes to move toward a performance measurement model that coordinates an approach to payment for post-acute services that reaches across settings and focuses on quality of care for the overall post-acute episode, regardless of provider type. This model would require CMS to transition from provider-specific payment approaches to patient-centric approaches based on patient characteristics and outcomes. This concept provides another opportunity to revisit the 75 percent rule when reviewing the entire post-acute care episode.

For the Medicare program to become a purchaser of value, it must focus on improving the health outcomes for program beneficiaries and more effectively manage the disperse resources that Congress provides. IHA has been a long-time supporter of the Medicare program becoming a purchaser of value. Any design of paying for the post-acute care episode based on patient characteristics and outcomes must embrace the following principles:

Payment incentives should:

- Reward providers for improving quality and providing effective care.
- Evaluate the consumption of resources in achieving desired health outcomes as this is necessarily required in measuring effective care.
- Use a system of rewards that increases payments and reduces regulatory burdens for successful providers.
- Be aligned between institutional providers and physicians.

Performance measures should be:

- Based on measures of adherence to quality improving processes.
- Selected to insure that all SNFs have an opportunity to participate and succeed.
- Selected to minimize the data collection burden for providers.

Thank you for your review and consideration of these comments. If you have questions, please contact me or Tracy Warner at the Iowa Hospital Association at 515/288-1955.

Sincerely,



Heather Olson
Director, Finance Policy

cc: Iowa Congressional Delegation
IHA Board of Trustees
Iowa hospitals
CMS Kansas City Regional Office

Submitter : Mr. Kerry Gillihan
Organization : Cardinal Hill Healthcare System
Category : Health Care Professional or Association

Date: 07/15/2005

Issue Areas/Comments

GENERAL

GENERAL

"Sec Attachment

Issue

Response to Comments

Proposed Rule on the IRF-PPS for FY 2006

CMS-1290-P-16-Attach-1.DOC

July 18, 2005

Centers for Medicare and Medicaid Services
Dept. of Health and Human Services
Attn: CMS-1290-P
P.O. Box 8010
Baltimore, MD 21244-8010

Dear Sir or Madam,

Submitted for your review are comments to the Proposed Rule on the IRF-PPS for FY 2006. We appreciate the opportunity to comment on the proposed rule, and respect the time and effort spent by CMS in evaluating all aspects of the IRF-PPS to assure adequate access to care for Medicare beneficiaries.

Quality of Care in IRF's

In previous proposed and final rules for post-acute care providers, it has been quite evident that CMS has consistently expressed significant interest in evaluating post-acute provider payment mechanisms. In this proposed rule, reference is made to a preliminary study by MedPAC to evaluate "challenges in improving the coordination of our post-acute care payment methods, and [MedPAC] suggested that it may be appropriate to explore additional options for paying for post-acute services."

When the IRF-PPS was initially designed, CMS proposed to use a patient classification system (MDS) unfamiliar to the rehabilitation industry, and inappropriate for evaluating the function of the population served in an acute rehabilitation setting. CMS listened to the acute rehabilitation providers following the initial proposed rule, and made significant modifications to the patient classification system based upon provider's recommendations. This was appreciated by the industry, and as a result, a vast database containing solid information about patient classification and functional improvements made in acute rehabilitation has been established.

Unfortunately, different patient classification systems are utilized in SNF, IRF, LTACH, and Home Care settings. Consequently, it is currently difficult to compare outcomes and effectively determine if Medicare dollars have been spent most appropriately to serve beneficiaries.

As CMS evaluates the issue of post-acute care payment, we urge you not only to continue to utilize the data available, but to also utilize the expertise of individual providers across the country in determining how to address the issue of post-acute payment.

Trade associations such as AMPRA and AHA do a respectable job in advocating for its members. However, both trade associations represent members with conflicting needs and allowing these associations to unduly influence post-acute payment policy may result in compromised recommendations for CMS. CMS could gain additional valuable information by seeking out the advice of a greater number of individual providers in the various post-acute fields while a new post-acute payment system is being developed. These same providers could be involved in field test(s) of possible new classification systems. Many post-acute providers now offer several segments of the post acute care continuum and could easily test classification systems in several settings. The Cardinal Hill Healthcare System is one such provider. We would welcome the opportunity to share our ideas for post-acute care payment and participate in beta testing of any proposed new classification system, which could serve as the basis for post acute payment in the future.

Proposed reduction of the standard payment amount

While a payment rate reduction in a market of increasing cost of delivering healthcare is not an action easily accepted by a healthcare provider, it appears that CMS has adequately justified doing so by thoroughly studying the IRF-PPS system. Because other adjustments have been made to the payment system to compensate facilities for caring for low- income patients and those with complicated medical conditions, this one-time rate reduction is one that can be implemented without undue hardship to our facility.

Proposed Market basket used for IRF market basket index and geographic labor market area definitions

The development of one market basket index for IRF, LTACH, and IPF providers and the application of CBSA's to IRF's appear to be appropriate modifications to the IRF-PPS.

Proposed change to the existing list of tier co-morbidity tiers and CMGs

The modifications made to CMGs are significant and, overall, will result in lower payments to IRFs. While it will be difficult to adapt to this change, we understand the concept of "compressing" data to apply more appropriately to the population served in IRFs. We do not have a reasonable alternative to suggest at this time, which is based upon better data than that studied by CMS. We would request that CMS continue to study the data after implementation of the proposed rule to determine whether the CMG classifications are indeed appropriate, and we urge CMS to continue to make modifications based upon objective analysis as needed. It

is important to recognize that care of the high cost patients needs to be adequately reimbursed in order to continue to assure access to an appropriate level of care, and we appreciate CMS' efforts to do so.

Several codes proposed to be deleted from the co-morbidity tiers should be retained. These are: 530.3 Esophageal Structure; V49.75, V49.76, and V49.77 dealing with lower extremity amputations; and 799.4 Cachexia. Each of these co-morbidities causes extra expenditure such as the provision of extra nutritional products and/or wound care supplies. As in other co-morbidities, which currently "count", a facility caring for individuals with wounds or nutritional deficits incurs added expense beyond the expense incurred by patients without these comorbidities. We request that these five co-morbidities be retained in a tier in the final rule.

Teaching status adjustment

The addition of a teaching status adjustment to the IRF-PPS is a significant improvement to the system. We recommend this be retained by CMS in the final rule.

Update to formulas used to compute LIP adjustments

The modification to the formula used to determine the adjustment to IRF-PPS payment for low-income patients is appropriate, and we recommend this be retained in the final rule.

Outlier threshold

The reduction of the outlier threshold appears to be appropriate given the anticipated reduction in the standard base payment. We appreciate CMS' decision to lower this threshold.

In summary, thank you for seeking out comments on this proposed rule. As a post-acute provider, we work very hard to provide the best care possible to allow Seniors to remain functional so they may "age in place" in the community. We would welcome the opportunity to actively participate in determining the best mechanism to build a strong post-acute care system that will be viable in the long run for Medicare beneficiaries.

All the best,

Kerry G. Gillihan, FACHE
President/CEO

KGG:plp

Submitter : Ms. Patricia Henry
Organization : RehabCare
Category : Health Care Provider/Association

Date: 07/15/2005

Issue Areas/Comments

Background

Background
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Issue

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Proposed FY 2006 Federal Prospective Payment Rates

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Collection of Information Requirements

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Regulatory Impact Statement

Regulatory Impact Statement

see attachment

CMS-1290-P-17-Attach-1.DOC

CMS-1290-P-17-Attach-2.DOC

July 11, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Dr. McClellan:

RehabCare Group Inc. ("RehabCare") is a publicly owned company that manages inpatient rehabilitation units in hospitals across the country. RehabCare appreciates the opportunity to provide comments and recommend options in response to the Inpatient Rehabilitation Facility Prospective Payment System for FY 2006; Proposed Rule, as published in the Federal Register on May 25, 2005 on pages 30188 through 30327. We respectfully submit these comments.

I. Proposed Refinements to the Patient Classification System

Proposed Changes to the Existing List of Tier Comorbidities

We disagree with the proposal to remove certain codes from the tier list. In particular, 261 (nutritional marasmus), 262 (other severe protein calorie deficiency), and 260 Kwashiorkor are being removed due to excessive utilization, despite their positive correlation to cost. Since these conditions are positively related to cost, the removal of these codes will negatively and unfairly impact reimbursement for patients with these conditions. We believe it is more appropriate to resolve this problem through increased review of patients coded in this manner for medical appropriateness. We also disagree with the proposal to eliminate 410.X1 (specific AMI, initial) from the tier list. Although AMI, NOS, initial may not be positively related to treatment cost, it does not appear that it has been shown that other specific AMI are not positively related to cost. We believe further analysis is warranted to ensure that this is true.

Proposed Changes to the CMGs

We agree with the objective of improving the correlation between reimbursement and the cost of delivering care, as well as maintaining budget neutrality. However, we are concerned that the weights as proposed will not ultimately attain these objectives. Our analysis calls into question the budget neutrality of the adjustments. We examined over 11,000 recent patient records from 113 facilities, and applied the proposed rules to their admission. If the adjustments were budget neutral, we would expect no change in case mix over such a large sample of patients. Our analysis predicts a reduction in case mix

index (CMI) of greater than 2.5%. We cannot be sure of the cause of this difference, but we suggest that it is likely due to the implementation of the revised 75/25 percent rule, which was not in effect in 2002. Because the 2002 data does not reflect the implementation of revised 75/25 percent rule, it does not reflect the current or future patient mix. We believe it would be most appropriate to postpone restructuring the CMG's until the revised 75/25 percent rule is fully implemented. At a minimum, we believe it would be appropriate to examine the estimated CMI impact based on data from facilities that have already started phase-in of revised 75/25 percent rule. We would prefer that the weightings be adjusted to reflect a constant CMI. However, if the currently proposed weightings are adopted, we believe it would be appropriate to increase the base rate by a factor to ensure the reimbursement on the current patient mix is not further negatively impacted due to an unintended decrease in the CMI.

We are also concerned that the new weightings run counter to the goals of the revised 75/25 percent rule. Based on our analysis, it is apparent that the CMG's for the highest functioning patients in each RIC are receiving the greatest increases in reimbursement. Alternatively, the CMG's for the lowest functioning patients in each RIC are receiving the greatest decrease in reimbursement. Consequently, facilities that care for the greatest acuity patients are most negatively impacted by the new case weights. At a time when the revised 75/25 percent rule mandates an increase in the acuity of the patient mix and restricts admissions, we are concerned that drastically reducing reimbursement for the admissions that will remain further unnecessarily threatens access to care.

II. Proposed FY 2006 Federal Prospective Payment Rates

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

We are concerned about the 1.9% downward adjustment that CMS has proposed to eliminate the impact of coding changes. In particular, we are concerned that RAND's methodology to estimate the lower bound of the impact may have neglected to recognize certain changes that occurred between 1999 and 2003. One of the key assumptions in their 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.

CMS has also requested comments on the effect of the proposed range of reduction on access to IRF care. Any downward adjustment to reimbursement has the potential to negatively impact access to patient care. Obviously, the proposed 1.9% reduction in reimbursement is less threatening than a 5.8% reduction. However, this reduction must be viewed in context of the other proposed rules and the continued implementation of the

revised 75/25 percent rule. We anticipate a number of facilities will be severely impacted by the current proposed rules, raising serious concerns about their ability to continue operations. This reduction comes at a time when many inpatient rehabilitation facilities are struggling to comply with the revised 75/25 percent rule. 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 reductions in reimbursement will further threaten the viability of acute rehabilitation in these facilities.

Proposed Revision of the IRF PPS Geographic Classification

We agree in principal with the adoption of the new CBSA designations. However, we do have several concerns about the short term impact of their implementation. We are especially concerned about the drastic decline in reimbursement at facilities that are going from a rural to urban designation. The proposed rule states that 91% of rural facilities that would be designated as urban under the proposed rules will experience an increase in the wage index and that 74% of these facilities will receive an increase of five percent to ten percent. We believe this means that virtually all facilities changing from rural to urban status will be seriously impacted, with reimbursement declining at least 10% in the best case scenario, and declining greater than 20% in the worst case scenario. We believe that this seriously threatens access to care in these areas, areas that up until this point have been considered rural. We believe it is appropriate to allow a transition of no shorter than three years to the new status. This would allow the affected facilities an opportunity to make operational changes and evaluate the long-term viability of the program. We believe the loss of rural status, in conjunction with the multitude of other changes at this time, may greatly reduce access to care in these areas.

We are also concerned about large swings in area wage index in some areas. We believe it would be reasonable to implement a transition period for areas that are highly impacted by this change.

Proposed Teaching Status Adjustment

We strongly disagree with the proposed teaching status adjustment. We share CMS's concern that the correlation between costs and a facility's teaching status may be a one-year aberration. Furthermore, we are concerned that increased costs for treating patients in teaching institutions do not reflect increased patient acuity, but instead reflect inefficiencies inherent in many teaching facilities. The CMG's are designed to capture patient acuity. Proper coding should ensure that teaching facilities receive appropriate reimbursement for any increase in patient acuity they have over the average. Increasing reimbursement for inefficiencies unjustly rewards the offending facility at the expense of other, more efficient facilities. Additionally, teaching facilities are not likely to cease their mission, or limit access to care, if they do not receive this additional reimbursement.

We are also concerned that the teaching status adjustment as proposed is inequitable. In particular, capping an IRF's FTE resident count based on the cost report ending on or before November 15, 2003 is arbitrary. Furthermore, it is not clear that all facilities would have carefully reflected an FTE count specific to rehab, as it did not impact reimbursement.

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.

July 11, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

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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 : Ms. Patricia henry
Organization : RehabCare
Category : Health Care Provider/Association

Date: 07/15/2005

Issue Areas/Comments

GENERAL

GENERAL

see attachment

Issue

Background

see attachment

Submitter : Dr. Allen Heinemann
Organization : Rehabilitation Institute of Chicago
Category : Health Care Professional or Association

Date: 07/15/2005

Issue Areas/Comments

GENERAL

GENERAL

See attachment

Submitter : Mr. Greg Dorris
Organization : Jewish Hospital Healthcare Services
Category : Hospital

Date: 07/18/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1290-P-20-Attach-1.DOC

CMS-1290-P-20-Attach-2.PDF

July 13, 2005

Mark McClellan, M. D., Ph. D.
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1290-P
P. O. Box 8010
Baltimore, MD 21244-8010

RE: CMS-1290-P; Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for FY 2006; Proposed Rule

Dear Dr. McClellan:

On behalf of Jewish Hospital Healthcare Services (JHHS) we appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) proposed rule establishing new policies and payment rates for inpatient rehabilitation services for the federal fiscal year 2006. The following are our comments:

I. Proposed Teaching Status Adjustment

We support the proposal to add a "teaching" payment to rehab PPS. Currently teaching facilities incur indirect costs related to training interns and residents that are not separately reimbursed. Under inpatient PPS a separate payment for indirect costs is made with each DRG payment. It is important that this add-on is implemented to more equitably pay rehabilitation facilities that take on the training of future physicians. In the proposed rule concern was raised over the possibility of shifting residents from the acute care side to rehabilitation in order to increase reimbursement. While we believe this is not likely, due to this specialized field we would support capping the residents as it has been done under inpatient PPS if CMS believes this would jeopardize the entire add-on payment. Another concern was expressed over the accurate counting of residents. The methodology for counting residents is already in place as most of these programs are associated with provider based facilities. The resident counts are already audited for GME purposes; extending this to IME would not be difficult.

II. Standard Payment Reduction of 1.9%

We oppose the proposed 1.9% reduction in payments based on evidence of coding increase rather than increased acuity. We have not seen any data that indicates significant coding increases are occurring. We strongly disagree with the implementation of this reduction until providers have a chance to review and address the assertions of increased coding.

III. Use of Core Based Statistical Areas

We believe that the change from metropolitan statistical areas (MSAs) to Core Based Statistical Areas (CBSAs) should be phased in using the method set up for general acute hospitals under inpatient PPS. We recommend that for rehabilitation hospitals that have a drop in their wage index in FY 2006 due to the move to CBSAs, those hospitals would have their wage index adjustment blended 50-50 under the MSA and CBSA indices. In FY2007, rehabilitation hospitals wage indices would then be based 100% on CBSA wage index.

We appreciate your consideration of these comments.

If you have any questions, please do not hesitate to contact me at (502) 587-4755.

Sincerely,

D. Gregory Dorris
Vice President of Finance/Revenue Cycle

cc: Alan L. Broude, Sr. Vice President & Chief Financial Officer

Submitter : Dr. Allen Heinemann
Organization : Rehabilitation Institute of Chicago
Category : Health Care Professional or Association

Date: 07/18/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1290-P-21-Attach-1.DOC



**Rehabilitation
Institute of
Chicago**
345 E. Superior Street
Chicago, IL 60611-4496

Center for Rehabilitation Outcomes Research
Director: Allen W. Heinemann, Ph.D.
Telephone: 312.238.2802
Fax number: 312.238.2383
E-mail: a-heinemann@northwestern.edu

July 13, 2005

Centers for Medicare and Medicaid Services,
Department of Health and Human Services
P.O. Box 8010
Baltimore, MD 21244-8010

Attention: CMS-1290-P

Dear Sir/Madam:

I am writing in response to CMS' Proposed Rule for Inpatient Rehabilitation Facilities' Prospective Payment System for Fiscal Year 2006. I am writing on behalf of my colleagues at Northwestern University's Institute for Healthcare Studies and the Rehabilitation Institute of Chicago's Center for Rehabilitation Outcomes Research.¹ We are a grant-funded research program focused on health service research issues in post-acute care, specifically issues related to post-acute care access, services, outcomes and costs. Information about our program is available at www.ric.org/research/outcomes. I also serve as the President of Division 22 (Rehabilitation Psychology) of the American Psychological Association and as President of the American Congress of Rehabilitation Medicine.

We appreciate the care and thoroughness with which the proposed rules were developed and are in agreement with most aspects of the proposed rule. There are two issues that concern us: (1) the use of a Weighted Motor Score Index and (2) the exclusion of depressive disorders in the comorbidity tiers.

Proposed Refinement to the Patient Classification System: Weighted Motor Score Index

The change in the motor score from one where each motor item is weighted equally to one where they are weighted unequally does not appear to be justified by the research results. RAND's technical report (Possible Refinements to the Construction of Function-Related Groups for the Inpatient Rehabilitation Facility Prospective Payment System) shows that within RICs there is some increase in explanatory power when using the logarithm of costs in regression analyses where the individual motor item coefficients are not constrained to 1 (i.e., do not require equal weighting).

¹ Anne Deutsch, PhD, Research Assistant Professor, Northwestern University; Deborah Dobrez, Ph.D., Assistant Professor, University of Illinois at Chicago; Elizabeth Durkin; Research Assistant Professor, Northwestern University; Trudy Mallinson, PhD, Research Assistant Professor, Northwestern University; Larry Manheim, PhD, Research Professor, Northwestern University; Parag Shah, M.D., Post-Doctoral Fellow, Northwestern University;

However, there appears to be little justification that this small increase in explanatory power is worth the major operational problems that are likely to occur as a result of these changes.

First, it is not clear what the benefits of the weighted motor score are relative to the unweighted score. RAND's technical report makes it clear that the most relevant indicator would be to compare the average and total R-squared values in Table A.8, which provides the increase in the explanatory value of the model when an unweighted sum of items is replaced with a weighted sum. The appropriate columns to compare are M2 (unweighted weighting) with M3-Alt4 (preferred weighted model). Total R-square changes from .3012 to .3163 and average R-squared changes from .1824 to .2002. These are increases in variance explained of .0151 and .0178, respectively. These may be statistically significant increases, but they are very small and inconsequential.

Further, these changes may be smaller than they seem because the weights and R-squares were calculated using the same data sets. Letting the data set determine the weights, rather than constraining the weights, usually improves the fit in a given data set. However, there is no assurance that the small improvements observed in one year would be replicated in the next year's data.

It appears that the R-squared values in Table A.8 are based on the logarithm of costs rather than on "raw" costs. We cannot find where our assumption is made explicit, but previous regressions were based on log-costs. While logarithms tend to improve normal distribution of variables and may improve predictive capability of the model, IRFs are paid costs, not log-costs. Consequently, the relevant comparison for A.8 would be to run the regression on costs, which may provide different results. Given the small changes in R-squares reported, these two factors could reverse the results. Even if they did not reverse the results, such small changes do not warrant this change in the scale given the costs of doing so. No discussion of costs associated with the use of weighted functional status scores is provided.

Every time a scale is changed, coding practices will change in response to new financial incentives. Indeed, there is substantial discussion in the proposed rules about how the scores have changed over time in response to the financial incentives related to PPS. *By making these weighting changes, there will be yet another strong incentive for coding changes that will result in up-coding of the highly weighted components of the revised scale.* This scale is particularly prone to coding changes because it heavily weights one item and heavily weights three other items. In particular, transfer to bed now accounts for 18% rather than .08% of the total motor score and four of the 12 measures now account for 57% instead of 33% of the score. This may cause IRFs to place special emphasis on these item ratings. Thus, one can expect that the effect of weighted scores may be another round of "upcoding" for some, but not all items. If there are coding changes, this could confound the measurement properties of the FIM instrument – which was created as a functional status measure.

As noted in the proposed rule, RAND considered competing goals in developing the weighted motor index: 1) developing a motor rating that would increase the predictive power of the system, and 2) maintaining simplicity and transparency in the payment system. A change of R-squared of less than .02 under the most favorable circumstances (i.e., using the same sample to create and validate the scale and using logarithm of costs instead of costs) is too small a gain to warrant such coding changes.

Proposed Refinements to the Patient Classification System: Depressive Disorders as Tier Comorbidities

Depression and other mental disorders continue to be excluded from the tiers in CMS's proposed refinements to the IRF PPS. The RAND report (Preliminary Analyses for the Refinement of the Tier Comorbidities in Inpatient Rehabilitation Facilities) cited several factors to support this exclusion, including concern that a payment adjustment would trigger coding of affective disorders for most rehabilitation cases and that affective disorders cannot be accurately diagnosed in IRF settings, which lack mental health providers. We believe that these concerns are unwarranted, reflect a misunderstanding of IRFs, and are outweighed by the negative consequences of not reimbursing facilities for patients with these conditions adequately.

Drawing on Fiscal Year 2003 IRF discharge data, the RAND report estimated that any affective disorder was associated with a greater than 3% increase in cost. Our own analyses of 35,667 patients discharged to community settings between 2002 and 2004 are consistent with RAND's findings: the presence of any affective disorder (including ICD-9-CM codes of 293.83 and 300.4 – excluded from RAND's affective disorder variable) was associated with a 2.5% increase in length of stay. Failure to reimburse for the additional costs associated with treating patients with depression reduces the incentives to adequately treat these patients, may limit their access to IRF care, and limit their functional outcomes.

Patients receiving IRF services have a variety of chronic and recent-onset conditions. Some will experience affective and other mental disorders. For example, *some* young adults incurring traumatic brain or spinal cord injury will experience an adjustment disorder characterized by depressive and anxious symptoms, and some patients with multiple sclerosis, admitted to improve functional status, *may* experience dysthymia or a major depression. Many cope quite well with life disruptions. The expectation that people with disabilities *should* experience negative emotional reactions has been called the "requirement of mourning,"² an expectation by nondisabled persons that a disability is something that ought to be grieved. In all patients with depressive or anxiety symptoms it is important to distinguish situational versus chronic affective disorders, as well as the duration and severity of conditions.

RAND's report notes that "few IRFs have psychiatric personnel and rehabilitation doctors rarely have the time required to observe the patient in order to make a complete psychiatric evaluation." Many IRF units are located in larger medical-surgical hospitals with adequate mental health resources. In addition, many IRFs, including most of the free-standing IRFs, are accredited by CARF...The Rehabilitation Accreditation Commission, which promulgates standards for patient care, including access to mental health services. These accredited facilities employ many psychologists and other mental health providers who are trained and licensed to diagnose and treat mental disorders. While RAND's concern that mental health diagnoses would be assigned incorrectly or not at all may be true in smaller IRF units, it seems unlikely that this would be the case in the majority of larger IRF units and free-standing IRFs.

Concern about mental health conditions should be considered within the larger issue of coding accuracy and the qualifications of IRFs to report accurate diagnoses. Comorbidity codes are often drawn from admitting and discharge reports of attending physicians. Attending physicians can consult with mental health providers – psychiatrists and clinical psychologists – to diagnose depressive disorders and other mental health conditions. Other specialists are consulted for endocrinologic, neurologic, cardiac and a variety of other conditions. One might wonder about the

² Wright, B.A. *Physical disability: A psychosocial approach* (2nd ed.) New York: Harper & Row, 1983.

ability of non-specialist physicians to provide specialty diagnoses for a variety of conditions, not only depressive disorders. There is no reason why mental health comorbidities should be singled out for extra scrutiny.

RAND should be lauded for recommending that affective disorder diagnoses demonstrate high reliability. The perception that IRFs lack mental health providers is inaccurate. It may be in some small IRF units that high reliability would be difficult to achieve. The recommended alternative, developing alternative scales that could be used by general practitioners and other staff without mental health training, is an unsatisfactory solution. There is a ready pool of competent clinicians able not only to code mental health disorders reliability, but able to provide care in a cost-effective manner – psychiatrists and rehabilitation psychologists.

Recommendations

In summary, we recommend that

- Weighted FIM scores *not* be used in computing CMG assignment at this time,
- Depressive disorders should be added as a Tier 3 condition, and
- Training materials should be developed to code affective disorder diagnoses accurately in the IRF-PAI.

I trust that the points outlined in this letter are clear. Do not hesitate to contact me if you have any questions.

Sincerely,

Allen W. Heinemann, Ph.D., ABPP
Professor, Department of Physical Medicine and Rehabilitation
Feinberg School of Medicine, Northwestern University
Associate Director, Research, Rehabilitation Institute of Chicago

Submitter : Ms. Rochelle Archuleta
Organization : American Hospital Association
Category : Health Care Professional or Association

Date: 07/18/2005

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment.

CMS-1290-P-22-Attach-1.PDF



**American Hospital
Association**

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325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

July 18, 2005

Mark 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-1290-P; Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for FY 2006; Proposed Rule.

Dear Dr. McClellan:

The American Hospital Association (AHA), on behalf of our 4,800 member hospitals, health care systems, and other health care organizations, and 33,000 individual members, including approximately 1,200 inpatient rehabilitation facilities (IRFs), appreciates the opportunity to comment on the fiscal year (FY) 2006 IRF prospective payment system (PPS) proposed rule. In addition to recommending a market basket update, the proposed rule calls for a restructuring of the current payment units, a re-weighting of the payment system, a modification of the comorbidity codes, adoption of a new teaching adjustment, the application of new labor market definitions, and a reduction in the outlier loss threshold.

The proposed rule represents the first attempt by the Centers for Medicare & Medicaid Services (CMS) to comprehensively update the IRF payment system. The rule includes major changes based on analyses using 2002 and 2003 IRF data. Currently, the key components of the IRF PPS that determine payment are based on data from 1998 and 1999 from a sample of hospitals. We appreciate the analysis undertaken by CMS and the RAND Corporation to update the payment system using more current data. In general, the AHA believes that regular updates of key components of every Medicare payment system using the most current data available are essential to maintaining a relevant and current framework that appropriately aligns payments with costs. Because of this, **AHA supports the proposed rule with respect to the market basket update, transition to new core-based statistical areas (CBSAs), and policy adjustments to account for the additional costs of teaching IRFs, rural IRFs, and low-income patients.**

Submitter : Mr. Frank Scudese
Organization : Bacharach Institute for Rehabilitation
Category : Hospital

Date: 07/18/2005

Issue Areas/Comments

GENERAL

GENERAL

7/18/2005

Issue

Proposed FY 2006 Federal Prospective Payment Rates

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

The proposed reduction of 1.9 percent is already a troubling change and financial burden when at the same time the cost to treat each Medicare patient is increasing due to the imposition of the 75% rule (50% test and subsequent 60% test). As facilities limit the number of non-compliant patients to meet the 75% rule, the burdens of fixed cost to operate a free-standing hospital are falling on fewer patients today. Any further increase in the reduction would exacerbate the financial condition of many facilities.

Proposed Revisions of the IRF PPS Geographic Classification

f. Wage Index Data

It is troubling that in as much CMS recognizes that "since both acute care hospitals and IRF's compete in the same labor markets" that CMS continues to treat us differently. CMS plans to use 2001 wage data when acute care facilities for the October 1, 2005 is based on 2002 wage data.

Further, CMS is using the "pre-floor wage index", excluding any rural floor provision. Again, we are treated different than the acute care facilities when we compete for the same types of personnel and have to compete by offering the same level of salaries and benefits.

Proposed Refinements to the Patient Classification System

Table 1: Proposed List of Codes to be Removed From the Tier

ICD-9-CM Code

V49.75 Status amputation below knee

V49.76 Status amputation above knee

V49.77 Status amputation hip

In a review of CMG cases for patients with a primary diagnosis other than amputation, BUT having a co-morbid condition of amputation, these patients cost us 5.4% more compared to the remaining patients in the same CMG categories without amputation as a co-morbid condition. This information was derived from our cost accounting and patient level revenue system. We would ask that you reconsider the removal of these three ICD-9-CM codes.

Proposed Changes to Move Dialysis to Tier One

We concur with this proposed change. These patients historically cost the facility more money.

Background

CORRECTION TO TABLE 3 ? Inpatient Rehabilitation Facilities with Corresponding State and County Location; Current Labor Market Area and Designation; and Proposed New CBSA-Based Labor Market Area Designation

Provider
Number

45T280 as listed and incorrect ? Bacharach Institute for Rehabilitation

313030 correct number

Submitter : Mr. Stephen Harwell
Organization : Healthcare Association of New York State
Category : Health Care Provider/Association

Date: 07/18/2005

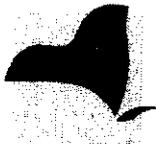
Issue Areas/Comments

GENERAL

GENERAL

Please see attached

CMS-1290-P-24-Attach-1.DOC



Healthcare Association
of New York State

July 18, 2005

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1500-P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Re: CMS-1290-P, Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for FFY 2006; 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) 2006 Prospective Payment System (PPS) for Inpatient Rehabilitation Facilities (IRFs).

Proposed FFY 2006 Federal PPS Rates—Reduction to the Standard Payment Rate

CMS is proposing to reduce the standard payment amount by 1.9% to eliminate the effect of coding changes that do not reflect real changes in case mix. This adjustment is based on an analysis of calendar year 2002 data that indicated that payments had increased because of changes in the classification of patients in IRFs. The analysis, conducted by the RAND Corporation, attempted to quantify the amount of the case mix change that was due to real changes in patient characteristics and the amount that was due solely to changes in coding practices.

RAND compared the 1999 data (currently used to construct the IRF PPS weights) with 2002 data (the first year of implementation for the PPS). RAND determined that the case mix for IRFs increased by 3.4% from 1999 to 2002. As CMS notes, 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.

The implementation of any new prospective payment system, such as the IRF PPS, will result in provider behavior changes that are reflected in changes in patient characteristics as measured by the case mix. According to CMS, the IRF PPS may have provided incentives for IRFs to admit patients with greater impairments, lower function, or more comorbidities. Under the IRF PPS, payments are tied directly to these patient characteristics and IRFs have greater incentives to admit more costly patients than they had under the prior payment system. Case mix changes due to these factors should be counted as “real changes” and be appropriately reflected in increased payments. CMS should not implement an adjustment for

Mark McClellan, M.D., Ph.D.

Page 2

July 18, 2005

coding improvements that might inappropriately reduce payments without an analysis that more definitively differentiates between coding changes and real patient changes.

Simultaneous with the proposed 1.9% reduction to the rate, CMS is proposing revisions to the case mix groups (CMGs) based on an analysis of data from 2002 and 2003. The proposed revisions include redefinitions of comorbidities to exclude some diagnosis codes that CMS believes are not related to increased costs and reassignment of other codes to provide lower payments that more accurately reflect observed costs. We address the proposed CMG changes elsewhere in this letter. However, the proposed 1.9% reduction for coding changes must be considered in relation to the CMG revisions. The CMG revisions would reduce payments for cases with reported comorbidities that the CMS analysis determined to be overpaid compared to actual costs. CMS justifies 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)." The proposed revision of the CMGs combined with the 1.9% reduction to the standard rate would adjust twice for the same coding changes. We believe that the proposed CMG revisions—based on specific codes that were identified as problems by a systematic analysis—are more equitable than an across-the-board 1.9% rate reduction that is based on circumstantial evidence.

In addition, the attempt to differentiate between coding changes and real patient changes is complicated by ongoing changes in IRF admission practices that result from facility attempts to comply with the "75% rule." CMS does reference the 75% rule regarding the 1.9% reduction to the standard payment rate. CMS states that, "... we chose the amount of the proposed reduction in the standard payment amount in order to recognize that IRFs' current cost structures may be changing as they strive to comply with other recent Medicare policy changes, such as the criteria for IRF classification commonly known as the '75 percent rule.'" We appreciate that CMS acknowledges the need to consider this factor when determining the amount of the coding reduction. However, given the significant changes in IRF patient admission patterns that would result from the implementation of the 75% rule, CMS should not make an adjustment for coding changes at this time.

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.

Proposed Refinements to the Patient Classification System

The current CMGs and comorbidity tiers are based on data from 1998 and 1999. CMS proposes refinements to the patient classification system based on an analysis of data from 2002 and 2003. CMS indicates that this refinement significantly improves the alignment between Medicare payments and actual IRF costs.

HANYS supports the updates and refinements proposed by CMS. The data from 1998 and 1999 do not accurately reflect the characteristics of patients treated in IRFs. Data from 2002 and 2003 are from periods subsequent to the implementation of the IRF-PPS and would provide for more accurate classification of patients.

As stated in the section of our comments regarding the 1.9% reduction to the standard rate, we believe that the proposed refinements to the CMGs and comorbidity tiers provide a reasonable and equitable adjustment

Mark McClellan, M.D., Ph.D.

Page 3

July 18, 2005

for changes in coding practices. We urge CMS to adjust for coding changes through systematic refinements to the patient classification system and eliminate the 1.9% across-the-board reduction from the final rule.

Proposed Revisions of the IRF PPS Geographic Classification

The current IRF PPS labor market areas are defined based on Metropolitan Statistical Areas (MSAs) from the 1990 U.S. Census. In FFY 2005, CMS implemented revised labor market areas based on the 2000 Census for the Inpatient PPS called Core-based Statistical Areas (CBSAs). CMS provided a one-year transition for hospitals that were harmed by the redefinition of the wage index areas, allowing inpatient hospitals experiencing a wage index decrease to receive a blend of 50% of the wage index based on the new definitions and 50% based on the old boundaries. CMS is proposing implementation of the revised labor market area definitions based upon the CBSAs adopted in the FFY 2005 Inpatient PPS final rule. CMS is proposing to base the IRF PPS wage index on the new wage area definitions without the transitional blend.

The redefinition of wage areas will have significant impacts on some IRFs that are similar to the impacts on Inpatient PPS hospitals. We urge CMS to provide the same transition as was applied to the inpatient PPS.

Proposed Teaching Status Adjustment

In the past, CMS has considered, but has not adopted, an adjustment for IRFs to account for the higher indirect operating costs experienced by facilities that participate in Graduate Medical Education programs. A RAND analysis of 2003 data found that the indirect teaching cost variable is significant in explaining the higher costs of IRFs that has teaching programs. Therefore, CMS is proposing to establish a facility-level teaching adjustment for IRFs.

HANYS supports implementation of an IRF teaching adjustment. This adjustment would increase payment equity by compensating for the higher costs experienced by facilities with teaching programs. Both the Inpatient PPS and the Inpatient Psychiatric PPS recognize the need for such an adjustment and the IRF PPS should be consistent with these systems.

While the proposal includes a teaching adjustment, CMS expresses several concerns and is soliciting comments on the proposed IRF teaching adjustment. CMS is concerned that the results of the RAND analysis based on 2003 data contradict the prior analysis of the 1999 data used to construct the initial IRF PPS, which found no significant relationship between teaching and increased costs. As we state in our comment supporting the CMS proposal to refine the patient classification system, data from 2003 represents a period subsequent to the implementation of the IRF PPS and provides for more accurate analysis of IRF costs under the PPS.

CMS further suggests that the results of the RAND analysis might reflect an aberration based on only a single year's data and suggests that analysis of future data from 2004 or later might provide a more accurate result.

CMS should not postpone or delay the implementation of a teaching adjustment in hopes of receiving later data that will provide results that are more accurate. A decision to postpone implementation is in

Submitter : Mr. John Prochilo
Organization : Northeast Rehabilitation Hospital
Category : Hospital

Date: 07/18/2005

Issue Areas/Comments

Issue

Proposed FY 2006 Federal Prospective Payment Rates
Please see Attachment

CMS-1290-P-25-Attach-1.DOC



NORTHEAST REHABILITATION
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(603) 893-2900 FAX (603) 893-1628
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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, S.W.
Washington, D.C. 20201

ATTN.: CMS-1290-P

Re: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for FY 2006; Proposed Rule, Federal Register, Volume 70, No. 100, Wednesday, May 25, 2005

Dear Dr. McClellan:

Northeast Rehabilitation Hospital appreciates the opportunity to comment on the proposed rule for the Inpatient Rehabilitation Facility Prospective Payment System for FY 2006 as published in the Federal Register on May 25, 2005. Northeast Rehabilitation Hospital (NRH) is a 102-bed acute rehabilitation facility offering comprehensive inpatient physical rehabilitation programs for both adults and children. We are accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), and serve patients from New Hampshire, Massachusetts, and surrounding areas. We are concerned that the proposed rule will significantly impact rehabilitation hospitals in New Hampshire. We respectfully request that CMS address this issue in the final rule.

Background

The implementation of the new Metropolitan Statistical Areas (MSA), as determined under the proposed new Core-Based Statistical Areas (CBSA) labor market area definition, using the standards developed for the 2000 Census have had a uniquely negative effect on the rehabilitation hospitals in the State of New Hampshire. These new standards, which radically altered the existing requirements for what constituted a Metropolitan Statistical Area, resulted in the Greater Boston MSA being broken up into six smaller MSAs. This outcome was unique to the Boston region; no other geographic areas suffered the same fate.

When CMS opted to use these new CBSA designations for the rehabilitation hospital Medicare inpatient reimbursement payment system, numerous facilities in Massachusetts, and New Hampshire were separated from the Boston MSA. The total reduction in payment attributable to the change in labor markets losses for inpatient reimbursement are estimated at more than **\$1,200,000 per year** for Salem, New Hampshire based Northeast Rehabilitation Hospital alone.

Northeast Rehabilitation Hospital Projected Impact FY 2006

Northeast Rehabilitation Hospital is located literally on the border of Massachusetts and New Hampshire. It competes in the same labor market as its Massachusetts, Rhode Island and Vermont counterparts. These other areas currently have positive Medicare margins and will see their overall margins stay the same or rise as a result of the proposed revisions to the geographic classification. Conversely the proposed changes in geographic classification will result in a reduction of the Medicare Base Reimbursement Rate for Northeast Rehabilitation Hospital by approximately eight (8%) percent. See Table 13 below.

Per Table 13: Projected Impact of FY 2006 Proposed Refinements on Base Rate

		Total % Change
ALL IRFs	1,188	+2.9%
New England Urban IRFs	35	-0.1%
Northeast Rehabilitation Hospital		-7.7%

Additionally, as a result of these proposed changes, Northeast Rehabilitation Hospital will be one of only eight rehabilitation facilities in the country to experience a wage index reduction of greater than 10%. See Table 15 below.

Per Table 15: Impact of the Proposed FY 2006 CBSA –Based Area Wage Index :

PERCENTAGE of Facilities with a <u>wage index</u> DECREASE of more than 10%	<u>0.7%</u>
Total Inpatient Rehabilitation Facilities (IRFs)	<u>1,188</u>
IRF's with a wage index decrease greater than 10%	<u>8</u>

In Summary, although CMS states that the overall impact of these changes will be an increase of 2.9% in the base rate to IRFs, Northeast will experience a DECREASE of 7.7% in our Adjusted Federal Prospective Payment Rate and is **one of only eight facilities nationally** that will have a **DECREASE** in wage index of **greater than 10%**.

Based on the above fact pattern, Northeast Rehabilitation Hospital is requesting relief through the following changes in the proposed rule:

3. Use a blended rate and allow a three year transition.
4. Include a hold harmless provision that limits the decrease to 3-4%.

Thank you for your consideration of our comments and request for relief. We would like to meet with agency staff to discuss this issue.

Sincerely,

John F. Prochilo, CEO/Administrator
Northeast Rehabilitation Hospital
70 Butler Street
Salem, NH 03079

James E. Murphy, Chief Financial Officer
Northeast Rehabilitation Hospital
70 Butler Street
Salem, NH 03079

Submitter : Mr. David Storto
Organization : Partners Continuing Care
Category : Other Health Care Provider

Date: 07/18/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1290-P-26-Attach-1.DOC

Mark B. McClellan, MD, PhD, Administrator, CMS
Comments to FY 06 Proposed Inpatient Rehabilitation Facilities Rule, July 18, 2005

Electronically

July 18, 2005

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

Attention: CMS-1290-P

Dear Dr. McClellan:

Partners HealthCare System, Inc. is pleased to comment on the Proposed Rule for the Medicare Program: Changes to the Inpatient Rehabilitation Facilities Prospective Payment Systems and Fiscal Year 2006 Rates, as published in the May 25, 2005 Federal Register, on behalf of its member inpatient rehabilitation facility:

Institution

Provider Number

Rehabilitation Hospital of the Cape and Islands

223032

Proposed Refinements to the Patient Classification System

We support the proposed refinements to the IRF Classification System. As a matter of policy, we believe that all PPS systems should continually be refined to ensure that payment under these systems reflects current medical practice. This proposed refinement is particularly apropos given the availability, for the first time, of PPS data describing the entire universe of Medicare-covered rehabilitation patients. For this reason, and the others cited by CMS, we request that CMS implement the proposed changes. We assume, however, that CMS will monitor the "success" of these proposed changes as well as their impact on providers and propose any changes it deems necessary in subsequent proposed rules.

Proposed Revisions to the IRF PPS Labor Market Areas

We support the adoption of the revised "core-based statistical areas" (CBSA's) for purposes of determining labor markets for the area wage adjustment. The refinements proposed by OMB are the result of an extensive review over several years of the criteria used to establish these socio-economic areas. This review process provided ample

Partners HealthCare System
Boston, MA

Mark B. McClellan, MD, PhD, Administrator, CMS
Comments to FY 06 Proposed Inpatient Rehabilitation Facilities Rule, July 18, 2005

opportunity for the industry and any other interested parties to provide comments. We strongly believe that CBSAs provide significantly better measures of individual labor markets and fully support their adoption.

Proposed Reduction to Account for Coding Changes

We oppose the proposed reduction in the standard payment rate to account for the impact of coding changes for the following reasons:

- There is, we believe, a reasonable chance that the “low” estimate may not represent the lowest “possible” impact of coding changes. As CMS acknowledges, this first approach does “not fully address all of the variables that may have contributed to the change in case mix”.
- The study, debate and subsequent rules regarding the 75 percent rule have, on the whole, put IRFs in a state of flux as to the mix of patients admitted and their clinical assessments. We do not believe it is prudent to implement a payment reduction based on estimates that have this level of uncertainty in the midst of this patient classification “flux”.
- In this same proposed rule, CMS is proposing significant and, as we commented above, beneficial changes to the patient classification system. We believe CMS should re-evaluate the extent, if any, of coding changes after these changes are implemented.

Should CMS decide to implement a reduction for coding changes, we urge that it be 1.9 percent for the following reasons:

- The impact of any payment reductions could be significant – it is therefore incumbent that any reductions be supported as strongly as possible by data and analysis. While both approaches taken by RAND appear reasonable, the uncertainty in each calls for taking the approach that presents the least amount of risk to providers. Moreover, as we note above, there is a possibility that the “true” impact of coding changes could be even less than 1.9 percent;
- RAND’s second approach is based on inferences from a subset of data (including patient characteristics) whose effect may be offset by other, unstudied factors; and,
- CMS should be as certain as possible that the proposed reduction does not affect access to care. Pending the attainment of that maximum certainty, the lowest reduction should be implemented.

Proposed Teaching Status Adjustment

At the outset, we understand the competing reasons for and against implementing an IME adjustment at this time that CMS is facing. Our only inpatient rehabilitation facility does not have a teaching program. However, in the future, Partners may have an additional rehabilitation provider that does have a teaching program. We have considered all the issues CMS has raised and believe that the most prudent course of action would be to implement the IME adjustment at 50 percent of its value in FY 2006 and implement in

Mark B. McClellan, MD, PhD, Administrator, CMS
Comments to FY 06 Proposed Inpatient Rehabilitation Facilities Rule, July 18, 2005

full in FY 2007 should the subsequent year's data (2004) re-affirm the statistically significant difference in costs between teaching and non-teaching IRFs. This approach, we believe, optimally balances the needs of teaching IRFs for additional payments while protecting non-teaching IRFs from too great a reduction should the 2003 results not be replicated (though we suspect they will).

As far as CMS concerns regarding the potential impact of the case mix refinements and area wage changes on the IME regression analysis: these will sort out over time. We do not believe CMS should refrain from taking current actions clearly supported by data because of the possibility that future events will argue against such actions. Prospective payment systems will better serve CMS and providers alike if they are dynamic systems, responding to the current environment in a manner that is both decisive and prudent.

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

Sincerely,

David Storto
President
Partners Continuing Care

Submitter : Mr. Kenneth Raske
Organization : Greater New York Hospital Association
Category : Health Care Professional or Association

Date: 07/18/2005

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-1290-P-27-Attach-1.PDF

CMS-1290-P-27-Attach-2.PDF



Greater New York Hospital Association

555 West 57th Street / New York, N.Y. 10019 / (212) 246-7100 / (212) 262-6350

Kenneth E. Raske, President

July
Eighteen
2005

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 443-G
200 Independence Avenue, S.W.
Washington, D.C. 20201

Subject: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Fiscal Year 2006; Proposed Rule, *Federal Register* 70, no. 100 (May 25, 2005): 30188-30327. [CMS-1290-P]

Dear Dr. McClellan:

On behalf of the more than 125 hospitals, both voluntary not-for-profit and public, that make up the membership of the Greater New York Hospital Association, I appreciate this opportunity to comment upon the Centers for Medicare & Medicaid Services' (CMS's) proposed rule for the Federal fiscal year 2006 inpatient rehabilitation facility prospective payment system (IRF PPS). This is a very significant rule because it proposes an overhaul of the payment model based on the first complete set of data that CMS has had the opportunity to analyze. The current payment model was based on 1998 and 1999 data for a sample of hospitals.

The following is a brief summary of our recommendations. They are discussed in much greater detail in the attached text.

SUMMARY OF RECOMMENDATIONS

1. *Revised payment model.* We strongly support CMS's proposal to revise the IRF PPS payment model based upon the analysis conducted by the RAND Corporation.
2. *Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI) data.* We recommend that CMS either expand the Medicare Provider Analysis and Review file or

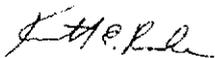
create a separate administrative database that includes the case-mix group assignment for each patient and the individual data elements collected through the IRF-PAI for each patient.

3. *Wage index labor markets.* For IRFs losing money because their wage index labor markets were expanded in the change from Metropolitan Statistical Areas (MSAs) to Core Based Statistical Areas (CBSAs), we urge CMS to provide a wage index that is a permanent blend of their MSA and CBSA wage indices.
4. *RPL market basket.* We support CMS's proposal to update the rehabilitation, psychiatric, and long-term care hospital market basket cost component weights to a 2002 base year, and we urge the Agency to designate professional liability insurance as a labor-related cost.
5. *GME affiliation agreements.* We strongly urge CMS to permit IRFs to elect to form Medicare graduate medical education affiliated group agreements, either with other IRFs or with acute care hospitals subject to the inpatient PPS.
6. *Counting residents for the teaching adjustment.* We recommend that CMS allow general hospitals to increase physiatrist training if they also decrease training in one or more specialties reimbursed under the inpatient PPS.

Again, I appreciate the opportunity to provide our comments. If you have any questions or would like further information, please contact Karen S. Heller, Executive Director of The Health Economics and Outcomes Research Institute, at (212) 506-5408 or heller@gnyha.org; or Elisabeth R. Wynn, Director of Finance, at (212) 259-0719 or wynn@gnyha.org.

My best.

Sincerely,



Kenneth E. Raske, President

Attachment

**Greater New York Hospital Association's
Comments on the Centers for Medicare & Medicaid Services'
Proposed Rule for the Federal Fiscal Year 2006
Inpatient Rehabilitation Facility Prospective Payment System**

The Federal fiscal year (FY) 2006 proposed rule for the inpatient rehabilitation facility prospective payment system (IRF PPS) is very significant because it proposes an overhaul of the payment model based on the first complete set of data that CMS has had the opportunity to analyze. The current payment model was based on 1998 and 1999 data for a sample of hospitals.

INPATIENT REHABILITATION FACILITY PATIENT ASSESSMENT INSTRUMENT (IRF-PAI) DATA

Before commenting upon CMS's specific proposals, we would like to express our continuing disappointment and frustration over the lack of access to patient-level functional impairment data. This lack of access prevents us from doing any empirical research on the IRF PPS patient classification system and payment model and, therefore, greatly limits our ability to provide constructive input to the rule-making process.

Equally important, however, is that our lack of access to the data prevents us from conducting research into risk-adjusted measures of quality and efficiency in inpatient rehabilitation facilities. The Health Economics and Outcomes Research Institute (THEORI) at the Greater New York Hospital Association (GNYHA) has been working since 1997 on developing and evaluating outcomes measures and has a very active Outcomes Research Committee through which we collaborate on research projects with experts in our membership. We lament that we've been forced to ignore the inpatient rehabilitation service sector because of the lack of access to patient-level functional impairment data.

Recommendation: Therefore, we strongly urge CMS to either expand the Medicare Provider Analysis and Review file or to create a separate administrative database that includes the case-mix group (CMG) assignment for each patient and the individual data elements collected through the IRF-PAI for each patient. At a minimum, CMS should make available the CMG assignment and composite functional and motor scores of each patient. Researchers would be able to access these data only through a strict and comprehensive data use agreement with CMS, which would fully protect the privacy of each Medicare beneficiary.

UPDATING THE IRF PPS PAYMENT MODEL

Because the original IRF PPS payment model was based upon 1998 and 1999 data for only a sample of hospitals, CMS was interested in revising the model once it had a full year's worth of reliable data from all hospitals. That opportunity occurred when the FY 2003 IRF-PAI database and hospital cost reports became available. (FY 2003 was the second year in which the IRF PPS was in effect, so any problems hospitals encountered in using the IRF-PAI in the first year would have been resolved.) Therefore, CMS asked the RAND Corporation, which had conducted the original research, to revise the patient classification system and payment parameters based on the FY 2003 data, and has proposed to implement the revisions in FY 2006.

The revised payment model changes the CMGs, the comorbidity tiers, the rural adjustment, and the low-income patient adjustment; it also introduces an indirect medical education (IME) adjustment. GNYHA has thoroughly studied the papers that RAND prepared on its methodology and findings, and we strongly support updating the IRF PPS payment model based on those findings. Despite our inability to replicate the analysis, we have a high degree of confidence in the technical skill and integrity of the RAND Corporation and in CMS's oversight of the research. Furthermore, after deriving and analyzing margins for various aggregations of hospitals—based on CMS's Impact File—we have concluded that the updated payment model improves payment equity.

We have heard that some other parties who are offering comments might oppose implementation of the revised model because CMS will probably request another revision once the 75% rule is fully in effect. Those parties may argue that the Agency should wait to implement all revisions at once. We believe that the benefit of a correctly specified payment model far outweighs the inconvenience of periodic updates. We feel a particular sense of urgency about implementing the teaching adjustment. We believe that teaching hospitals have been under-reimbursed since the inception of the IRF PPS because they were under-represented in the sample of hospitals whose data were used to develop the original payment model.

Recommendation: CMS should revise the IRF PPS payment model based on the analysis conducted by the RAND Corporation.

WAGE INDEX LABOR MARKETS

CMS adjusts the payment rates to account for regional variation in wage levels. The current adjustment is based on acute care hospital wage data for the Metropolitan Statistical Area (MSA) in which each facility is located and does not recognize geographic reclassifications of acute care hospitals with rehabilitation units.

For FY 2006, CMS is proposing to adopt the Census Bureau's Core Based Statistical Areas (CBSAs) as the labor market definition for wage index purposes as it did in the inpatient PPS in FY 2005. The change would redistribute funding among hospitals located in labor markets that were either subdivided or expanded. However, CMS declined to propose a mechanism to mitigate the effect of the change on disadvantaged hospitals, as it did in the inpatient PPS. For acute care hospitals, CMS computed the area wage indices based upon a blend of the old and new labor market definitions for those hospitals. CMS stated that it does not believe that a hold-harmless strategy is necessary since the IRF PPS is relatively new.

As we have stated in the past on many occasions, we object to the implementation of CBSAs that combine clearly distinct hospital labor markets. Both the U.S. Government Accountability Office and the Medicare Payment Advisory Commission have criticized some MSAs in the past because they were too large to discriminate effectively between separate hospital labor markets. The CBSAs corrected that problem in many areas of the country by subdividing MSAs; however, they also created new problems by combining former MSAs that represented separate hospital labor markets.

Hospitals located in expanded wage index labor markets, such as the New York City area, incurred losses that were completely unwarranted. Therefore, in our most recent comment letter on the FY 2006 inpatient PPS, we recommended that CMS use the reclassification process to establish core urban areas within CBSAs that combine distinct labor markets and to continue the blended wage index until that process is in place. Since post-acute care providers, such as IRFs, do not have access to the reclassification process, the blend is the only available mechanism to mitigate some of their arbitrary losses.

Blended payments are often temporary because the new payment system is considered superior to the old system. That is, CMS provides blended payments in order to help hospitals adjust to a lower level of reimbursement, even though that lower level is considered appropriate. In the case of hospitals losing funding because their labor market was expanded, the new, lower level is not appropriate, but rather arbitrary. Therefore, in this situation, the blended wage index should be permanent.

Recommendation: For IRFs losing money because their wage index labor markets were expanded in the change from MSAs to CBSAs, CMS should provide a wage index that is a permanent blend of their MSA and CBSA wage indices.

REHABILITATION, PSYCHIATRIC, AND LONG-TERM CARE (RPL) HOSPITAL MARKET BASKET

The current RPL hospital market basket cost category weights are based on 1997 data and the cost categories designated as labor-related are wages and salaries, employee benefits, professional fees, and all other labor-intensive services. For FY 2006, CMS is proposing to rebase the market basket to reflect FY 2002 data. We fully support this proposal.

In addition, we believe that CMS should designate professional liability insurance as a labor-related cost. These costs are clearly labor-related—indeed, they are reported in the wage index—and are clearly locally determined. We believe that the failure to include professional liability insurance in the wage-adjusted portion of the Federal rate in all prospective payment systems has been an unfortunate oversight.

Recommendations:

- CMS should update the RPL hospital market basket cost component weights to a 2002 base year.
- CMS should designate professional liability insurance as a labor-related cost.

GRADUATE MEDICAL EDUCATION (GME)

CMS is proposing two provisions pertaining to GME. One provision would prohibit IRFs from aggregating the full-time equivalent (FTE) resident caps used to compute the teaching adjustment through affiliation agreements. The other provision would cap the number of residents that may be counted for the purpose of calculating the ratio of interns and residents to

the average daily census (IRADC)—the IME variable—based on the final settlement of each IRF's most recent cost-reporting period ending on or before November 15, 2003.

Medicare GME Affiliated Group Agreements

In the proposed rule, CMS states that, "contrary to the policy for IME FTE resident caps under the acute care PPS, we would not allow IRFs to aggregate the FTE resident caps used to compute the IRF PPS teaching status adjustment through affiliation agreements." The rationale provided for this proposal is that CMS wants to "avoid incentives for IRFs to add FTE residents in order to increase their payments." We believe that this proposal is inappropriate and reflects a misreading of the intent and practical impact of the inpatient acute care PPS provision that allows two or more hospitals to voluntarily elect to form a Medicare GME affiliated group agreement.

Under the provisions of the Balanced Budget Act of 1997 (BBA), teaching hospitals subject to the inpatient PPS were granted the flexibility to voluntarily aggregate resident FTE caps in order to enter academic affiliations that serve clinical physician education needs. Representatives of the academic medicine community had made the compelling and convincing case that the fluid system of affiliations inherent within the medical education system must be respected in order to ensure the proper post-graduate training of physicians. In particular, there was great concern that physician education would be hampered by the FTE caps because teaching institutions would not be able to rotate residents to other hospital training sites since "receiving sites" would be unwilling to exceed their hospital-specific FTE caps.

The BBA recognized appropriately that Medicare payment control could be achieved by requiring that Medicare GME affiliated group agreements ensure that any increase in one or more hospitals' resident caps be offset by an equivalent decrease in the other hospitals' caps, thus creating a "net zero" effect from the policy. The academic medicine community was extremely grateful that the Congress recognized, and CMS implemented, a policy that does not impose a hospital-specific, absolute cap on the number of FTE residents for which a teaching hospital subject to the inpatient PPS may receive Medicare direct GME and IME reimbursement.

The current requirements for physical medicine and rehabilitation residency programs established by the Residency Review Committee (RRC) of the Accreditation Council for Graduate Medical Education, the organization that establishes the required educational components of training in this specialty, states very clearly that "the clinical portion of the curriculum must include a sufficient variety, depth, and number of clinical experiences." The requirements define 18 different areas in which competency must be developed and list 15 different conditions to which the physiatrist-in-training must be exposed in order to complete the residency program.

As a result of changes in services provided by a teaching institution and/or updates in the requirements of the RRC, the teaching institutions may need to establish new rotations in order to ensure that appropriate education can occur. These complex medical education clinical requirements are precisely why teaching institutions need the flexibility that affiliated group agreements grant them. In fact, a teaching institution would be remiss in not establishing academic affiliations with other institutions in order to ensure the proper training of these

physicians. CMS should, therefore, establish Medicare IME payment policies for IRFs that recognize this educational reality and grant the flexibility necessary to ensure that needed medical training rotations between institutions can occur.

It is important to note that CMS's overall system for ensuring that resident FTE counts are accurate is well established. When submitting their Medicare cost reports, teaching hospitals seeking direct GME payments, IME payments, or both are required to also submit a separate diskette that contains their accompanying Intern-and-Resident-Information-System files. Those files, which include both "Master" information and "Assignment" information, are used by the fiscal intermediary as an audit tool to ensure that teaching hospitals are not inadvertently overpaid as a result of miscounting residents.

The Master information includes all the data used to establish that each resident being reported as having trained in the hospital during the cost-report year is training in a program approved for Medicare GME reimbursement and is eligible to be included in the count. The Assignment information includes the specific dates that the resident was training at the hospital. The IRIS submissions from all the teaching hospitals served by a particular fiscal intermediary are combined for a "duplication run" that disallows a resident assignment automatically if it overlaps with another hospital on a specific date. This audit protocol ensures that the Medicare program does not overpay for residency training time in teaching hospitals participating in the Medicare program.

Recommendation: CMS should permit IRFs to elect to form Medicare GME affiliated group agreements, either with other IRFs or with acute care hospitals subject to the inpatient PPS.

Capping Residents for the IME Adjustment

In contemplating CMS's proposal to cap residents in the computation of the IRADC for the IRF PPS IME adjustment, we realized that a cap on psychiatrist residents—like the current cap on psychiatric residents in the inpatient psychiatric facility (IPF) PPS—is ill-advised because it limits the ability of general hospitals to alter their teaching programs in response to changes in the need for training in different specialties. Instead, we believe that general hospitals should be allowed to increase training in those specialties if they decrease the number of FTEs included in the inpatient PPS IME formula.

Recommendation: We recommend that CMS allow general hospitals to increase psychiatrist and psychiatric training in IRFs and IPFs, respectively, if they also decrease training in specialties reimbursed under the inpatient PPS.



Greater New York Hospital Association

555 West 57th Street / New York, N.Y. 10019 / (212) 246-7100 / (212) 262-6350
Kenneth E. Raske, President

July
Eighteen
2005

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 443-G
200 Independence Avenue, S.W.
Washington, D.C. 20201

Subject: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Fiscal Year 2006; Proposed Rule, *Federal Register* 70, no. 100 (May 25, 2005): 30188-30327. [CMS-1290-P]

Dear Dr. McClellan:

On behalf of the more than 125 hospitals, both voluntary not-for-profit and public, that make up the membership of the Greater New York Hospital Association, I appreciate this opportunity to comment upon the Centers for Medicare & Medicaid Services' (CMS's) proposed rule for the Federal fiscal year 2006 inpatient rehabilitation facility prospective payment system (IRF PPS). This is a very significant rule because it proposes an overhaul of the payment model based on the first complete set of data that CMS has had the opportunity to analyze. The current payment model was based on 1998 and 1999 data for a sample of hospitals.

The following is a brief summary of our recommendations. They are discussed in much greater detail in the attached text.

SUMMARY OF RECOMMENDATIONS

1. *Revised payment model.* We strongly support CMS's proposal to revise the IRF PPS payment model based upon the analysis conducted by the RAND Corporation.
2. *Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI) data.* We recommend that CMS either expand the Medicare Provider Analysis and Review file or

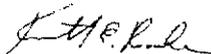
create a separate administrative database that includes the case-mix group assignment for each patient and the individual data elements collected through the IRF-PAI for each patient.

3. *Wage index labor markets.* For IRFs losing money because their wage index labor markets were expanded in the change from Metropolitan Statistical Areas (MSAs) to Core Based Statistical Areas (CBSAs), we urge CMS to provide a wage index that is a permanent blend of their MSA and CBSA wage indices.
4. *RPL market basket.* We support CMS's proposal to update the rehabilitation, psychiatric, and long-term care hospital market basket cost component weights to a 2002 base year, and we urge the Agency to designate professional liability insurance as a labor-related cost.
5. *GME affiliation agreements.* We strongly urge CMS to permit IRFs to elect to form Medicare graduate medical education affiliated group agreements, either with other IRFs or with acute care hospitals subject to the inpatient PPS.
6. *Counting residents for the teaching adjustment.* We recommend that CMS allow general hospitals to increase psychiatrist training if they also decrease training in one or more specialties reimbursed under the inpatient PPS.

Again, I appreciate the opportunity to provide our comments. If you have any questions or would like further information, please contact Karen S. Heller, Executive Director of The Health Economics and Outcomes Research Institute, at (212) 506-5408 or heller@gnyha.org; or Elisabeth R. Wynn, Director of Finance, at (212) 259-0719 or wynn@gnyha.org.

My best.

Sincerely,



Kenneth E. Raske, President

Attachment

**Greater New York Hospital Association's
Comments on the Centers for Medicare & Medicaid Services'
Proposed Rule for the Federal Fiscal Year 2006
Inpatient Rehabilitation Facility Prospective Payment System**

The Federal fiscal year (FY) 2006 proposed rule for the inpatient rehabilitation facility prospective payment system (IRF PPS) is very significant because it proposes an overhaul of the payment model based on the first complete set of data that CMS has had the opportunity to analyze. The current payment model was based on 1998 and 1999 data for a sample of hospitals.

INPATIENT REHABILITATION FACILITY PATIENT ASSESSMENT INSTRUMENT (IRF-PAI) DATA

Before commenting upon CMS's specific proposals, we would like to express our continuing disappointment and frustration over the lack of access to patient-level functional impairment data. This lack of access prevents us from doing any empirical research on the IRF PPS patient classification system and payment model and, therefore, greatly limits our ability to provide constructive input to the rule-making process.

Equally important, however, is that our lack of access to the data prevents us from conducting research into risk-adjusted measures of quality and efficiency in inpatient rehabilitation facilities. The Health Economics and Outcomes Research Institute (THEORI) at the Greater New York Hospital Association (GNYHA) has been working since 1997 on developing and evaluating outcomes measures and has a very active Outcomes Research Committee through which we collaborate on research projects with experts in our membership. We lament that we've been forced to ignore the inpatient rehabilitation service sector because of the lack of access to patient-level functional impairment data.

Recommendation: Therefore, we strongly urge CMS to either expand the Medicare Provider Analysis and Review file or to create a separate administrative database that includes the case-mix group (CMG) assignment for each patient and the individual data elements collected through the IRF-PAI for each patient. At a minimum, CMS should make available the CMG assignment and composite functional and motor scores of each patient. Researchers would be able to access these data only through a strict and comprehensive data use agreement with CMS, which would fully protect the privacy of each Medicare beneficiary.

UPDATING THE IRF PPS PAYMENT MODEL

Because the original IRF PPS payment model was based upon 1998 and 1999 data for only a sample of hospitals, CMS was interested in revising the model once it had a full year's worth of reliable data from all hospitals. That opportunity occurred when the FY 2003 IRF-PAI database and hospital cost reports became available. (FY 2003 was the second year in which the IRF PPS was in effect, so any problems hospitals encountered in using the IRF-PAI in the first year would have been resolved.) Therefore, CMS asked the RAND Corporation, which had conducted the original research, to revise the patient classification system and payment parameters based on the FY 2003 data, and has proposed to implement the revisions in FY 2006.

The revised payment model changes the CMGs, the comorbidity tiers, the rural adjustment, and the low-income patient adjustment; it also introduces an indirect medical education (IME) adjustment. GNYHA has thoroughly studied the papers that RAND prepared on its methodology and findings, and we strongly support updating the IRF PPS payment model based on those findings. Despite our inability to replicate the analysis, we have a high degree of confidence in the technical skill and integrity of the RAND Corporation and in CMS's oversight of the research. Furthermore, after deriving and analyzing margins for various aggregations of hospitals—based on CMS's Impact File—we have concluded that the updated payment model improves payment equity.

We have heard that some other parties who are offering comments might oppose implementation of the revised model because CMS will probably request another revision once the 75% rule is fully in effect. Those parties may argue that the Agency should wait to implement all revisions at once. We believe that the benefit of a correctly specified payment model far outweighs the inconvenience of periodic updates. We feel a particular sense of urgency about implementing the teaching adjustment. We believe that teaching hospitals have been under-reimbursed since the inception of the IRF PPS because they were under-represented in the sample of hospitals whose data were used to develop the original payment model.

Recommendation: CMS should revise the IRF PPS payment model based on the analysis conducted by the RAND Corporation.

WAGE INDEX LABOR MARKETS

CMS adjusts the payment rates to account for regional variation in wage levels. The current adjustment is based on acute care hospital wage data for the Metropolitan Statistical Area (MSA) in which each facility is located and does not recognize geographic reclassifications of acute care hospitals with rehabilitation units.

For FY 2006, CMS is proposing to adopt the Census Bureau's Core Based Statistical Areas (CBSAs) as the labor market definition for wage index purposes as it did in the inpatient PPS in FY 2005. The change would redistribute funding among hospitals located in labor markets that were either subdivided or expanded. However, CMS declined to propose a mechanism to mitigate the effect of the change on disadvantaged hospitals, as it did in the inpatient PPS. For acute care hospitals, CMS computed the area wage indices based upon a blend of the old and new labor market definitions for those hospitals. CMS stated that it does not believe that a hold-harmless strategy is necessary since the IRF PPS is relatively new.

As we have stated in the past on many occasions, we object to the implementation of CBSAs that combine clearly distinct hospital labor markets. Both the U.S. Government Accountability Office and the Medicare Payment Advisory Commission have criticized some MSAs in the past because they were too large to discriminate effectively between separate hospital labor markets. The CBSAs corrected that problem in many areas of the country by subdividing MSAs; however, they also created new problems by combining former MSAs that represented separate hospital labor markets.

Hospitals located in expanded wage index labor markets, such as the New York City area, incurred losses that were completely unwarranted. Therefore, in our most recent comment letter on the FY 2006 inpatient PPS, we recommended that CMS use the reclassification process to establish core urban areas within CBSAs that combine distinct labor markets and to continue the blended wage index until that process is in place. Since post-acute care providers, such as IRFs, do not have access to the reclassification process, the blend is the only available mechanism to mitigate some of their arbitrary losses.

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Recommendations:

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CMS is proposing two provisions pertaining to GME. One provision would prohibit IRFs from aggregating the full-time equivalent (FTE) resident caps used to compute the teaching adjustment through affiliation agreements. The other provision would cap the number of residents that may be counted for the purpose of calculating the ratio of interns and residents to

the average daily census (IRADC)—the IME variable—based on the final settlement of each IRF’s most recent cost-reporting period ending on or before November 15, 2003.

Medicare GME Affiliated Group Agreements

In the proposed rule, CMS states that, “contrary to the policy for IME FTE resident caps under the acute care PPS, we would not allow IRFs to aggregate the FTE resident caps used to compute the IRF PPS teaching status adjustment through affiliation agreements.” The rationale provided for this proposal is that CMS wants to “avoid incentives for IRFs to add FTE residents in order to increase their payments.” We believe that this proposal is inappropriate and reflects a misreading of the intent and practical impact of the inpatient acute care PPS provision that allows two or more hospitals to voluntarily elect to form a Medicare GME affiliated group agreement.

Under the provisions of the Balanced Budget Act of 1997 (BBA), teaching hospitals subject to the inpatient PPS were granted the flexibility to voluntarily aggregate resident FTE caps in order to enter academic affiliations that serve clinical physician education needs. Representatives of the academic medicine community had made the compelling and convincing case that the fluid system of affiliations inherent within the medical education system must be respected in order to ensure the proper post-graduate training of physicians. In particular, there was great concern that physician education would be hampered by the FTE caps because teaching institutions would not be able to rotate residents to other hospital training sites since “receiving sites” would be unwilling to exceed their hospital-specific FTE caps.

The BBA recognized appropriately that Medicare payment control could be achieved by requiring that Medicare GME affiliated group agreements ensure that any increase in one or more hospitals’ resident caps be offset by an equivalent decrease in the other hospitals’ caps, thus creating a “net zero” effect from the policy. The academic medicine community was extremely grateful that the Congress recognized, and CMS implemented, a policy that does not impose a hospital-specific, absolute cap on the number of FTE residents for which a teaching hospital subject to the inpatient PPS may receive Medicare direct GME and IME reimbursement.

The current requirements for physical medicine and rehabilitation residency programs established by the Residency Review Committee (RRC) of the Accreditation Council for Graduate Medical Education, the organization that establishes the required educational components of training in this specialty, states very clearly that “the clinical portion of the curriculum must include a sufficient variety, depth, and number of clinical experiences.” The requirements define 18 different areas in which competency must be developed and list 15 different conditions to which the physiatrist-in-training must be exposed in order to complete the residency program.

As a result of changes in services provided by a teaching institution and/or updates in the requirements of the RRC, the teaching institutions may need to establish new rotations in order to ensure that appropriate education can occur. These complex medical education clinical requirements are precisely why teaching institutions need the flexibility that affiliated group agreements grant them. In fact, a teaching institution would be remiss in not establishing academic affiliations with other institutions in order to ensure the proper training of these

physicians. CMS should, therefore, establish Medicare IME payment policies for IRFs that recognize this educational reality and grant the flexibility necessary to ensure that needed medical training rotations between institutions can occur.

It is important to note that CMS's overall system for ensuring that resident FTE counts are accurate is well established. When submitting their Medicare cost reports, teaching hospitals seeking direct GME payments, IME payments, or both are required to also submit a separate diskette that contains their accompanying Intern-and-Resident-Information-System files. Those files, which include both "Master" information and "Assignment" information, are used by the fiscal intermediary as an audit tool to ensure that teaching hospitals are not inadvertently overpaid as a result of miscounting residents.

The Master information includes all the data used to establish that each resident being reported as having trained in the hospital during the cost-report year is training in a program approved for Medicare GME reimbursement and is eligible to be included in the count. The Assignment information includes the specific dates that the resident was training at the hospital. The IRIS submissions from all the teaching hospitals served by a particular fiscal intermediary are combined for a "duplication run" that disallows a resident assignment automatically if it overlaps with another hospital on a specific date. This audit protocol ensures that the Medicare program does not overpay for residency training time in teaching hospitals participating in the Medicare program.

Recommendation: CMS should permit IRFs to elect to form Medicare GME affiliated group agreements, either with other IRFs or with acute care hospitals subject to the inpatient PPS.

Capping Residents for the IME Adjustment

In contemplating CMS's proposal to cap residents in the computation of the IRADC for the IRF PPS IME adjustment, we realized that a cap on physiatrist residents—like the current cap on psychiatric residents in the inpatient psychiatric facility (IPF) PPS—is ill-advised because it limits the ability of general hospitals to alter their teaching programs in response to changes in the need for training in different specialties. Instead, we believe that general hospitals should be allowed to increase training in those specialties if they decrease the number of FTEs included in the inpatient PPS IME formula.

Recommendation: We recommend that CMS allow general hospitals to increase physiatrist and psychiatrist training in IRFs and IPFs, respectively, if they also decrease training in specialties reimbursed under the inpatient PPS.

Submitter : Mr. Kenneth Raske
Organization : GNYHA
Category : Health Care Provider/Association

Date: 07/18/2005

Issue Areas/Comments

GENERAL

GENERAL

See attachment

Submitter : Mr. Michael Pelc
Organization : Rehabilitation Institute of Michigan
Category : Hospital

Date: 07/18/2005

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-1290-P-29-Attach-1.DOC

July 18, 2005
Center for Medicare and Medicaid Services
Attention CMS-1290-P
P.O. Box 8010
Baltimore, MD 21244-8010

Re CMS-1290-P IRF PPS Proposed Rule FY 2006

Dear Sir

The Rehabilitation Institute of Michigan a 94 bed freestanding rehabilitation facility located in Detroit Michigan welcomes this opportunity to comment on the proposed rules for the Inpatient Rehabilitation Facility Prospective Payment System for FY 2006 as published in the May 25,2005 Federal Register.

I. THE IRF PPS MUST INCLUDE A TEACHING ADJUSTMENT

Since the beginning of the IRF PPS there has been a disparity in the payment equity for teaching facilities. This was demonstrated in the financial impact table accompanying the initial IRF PPS final rule. The analyses conducted by the RAND Corporation (RAND) using 2003 data show that this inequity is continuing. As their analyses demonstrated, teaching rehabilitation facilities have higher costs than their non-teaching counterparts and these higher costs are associated with their teaching status.

RAND's results are not surprising -- clinical operations are inherently more costly when teaching and training is involved and facilities with larger teaching programs generally treat more costly patient populations. Such a finding has been borne out in both the inpatient and psychiatric prospective payment systems, both of which include a teaching adjustment.

CMS also expressed a concern about implementing an adjustment at the current time because other changes that might be implemented could affect future data outcomes. . We strongly believe that theoretical, non specific; concerns about the future should not override current analytically-sound analyses. As with all of Medicare's payment systems, policies and decisions are, and must, be made based on the best data currently available. If in the future data analyses show different results, CMS has the authority to make modifications to the system, including the teaching adjustment. Unlike the inpatient PPS, in which changes to the indirect medical education (IME) adjustment requires legislative action, CMS has ample opportunity to modify IRF teaching adjustment through the regulatory process if that is deemed appropriate at a later date.

In sum, RAND's analyses demonstrate that teaching IRFs were underpaid in 2003, which means that they were underpaid in 2004 and currently are being underpaid. Moreover, their regression analyses clearly show a statistically significant teaching affect.

A teaching adjustment is long overdue for this payment system. Including a teaching adjustment will not rectify the past and current payment inequity; however it will help ensure a more equitable system going forward. We urge CMS to continue its commitment to empirically-based decision-making and include a teaching adjustment in the final rule.

II. THE IRF PPS LOW INCOME PATIENT PERCENTAGE CALCULATION (LIP)

We are supportive of CMS's proposed changes to the LIP patient percentage calculation as it appropriately recognizes the financial burden IRF's face in treating a disproportionate share of low income patients.

III. Outlier Threshold

We are supportive of CMS's proposed reduction in the outlier threshold from \$11,211 to \$4,911.

If you have any questions regarding these comments please contact me at 313 578-2820.

Michael Pelc
Vice President Finance
Reimbursement Division

Submitter : Mr. Thomas Donovan
Organization : SUNY Upstate Medical University
Category : Hospital

Date: 07/18/2005

Issue Areas/Comments

Background

Background

See attachment

Submitter : Ms. Marilyn Litka-Klein
Organization : Michigan Health & Hospital Association
Category : Health Care Provider/Association

Date: 07/18/2005

Issue Areas/Comments

GENERAL

GENERAL

Please see our attached comment letter.

CMS-1290-P-31-Attach-1.DOC



MICHIGAN HEALTH & HOSPITAL ASSOCIATION

Advocating for hospitals and the patients they serve.

July 18, 2005

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1500-P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Re: CMS-1290-P, Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for FY 2006; Proposed Rule

Dear Dr. McClellan:

On behalf of its 145 member hospitals and other healthcare providers, the Michigan Health & Hospital Association (MHA) appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) regarding the proposed rule related to the Fiscal Year (FY) 2006 Prospective Payment System (PPS) for Inpatient Rehabilitation Facilities (IRFs).

75% Rule

During the first year of the 75% Rule, providers relied on various approaches to adapt to the new classification criteria and comply with the first-year threshold of 50 percent. For example, many IRFs changed patient mix by reducing patient admissions in many of the rehabilitation impairment categories, including joint replacement, osteoarthritis, cardiac, pulmonary, and miscellaneous. To meet the 50 percent threshold, some IRFs also closed beds, reduced staff (physicians, therapists, nurses, support staff), and/or recertified IRF beds as skilled nursing or general acute beds. In some cases, even admissions in categories that qualify under the 75% Rule, such as stroke and major multiple trauma, have dropped because of reduced overall IRF capacity. Based on IRF patient assessment data submitted to UDS MR and eRehabData, the number of IRF patients has decreased by more than 34,000 during the first 12 months under the 75% Rule. This number climbs even higher when all IRFs are included. These consequences resulting from IRF operational changes designed to achieve 75% Rule compliance will grow under the 60% threshold and continue to increase as the threshold moves toward the 75% level.

The MHA is very concerned about the proposed rule's failure to adequately acknowledge the substantial volatility experienced by IRFs because of the implementation of the 75% Rule. We urge the CMS to take into account the current and anticipated volatility related to the 75% Rule in this proposed rule and, to the extent possible, take steps to ensure that analyses reflect changes in the types of patients treated in IRFs and the subsequent impact on case mix, length of stay, and costs. The current proposed rule relies on analyses of 2002 and 2003 data that do not include the substantial

SPENCER JOHNSON, PRESIDENT

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impact of the 75% Rule. As a result, the rule makes proposals for FY 2006 that are out of step with the regulatory environment that IRFs actually will face in FY 2006. Therefore, **we urge CMS to proceed cautiously with rulemaking on the IRF payment system.**

Proposed Federal Prospective Payment Rates - Reduction to the Standard Payment Rate

To eliminate the impact of coding changes that do not reflect actual changes in case mix, the CMS is proposing to reduce the standard payment amount by 1.9 percent. This adjustment is based upon an analysis of data from calendar year 2002 which indicated that IRF payments had increased due to revisions in the classification of patients. The analysis, conducted by the RAND Corporation, attempted to quantify the amount of the case mix change that resulted from changes in patient characteristics and the amount that attributed to changes in coding practices.

In this analysis, RAND compared the 1999 data, which was used to construct the IRF PPS weights, to the 2002 data, the first year of PPS implementation, and determined that the case mix for IRFs increased by 3.4 percent during that timeframe. As noted by the CMS, while the RAND analysis could determine the total change in case mix, it could not precisely determine the amount of the total change that resulted due to coding modifications. Instead, RAND used indirect evidence to estimate that between 1.9 and 5.8 percent of the IRF case mix increase might be attributable to coding changes.

Implementation of any new prospective payment system, such as the IRF PPS, will result in changes in provider behavior which are reflected in changes in patient characteristics as measured by the case mix. According to the CMS, since IRF PPS payment levels correspondence directly to patient characteristics, the IRF PPS may have provided incentives to admit patients with greater impairments, lower function, or more comorbidities than under the previous payment system. Case mix changes due to these factors should be counted as "real changes" and are appropriately reflected in increased payments. The CMS should not implement an adjustment for coding improvements that might inappropriately reduce payments without a thorough analysis that more definitively differentiates between changes in coding practices and changes in patient characteristics.

Simultaneous with the proposed 1.9 percent rate reduction, the CMS is proposing revisions to the case mix groups (CMGs) based upon an analysis of data from 2002 and 2003. The proposed revisions include redefinitions of comorbidities to exclude some diagnosis codes that the CMS believes are not related to increased costs and reassignment of other codes to provide lower payments that more accurately reflect observed costs. We will address the proposed CMG changes later in our comments. However, the proposed 1.9 percent reduction for coding changes must be considered in relation to the CMG revisions. The CMG revisions would reduce payments for cases with reported comorbidities that the CMS analysis determined to be overpaid compared to actual costs. The CMS justifies 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)". The proposed revision of the CMGs combined with the 1.9 percent reduction to the standard rate would adjust twice for the same coding revisions. We believe that the proposed CMG revisions based upon specific codes that are identified as being problematic are more equitable than an across-the-board 1.9 percent rate reduction that is based upon circumstantial evidence.

In addition, the attempt to differentiate between coding practice changes and changes in patient characteristics is further complicated by ongoing changes in IRF admission practices resulting from

facility attempts to comply with the "75 percent rule". The CMS referenced the 75 percent rule regarding the 1.9 percent reduction to the standard payment rate. The CMS states that "... we chose the amount of

the proposed reduction in the standard payment amount in order to recognize that IRFs' current cost structures may be changing as they strive to comply with other recent Medicare policy changes, such as the criteria for IRF classification commonly known as the "75 percent rule." We appreciate that the CMS acknowledges the need to consider this factor when determining the amount of the coding reduction. However, given the significant changes in IRF patient admission patterns that will result from the implementation of the 75 percent rule, we believe that the CMS should not make an adjustment for coding changes at this time.

As a result, the **MHA urges the CMS to eliminate the proposed reduction for coding changes in the final rule.** This is particularly important since most IRFs are currently facing substantial obstacles and disruptions as they attempt to adapt to the requirements of the 75 percent rule. The CMS should not further increase this burden by implementing an across-the-board reduction based on data that does not reflect current IRF admission practices.

Proposed Refinements to the Patient Classification System

The current CMGs and comorbidity tiers are based on data from 1998 and 1999. In order to more closely align Medicare payment levels to actual costs, the CMS proposes to refine the patient classification system based on an analysis of data from 2002 and 2003

The MHA supports the updates and refinements proposed by the CMS since we believe the data from 1998 and 1999 does not accurately reflect the characteristics of patients treated in IRFs today. Using 2002 and 2003 data, which is for periods subsequent to the implementation of the IRF-PPS, will result in a more accurate patient classification.

As indicated in our comments regarding the 1.9 percent reduction to the standard rate, we believe that the proposed refinements to the CMGs and comorbidity tiers provide a reasonable and equitable adjustment to account for changes in coding practices. **The MHA urges the CMS to adjust for coding changes through systematic refinements to the patient classification system and eliminate the 1.9 percent across-the-board reduction in the final rule.**

Proposed Revisions of the IRF PPS Geographic Classification

The current IRF PPS labor market areas were defined based upon Metropolitan Statistical Areas (MSAs) from the 1990 Census. In FY 2005, the CMS updated the labor markets for the inpatient PPS, based upon the 2000 Census, which established the Core-based Statistical Areas (CBSAs). Under the IPPS, the CMS provided a one-year transition for hospitals that were negatively impacted by the redefined labor markets, allowing inpatient hospitals that experienced a wage index decrease due to the CBSAs to receive a 50/50 blend of the old MSA wage index and the new CBSA index. However, for IRFs, the CMS is proposing full implementation of the new CBSAs in FY 2006, with no transition period.

Similar to the impact on IPPS hospitals, some IRFs will experience a significant negative impact as a result of implementing the new CBSAs. **As a result, the MHA urges the CMS to provide a 50/50 transition, as allowed under the inpatient PPS.**

Proposed Teaching Status Adjustment

In the past, to account for the higher operating costs experienced by teaching facilities, the CMS has considered, but has **not** adopted a teaching adjustment. A RAND analysis of 2003 data found that the indirect teaching cost variable is significant in explaining the higher costs of IRFs that have teaching programs. Therefore, the CMS is proposing to establish a facility level teaching adjustment for IRFs.

The MHA supports the proposed implementation of an IRF teaching adjustment. This adjustment would increase payment equity by compensating for the higher costs experienced by facilities with teaching programs. Both the inpatient PPS and the inpatient psychiatric PPS recognize the need for such an adjustment and the inpatient rehabilitation PPS should be consistent with these systems.

While the proposal includes a teaching adjustment, the CMS expressed several concerns regarding the proposed adjustment. Primarily, the CMS is concerned that the results of the RAND analysis based on the 2003 data contradict the prior analysis that used 1999 data, and which was used to construct the initial IRF PPS. While the 2003 data supports the need for a teaching adjustment, the earlier data failed to reflect a significant relationship between teaching programs and higher costs. As indicated in our comment to support the proposal for refinement of the patient classification system, data from 2003 represents a period subsequent to the implementation of the IRF-PPS which provides a more accurate analysis of costs under the PPS.

In addition, the CMS suggests that the results of the RAND analysis may be an aberration based on use of a single year's data. As a result, the CMS suggests that analysis of future data from 2004 or later may provide a more accurate result. The MHA believes that the CMS should not postpone or delay implementation of a teaching adjustment in hopes of receiving later data that will provide more accurate results. A decision to postpone implementation is, in effect, a decision to continue to utilize results based on 1999 data, rather than reflecting results based on 2003 data. In the proposed rule, the CMS clearly indicated the limitations and data problems that are associated with the 1999 data, which is a key reason that several of the significant policy changes are being proposed.

The CMS utilized the same data, as that used for the proposed teaching adjustment, to determine the proposed increases in the low-income patient adjustment and the rural location adjustment. The MHA supports each of these proposed adjustments, which will increase payment equity and more accurately reflect the actual costs incurred by IRFs. We do not believe that the CMS should selectively apply the results of the RAND analysis in some instances but reject the results in others. **The MHA urges the CMS to implement the proposed teaching adjustment in FY 2006 along with the increases in the low-income patient adjustment and the rural location adjustment.**

Low-Income Patient Adjustment

To account for differences in costs related to treating low-income patients, IRFs receive an adjustment to the federal prospective payment rate. Based on the RAND analysis of 2003 data, the CMS is proposing to update the formula used to calculate the LIP, which would result in increasing these payments. The MHA supports this proposal which will provide more accurate and equitable payment to IRFs that serve a higher proportion of low-income patients.

July 18, 2005.

Page 5 of 5

Rural Location Adjustment

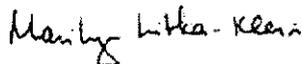
Currently, IRFs located in rural areas receive a 19.14 percent add-on to the federal base rate per discharge. Based on the RAND analysis of 2003 data, the CMS proposes to increase this add-on to 24.1 percent. The MHA supports this proposal which will provide increased reimbursement that better reflects the higher costs associated with caring for Medicare beneficiaries in rural facilities.

Proposed Update to the Outlier Threshold Amount

Similar to other prospective payment systems, the CMS established an IRF PPS outlier policy for cases that require more costly care with the methodology designed to result in outlier payments that are 3 percent of total IRF payments. For FY 2006, the CMS proposes to decrease the outlier threshold from the current \$11,211 to \$4,911, which will increase the number of cases that will qualify for outlier payments. The CMS estimates that this change is required to maintain outlier payments at 3 percent of total IRF PPS payments. The MHA supports the proposed revision to the outlier threshold that will ensure that IRFs receive compensation for the treatment of high cost patients.

Thank you for your review and consideration of these comments. If you have any questions, please contact me at (517)703-8603 or via email at mklein@mha.org.

Sincerely,



Marilyn Litka-Klein
Senior Director, Health Policy

Submitter : Mr. Thomas Donovan
Organization : SUNY Upstate Medical University
Category : Hospital

Date: 07/18/2005

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

Submitter : Mr. Thomas Donovan
Organization : SUNY Upstate Medical University
Category : Hospital

Date: 07/18/2005

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1290-P-33-Attach-1.PDF

CMS-1290-P-33-Attach-2.PDF

July 18, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention CMS-1290-P
P.O. Box 8010
Baltimore, MD 21244-8010

Regarding: CMS-1290-P

Dear Administrator:

University Hospital appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS or the Agency) proposed Inpatient Rehabilitation Rule for 2006. The Hospital operates a 32 bed Rehabilitation Unit and currently is receiving approximately 88% of its costs under IRF PPS. This gap between the cost of care provided at an IRF which is part of a teaching institution and the current payment methodology will continue to widen unless CMS implements the proposed facility level teaching status adjustment.

Since the beginning of the IRF PPS there has been a disparity in the payment equity for teaching facilities. This was demonstrated in the financial impact table accompanying the initial IRF PPS final rule. The analyses conducted by the RAND Corporation (RAND) using 2003 data show that this inequity is continuing. As their analyses demonstrated, teaching rehabilitation facilities have higher costs than their non-teaching counterparts and these higher costs are associated with their teaching status. Consequently, without an adjustment, a facility such as University Hospital will continue to fare worse under a national average payment system.

RAND's results are not surprising – critical operations are inherently more costly when teaching and training is involved and facilities with larger teaching programs generally treat more costly patient populations. Such a finding has been borne out in both the inpatient and psychiatric prospective payment systems, both of which include a teaching adjustment.

RAND's original analyses were based on pre-PPS (1999) data from only a sample of hospitals, of which major teaching hospitals were under-represented. By contrast, their current analyses were based on post-PPS (2003) data, representing the universe of Medicare IRF cases. Even CMS noted (70 Fed. Reg. at 30197) that "this larger file enabled RAND to obtain greater precision in their analysis and ensures a more balanced and complete picture of patients under the IRF PPS".

CMS has expressed a concern about implementing an adjustment at the current time because other changes that might be implemented could affect future data outcomes. Any apprehension for the theoretical, non-specific, concerns about the future should not override current analytically sound analyses. As with all of Medicare's payment systems, policies and decisions are, and must, be made based on the best data currently available. If in the future data analyses show different results, CMS has the authority to make modifications to the system, including the teaching adjustment. Unlike the inpatient PPS, in which changes to the indirect medical education (IME) adjustment requires legislative action, CMS has ample opportunity to modify IRF teaching adjustment through the regulatory process if that is deemed appropriate at a later date.

In sum, RAND's analyses demonstrate that teaching IRFs were underpaid in 2003, which means that they were underpaid in 2004 and currently are being underpaid. Moreover, their regression analyses clearly show a statistically significant teaching affect.

A teaching adjustment is long overdue for this payment system. Including a teaching adjustment will not rectify the past and current payment inequity, however it will help ensure a more equitable system going forward. I urge the Agency to continue its commitment to empirically based decision-making and include a teaching adjustment in the final rule.

Thank you for this opportunity to present the views of University Hospital. If you have any questions concerning these comments, please feel free to call me at (315) 464-6530.

Sincerely,

Thomas J. Donovan
Chief Financial Officer

Cc: Phillip S. Schaengold, J.D.

Submitter : Mrs. Jean Morris
Organization : Sun Health
Category : Hospital

Date: 07/18/2005

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1290-P-34-Attach-I.DOC



July 15, 2005

Attention: Department of Health and Human Services
Centers for Medicare & Medicaid Services
P.O. Box 8010
Baltimore, MD 21244-8010
<http://www.cms.hhs.gov/regulations/ecomments>

Re: file code CMS-1290-P

Dear August Nemeck,

I am responding to the Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for FY 2006; Proposed Rule published May 25th, 2005.

I represent Sun Health Corporation, a hospital system that provides inpatient rehabilitation services to a geriatric population for the communities that it serves. The organization's mission is to promote excellence in medical care, wellness programs, research and education.

Sun Health is concerned about the "Proposed Changes to the Existing List of Tier Comorbidities" as currently written.

It is surprising that RAND's technical expert panel (TEP) found these malnutrition diagnoses to be "unrealistic and recommended that it be removed from the tier list". The article *Nutrition in Older Adults* from the American Journal of Nursing (AJN) published in March of 2005, states "Protein-energy undernutrition is the type of undernutrition found most often in older adults. Marasmus and kwashiorkor are two frequently discussed kinds of protein-energy undernutrition". The article also states "The Nutrition Screening Initiative (NSI), a multidisciplinary coalition headed by the American Academy of Family Physician, estimates that 40% to 60% of hospitalized older adults are malnourished or at risk for malnutrition". CMS has identified that these malnutrition co morbidities are "positively related to cost" but increased lengths of stays are also positively related to cost. The above referenced article from AJN

states "For those responsible for the care of these patients, this is important because malnutrition is associated with longer lengths of stay in hospitals and increased costs".

Sun Health has identified that our geriatric population needs proper nutrition for healing. Due to this belief, every patient receives a nutrition consult upon admission to the rehab program. Patients are identified, treated and receive continuous monitoring of their nutrition status by personnel from the dietary department. This optimizes the patient's ability to participate in an intensive rehabilitation program.

We believe that RAND's data does not represent appropriate interpretation to recent findings on nutrition and America's senior adults. Sun Health requests that the malnutrition codes remain as part of the current tier lists.

Thank you,

Jean Morris, RN, BA, MSM
Director Inpatient Rehabilitation Services
Sun Health Corporation
Walter O. Boswell Memorial Hospital
Del E. Webb Memorial Hospital
Sun City, Arizona

Submitter : Mr. Thomas Donovan
Organization : SUNY Upstate Medical University
Category : Hospital

Date: 07/18/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1290-P-35-Attach-I.PDF

July 18, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention CMS-1290-P
P.O. Box 8010
Baltimore, MD 21244-8010

Regarding: CMS-1290-P

Dear Administrator:

University Hospital appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS or the Agency) proposed Inpatient Rehabilitation Rule for 2006. The Hospital operates a 32 bed Rehabilitation Unit and currently is receiving approximately 88% of its costs under IRF PPS. This gap between the cost of care provided at an IRF which is part of a teaching institution and the current payment methodology will continue to widen unless CMS implements the proposed facility level teaching status adjustment.

Since the beginning of the IRF PPS there has been a disparity in the payment equity for teaching facilities. This was demonstrated in the financial impact table accompanying the initial IRF PPS final rule. The analyses conducted by the RAND Corporation (RAND) using 2003 data show that this inequity is continuing. As their analyses demonstrated, teaching rehabilitation facilities have higher costs than their non-teaching counterparts and these higher costs are associated with their teaching status. Consequently, without an adjustment, a facility such as University Hospital will continue to fare worse under a national average payment system.

RAND's results are not surprising – critical operations are inherently more costly when teaching and training is involved and facilities with larger teaching programs generally treat more costly patient populations. Such a finding has been borne out in both the inpatient and psychiatric prospective payment systems, both of which include a teaching adjustment.

RAND's original analyses were based on pre-PPS (1999) data from only a sample of hospitals, of which major teaching hospitals were under-represented. By contrast, their current analyses were based on post-PPS (2003) data, representing the universe of Medicare IRF cases. Even CMS noted (70 Fed. Reg. at 30197) that "this larger file enabled RAND to obtain greater precision in their analysis and ensures a more balanced and complete picture of patients under the IRF PPS".

CMS has expressed a concern about implementing an adjustment at the current time because other changes that might be implemented could affect future data outcomes. . Any apprehension for the theoretical, non-specific, concerns about the future should not override current analytically sound analyses. As with all of Medicare's payment systems, policies and decisions are, and must, be made based on the best data currently available. If in the future data analyses show different results, CMS has the authority to make modifications to the system, including the teaching adjustment. Unlike the inpatient PPS, in which changes to the indirect medical education (IME) adjustment requires legislative action, CMS has ample opportunity to modify IRF teaching adjustment through the regulatory process if that is deemed appropriate at a later date.

In sum, RAND's analyses demonstrate that teaching IRFs were underpaid in 2003, which means that they were underpaid in 2004 and currently are being underpaid. Moreover, their regression analyses clearly show a statistically significant teaching affect.

A teaching adjustment is long overdue for this payment system. Including a teaching adjustment will not rectify the past and current payment inequity, however it will help ensure a more equitable system going forward. I urge the Agency to continue its commitment to empirically based decision-making and include a teaching adjustment in the final rule.

Thank you for this opportunity to present the views of University Hospital. If you have any questions concerning these comments, please feel free to call me at (315) 464-6530.

Sincerely,

Thomas J. Donovan
Chief Financial Officer

Cc: Phillip S. Schaengold, J.D.

Submitter : Ms. Cheri Rinehart
Organization : The Hospital & Healthsystem Association of Pennsyl
Category : Health Care Professional or Association

Date: 07/18/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1290-P-36-Attach-1.DOC



THE HOSPITAL & HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA

July 18, 2005

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1500-P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: CMS-1290-P, Medicare Program: Inpatient Rehabilitation Facility Prospective Payment System for FY 2006; 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, rehabilitation, primary care, subacute care, long-term care, home health, and hospice providers, as well as the patients and communities they serve, we welcome the opportunity to comment on the inpatient rehabilitation facility (IRF) prospective payment system (PPS) proposed rule for federal fiscal year 2006.

While we are supportive of the use of updated data and some of the payment changes proposed, we have some overriding concerns about the proposal:

1. *The impact of the proposed changes are difficult to analyze because they are based on data prior to implementation of the revised interpretation of the 75% Rule.* While our modeling projects that the majority of IRFs in Pennsylvania will benefit from revisions to the co-morbidity tiers and case-mix groups (CMG) of the patient classification system, we have concerns because the data used to develop and analyze the proposal are from federal fiscal year 2003 and may not be representative of current conditions and treatment patterns of IRFs as they adapt to implementation of the revised CMS interpretation of the 75% Rule.
2. *The CMS proposal to reduce the standardized payment amount to eliminate the effect of coding changes "that do not reflect real changes in case mix" is not adequately supported by data.* Prior to 2004, there was little to no incentive for IRFs to code co-morbidities as there was no return on the investment of personnel time to do so. With the implementation of the IRF PPS and implementation of CMS' revised interpretation of the 75% Rule, co-morbidities influenced payment, and therefore, IRFs began coding them. Since these conditions were not previously coded, CMS's assertion that the coding changes do not reflect real changes in case mix is at best conjecture and an inappropriate basis for a proposed payment

reduction. Given the significant changes in IRF patient admission patterns resulting from implementation of the 75% Rule, CMS should not make an adjustment for coding changes at this time.

3. *Additional decreases in revenue will continue to erode access to inpatient rehabilitation services for patients.* CMS projected in its May 2004 final rule that 1,750 people would lose access to inpatient rehabilitation services during the first year of phase-in at 50 percent. The actual drop in Medicare discharges from the first three quarters of fiscal year 2004 to fiscal year 2005 was 55,228. CMS should exercise extreme caution in introduction of changes that could result in further erosion of access.
4. *More changes, particularly significant changes, during the extended period of financial instability IRFs have experienced because of national debate on the 75 % Rule may be inappropriate.* IRFs have had to make major operational changes over the past few years to adapt to the revised 75% Rule definition. IRFs have had to modify admission policies and procedures, staffing complements, and work with their acute care counterparts to revise clinical pathways. Major payment revisions during this period of volatility, unpredictability and adaptation may put too much stress on an already over-stressed system.
5. *The lack of some data and late availability of other data made modeling the proposed changes challenging.* Assessment of the impact of the proposal by and for individual IRFs was hampered by the fact that CMS did not release adequate facility and patient level data to conduct a complete assessment. In addition, CMS did not share an impact file with provider numbers with the field until June 29, less than three weeks before the comment period deadline. The lack of complete data, such as is available for evaluation of changes to the inpatient hospital prospective payment system (IPPS), compromised field evaluation of the proposed changes.

Proposed Reduction to the Standard Payment Rate

CMS is proposing to reduce the standard payment rate by 1.9 percent to eliminate the “effect of coding changes that do not reflect real changes in case mix.” The proposed adjustment is based on an analysis by RAND of calendar year 2002 data that indicated payments had increased because of changes in the classification of patients in IRFs. RAND compared the 1999 data used to construct the original IRF PPS weights with data from the first year of implementation of the IRF PPS—2002—and determined that case mix increased 3.4 percent from 1999 to 2002. As CMS notes, while RAND could determine the total change in case mix, it was not able to precisely measure the amount of the total change that was real versus the amount due to coding. Instead, RAND relied on indirect evidence to quantify the amount attributed to coding changes.

As CMS notes, the IRF PPS may have provided incentives for IRFs to admit patients with greater impairments, lower function, or more comorbidities, since under the IRF

PPS IRFs have greater incentives to admit more costly patients than they had under the prior payment system. In addition, the attempt to differentiate between coding changes and real patient changes is complicated by ongoing changes in IRF admission practices resulting from facility attempts to comply with the 75% Rule, as CMS acknowledges. Case mix changes due to these changes in admission practice are real changes and should be counted and reimbursed as such.

RECOMMENDATION: HAP urges CMS not to make an adjustment for coding changes at this time. CMS should not implement an adjustment for coding improvements that will reduce payments without definitive evidence that this is justified—evidence not provided in the RAND analysis.

Proposed Refinements to the Patient Classification System

CMS is proposing refinements to the patient classification system based on an analysis of 2002 and 2003 data. HAP strongly believes that some of the key components of the IRF PPS must be updated using more current and complete data. However, we are concerned with CMS proposed changes to the structure and weights of the CMGs and with the concept of weighting the motor score index. These changes make significant fundamental changes to the case-mix system at the same time IRFs are dealing with the significant operational changes precipitated by implementation of the revised 75% Rule. In addition, the proposed changes will make it much more difficult for IRFs to predict a patient's CMG based on a pre-admission assessment and result in even less predictability in an environment that has already lost much of its historical predictability.

RECOMMENDATION: HAP urges CMS to delay the proposed changes to the structure and weights of the CMGs, as well as the proposed weighting of the motor score index until there is data available post implementation of the revised 75% Rule.

Proposed Teaching Adjustment

CMS is proposing to establish a facility level teaching adjustment for IRFs, based on RAND analysis of 2003 data that found that the indirect teaching costs variable is significant in explaining the higher costs of IRFs that have teaching programs. The RAND analysis is based on data subsequent to implementation of the IRF PPS.

RECOMMENDATION: HAP supports CMS' proposal to adopt the facility level teaching adjustment to more accurately reflect IRF costs under PPS—cost differentials not under the IRF's control.

Proposed Revision of the IRF PPS Geographic Classification

CMS is proposing implementation of the revised labor market definitions for IRFs based upon the Core-based Statistical Areas (CBSA) adopted in the FFY inpatient PPS final rule. The redefinition of wage areas will have a significant impact on some IRFs that are similar to the impacts on inpatient prospective payment system (IPPS) hospitals.

RECOMMENDATION: HAP urges CMS to mitigate the impact of the change from metropolitan statistical areas to CBSAs by phasing in the change with transition options similar to those provided to IPPS hospitals.

Mark McClellan, M.D., Ph.D.

July 18, 2005

Page 4

Proposed Update to the Outlier Threshold

CMS has established an IRF PPS outlier policy for cases that require more costly care. The methodology was designed to result in outlier payments that are three percent of total IRF payments. CMS proposes to decrease the outlier threshold from the current \$11,211 to \$4,911 in 2006.

RECOMMENDATION: HAP supports the proposed decrease in the outlier threshold to ensure that the full three percent of payments allocated to outlier payments is received by IRFs and to ensure that medically complex patients with medical necessity for inpatient rehabilitation receive those services.

Proposed Rural Location Adjustment

CMS proposes to increase the add-on for rural IRFs from the current 19.14 percent to 24.1 percent to more accurately reflect the higher costs for these facilities.

RECOMMENDATION: HAP supports this proposal to better reflect the higher costs associated with caring for Medicare patients in rural IRFs.

Proposed Low Income Patient Adjustment

CMS is proposing, based on more recent data, to increase the low income patient (LIP) adjustment used to account for differences in costs associated with treating a higher preponderance of low-income patients.

RECOMMENDATION: HAP supports the CMS proposal to increase the LIP adjustment to provide more accurate and equitable payment to IRFs that serve low-income patients.

In summary, while HAP supports proposed changes to the IRF PPS that reflect more current data, we do not support significant changes to the structure of the IRF PPS that may introduce more volatility to a field already dealing with significant change and unpredictability.

We appreciate the opportunity to comment on this proposed rule. If you have any questions about our comments, please contact Cheri Rinehart, vice president, integrated delivery systems, HAP, at (717) 561-5325, or crinehart@haponline.org.

Sincerely,



PAULA A. BUSSARD
Senior Vice President

PAB/dd

Submitter : Mr. Michael Vanderlinde
Organization : Harborview Medical Center
Category : Health Care Professional or Association

Date: 07/18/2005

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1290-P-37-Attach-1.DOC

7/15/2005



Harborview Medical Center
Michael G Vanderlinde; +1 206 744-9701; Box 359750
Director, Government Financial Relations & Reimbursement
325 9th AVE, Seattle Washington 98104-2420

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1290-P
P.O. Box 8010
Baltimore, MD 21244-8010

RE: Including an IME adjustment in the Medicare Inpatient Rehabilitation Facility (IRF)

I am writing on behalf of Harborview Medical Center, and our Rehabilitation facility, in regard to the proposed IME Rehab teaching adjustment. We are a 350+ bed teaching facility in Seattle Washington, which includes a 25 bed rehabilitation excluded unit. The annual direct GME costs for this unit were approximately \$263K, with estimated indirect costs of \$190K, for 3 Resident fte's in FY 2004. The additional costs incurred by HMC to support these residents, particularly the indirect costs are not adequately covered, and the Medicare program's failure to reimburse these expenses has resulted in a significant drain on HMC's financial resources. We appreciate the opportunity to comment and provide to you support for why the teaching adjustment must be included in the Medicare FY 2006 IRF final rule.

Since the beginning of the IRF PPS there has been a disparity in the payment equity for teaching facilities. This was demonstrated in the financial impact table accompanying the initial IRF PPS final rule. The analyses conducted by the RAND Corporation (RAND) using 2003 data show that this inequity is continuing. As their analyses demonstrated, teaching rehabilitation facilities have higher costs than their non-teaching counterparts and these higher costs are associated with their teaching status. Consequently, without an adjustment, they will continue to fare worse under a national average payment system.

RAND's results are not surprising -- clinical operations are inherently more costly when teaching and training is involved and facilities with larger teaching programs generally treat more costly patient populations. Such a finding has been borne out in both the inpatient and psychiatric prospective payment systems, both of which include a teaching adjustment.

In the proposed rule preamble discussion, CMS expresses some concern about including a teaching adjustment, noting that RAND's analyses involved only a single year of data (2003) and that RAND did not find a statistically-significant teaching affect when it did its original analyses in [2000]. We believe such concerns are unfounded and do not warrant overriding RAND's statistically valid findings.

RAND's original analyses were based on pre-PPS (1999) data from only a sample of hospitals, of which major teaching hospitals were under-represented. By contrast, their current analyses were based on post-PPS (2003) data, representing the universe of Medicare IRF cases. As CMS noted "this larger file enables RAND to obtain greater precision in their analysis and ensures a more balanced and complete picture of patients under the IRF PPS" (70 Fed. Reg. at 30197). In addition, RAND utilized an expert panel that "reviewed RAND's methodologies and advised RAND on many technical issues" (70 Fed. Reg. at 30196).

CMS also expressed a concern about implementing an adjustment at the current time because other changes that might be implemented could affect future data outcomes. We strongly believe that theoretical, non specific, concerns about the future should not override current analytically-sound analyses.¹ As with all of Medicare's payment systems, policies and decisions are, and must, be made based on the best data currently available. If in the future data analyses show different results, CMS has the authority to make modifications to the system, including the teaching adjustment. Unlike the inpatient PPS, in which changes to the indirect medical education (IME) adjustment requires legislative action, CMS has ample opportunity to modify IRF teaching adjustment through the regulatory process if that is deemed appropriate at a later date.

In sum, RAND's analyses demonstrate that teaching IRFs were underpaid in 2003, which means that they were underpaid in 2004 and currently are being underpaid. Moreover, their regression analyses clearly show a statistically significant teaching affect.

A teaching adjustment is long overdue for this payment system. Including a teaching adjustment will not rectify the past and current payment inequity, however it will help ensure a more equitable system going forward. We urge the Agency to continue its commitment to empirically-based decision-making and include a teaching adjustment in the final rule.

¹ We also understand that there might be some concern about the impact of the full implementation of the 75 percent rule on the rehabilitation PPS and any payment adjustments. Once again, we believe any such concerns are solely theoretical. There are no data to support a conclusion that the teaching affect will be less as a result of the 75 percent rule. Teaching facilities should not be penalized until such time that the theory is disproved.

Thank you for the opportunity to provide these comments.

Sincerely,

Michael Vanderlinde
Director, Government Financial Relations & Reimbursement

Submitter : Mr. Michael Hill
Organization : New Hampshire Hospital Association
Category : Health Care Professional or Association

Date: 07/18/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1290-P-38-Attach-1.DOC

admit more costly patients than they had under the prior payment system. Case mix changes due to these factors should be counted as “real changes” and are appropriately reflected in increased payments. CMS should not implement an adjustment for coding improvements that might inappropriately reduce payments without an analysis that more definitively differentiates between coding changes and real patient changes.

Simultaneous with the proposed 1.9% reduction to the rate, CMS is proposing revisions to the case mix groups (CMGs) based on an analysis of data from 2002 and 2003. The proposed revisions include redefinitions of comorbidities to exclude some diagnosis codes that CMS believes are not related to increased costs and reassignment of other codes to provide lower payments that more accurately reflect observed costs. We address the proposed CMG changes elsewhere in this letter. However, the proposed 1.9% reduction for coding changes must be considered in relation to the CMG revisions. The CMG revisions would reduce payments for cases with reported comorbidities that the CMS analysis determined to be overpaid compared to actual costs. CMS justifies 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)”. The proposed revision of the CMGs combined with the 1.9% reduction to the standard rate would adjust twice for the same coding changes. We believe that the proposed CMG revisions based on specific codes that were identified as problems by a systematic analysis are more equitable than an across-the-board 1.9% rate reduction that is based on circumstantial evidence.

In addition, the attempt to differentiate between coding changes and real patient changes is complicated by ongoing changes in IRF admission practices that result from facility attempts to comply with the “75% rule”. CMS does reference the 75% rule regarding the 1.9% reduction to the standard payment rate. CMS states that “. . . we chose the amount of the proposed reduction in the standard payment amount in order to recognize that IRFs’ current cost structures may be changing as they strive to comply with other recent Medicare policy changes, such as the criteria for IRF classification commonly known as the “75 percent rule.” We appreciate that CMS acknowledges the need to consider this factor when determining the amount of the coding reduction. However, given the significant changes in IRF patient admission patterns that will result from the implementation of the 75% rule, CMS should not make an adjustment for coding changes at this time.

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 does not reflect current IRF admission practices.

Proposed Refinements to the Patient Classification System

The current CMGs and comorbidity tiers are based on data from 1998 and 1999. CMS proposes refinements to the patient classification system based on an analysis of data from 2002 and 2003. CMS indicates that this refinement significantly improves the alignment between Medicare Payments and actual IRF costs.

NHHA supports the updates and refinements proposed by CMS. The data from 1998 and 1999 does not accurately reflect the characteristics of patients treated in IRFs. Data from 2002 and 2003 are from periods subsequent to the implementation of the IRF-PPS and will provide for more accurate classification of patients.

As stated in the section of our comments regarding the 1.9% reduction to the standard rate, we believe that the proposed refinements to the CMGs and comorbidity tiers provide a reasonable and equitable adjustment for changes in coding practices. We urge CMS to adjust for coding changes through systematic refinements to the patient classification system and eliminate the 1.9% across-the-board reduction from the final rule.

Proposed Revisions of the IRF PPS Geographic Classification

The current IRF PPS labor market areas are defined based on Metropolitan Statistical Areas (MSAs) from the 1990 Census. In FFY 2005, CMS implemented revised labor market areas based on the 2000 Census for the inpatient PPS called Core-based Statistical Areas (CBSAs). CMS provided a one-year transition for hospitals that were harmed by the redefinition of the wage index areas, allowing inpatient hospitals experiencing a wage index decrease to receive a blend of 50% of the wage index based on the new definitions and 50% based on the old boundaries. CMS is proposing implementation of the revised labor market area definitions based upon the CBSAs adopted in the FFY 2005 inpatient PPS final rule. CMS is proposing to base the IRF PPS wage index on the new wage area definitions without the transitional blend.

The redefinition of wage areas will have significant impacts on the IRFs in New Hampshire that are similar to the impacts on inpatient PPS hospitals in New Hampshire. These new standards, which radically altered the existing requirements for what constituted a MSA, resulted in the Greater Boston MSA being broken up into six smaller MSAs. This outcome was unique to the Boston region; no other geographic area suffered the same impact. The total negative impact in payments attributable to the changes to the CBSA designations will result in over a \$2 million a year reduction per year for New Hampshire IRFs, which equates to a 5% wage reduction. We urge CMS to reconsider imposing this full wage reduction on the IRFs with a disproportionately negative impact. CMS should consider alternative implementation timeframes to allow for the application of a blended rate and the same three year transition as was applied to the inpatient PPS. In addition, CMS should consider including a hold harmless provision to allow for a wage impact decrease no greater than 3%.

Proposed Teaching Status Adjustment

In the past, CMS has considered, but has not adopted an adjustment for IRFs to account for the higher indirect operating costs experienced by facilities that participate in Graduate Medical Education programs. A RAND analysis of 2003 data found that the indirect teaching cost variable is significant in explaining the higher costs of IRFs who have teaching programs. Therefore, CMS is proposing to establish a facility level teaching adjustment for IRFs.

NHHA supports implementation of an IRF teaching adjustment. This adjustment would increase payment equity by compensating for the higher costs experienced by facilities with teaching programs. Both the inpatient PPS and the inpatient psychiatric PPS recognize the need for such an adjustment and the inpatient rehabilitation PPS should be consistent with these systems.

CMS suggests that the results of the RAND analysis might reflect an aberration based on only a single year's data and suggests that analysis of future data from 2004 or later might provide a more accurate result. CMS should not postpone or delay the implementation of a teaching adjustment in hopes of receiving later data that will provide more accurate results. A decision to postpone implementation is in effect a decision to continue to use results based on 1999 data rather than use results based on 2003 data. In the proposed rule, CMS clearly indicates the

limitations and data problems that are associated with the 1999 data. That is the reason that CMS has proposed several of the major policy changes that are contained in this rule.

Moreover, the proposed increases in the low-income patient adjustment and the rural location adjustment are based on the same data and analysis as was used for the proposed teaching adjustment. NHHA supports all three of these proposed adjustments, which will increase payment equity and more accurately reflect the costs incurred by IRFs. We do not believe that CMS should selectively apply the results of the RAND analysis in some instances but reject the results in others. We urge CMS to implement the proposed teaching adjustment in FFY 2006 along with the increases in the low-income patient adjustment and the rural location adjustment.

Low-Income Patient Adjustment

IRFs receive an adjustment to the Federal prospective payment rate to account for differences in costs associated with the treatment of low-income patients. Based on the RAND analysis of 2003 data, CMS is proposing to update the formula used to calculate the LIP and thereby increase these payments. NHHA supports this proposal, which will provide more accurate and equitable payment to IRFs that serve low-income patients.

Rural Location Adjustment

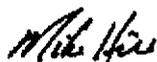
Currently, IRFs located in rural areas receive a 19.14% add-on to the Federal per discharge base rate. Based on the RAND analysis of 2003 data, CMS proposes to increase this add-on to 24.1%. NHHA supports this proposal, which will provide increased reimbursement that better reflects the higher costs associated with caring for Medicare patients in rural facilities.

Proposed Update to the Outlier Threshold Amount

CMS has established an IRF PPS outlier policy for cases that require more costly care. The methodology is designed to result in outlier payments that are 3% of total IRF payments. CMS proposes to decrease the outlier threshold from \$11,211 in FFY 2005 to \$4,911 in FFY 2006, hereby increasing the number of cases that will qualify for outlier payments. CMS estimates that this change is required to maintain outlier payments at 3% of total IRF PPS payments. NHHA supports the proposed revision to the outlier threshold that will ensure that IRFs receive compensation for the treatment of high cost patients.

Please contact me at (603) 225-0900 or mhill@nhha.org if you have any questions.

Sincerely,



Mike Hill
President, NH Hospital Association

Submitter : David Sibert
Organization : Kalispell Regional Medical Center
Category : Hospital

Date: 07/18/2005

Issue Areas/Comments

GENERAL

GENERAL

Correction of Error in Facility Listing - See attachment

CMS-1290-P-39-Attach-1.DOC



July 18, 2005

Department of Health and Human Services
Centers for Medicare & Medicaid Services
[CMS-1290-P]

Re: Correction of Error in Facility Listing contained in Table 3 of the Proposed Rule
(42 CFR Part 412)

To Whom It May Concern:

We wish to call your attention to an error in the labeling of our rehabilitation facility listing in Table 3 of the Addendum to the Proposed Rule for the Inpatient Rehabilitation Facility Prospective Payment System for FY 2006. This error appears to have assigned us an urban designation as indicated in your electronic listing of rehabilitation facilities.

Requested corrections:

1. The provider number of our facility, Kalispell Regional Medical Center, is incorrectly listed as 05T073. **Our correct provider number is 290122.**
2. We are located in Kalispell, Montana, in Flathead County, a rural area of northwest Montana. The table incorrectly locates us in the Vallejo-Fairfield-Napa, California urban area [MSA Code 8720; CBSA Code 46700].

We have always maintained our rural designation. We are 120 miles away from the nearest MSA (Missoula, Montana) and serve several very rural counties around the Continental Divide including Glacier County, a frontier county. Our interpretation of 42 CFR Section 412.64 (b) (ii) (A) [Metropolitan Statistical Area] and CFR Section 412.64 (b) (ii) (C) is that we do not meet the requirements for inclusion in a MSA and do meet the definition of a rural area. We are unaware of any reason, other than the incorrect listing, that would account for a change to urban status.

We appreciate your assistance in correcting this information. As confirmation, a copy of this letter will be sent to your post office box in Baltimore, Maryland, via certified mail.

Sincerely,

David Sibert
Compliance Officer

Paula Sandman, RN
Manager, Rehabilitation Services

cc: Pete Diaz & Zinnia Ng (CMS)

Submitter : Mr. Steven Holzman
Organization : Penn State Milton S. Hershey Medical Center
Category : Hospital

Date: 07/18/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1290-P-40-Attach-1.WPD

PENNSTATE



Milton S. Hershey Medical Center
College of Medicine

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Steven M. Holzman
Sr. Reimbursement & Decision Support
Analyst

July 15, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1290-P
P.O. Box 8010
Baltimore, MD 21244-8010

Re: File Code CMS-1290-P

Penn State Milton S. Hershey Medical Center (PSHMC) wishes to voice its support for the addition of an IME adjustment to the Medicare Inpatient Rehabilitation Facility (IRF) PPS. PSHMC operates a 36-bed medical rehabilitation hospital in Hershey, Pennsylvania and treats approximately 1000 inpatients per year.

Since the IRF PPS was created, there has been a disparity in the payments for teaching facilities due to the higher costs incurred by teaching hospitals than non-teaching facilities. Without an IME adjustment, teaching rehabilitation facilities continue to fare worse under the IRF PPS than their non-teaching counterparts.

Costs for clinical operations are inherently higher when teaching and training is involved and facilities with teaching programs generally treat more costly patient populations. These conclusions have been borne out in both the inpatient and psychiatric prospective payment systems, both of which include a teaching adjustment.

PSHMC believes the addition of an IME adjustment to the IRF PPS would result in more equitable payments to the teaching facilities and encourages CMS to implement this change as soon as possible.

Sincerely,

Steven M. Holzman

Steven M. Holzman
Sr. Reimbursement & Decision Support Analyst

Submitter : Ms. Leslie Lloyd
Organization : The American Occupational Therapy Association
Category : Occupational Therapist

Date: 07/18/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1290-P-41-Attach-1.DOC

Submitter : Ms. Maureen Van Benthuyzen
Organization : The Mount Sinai Hospital
Category : Other Health Care Provider

Date: 07/18/2005

Issue Areas/Comments

GENERAL

GENERAL

July 18, 2005

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 443-G
200 Independence Avenue, S.W.
Washington, D.C. 20201

Subject: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Fiscal Year 2006; Proposed Rule, Federal Register, Vol. 70, No. 100 (May 25, 2005): 30188?30327. [CMS-1290-P]

Dear Dr. McClellan:

We are corresponding to you from The Mount Sinai Rehabilitation Center in regards to the pending proposed rule pertaining to the federal fiscal year 2006 inpatient rehabilitation facility prospective payment system. Understanding that the current payment methodology is based on 1998 and 1999, this presents as an opportunity to consider the first complete set of available data and to make needed adjustments.

Our one hundred bed acute rehabilitation hospital is located onsite at a one thousand bed academic medical center in upper Manhattan. The Mount Sinai Hospital is nationally recognized for its programs in Spinal Cord Injury and Head Injury. We are one of an elite group of six rehabilitation facilities in the country that maintains dual Model Systems designations for both programs by the National Institute on Disability and Rehabilitation. With our program located essentially within a large, urban academic medical center, nationally acclaimed for its graduate medical education and residency training program in Physiatry, we are likely to be significantly impacted by many aspects of the proposed rule. Therefore, consistent with the recommendations already set forth by The Greater New York Hospital Association, we request your support with the following key aspects of this rule:

1. Revised payment model. We strongly support CMS's proposal to implement all of the components of the revised patient classification system and payment adjustments developed by the RAND Corporation.
2. IRF-PAI data. We recommend that CMS either expand the Medicare Provider Analysis and Review file or create a separate administrative database that includes the case-mix group assignment for each patient and the individual data elements collected through the IRF patient assessment instrument (IRF-PAI) for each patient.
3. Wage index labor markets. For IRFs losing money because their wage index labor markets were expanded in the change from metropolitan statistical areas (MSAs) to core based statistical areas (CBSAs), we urge CMS to provide a wage index that is a permanent blend of their MSA and CBSA wage indices.
4. RPL market basket. We support CMS's proposal to update the rehabilitation, psychiatric, and long-term care (RPL) hospital market basket cost component weights to a 2002 base year, and we urge the Agency to designate professional liability insurance as a labor-related cost.
5. GME affiliation agreements. We strongly urge CMS to permit IRFs to elect to form Medicare graduate medical education (GME) affiliated group agreements, either with other IRFs or with acute care hospitals subject to the inpatient PPS.
6. Counting residents for the teaching adjustment. We recommend that CMS allow general hospitals to increase physiatrist training if they also decrease training in one or more specialties reimbursed under the inpatient PPS.

Thank you for this opportunity to provide comments.

Sincerely,

Maureen Van Benthuyzen
Director, Rehabilitation Center

And

Kristjan T. Ragnarsson, M.D.
Dr. Lucy G. Moses Professor and Chairman
Department of Rehabilitation Medicine

Submitter : Mr. David McClure
Organization : Tennessee Hospital Association
Category : Hospital

Date: 07/18/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1290-P-43-Attach-1.DOC



July 18, 2005

Centers for Medicare & Medicaid Services
Attention: CMS-1290-P
PO Box 8010
Baltimore, MD 21244-8010

Re: CMS-1290-P, Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for FY 2006; Proposed Rule

Dear Sirs:

On behalf of the Tennessee Hospital Association (THA), we appreciate the opportunity to submit comments on the fiscal year (FY) 2006 inpatient rehabilitation facility prospective payment system proposed rule.

THA, established in 1938, serves as an advocate for hospitals, health systems and other healthcare organizations and the patients they serve. The association represents over 200 healthcare facilities, including hospitals, home care agencies, nursing homes, and health-related agencies and businesses, and over 2,000 employees of member healthcare institutions, such as administrators, board members, nurses and many other health professionals. THA is the premiere organization in Tennessee that promotes and represents the interests of all health careers, hospitals and health systems.

While THA is supportive of many of the provisions in the proposed rule, we are particularly concerned and oppose the continued position by CMS to impose and enforce the 75 percent rule.

Attached are THA's detailed comments regarding CMS' proposed changes to the inpatient payment system. If you have any questions about these comments, please feel free to contact me or David McClure, THA vice president of finance, at 615-256-8240.

Sincerely,

Craig A. Becker, FACHE
President

Attachment

Proposed FY 2006 Federal Prospective Payment Rates--Reduction to Standard Payment Rate

CMS is proposing to reduce the standard payment amount by 1.9 percent to eliminate the effect of coding changes that do not reflect real changes in case mix. This adjustment is based on an analysis of calendar year 2002 data, which indicated payments had increased because of changes in the classification of patients in inpatient rehabilitation facilities (IRFs). As CMS notes, while the 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, the study used indirect evidence to estimate that somewhere between 1.9 percent and 5.8 percent of the case mix change experienced in IRFs might be attributed to coding changes.

CMS should not implement an adjustment for coding improvements that might inappropriately reduce payments without an analysis that more definitively differentiates between coding changes and real patient changes.

Simultaneous with the proposed 1.9 percent reduction to the rate, CMS is proposing revisions to the case mix groups (CMGs) based on an analysis of data from 2002 and 2003. The proposed revisions include redefinitions of comorbidities to exclude some diagnosis codes that CMS believes are not related to increased costs and reassignment of other codes to provide lower payments that more accurately reflect observed costs. We address the proposed CMG changes elsewhere in this letter. The proposed revision of the CMGs, combined with the 1.9 percent reduction to the standard rate, would adjust twice for the same coding changes. We believe the proposed CMG revisions, based on specific codes that were identified as problems by a systematic analysis, are more equitable than an across-the-board 1.9 percent rate reduction that is based on circumstantial evidence.

In addition, the attempt to differentiate between coding changes and real patient changes is complicated by ongoing changes in IRF admission practices that result from facility attempts to comply with the 75 percent rule. We appreciate that CMS acknowledges the need to consider this factor when determining the amount of the coding reduction. However, given the significant changes in IRF patient admission patterns that will result from the implementation of the 75 percent rule, CMS should not make an adjustment for coding changes at this time.

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

Proposed Refinements to Patient Classification System

The current CMGs and comorbidity tiers are based on data from 1998 and 1999. CMS proposes refinements to the patient classification system based on an analysis of data

from 2002 and 2003. CMS indicates that this refinement significantly improves the alignment between Medicare payments and actual IRF costs.

As stated in the section of our comments regarding the 1.9 percent reduction to the standard rate, we believe the proposed refinements to the CMGs and comorbidity tiers provide a reasonable and equitable adjustment for changes in coding practices. **We urge CMS to adjust for coding changes through systematic refinements to the patient classification system and eliminate the 1.9 percent across-the-board reduction from the final rule.**

Proposed Revisions of IRF PPS Geographic Classification

The current IRF PPS labor market areas are defined based on metropolitan statistical areas (MSAs) from the 1990 census. In FFY 2005, CMS implemented revised labor market areas based on the 2000 census for the inpatient PPS called core-based statistical areas (CBSAs). CMS provided a one-year transition for hospitals that were harmed by the redefinition of the wage index areas, allowing inpatient hospitals experiencing a wage index decrease to receive a blend of 50 percent of the wage index based on the new definitions and 50 percent based on the old boundaries. CMS is proposing implementation of the revised labor market area definitions based on the CBSAs adopted in the FFY 2005 inpatient PPS final rule. CMS is proposing to base the IRF PPS wage index on the new wage area definitions without the transitional blend.

The redefinition of wage areas will have significant impacts on some IRFs that are similar to the impacts on inpatient PPS hospitals. We urge CMS to provide the same transition that was applied to the inpatient PPS.

Proposed Teaching Status Adjustment

In the past, CMS has considered, but has not adopted, an adjustment for IRFs to account for the higher indirect operating costs experienced by facilities that participate in graduate medical education (GME) programs. A RAND analysis of 2003 data found that the indirect teaching cost variable is significant in explaining the higher costs of IRFs that have teaching programs. Therefore, CMS is proposing to establish a facility level teaching adjustment for IRFs.

THA supports implementation of an IRF teaching adjustment. This adjustment would recognize the higher costs experienced by facilities with teaching programs. Both the inpatient PPS and inpatient psychiatric PPS recognize the need for such an adjustment, and the inpatient rehabilitation PPS should be consistent with these systems. THA believes data from 2003 represents a period subsequent to the implementation of the IRF-PPS and provides for more accurate analysis of IRF costs under the PPS.

CMS should not postpone or delay the implementation of a teaching adjustment in hopes of receiving later data that will provide more accurate results. A decision to postpone implementation is, in effect, a decision to continue to use results based on

1999 data rather than results based on 2003 data. In the proposed rule, CMS clearly indicates the limitations and data problems that are associated with the 1999 data. That is the reason that CMS has proposed several of the major policy changes that are contained in this rule.

Moreover, the proposed increases in the low-income patient adjustment and rural location adjustment are based on the same data and analysis as was used for the proposed teaching adjustment. THA supports all three of these proposed adjustments, which will increase payment equity and more accurately reflect the costs incurred by IRFs. We do not believe CMS should selectively apply the results of the RAND analysis in some instances but reject the results in others. **We urge CMS to implement the proposed teaching adjustment in FFY 2006, along with the increases in the low-income patient adjustment and rural location adjustment.**

Low-Income Patient Adjustment

IRFs receive an adjustment to the federal prospective payment rate to account for differences in costs associated with the treatment of low-income patients (LIP). Based on the RAND analysis of 2003 data, CMS is proposing to update the formula used to calculate the LIP and thereby increase these payments. THA supports this proposal, which will provide more accurate and equitable payment to IRFs that serve low-income patients.

Rural Location Adjustment

Currently, IRFs located in rural areas receive a 19.14 percent add-on to the federal per discharge base rate. Based on the RAND analysis of 2003 data, CMS proposes to increase this add-on to 24.1 percent. **THA supports this proposal, which will provide increased reimbursement that better reflects the costs associated with caring for Medicare patients in rural facilities.**

Proposed Update to Outlier Threshold Amount

CMS has established an IRF PPS outlier policy for cases that require more costly care. The methodology is designed to result in outlier payments that are 3 percent of total IRF payments. CMS proposes to decrease the outlier threshold from \$11,211 in FFY 2005 to \$4,911 in FFY 2006, thereby increasing the number of cases that will qualify for outlier payments. CMS estimates this change is required to maintain outlier payments at 3 percent of total IRF PPS payments. **THA supports the proposed revision to the outlier threshold that will ensure IRFs receive compensation for the treatment of high cost patients.**

Submitter : Ms. Carol Ormay
Organization : Kentucky Hospital Association
Category : Health Care Provider/Association

Date: 07/18/2005

Issue Areas/Comments

Issue

Provisions of the Proposed Rule

Geographic Reclassification

CMS defines hospital labor market areas based on the definitions of statistical areas established by OMB. In December, 2000, OMB announced its new standards which provided for the identification of the following statistical areas:

- ? Metropolitan Statistical Areas
- ? Micropolitan Statistical Areas
- ? Metropolitan Divisions
- ? Combined Statistical Areas
- ? New England City and Town Areas
- ? New England City and Town Area Divisions
- ? Combined New England City and Town Areas

Metropolitan Statistical Areas are defined as having at least one urbanized area of 50,000 or more population, plus adjacent territory that is socially and economically integrated. In its 2005 IPPS rule, CMS adopted the revised OMB Metropolitan Statistical Areas (MSAs). This change resulted in the creation of two new MSAs in Kentucky: Bowling Green and Elizabethtown. These MSAs are included in the IRF rule as well.

The Bowling Green MSA includes the city of Bowling Green, Warren and Edmonson Counties. The Elizabethtown MSA includes the city of Elizabethtown, Hardin and Larue Counties. While these new Kentucky MSAs meet the criteria of having one urbanized area and adjacent territory that is socially and economically integrated, these adjacent counties are extremely rural and the IRFs in these areas draw patients and employees from an even wider geographic area that is again extremely rural. We believe that CMS should reconsider this designation for rehabilitation facilities as their patient and employee reach extends beyond that of the typical acute care hospitals?

The proposed rule states that 91 percent of rural facilities that would be designated as urban under the CBSA-based definitions would experience an increase in the wage index. Furthermore, a majority (74 percent) of rural facilities that become urban would experience at least a five percent to 10 percent or more increase in wage index. We would request that CMS make some provision, such as a hold harmless, for those nine to 26 percent of hospitals that will not experience an increase in the wage index and will suffer significant harm from being re-designated as an urban facility. While hospitals moving from rural to urban will receive an increased wage index, they will lose the rural adjustment which increases from 19.14 percent to 24.1 percent. The increase in the urban wage index will not offset the loss of the rural adjustment. The IRF located in the Bowling Green MSA will lose \$2.5 million (16 percent loss) and the IRF located in the Elizabethtown MSA will lose \$1.3 million (13 percent loss).

Recommendation: The final rule be amended to include a provision for IRFs being geographically reclassified under the proposed rule to be allowed to remain in their previous geographic classification if they choose.

Proposed FY 2006 Federal Prospective Payment Rates

Proposed Teaching Status Adjustment

We support the proposal to add a teaching payment to rehab PPS. Teaching facilities incur indirect costs related to training interns and residents that are not currently separately reimbursed. Under inpatient PPS a separate payment for indirect costs is made with each DRG payment. It is important that this add-on is implemented to more equitably pay IRFs that assume the training of future physicians.

In the proposed rule concern was raised over the possibility of shifting residents from the acute care side to rehabilitation in order to increase reimbursement. While we believe this is not likely due to this specialized field, we would support capping the residents as it has been done under inpatient PPS if this would jeopardize the entire add-on payment. Another concern was expressed over the accurate counting of residents. The methodology for counting residents is already in place as most of these programs are associated with provider based facilities. The resident counts are already audited for GME purposes, extending this to IME would not be difficult.

Recommendation: We support the addition of a teaching payment to rehab PPS.

Standard Payment Reduction of 1.9 Percent

We oppose the proposed 1.9 percent reduction in payments based on evidence of coding increase rather than increased acuity. We have not seen any data that indicates significant coding increases are occurring. We strongly disagree with the implementation of this reduction until providers have a chance to review and address the assertions of increased coding.

Proposed Refinements to the Patient Classification System

Revisions to Co-morbidity Tiers and CMGs

CMS-1290-P-44

The modifications made to CMGs are significant and, overall, will result in lower payments to IRFs. While this is a difficult change to accept, we understand the concept of "compressing" data to apply more appropriately to the population served in IRFs. We do not have a reasonable alternative to suggest at this time, which is based upon better data than that studied by CMS. We would request that CMS continue to study the data after implementation of the proposed rule to determine whether the CMG classifications are indeed appropriate, and urge CMS to continue to make modifications based upon objective analysis as needed. It is important to recognize that care of the high cost patients needs to be adequately reimbursed in order to continue to assure access to an appropriate level of care.

Recommendations: CMS should continue to study the data after implementation of the proposed rule to determine whether the CMG classifications are indeed appropriate, and make modifications based upon objective analysis as needed.

Several codes proposed to be deleted from the co-morbidity tiers should be retained. These are 530.3 Esophageal Structure; V49.75, V49.76, and V49.77 dealing with lower extremity amputations; and 799.4 Cachexia.

Each of these co-morbidities causes extra expenditure such as the provision of extra nutritional products and/or wound care supplies. As in other co-morbidities which currently "count," a facility caring for individuals with wounds or nutritional deficits incur added expense beyond these typically seen with the principle diagnosis. We request that these co-morbidities be retained in the final rule.

CMS-1290-P-44-Attach-1.DOC

CMS-1290-P-44-Attach-2.DOC

CMS-1290-P-44-Attach-3.DOC

July 18, 2005

The Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1290-P
PO Box 8010
Baltimore, Maryland 21244-8010

Dear Sir or Madam:

On behalf of the Kentucky Hospital Association's Rehabilitation Hospital Forum, I am writing in response to 42 CFT Part 412, Medicare Program: Inpatient Rehabilitation Facility Prospective Payment System for FY 2006; Proposed Rule. The Kentucky Hospital Association represents 100 percent of Kentucky's hospitals including 18 inpatient rehabilitation facilities (IRFs) with a total of 728 beds. Six of Kentucky's IRFs are freestanding with the rest being inpatient units of acute care hospitals. The average occupancy statewide is 74 percent. The smallest facility has 10 beds and the largest has 135, both those are IRFs located within acute care hospitals. The Appalachian region of the state (which has some of the highest levels of poverty in the country) has six IRFs. The Delta Region (identified by the Delta Regional Authority) has two. Only nine (50 percent) of Kentucky's IRFs are located in MSAs, although the proposed rule will move two facilities into new MSAs.

We appreciate the opportunity to comment on the proposed rule and below are our areas of interest:

Geographic Reclassification

CMS defines hospital labor market areas based on the definitions of statistical areas established by OMB. In December, 2000, OMB announced its new standards which provided for the identification of the following statistical areas:

- Metropolitan Statistical Areas
- Micropolitan Statistical Areas
- Metropolitan Divisions
- Combined Statistical Areas
- New England City and Town Areas
- New England City and Town Area Divisions
- Combined New England City and Town Areas

Metropolitan Statistical Areas are defined as having at least one urbanized area of 50,000 or more population, plus adjacent territory that is socially and economically integrated. In its 2005 IPPS rule, CMS adopted the revised OMB Metropolitan Statistical Areas (MSAs). This change resulted in the creation of two new MSAs in Kentucky: Bowling Green and Elizabethtown. These MSAs are included in the IRF rule as well.

The Bowling Green MSA includes the city of Bowling Green, Warren and Edmonson Counties. The Elizabethtown MSA includes the city of Elizabethtown, Hardin and Larue Counties. While these new Kentucky MSAs meet the criteria of having one urbanized area and adjacent territory that is socially and economically integrated, these adjacent counties are extremely rural and the IRFs in these areas draw patients and employees from an even wider geographic area that is again extremely rural. We believe that CMS should reconsider this designation for rehabilitation facilities as their patient and employee 'reach' extends beyond that of the typical acute care hospitals'.

The proposed rule states that "...91 percent of rural facilities that would be designated as urban under the CBSA-based definitions would experience an increase in the wage index. Furthermore, a majority (74 percent) of rural facilities that become urban would experience at least a five percent to 10 percent or more increase in wage index." We would request that CMS make some provision, such as a hold harmless, for those **nine to 26 percent of hospitals that will not experience an increase in the wage index and will suffer significant harm from being re-designated as an urban facility.** While hospitals moving from rural to urban will receive an increased wage index, they will lose the rural adjustment which increases from 19.14 percent to 24.1 percent. The increase in the urban wage index will not offset the loss of the rural adjustment. The IRF located in the Bowling Green MSA will lose \$2.5 million (16 percent loss) and the IRF located in the Elizabethtown MSA will lose \$1.3 million (13 percent loss).

Recommendation: The final rule be amended to include a provision for IRFs being geographically reclassified under the proposed rule to be allowed to remain in their previous geographic classification if they choose.

Standard Payment Reduction of 1.9 Percent

We oppose the proposed 1.9 percent reduction in payments based on evidence of coding increase rather than increased acuity. We have not seen any data that indicates significant coding increases are occurring. **We strongly disagree with the implementation of this reduction until providers have a chance to review and address the assertions of increased coding.**

Revisions to Co-morbidity Tiers and CMGs

The modifications made to CMGs are significant and, overall, will result in lower payments to IRFs. While this is a difficult change to accept, we understand the concept of "compressing" data to apply more appropriately to the population served in IRFs. We do not have a reasonable alternative to suggest at this time, which is based upon better data than that studied by CMS. We would request that CMS continue to study the data after implementation of the proposed rule to determine whether the CMG classifications are indeed appropriate, and urge CMS to continue to make modifications based upon objective analysis as needed. It is important to recognize that care of the high cost patients needs to be adequately reimbursed in order to continue to assure access to an appropriate level of care.

Recommendations: CMS should continue to study the data after implementation of the proposed rule to determine whether the CMG classifications are indeed appropriate, and make modifications based upon objective analysis as needed.

Several codes proposed to be deleted from the co-morbidity tiers should be retained. These are 530.3 Esophageal Structure; V49.75, V49.76, and V49.77 dealing with lower extremity amputations; and 799.4 Cachexia.

Each of these co-morbidities causes extra expenditure such as the provision of extra nutritional products and/or wound care supplies. As in other co-morbidities which currently "count," a facility caring for individuals with wounds or nutritional deficits incur added expense beyond these typically seen with the principle diagnosis. We request that these co-morbidities be retained in the final rule.

Proposed Teaching Status Adjustment

We support the proposal to add a "teaching" payment to rehab PPS. Teaching facilities incur indirect costs related to training interns and residents that are not currently separately reimbursed. Under inpatient PPS a separate payment for indirect costs is made with each DRG payment. It is important that this add-on is implemented to more equitably pay IRFs that assume the training of future physicians.

In the proposed rule concern was raised over the possibility of shifting residents from the acute care side to rehabilitation in order to increase reimbursement. While we believe this is not likely due to this specialized field, we would support capping the residents as it has been done under inpatient PPS if this would jeopardize the entire add-on payment. Another concern was expressed over the accurate counting of residents. The methodology for counting residents is already in place as most of these programs are associated with provider based facilities. The resident counts are already audited for GME purposes, extending this to IME would not be difficult.

Recommendation: We support the addition of a teaching payment to rehab PPS.

Thank you again for the opportunity to comment on **42 CFT Part 412, Medicare Program: Inpatient Rehabilitation Facility Prospective Payment System for FY 2006; Proposed Rule**. KHA appreciates the opportunity to submit these comments on behalf of all of Kentucky's hospitals, and we hope they will be reflected in changes to the final rule. Please feel free to contact me at 502-426-6220 or via e-mail at cormay@kyha.com, if you have any questions or desire additional information.

Sincerely,

Carol Blevins Ormay, MA, CHE
Vice President, Membership Services

July 18, 2005

The Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1290-P
PO Box 8010
Baltimore, Maryland 21244-8010

Dear Sir or Madam:

On behalf of the Kentucky Hospital Association's Rehabilitation Hospital Forum, I am writing in response to 42 CFT Part 412, Medicare Program: Inpatient Rehabilitation Facility Prospective Payment System for FY 2006; Proposed Rule. The Kentucky Hospital Association represents 100 percent of Kentucky's hospitals including 18 inpatient rehabilitation facilities (IRFs) with a total of 728 beds. Six of Kentucky's IRFs are freestanding with the rest being inpatient units of acute care hospitals. The average occupancy statewide is 74 percent. The smallest facility has 10 beds and the largest has 135, both those are IRFs located within acute care hospitals. The Appalachian region of the state (which has some of the highest levels of poverty in the country) has six IRFs. The Delta Region (identified by the Delta Regional Authority) has two. Only nine (50 percent) of Kentucky's IRFs are located in MSAs, although the proposed rule will move two facilities into new MSAs.

We appreciate the opportunity to comment on the proposed rule and below are our areas of interest:

Geographic Reclassification

CMS defines hospital labor market areas based on the definitions of statistical areas established by OMB. In December, 2000, OMB announced its new standards which provided for the identification of the following statistical areas:

- Metropolitan Statistical Areas
- Micropolitan Statistical Areas
- Metropolitan Divisions
- Combined Statistical Areas
- New England City and Town Areas
- New England City and Town Area Divisions
- Combined New England City and Town Areas

Metropolitan Statistical Areas are defined as having at least one urbanized area of 50,000 or more population, plus adjacent territory that is socially and economically integrated. In its 2005 IPPS rule, CMS adopted the revised OMB Metropolitan Statistical Areas (MSAs). This change resulted in the creation of two new MSAs in Kentucky: Bowling Green and Elizabethtown. These MSAs are included in the IRF rule as well.

The Bowling Green MSA includes the city of Bowling Green, Warren and Edmonson Counties. The Elizabethtown MSA includes the city of Elizabethtown, Hardin and Larue Counties. While these new Kentucky MSAs meet the criteria of having one urbanized area and adjacent territory that is socially and economically integrated, these adjacent counties are extremely rural and the IRFs in these areas draw patients and employees from an even wider geographic area that is again extremely rural. We believe that CMS should reconsider this designation for rehabilitation facilities as their patient and employee 'reach' extends beyond that of the typical acute care hospitals'.

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Recommendation: The final rule be amended to include a provision for IRFs being geographically reclassified under the proposed rule to be allowed to remain in their previous geographic classification if they choose.

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We oppose the proposed 1.9 percent reduction in payments based on evidence of coding increase rather than increased acuity. We have not seen any data that indicates significant coding increases are occurring. **We strongly disagree with the implementation of this reduction until providers have a chance to review and address the assertions of increased coding.**

Revisions to Co-morbidity Tiers and CMGs

The modifications made to CMGs are significant and, overall, will result in lower payments to IRFs. While this is a difficult change to accept, we understand the concept of "compressing" data to apply more appropriately to the population served in IRFs. We do not have a reasonable alternative to suggest at this time, which is based upon better data than that studied by CMS. We would request that CMS continue to study the data after implementation of the proposed rule to determine whether the CMG classifications are indeed appropriate, and urge CMS to continue to make modifications based upon objective analysis as needed. It is important to recognize that care of the high cost patients needs to be adequately reimbursed in order to continue to assure access to an appropriate level of care.

Recommendations: CMS should continue to study the data after implementation of the proposed rule to determine whether the CMG classifications are indeed appropriate, and make modifications based upon objective analysis as needed.

Several codes proposed to be deleted from the co-morbidity tiers should be retained. These are 530.3 Esophageal Structure; V49.75, V49.76, and V49.77 dealing with lower extremity amputations; and 799.4 Cachexia.

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In the proposed rule concern was raised over the possibility of shifting residents from the acute care side to rehabilitation in order to increase reimbursement. While we believe this is not likely due to this specialized field, we would support capping the residents as it has been done under inpatient PPS if this would jeopardize the entire add-on payment. Another concern was expressed over the accurate counting of residents. The methodology for counting residents is already in place as most of these programs are associated with provider based facilities. The resident counts are already audited for GME purposes, extending this to IME would not be difficult.

Recommendation: We support the addition of a teaching payment to rehab PPS.

Thank you again for the opportunity to comment on **42 CFT Part 412, Medicare Program: Inpatient Rehabilitation Facility Prospective Payment System for FY 2006; Proposed Rule**. KHA appreciates the opportunity to submit these comments on behalf of all of Kentucky's hospitals, and we hope they will be reflected in changes to the final rule. Please feel free to contact me at 502-426-6220 or via e-mail at cormay@kyha.com, if you have any questions or desire additional information.

Sincerely,

Carol Blevins Ormay, MA, CHE
Vice President, Membership Services

Mark McClellan, M.D., Ph.D.

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However, other recommended changes in this proposed rule raise serious concerns. We are particularly concerned that CMS has not adequately factored implementation of the 75% Rule into its data analysis. As a result, **we do not believe CMS should proceed with the proposed restructuring or re-weighting of the case mix groups (CMGs), the across-the-board coding adjustment, or the weighted motor score index.**

Interaction of the 75% Rule and the IRF PPS

During the first year of the 75% Rule, providers relied on various approaches to adapt to the new classification criteria and comply with the first-year threshold of 50 percent. For example, many IRFs changed patient mix by reducing patient admissions in many of the rehabilitation impairment categories, including joint replacement, osteoarthritis, cardiac, pulmonary, and miscellaneous. To meet the 50 percent threshold, some IRFs also closed beds, reduced staff (physicians, therapists, nurses, support staff), and/or recertified IRF beds as skilled nursing or general acute beds. In some cases, even admissions in categories that qualify under the 75% Rule, such as stroke and major multiple trauma, have dropped because of reduced overall IRF capacity. Based on IRF patient assessment data submitted to UDS MR and eRehabData, the number of IRF patients has decreased by more than 34,000 during the first 12 months under the 75% Rule. This number climbs even higher when all IRFs are included. These consequences resulting from IRF operational changes designed to achieve 75% Rule compliance will grow under the 60% threshold and continue to increase as the threshold moves toward the 75% level.

We are very concerned about the proposed rule's failure to adequately acknowledge the substantial volatility experienced by IRFs because of the implementation of the 75% Rule. **CMS should account for current and anticipated volatility related to the 75% Rule in this proposed rule and, to the extent possible, take steps to ensure that analyses reflect changes in the types of patients treated in IRFs and the subsequent impact on case mix, length of stay, and costs.** The current proposed rule relies on analyses of 2002 and 2003 data that do not include the substantial impact of the 75% Rule. As a result, the rule makes proposals for FY 2006 that are out of step with the regulatory environment that IRFs actually will face in FY 2006. Therefore, **we urge CMS to proceed cautiously with rulemaking on the IRF payment system.**

Recommendations

Proposed Payment Adjustments Specifically Related to the IRF PPS

Current IRF payments are being driven by 1998 and 1999 data from only a sample of IRFs. Although the AHA strongly believes that key components of the IRF PPS must be updated using more current and complete data, there are significant problems associated with using 2002 and 2003 data as proposed by CMS. Namely, the 2002 and 2003 data fail to reflect the impact of the 75% Rule on IRFs. This limitation must not be ignored nor minimized. Additionally, a substantial portion of cost report data for all HealthSouth facilities was excluded from the 2002 and 2003 cost reports. As a result, there is a material gap between the data used to develop the CMS proposals and the environment expected in FY 2006. This misalignment must be

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addressed by CMS in its analyses and its final determination of how to update the IRF PPS for FY 2006.

We are particularly concerned with CMS' proposed changes to the structure and weights of the CMGs and with the concept of weighting the motor score index. These are extensive changes that essentially revise the IRF PPS patient classification system. Such revisions to the classification system must be done in a measured and thoughtful manner with an opportunity for other options to be considered and debated. **CMS' proposed changes to the CMGs must be judiciously examined before CMS proceeds and should be based on more current data that capture at least one year of experience under the 75% Rule changes implemented July 1, 2004.**

Remove the Across-the-Board Coding Reduction

The proposed 1.9 percent across-the-board reduction intended to account for coding behavior should not be implemented. CMS should not overlook the 16 percent behavioral offset that was 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." A second adjustment for behavioral changes associated with improved coding would be redundant and inappropriate. The proposed 1.9 percent reduction would also exacerbate the instability caused by the 75% Rule, which will increase during FY 2006 as facilities adjust to the new 60 percent threshold. Therefore, **AHA strongly urges CMS to remove this reduction from the final rule.**

Payment Adjustments for Costs Beyond IRF Control

The proposed rule would also create a new payment adjustment for teaching facilities and increase the current payment adjustments for rural hospitals and low-income patients. The higher costs associated with resident training in teaching facilities are widely recognized and are included as an adjustment in the inpatient PPS and the new inpatient psychiatric facility PPS. Adding a similar adjustment to the IRF PPS is clearly appropriate and supported by the RAND analysis. The lack of an indirect medical education adjustment penalizes IRFs with teaching programs that currently absorb the additional costs of training new physicians – leaving many teaching IRFs with much lower Medicare margins than non-teaching IRFs. **AHA strongly supports these proposed adjustments that are designed to improve payment accuracy.**

IRFs with significant teaching programs, rural IRFs, and IRFs with greater low-income percentages (LIPs) currently experience some of the smallest Medicare margins under the IRF PPS. Ensuring that these facilities, which often treat some of the most clinically complex, poor, and rurally isolated patients, maintain the ability to serve these vulnerable populations is especially important given the added volatility caused by the 75% Rule. While data used to develop the teaching, rural and LIP recommendations also contain the flaws we previously discussed, these changes are necessary and appropriate as a first step toward broader refinement

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to address the cost differences experienced by these facilities, which are largely beyond an IRF's control. When data become available to account for the 75% Rule, payment adjustment amounts should be updated to reflect newer data and regression analyses.

Inflationary Update and Rebasings of the Excluded Hospital Market Basket

Current law sets the FY 2006 IRF PPS update for hospitals and units at the rate of increase in the excluded hospital market basket including capital. That rate is now estimated at 3.1 percent. However, as detailed in AHA's June 24 comment letter regarding the FY 2006 inpatient PPS rule for general acute care hospitals, we are concerned that CMS may be using a methodology that systematically underestimates the change in the market basket rate from one year to another. As described in our previous letter, the hospital market basket projection has been lower than the actual increase for seven of the last eight years. While the hospital market basket was overestimated for a number of years prior to that time, a methodology change was made in 1998 that appears to have overcorrected for the previous underestimations. We are concerned that the methods used to project the market basket increase (for both general acute hospitals and excluded hospitals) are flawed and fail to provide a reliable estimate of hospital cost increases. As stated in our inpatient PPS proposed rule comment letter, **we again request that CMS review the methodology that was used to determine the projected FY 2005 excluded hospital market basket, and revise it for the FY 2006 projection. We also urge CMS to make public the details of the calculation.**

Change to CBSAs Should be Phased In

To mitigate excessive changes in IRF wage index adjustments, the change from metropolitan statistical areas (MSAs) to core-based statistical areas (CBSAs) should be phased-in using parameters similar to those applied to general acute hospitals. That is, IRFs that would experience a drop in their wage indices in FY 2006 because of the adoption of the new labor market areas would have their wage index adjustments applied based on a 50-50 blend of the MSA and CBSA adjustment. A transition of this type would provide consistent treatment across payment systems and should be applied in a budget-neutral manner.

Outliers

AHA strongly urges CMS to ensure that all FY 2006 funds intended for the IRF PPS are spent on rehabilitation care, including the 3 percent intended for the outlier pool. CMS estimates that only 1.2 percent of this pool will be paid in FY 2005, while the remaining \$113 million will be left unspent. For FY 2006, CMS proposes to decrease the FY 2005 outlier loss threshold of \$11,211 to \$4,911. As discussed in our recent inpatient PPS comment letter, we are concerned about the methodology used by CMS to estimate cost and charge growth. We recommended an alternative methodology and encourage CMS to apply that same methodology to the IRF PPS to ensure that the full 3 percent of funds is used. Lowering the threshold will ensure access to care for the most costly patients and contribute to stability of the field as a whole. Because data are not available, we were unable to model this provision and provide an alternative threshold amount.

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Availability of Data

We are very concerned that CMS did not release adequate facility and patient level data, for IRFs, AHA and other associations to duplicate CMS' impact analyses and proposals. The proposed rule would result in material changes to the structure of the payment system and would significantly redistribute funds among providers. **Yet, the AHA and others lack the data to conduct a complete assessment of the proposed rule's implications.** In addition, it was only as recently as June 29 – less than three weeks before the comment period deadline – that CMS shared with the field an impact file with provider numbers. While this disclosure was helpful to entities seeking to analyze the impact of the proposed rule, it falls far short of the regulatory transparency associated with the inpatient PPS. For that payment system, stakeholders have nearly full access to facility and patient-level data used by CMS to develop annual updates and payment system revisions. The lack of transparency in IRF PPS rulemaking places providers, the AHA, other associations – and ultimately CMS – at a tremendous disadvantage. **CMS should provide more sufficient data in the future to address this critical problem.**

Additionally, given the significant ramifications of the proposed rule, the proposed changes should have been presented to the field with adequate time to assess them and develop an informed reaction to them. To provide for a 60-day comment period, CMS allowed only two weeks between the deadline for public comments and the release of a final rule. It would seem that CMS would require more than a two-week window between the close of the comment period and the publication of a final rule to thoughtfully consider comments and incorporate appropriate recommendations into the final rule. We are very concerned that CMS is inappropriately rushing a very significant rule through the regulatory process.

We appreciate the opportunity to comment on this proposed rule. We offer our collaboration as CMS works to improve the IRF PPS and implement the 75% Rule. To discuss our comments, please contact me or Rochelle Archuleta, AHA senior associate director for policy, at (202) 626-2320.

Sincerely,



Rick Pollack
Executive Vice President

Submitter : Mr. Andrew Wigglesworth
Organization : Delaware Valley Healthcare Council
Category : Health Care Professional or Association

Date: 07/18/2005

Issue Areas/Comments

GENERAL

GENERAL

The attached MS Word document contains the comments.

CMS-1290-P-45-Attach-1.DOC



DELAWARE VALLEY HEALTHCARE COUNCIL
of The Hospital & Healthsystem Association of Pennsylvania

July 18, 2005

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

Re: Medicare Program; Proposed Changes to the Inpatient Rehabilitation Facility Prospective Payment System for Fiscal Year 2006; (Federal Register: May 25, 2005 Volume 70, Number 100 pages 30187-30327).

Dear Dr. McClellan:

On behalf of the more than 150 member hospitals, health systems and other health related organizations in Southeastern Pennsylvania, Southern New Jersey and Delaware, including four inpatient rehabilitation facilities (IRF) and 20 inpatient rehab units, I am writing to convey our views on the proposed rule "Medicare Program: Inpatient Rehabilitation Facility Prospective Payment System for FY 2006." Hospitals, health systems and rehabilitation facilities throughout the Delaware Valley are under severe financial pressure. In order to ensure continued access to high quality health care for Medicare beneficiaries in southeastern Pennsylvania, adequate payments for rehabilitative services under the Medicare Prospective Payment System (PPS) is critical.

There are over 13,000 rehabilitation patients in southeastern Pennsylvania, and changes to the financial status of our rehabilitation hospitals could have a severe effect on the quality of health care and ultimately deny thousands of patients' access to inpatient rehabilitation in this region and jeopardize the ability of patients to lead independent lives to the greatest extent possible. Although changes to the IRF PPS would adversely affect patients nationwide, southeastern Pennsylvania would be hit especially hard by the changes in the Medicare guidelines because of the high concentration of Medicare recipients in this region. Our comments primarily focus on four specific aspects of the proposed regulation: the standard payment amount, the outlier threshold, the teaching adjustment and the adjustment for low-income patients. The Delaware Valley Healthcare Council (DVHC) requests that the Centers for Medicare and Medicaid Services (CMS) modify the proposed rule to ensure that inpatient rehabilitation facilities receive adequate reimbursement for their services as follows:

Standard Payment Amount

According to the proposed rule, CMS recommends an across the board reduction in rehabilitation payments by 1.9 percent intended to account for coding behavior. DVHC disagrees with this proposed change as it is based on an analysis of data from 2002 and 2003 that fails to take into account the impact of the 75% Rule on IRFs. This limitation must not be ignored nor minimized. We are very concerned about the proposed rule's failure to adequately acknowledge the substantial volatility experienced by IRFs because of the CMS revised interpretation of the 75% Rule. It is critical that CMS take into account the current and anticipated volatility for IRFs related to the 75% Rule and, to the extent possible, take steps to ensure that analyses reflect changes in the types of patients treated in IRFs and the subsequent impact on case mix, length of stay, and costs. The proposed 1.9 percent reduction would exacerbate the instability caused by the 75% Rule, which will increase during FY 2006 as facilities adjust to the new 60 percent threshold.

In addition, CMS should not overlook the 16 percent behavioral offset that was 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." A second adjustment for behavioral changes associated with improved coding would be redundant and inappropriate. **Therefore, DVHC recommends that the proposed decrease in the standard payment amount by 1.9 percent should not be implemented and should be removed from the final rule.**

Outlier Threshold

We agree with CMS' plan to substantially reduce the outlier loss threshold to \$4,911 from its current \$11,211 making it easier for cases to qualify for outlier payments. We believe that providing extra payments for cases with unusually high costs that are determined to be outliers is essential as it limits the rehabilitation facility's financial risk from extreme costs and removes any financial disincentive for treating Medicare patients with especially serious conditions. **As it is critical that rehabilitation facilities receive special payments to cover the extremely high-costs associated with extraordinary cases, DVHC supports CMS' proposal to decrease the outlier threshold.**

Payment Adjustments for Costs Beyond IRF Control

We are pleased that the proposed rule suggests a new payment adjustment for teaching facilities. The higher costs associated with resident training in teaching facilities are widely recognized and are included as an adjustment in the inpatient PPS and the new inpatient psychiatric facility PPS. Adding a similar adjustment to the IRF PPS is clearly appropriate. The lack of an indirect medical education adjustment penalizes IRFs with teaching programs that currently absorb the additional costs of training new physicians – leaving many teaching IRFs with much lower Medicare margins than non-teaching IRFs.

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Likewise, we support the proposal to increase the adjustment for IRFs with greater low-income percentages (LIPs) as they currently experience some of the smallest Medicare margins under the IRF PPS. Ensuring that these facilities, which often treat some of the most clinically complex, poor, and rurally isolated patients, maintain the ability to serve these vulnerable populations is especially important given the added instability caused by the 75% Rule. Implementing these payment adjustments is a positive step toward a more refined system that would address the cost differences experienced by these facilities, which are largely beyond an IRF's control. **DVHC strongly supports these proposed adjustments that are designed to improve payment accuracy.**

Thank you for the opportunity to express our views on this important regulation as it will greatly impact on rehabilitation services received by Medicare beneficiaries in the Philadelphia area as well as other parts of the Commonwealth and the nation. If you or your staff needs further clarification of our views, please do not hesitate to contact me at (215) 735-3295 or Pamela Clarke, DVHC's Vice President of Managed Care at (215) 735-3265.

Sincerely,



Andrew Wigglesworth
President

Submitter : Ms. Carol Ormay
Organization : Kentucky Hospital Association
Category : Health Care Provider/Association

Date: 07/18/2005

Issue Areas/Comments

Issue

Provisions of the Proposed Rule

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The proposed rule states that 91 percent of rural facilities that would be designated as urban under the CBSA-based definitions would experience an increase in the wage index. Furthermore, a majority (74 percent) of rural facilities that become urban would experience at least a five percent to 10 percent or more increase in wage index. We would request that CMS make some provision, such as a hold harmless, for those nine to 26 percent of hospitals that will not experience an increase in the wage index and will suffer significant harm from being re-designated as an urban facility. While hospitals moving from rural to urban will receive an increased wage index, they will lose the rural adjustment which increases from 19.14 percent to 24.1 percent. The increase in the urban wage index will not offset the loss of the rural adjustment. The IRF located in the Bowling Green MSA will lose \$2.5 million (16 percent loss) and the IRF located in the Elizabethtown MSA will lose \$1.3 million (13 percent loss).

Recommendation: The final rule be amended to include a provision for IRFs being geographically reclassified under the proposed rule to be allowed to remain in their previous geographic classification if they choose.

Proposed Refinements to the Patient Classification System

Revisions to Co-morbidity Tiers and CMGs

The modifications made to CMGs are significant and, overall, will result in lower payments to IRFs. While this is a difficult change to accept, we understand the concept of "compressing" data to apply more appropriately to the population served in IRFs. We do not have a reasonable alternative to suggest at this time, which is based upon better data than that studied by CMS. We would request that CMS continue to study the data after implementation of the proposed rule to determine whether the CMG classifications are indeed appropriate, and urge CMS to continue to make modifications based upon objective analysis as needed. It is important to recognize that care of the high cost patients needs to be adequately reimbursed in order to continue to assure access to an appropriate level of care.

Recommendations: CMS should continue to study the data after implementation of the proposed rule to determine whether the CMG classifications are indeed appropriate, and make modifications based upon objective analysis as needed.

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Proposed FY 2006 Federal Prospective Payment Rates

Proposed Teaching Status Adjustment

We support the proposal to add a ?teaching? payment to rehab PPS. Teaching facilities incur indirect costs related to training interns and residents that are not currently separately reimbursed. Under inpatient PPS a separate payment for indirect costs is made with each DRG payment. It is important that this add-on is implemented to more equitably pay IRFs that assume the training of future physicians.

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Recommendation: We support the addition of a teaching payment to rehab PPS.

Standard Payment Reduction of 1.9 Percent

We oppose the proposed 1.9 percent reduction in payments based on evidence of coding increase rather than increased acuity. We have not seen any data that indicates significant coding increases are occurring. We strongly disagree with the implementation of this reduction until providers have a chance to review and address the assertions of increased coding.

CMS-1290-P-46-Attach-1.DOC

July 18, 2005

The Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1290-P
PO Box 8010
Baltimore, Maryland 21244-8010

Dear Sir or Madam:

On behalf of the Kentucky Hospital Association's Rehabilitation Hospital Forum, I am writing in response to 42 CFT Part 412, Medicare Program: Inpatient Rehabilitation Facility Prospective Payment System for FY 2006; Proposed Rule. The Kentucky Hospital Association represents 100 percent of Kentucky's hospitals including 18 inpatient rehabilitation facilities (IRFs) with a total of 728 beds. Six of Kentucky's IRFs are freestanding with the rest being inpatient units of acute care hospitals. The average occupancy statewide is 74 percent. The smallest facility has 10 beds and the largest has 135, both those are IRFs located within acute care hospitals. The Appalachian region of the state (which has some of the highest levels of poverty in the country) has six IRFs. The Delta Region (identified by the Delta Regional Authority) has two. Only nine (50 percent) of Kentucky's IRFs are located in MSAs, although the proposed rule will move two facilities into new MSAs.

We appreciate the opportunity to comment on the proposed rule and below are our areas of interest:

Geographic Reclassification

CMS defines hospital labor market areas based on the definitions of statistical areas established by OMB. In December, 2000, OMB announced its new standards which provided for the identification of the following statistical areas:

- Metropolitan Statistical Areas
- Micropolitan Statistical Areas
- Metropolitan Divisions
- Combined Statistical Areas
- New England City and Town Areas
- New England City and Town Area Divisions
- Combined New England City and Town Areas

Metropolitan Statistical Areas are defined as having at least one urbanized area of 50,000 or more population, plus adjacent territory that is socially and economically integrated. In its 2005 IPPS rule, CMS adopted the revised OMB Metropolitan Statistical Areas (MSAs). This change resulted in the creation of two new MSAs in Kentucky: Bowling Green and Elizabethtown. These MSAs are included in the IRF rule as well.

The Bowling Green MSA includes the city of Bowling Green, Warren and Edmonson Counties. The Elizabethtown MSA includes the city of Elizabethtown, Hardin and Larue Counties. While these new Kentucky MSAs meet the criteria of having one urbanized area and adjacent territory that is socially and economically integrated, these adjacent counties are extremely rural and the IRFs in these areas draw patients and employees from an even wider geographic area that is again extremely rural. We believe that CMS should reconsider this designation for rehabilitation facilities as their patient and employee 'reach' extends beyond that of the typical acute care hospitals'.

The proposed rule states that "...91 percent of rural facilities that would be designated as urban under the CBSA-based definitions would experience an increase in the wage index. Furthermore, a majority (74 percent) of rural facilities that become urban would experience at least a five percent to 10 percent or more increase in wage index." We would request that CMS make some provision, such as a hold harmless, for those **nine to 26 percent of hospitals that will not experience an increase in the wage index and will suffer significant harm from being re-designated as an urban facility.** While hospitals moving from rural to urban will receive an increased wage index, they will lose the rural adjustment which increases from 19.14 percent to 24.1 percent. The increase in the urban wage index will not offset the loss of the rural adjustment. The IRF located in the Bowling Green MSA will lose \$2.5 million (16 percent loss) and the IRF located in the Elizabethtown MSA will lose \$1.3 million (13 percent loss).

Recommendation: The final rule be amended to include a provision for IRFs being geographically reclassified under the proposed rule to be allowed to remain in their previous geographic classification if they choose.

Standard Payment Reduction of 1.9 Percent

We oppose the proposed 1.9 percent reduction in payments based on evidence of coding increase rather than increased acuity. We have not seen any data that indicates significant coding increases are occurring. **We strongly disagree with the implementation of this reduction until providers have a chance to review and address the assertions of increased coding.**

Revisions to Co-morbidity Tiers and CMGs

The modifications made to CMGs are significant and, overall, will result in lower payments to IRFs. While this is a difficult change to accept, we understand the concept of "compressing" data to apply more appropriately to the population served in IRFs. We do not have a reasonable alternative to suggest at this time, which is based upon better data than that studied by CMS. We would request that CMS continue to study the data after implementation of the proposed rule to determine whether the CMG classifications are indeed appropriate, and urge CMS to continue to make modifications based upon objective analysis as needed. It is important to recognize that care of the high cost patients needs to be adequately reimbursed in order to continue to assure access to an appropriate level of care.

Recommendations: CMS should continue to study the data after implementation of the proposed rule to determine whether the CMG classifications are indeed appropriate, and make modifications based upon objective analysis as needed.

Several codes proposed to be deleted from the co-morbidity tiers should be retained. These are 530.3 Esophageal Structure; V49.75, V49.76, and V49.77 dealing with lower extremity amputations; and 799.4 Cachexia.

Each of these co-morbidities causes extra expenditure such as the provision of extra nutritional products and/or wound care supplies. As in other co-morbidities which currently "count," a facility caring for individuals with wounds or nutritional deficits incur added expense beyond these typically seen with the principle diagnosis. We request that these co-morbidities be retained in the final rule.

Proposed Teaching Status Adjustment

We support the proposal to add a "teaching" payment to rehab PPS. Teaching facilities incur indirect costs related to training interns and residents that are not currently separately reimbursed. Under inpatient PPS a separate payment for indirect costs is made with each DRG payment. It is important that this add-on is implemented to more equitably pay IRFs that assume the training of future physicians.

In the proposed rule concern was raised over the possibility of shifting residents from the acute care side to rehabilitation in order to increase reimbursement. While we believe this is not likely due to this specialized field, we would support capping the residents as it has been done under inpatient PPS if this would jeopardize the entire add-on payment. Another concern was expressed over the accurate counting of residents. The methodology for counting residents is already in place as most of these programs are associated with provider based facilities. The resident counts are already audited for GME purposes, extending this to IME would not be difficult.

Recommendation: We support the addition of a teaching payment to rehab PPS.

Thank you again for the opportunity to comment on **42 CFT Part 412, Medicare Program: Inpatient Rehabilitation Facility Prospective Payment System for FY 2006; Proposed Rule**. KHA appreciates the opportunity to submit these comments on behalf of all of Kentucky's hospitals, and we hope they will be reflected in changes to the final rule. Please feel free to contact me at 502-426-6220 or via e-mail at cormay@kyha.com, if you have any questions or desire additional information.

Sincerely,

Carol Blevins Ormay, MA, CHE
Vice President, Membership Services

Submitter : David Sibert
Organization : Kalispell Regional Medical Center
Category : Hospital

Date: 07/18/2005

Issue Areas/Comments

GENERAL

GENERAL

CORRECTION OF PREVIOUSLY SUBMITTED ATTACHMENT. The correct file may not have been attached to our request to correct an error in our facility listing. See attachment.

CMS-1290-P-47-Attach-1.DOC



July 18, 2005

Department of Health and Human Services
Centers for Medicare & Medicaid Services
[CMS-1290-P]

Re: Correction of Error in Facility Listing contained in Table 3 of the Proposed Rule
(42 CFR Part 412)

To Whom It May Concern:

We wish to call your attention to an error in the labeling of our rehabilitation facility listing in Table 3 of the Addendum to the Proposed Rule for the Inpatient Rehabilitation Facility Prospective Payment System for FY 2006. This error appears to have assigned us an urban designation as indicated in your electronic listing of rehabilitation facilities.

Requested corrections:

1. The provider number of our facility, Kalispell Regional Medical Center, is incorrectly listed as 05T073. **Our correct provider number is 290122.**
2. We are located in Kalispell, Montana, in Flathead County, a rural area of northwest Montana. The table incorrectly locates us in the Vallejo-Fairfield-Napa, California urban area [MSA Code 8720; CBSA Code 46700].

We have always maintained our rural designation. We are 120 miles away from the nearest MSA (Missoula, Montana) and serve several very rural counties around the Continental Divide including Glacier County, a frontier county. Our interpretation of 42 CFR Section 412.64 (b) (ii) (A) [Metropolitan Statistical Area] and CFR Section 412.64 (b) (ii) (C) is that we do not meet the requirements for inclusion in a MSA and do meet the definition of a rural area. We are unaware of any reason, other than the incorrect listing, that would account for a change to urban status.

We appreciate your assistance in correcting this information. As confirmation, a copy of this letter will be sent to your post office box in Baltimore, Maryland, via certified mail.

Sincerely,

David Sibert
Compliance Officer

Paula Sandman, RN
Manager, Rehabilitation Services

cc: Pete Diaz & Zinnia Ng (CMS)

Submitter : Ms. Tina Ford
Organization : BESLER Consulting
Category : Health Care Industry

Date: 07/18/2005

Issue Areas/Comments

Issue

Proposed FY 2006 Federal Prospective Payment Rates

"See Attachment"

Proposed Refinements to the Patient Classification System

"See Attachment"

CMS-1290-P-48-Attach-1.DOC



July 18, 2005

Dr. Mark McClellan
CMS Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1290-P
P.O. Box 8010
Baltimore, MD 21244-8010

Re: File Code CMS-1290-P

Dear Dr. McClellan:

BESLER Consulting (BESLER) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule entitled *Medicare Program; Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) for FY 2006; Proposed Rule*, 70 Federal Register 30188 (May 25, 2005).

The following comments/questions will apply to the various labeled sections from the aforementioned proposed ruling:

- **“Proposed FY 2006 Federal Prospective Payment Rates”:**

Subsection f: Wage Index Data:

1. It is proposed to utilize FY 2001 wage index cost report data for FY 2006 IRF PPS payment rates because it is the most recent final data available at the time the final IRF PPS regulations are issued. There is a five year time lag between cost report data and the applicable rate year of implementation for IRF. There is only a four year time lag for inpatient acute care hospitals.

There is a time lag of one year between IRF and inpatient acute care hospitals regarding wage index impacts. The preamble to IRF PPS proposed rule recognizes that both the IRF and the inpatient acute care hospital compete in the same labor market; however, the playing field is not always even due to this one year time lag.

Furthermore, the inpatient acute care wage index data is updated within a few weeks of the issuance of the IRF PPS final rule. CMS should include the same final wage index data in IRF payments to coincide with the inpatient acute care hospital for the same fiscal year.

2. The proposed rule does not take into account for wage index purposes geographic reclassifications and does not apply a "rural floor" citing that there is no specific IRF wage index data to determine if reclassifications and "rural floor" designations are warranted for IRF. It should be noted that these designations are applied to inpatient acute care hospitals and as cited above, both IRF and inpatient acute care hospitals compete for the same labor market. By routinely dismissing these designations, IRF are unfairly disadvantaged.

In accordance with section 1886(j) (6) of the Social Security Act, the Secretary is given broad discretion in setting IRF wage index methodology. Therefore, CMS should adopt a policy of allowing geographic reclassifications and implementing the "rural floor" for IRF. The most obvious would be a mechanism for geographic reclassification if there is an applicable county reclassification of inpatient acute care hospitals.

- **"Proposed Refinements to the Patient Classification System"**

1. Reimbursement for Traumatic Brain Injury cases that fall under newly defined CMGs 0206 and 0207 should be reevaluated. It appears that the reimbursement for this area, which is very resource intensive, is inadequate.

Thank you for this opportunity to comment.

Respectfully submitted,
BESLER Consulting



Philip A. Besler
President

Submitter : Ms. Luci Neumann
Organization : Baylor Institute for Rehabilitation
Category : Hospital

Date: 07/18/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1290-P-49-Attach-1.DOC



3505 Gaston Avenue
Dallas, Texas 75246

July 18, 2005

Mark McClellan, M.D. PhD
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services
Attention: CMS-1290-P
PO Box 8010
Baltimore, MD 21244-8010

Cc: 445-G Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, DC 20201

Ref: CMS – 1290-P, 70 F.R. 30188, May 25, 2005, “Medicare Program; Inpatient Rehabilitation Payment System for FY 2006, Proposed Rule”

Dear Dr. McClellan:

Baylor Institute for Rehabilitation (BIR) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule entitled “Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for FY2006.” BIR is a 116-bed free standing inpatient rehabilitation facility located in Dallas, Texas, and is heavily involved in medical education. As a teaching hospital located in an urban area where one in four citizens is without healthcare coverage, we commend CMS for its proposal to include a teaching hospital adjustment and to increase the low-income patient adjustment.

RAND studies have demonstrated that teaching rehabilitation hospitals have higher costs than their non-teaching counterparts. This finding has also been borne out in the inpatient acute prospective payment system and is thus not a surprising finding.

CMS has expressed some concern over including the medical education adjustment secondary to the fact that RAND's study only covered 2003 data. However, on page 30197 CMS indicates that the use of this file provides for a larger and more complete set of data from which more balanced decisions can be made. RAND's original analysis was done pre-PPS in 1999 on a limited number of facilities. The 2003 data set is complete and includes all facilities and admissions for 2003. RAND's data is statistically significant. This combined with the fact that a similar effect is seen in the inpatient acute environment, provide strong support to include the medical education adjustment.

The wage index adjustment and IP proposals are consistent with the current economic environment and are consistent with the BIR experience.

RAND's studies were based on 2002 and 2003 data prior to the enforcement of the 75% Rule, and do not reflect the impact the enforcement of the rule has had on access and cost structure in IRF's. Due to the changing rehabilitation landscape, we oppose the CMS proposed decrease in the standard payment amount, the changes to the CMG's and relative weights, and the changes to the co-morbidities that comprise the tiers. The list of co-morbidities that comprise the tiers do not reflect the challenges that contribute to higher costs in the rehabilitation setting. CMS notes on page 30222 that it has concerns regarding the impact of the decrease in the standard payment amount on access, and of the potential impact of the 75% Rule on hospital cost structures.

Based on the lack of understanding of the full impact of the 75% Rule, we strongly encourage CMS not change these factors and to engage RAND to conduct studies on calendar year 2005 data and to work with experts in the field to understand these effects prior to making substantive and potentially damaging changes to the IRF-PPS.

Thank you for the opportunity to provide comment on the proposed rule.

Sincerely,



Luci Neumann
President
Baylor Institute for Rehabilitation

Submitter : Mrs. Mary Whitbread
Organization : Henry Ford Health System
Category : Health Care Provider/Association

Date: 07/18/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1290-P-50-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 18, 2005

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

Department for Health and Human Services

**Re: CMS-1290-P – Medicare Program; Proposed Changes to the Inpatient Rehabilitation Facility Prospective Payment System for FY 2006; May 25, 2005
*Federal Register***

Dear Dr. McClellan:

On behalf of Henry Ford Health System, we appreciate the opportunity to provide comments on the proposed rule for the FY 2006 Inpatient Rehabilitation Facility Prospective Payment System published in the May 25, 2005 *Federal Register*. Our comments reflect the issues we face as a large, fully-integrated, not-for-profit health system providing care across virtually the entire continuum of health care services. Our system provides services to some 800,000 southeast Michigan residents in three hospitals and more than 70 ambulatory and outpatient care centers. With well over 2.5 million outpatient visits per year, this rule is of significant concern to us.

A. Implementation Using 2002 and 2003 Data in the Current Regulatory Environment

On pg. 30222, in the discussion regarding the proposed reduction in the standard payment amount for coding, CMS raises concern about the impact of that change and any potential impact on access. It also acknowledges that the current cost structures of inpatient rehabilitation facilities (IRFs) may be changing as they try to comply with implementation of the 75% rule effective for cost reports beginning on or after July 1, 2004 as published in the May 7, 2004 Federal Register, "*Changes to the Criteria for Being Classified as an Inpatient Rehabilitation Facility*". We commend CMS for recognizing these concerns and changes in the IRF environment.

We believe that the rule is having, and will continue to have, a drastic impact on the IRF field far beyond CMS's original estimates or intent. We think that the ultimate impact on the field using 2002 as a base year will be a reduction in Medicare payments.

In so doing, the case mix of facilities will continue to change as it already has started to change, reversing the noted increases in joint replacement cases and decline in the percentage of stroke

cases, among others. Eliminating care for these shorter stay, less costly patients and taking longer, stay more complex patients, along with closing beds (assuming a full substitution of cases cannot be found) will result in a change in facilities' cost structure. Hence, by October 1, 2005 when these changes are proposed to become effective they will be applied to a patient and cost environment very different and more volatile from that which was observed and upon which the research recommendations and subsequent policy recommendations were made.

CMS notes it believes that if all facilities went initially to 100% IRF PPS payments that they would have been paid 17% over cost. We are concerned that implementing this rule into this new environment would not only eliminate all of this alleged margin but also pay for some cases below cost.

Recommendation:

We recommend that CMS delay a broad refinement to the IRF-PPS until more current data is collected and analyzed.

B. Updating the CMGs, pg. 30197

1. *Change in the Number and Composition of CMGs*

CMS proposes to change the number of CMGs from 95 to 87, change the case weights, average lengths of stay and CMG descriptions based on rehabilitation impairment categories (RIC), age, and motor and cognitive function.

Recommendation:

Again and as noted above we are concerned that the field has not had access to the 2003 data analysis. We also recommend the analysis be conducted again using more current data and recommend the analysis using 2003 data be released to the field.

2. *Drop of Cognitive Scores Showing as Determinants in Defining CMGs*

CMS proposes to reduce the number of CMGs. The new cut points do not include the cognitive scores as frequently as before. In the current CMGs, cognitive scores are present in 15 CMGs representing 6 RICs. In the proposed system only 5 CMGs and 2 RICs show the presence of cognitive scores as a factor in the description of the CMGs. We are concerned that they actually do affect resource utilization, LOS and caregiver burden more than the data appear to show.

Recommendation:

We recommend that CMS reexamine the orthopedic and multiple trauma CMGs in particular regarding the influence of the cognitive items on affecting cost. Second, we recommend that CMS work with rehabilitation providers to develop cognitive measures that are more sensitive to patients' status and have better predictive qualities.

3. *Weighting the Motor Functional Items*

CMS proposes a change in the calculation of the 12 motor items that, when totaled, result in a CMG to be assigned. The proposal states that the weighting system will provide better predictability of costs. The weights range from .2 to 2.2 and serve as multipliers to the score that is assigned each patient for each item.

We are concerned that the weighting system may result in a disadvantage for patients who present with mild lower extremity dysfunction but have cognitive problems that are reflected in the current CMGs that have lower weights. Many of the upper body functional motor scores are tasks that are sequential or multi-stage and are accomplished through higher level organizational skills. Patients with cognitive impairments may display problems with tasks such as these. These characteristics are commonly seen in patients with traumatic brain injury but are also seen in certain patients with stroke.

We are concerned that for these cognitively impaired patients, weighting the motor items will result in the following:

- a. Patients with significant lower body impairment will have a higher probability of being classified in a higher paying CMG; and
- b. Patients with a significant dysfunction in upper body and bladder/bowel problems will have a higher probability in being classified in a lower paying CMG. Patients with these characteristics need professional intervention that assists the patients with sequencing tasks in proper order and relatively intense levels of intervention due to the patients' inability to perform therapy tasks on their own. There is also increased likelihood that such patients need observation at night by rehabilitation nursing staff to assure that they remain safe.

Recommendation:

We recommend that the weighting system be held in abeyance at this time until it is tested on different patient groups and determined if there is any unfair CMG categorization of patients.

C. Changes to Standard Payment Amount for Coding of Minus 1.9%, pg. 30220

CMS is proposing a one-time adjustment to the standard payment amount to account for coding changes observed during the first years of implementation of the IRF PPS. It is proposing to reduce the standard payment amount by 1.9% which will reduce the per case payment amount by \$254. CMS states this proposal is based on RAND's analysis.

RAND found it was quite difficult to characterize how much of the change in case mix was a function in the change of the acuity of patients and how much was a function of coding due to changes in the coding instructions and more accuracy in coding. Hence it analyzed the data from two perspectives. From these analyses it constructed an upper and lower bound for both factors. It stated: "our final bounds on the causes of the increase in the CMI are:

- coding change between 1.9 percent and 5.9 percent
- real change between a 1.4-percent decline and a 2.4 percent increase."

It then recommended that CMS either "reduce weights by at least 1.9% or reduce the conversion factor by at least 1.9% less than the market basket update... Further since in 2002 many hospitals were on the PPS for only part of the year, we believe that this analysis should be repeated using more recent data in order to gauge the full impact of the PPS on case mix change."

Recommendation:

Again, because of the 75% rule, we recommend no decrease at this time pending analyses based on more current data. It appeared from the RAND report that this is a very difficult area to analyze using this early and incomplete data.

D. Proposed Adjustment to Determine the Proposed FY 2006 Standard Payment Conversion Factor, pg. 30222

1. Revision and Rebasing of the Market Basket , pg. 30223

CMS is proposing to create a market basket exclusively for the rehabilitation, psychiatric and long term care hospitals (RPL). In so doing it notes that the cost structure of these hospitals is more labor intensive than the other categories of excluded hospitals—children and cancer. CMS proposes to use FY 2002 as the base period for constructing the new market basket. It

57.579 in the FY 1997 based market basket. Several factors are involved in this difference: the new base year, the revised LOS change and exclusion of cancer and children's hospitals.

It also appears that CMS is using the same methodology for the capital portion of the market basket as in the final rule published on August 7, 2001.

We note in Table 9 that the increases in the FY 1997 market basket for FY 2004 was 3.6% and for 2005 was 3.8%. However, the IRFs received only 3.2% in FY 2004 and 3.1% in FY 2005 for an increase. We understand that the SNFs receive an adjustment in their update if the market basket forecast varies from the actual market basket by .25%. We recommend a similar approach be taken for the IRF update.

Recommendation:

1. We recommend that the current update be increased to reflect the differences between the updates given in FY 2004 and 2005 and the final market basket increases.
2. We recommend an adjustment for market basket forecast errors as is utilized for other providers as noted above.
3. Otherwise, we support the rebasing and revisions leading to the creation of the RPL market basket.

E. Proposed Area Wage Adjustment- Move to CBSAs from MSAs, pg.30235

We noticed a disparity between the way the acute hospital wage data is being used for acute hospitals and IRFs. Under the IPPS rules proposed for acute hospitals for FY 2006, wage index data based on FY 2002 cost reports will be used. For IRFs, CMS proposes to use FY 2001 cost report data.

Recommendation:

We recommend the FY 2002 cost report data should be used for IRFs as well, because the most recent data available for computing wage indices should be applied. Furthermore, recognizing that 82 percent of all IRFs are hospital-based, it would be more consistent for them to use the same wage indices for their entire hospital.

F. Proposed Facility Level Adjustments, pg. 30241

1. Proposed Teaching Status Adjustment, p. 30241

CMS is proposing, with some reservation, recognition of the costs of providing medical education programs, specifically for the indirect teaching costs based on an analysis by RAND of the FY 2003 data. The adjustment would be calculated as 1+ the full time resident equivalent divided by the average daily census raised to the power of 1.083. The adjustment would be subject to a cap as are the IPPS hospitals and the cap established for graduate medical expenses for all hospitals. The cap would be calculated using the FTE resident number for settled cost reports for the most recent cost reporting period ending on or before November 15, 2003.

Recommendation:

1. We recommend that the proposed teaching status adjustment not be implemented. Our findings show that the budget neutral adjustment to the standardized payment is not offset by the proposed Teaching Status Adjustment. Our facility's low percentage of residents in our Rehab program has little effect towards a Teaching adjustment.

G. Low Income Adjustment, pg. 30245

CMS proposed to increase the low income adjustment from $((1+DSH) ^ 0.438$ to $((1+DSH) ^ 0.636$. "DSH" represents the disproportionate share percentage as used in the final rule.

Recommendation:

We support the proposal. However, again we recommend it be rerun using calendar year 2005 data.

H. Proposed Increase in the Outlier Threshold Amount, pg. 30245

Since the inception of IRF PPS, CMS has set aside an estimated three percent (3%) of total IRF payments for outlier payments in addition to the regular case payments. The statute provides that up to 5% of total payments may be set aside to account for paying for cases that have extraordinary high costs. In the 2001 IRF-PPS final rule, CMS chose to set aside 3% of total estimated payments for additional payments to these outlier cases

One of the purposes of the outlier policy is to assure access to these complex, costly patients (see August 7, 2001 Federal Register pages 41361 and 41362). CMS states that the results of financial risk, accuracy at the case level, and accuracy at the hospital level suggest that there should be a limit on the outlier percentage that is less than the statutory limit and that balances the need to compensate accurately for high-cost care while still maximizing remaining resources to improve the payment accuracy of non-outlier cases. The original threshold was \$11,211. This outlier threshold has remained constant for FY 2003, 2004 and 2005 without regard to actual outlier payments.

The outlier policy has resulted in unexpended funds to providers. For example, CMS estimates that only 1.2% of the dollars allotted for outlier payments will be paid in FY 2005 (p. 30266). Hence, our work group estimated providers will be underpaid by approximately \$113,000,000 in 2005 because of the current outlier threshold. Based upon the 2005 projected experience, it is possible that CMS may have retained as much as \$460 million since inception of the IRF PPS, since few cases qualified as outliers, and hospitals may have not admitted potential outlier cases because of the higher threshold.

The rule proposes to decrease the outlier threshold from \$11,211 to \$4,911 to ensure that all outlier funds are distributed to providers rather than remaining with CMS. We applaud CMS for recommending this change. We, however, have concerns that the proposed outlier threshold of \$4,911 may be so low that it creates other adverse incentives.

Recommendation:

As with other sections of the rule, we recommend that the analyses pertaining to the outlier policy be conducted anew.

We recommend that CMS consider continuing with the FY 2005 outlier threshold of \$11,211. We believe that the redistribution of the estimated \$113 million from the outlier pool to the base rate would mitigate some of the impact of the other proposed standard payment rate reductions. We also believe that setting the outlier threshold at an adequate level will protect the overall structure and efficiency of the IRF PPS system.

We believe that CMS should monitor this issue closely. If it is determined that access to care becomes problematic for some patient populations or that specific providers experience significant harm because of a disproportionate share of high cost outliers, modifications to the outlier percentage should be considered.

Alternatively, we would support the outlier provision as proposed as it will at least ensure that all of the outlier funds set-aside are paid out.

I Conclusion

Thank you for your 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 : Ms. Judith Bishpo
Organization : Sunset Retirement Communities
Category : Long-term Care

Date: 07/18/2005

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1290-P-51-Attach-1.DOC

Centers for Medicare and Medicaid Services

Department of Health and Human Services

P.O. Box 8016

Baltimore, MD 21244-8016

Attention: CMS 1282-P

Date: July 18, 2005,

Deleted: <http://www.cms.hhs.gov/regulations/comments/>

My name is Judith A. Bishop, and I am writing on behalf of Sunset Retirement Communities, Inc., to offer testimony for the proposed Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2006.

My comments are specific to possible changes that CMS might consider in the future.

Section: P1a, IV medications, suctioning, tracheostomy care and use of ventilator/respirator that classify residents into Extensive Services.

The proposal to eliminate the 14-day look back period for the items in P1a that cause a resident to group in Extensive Services will greatly affect the number of residents who attain that category and may affect the quality of care those residents receive if those items are not addressed on the Minimum Data Set (MDS). I respectfully ask that CMS remember the original reason for the MDS assessment, which is to provide a standardized assessment tool to improve quality of care in the long-term care setting. A comprehensive assessment requires that information be obtained from a variety of sources, thus eliminating the 14-day look back period for these items would compromise the resident's assessment. Proposing to eliminate the look back period would not identify special needs of the resident and would negatively impact the care planning process and level of quality care. Residents who are transferred to a long term care facility and who have experienced IV medications, suctioning, tracheostomy care and/or use of a ventilator/ respirator during their hospital stay have special care requirements upon admission, requiring more acute monitoring for possible infections and complications following those treatments. Respiratory care residents are often known to have frequent relapses after receiving suctioning or if they have had a tracheostomy or have had ventilator/respiratory care.

5-Day Grace Day Period

Eliminating the grace day period for the 5-day PPS MDS assessment would have a, clinically, negative impact for long term care residents. Frequently, newly admitted residents cannot tolerate therapy on the day of admission because many are admitted in the afternoon or evening and they are extremely tired. If, residents are required to be evaluated on the day of admission their abilities and potential, may be misinterpreted

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because of admission anxiety or fatigue. Requiring therapy evaluations on the day of admission would in most cases not be wise and done only for reimbursement purposes. It would be done because the MDS must reflect therapy actually given in the facility for a seven-day period. Residents who are experiencing anxiety or extreme fatigue on admission will be asked to participate in therapy in order to maintain their Medicare Part A status regardless of their physical and emotional ability.

In addition, I respectfully encourage CMS to consider the information found on page 2-28 of the Resident Assessment Instrument Version 2.0 manual which specifically states, "Grace days can be added to the Assessment Reference Date (ARD) in situations such as absence/illness of the RN assessor, reassignment of the assessor to other duties for a short period of time, or an unusually large number of assessments due at approximately the same time. Grace days may also be used to more fully capture therapy minutes or other treatments. The use of grace days allows clinical flexibility in setting the ARDs, and should be used sparingly." I would ask that CMS remember that there is a severe nursing shortage in this country which effects staffing in long term care facilities. Further, there is a shortage of physical therapist as well that impact the start dates of therapies, especially related to weekends, holidays and evenings.

Elimination of the Projected Therapy on the 5-day Assessment in Section T of the MDS

I encourage CMS to maintain the current policy for Section T of the MDS. Often within the ARD of the 5-day assessment it is not possible to attain the 5-days of therapy required to classify in the Rehab category. The projection of days and minutes allows for this consideration and permits facilities to capture payment that is provided on the remaining days of this payment period. Without the projected days, facilities will not be compensated. More importantly the Medicare beneficiary may not receive the services at a level they require or can benefit from when there is inadequate compensation for the services. The projected therapy should remain to capture a situation where the beneficiary does not start out strong in therapy, but is assessed to have a good potential for an aggressive program.

I would like to thank you for the opportunity to submit comments and suggestions.

Sincerely,

Judith A. Bishop

Executive Director/VP of Operations

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Submitter : R. Dawn Brennaman
Organization : AAPM&R and the AAP
Category : Health Care Professional or Association

Date: 07/18/2005

Issue Areas/Comments

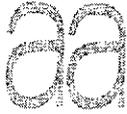
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see attachment

CMS-1290-P-52-Attach-1.DOC

CMS-1290-P-52-Attach-2.DOC



American Academy of
Physical Medicine and Rehabilitation



July 18, 2005

Mark McClellan, MD, PhD
Administrator
The Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1290-P
P.O. Box 8010
Baltimore, MD 21244-8010

Dear Administrator McClellan:

These comments are submitted on behalf of the American Academy of Physical Medicine and Rehabilitation (AAPM&R), the national medical society representing nearly 7,000 physiatrists, physicians who are specialists in the field of physical medicine and rehabilitation and the Association of Academic Physiatrists (AAP), the national association of 1, 205 physiatrists who are affiliated with medical schools. Most, if not all, of the AAPM&R and AAP members participate in the Medicare program. We appreciate the opportunity to share our views on the Center for Medicare and Medicaid Services' (CMS), 42 CFR Part 412 proposed rule for the Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System (IRF-PPS) for FY 2006 (file code CMS-1290-P) *Federal Register*, May 25, 2005, regarding the update of prospective payment rates for inpatient rehabilitation facilities (IRFs). Our comments are in support of the Teaching Status Adjustment proposed in the rule and described at pages 30241 through 30244 of the *Federal Register* though we have a reservation as to one aspect of the provision.

Physiatrists provide care in both inpatient and ambulatory settings. The most common inpatient setting in which practice is carried out is the rehabilitation hospital or rehabilitation unit of an acute hospital in which a physiatrist is usually the attending physician. Other inpatient settings include acute hospitals and skilled nursing facilities. In the ambulatory setting, the most common place of practice is the physician's office, clinic, or the hospital outpatient department.

AAPM&R and AAP Position on the Rule and the Teaching Status Adjustment

The AAPM&R and the AAP believe that a failure to include the teaching status proposal would perpetuate an unfair payment system which discriminates against the IRFs with

teaching programs. The most recent and accurate data of 2003 reflect the additional costs of care of such programs which, if uncompensated, would discourage IRFs from continuing their teaching programs at their current size and cost. The AAPM&R and the AAP believe the 2003 data are reasonable and should be relied upon by CMS.

The proposed rule recommends a facility level adjustment to the IRF PPS Federal per discharge base rate for IRFs which have qualified teaching programs. This change would affect both rehabilitation hospitals and units and would bring the IRF PPS into conformity with the PPS for acute care hospitals, which has had a teaching hospital adjustment to the DRG PPS from its inception in 1983. The IRF PPS was established in a final rule published in the Federal Register on August 7, 2001, effective for cost reports of hospitals filed January 1, 2002 and thereafter. The August 7, 2001 final rule did not include an adjustment to the Federal per discharge rate for teaching institutions though it did have adjustments for low income patient mix and for rural facilities. The regression analyses prepared by the Rand Corporation for the 2001 rule, using 1999 data did not reflect additional cost attributable to teaching programs and facilities. The 2005 proposed rule includes such an adjustment since the Rand Corporation analyses for this rule, based on more recent 2003 data, does show a significant cost differential between IRFs with teaching programs and those without such programs.

The AAPM&R and the AAP are very supportive of the teaching hospital adjustment for without it we believe IRFs with teaching programs will be underpaid for inpatient care. This payment inequity would create a disincentive for teaching programs in IRFs at a time when such programs are very necessary for the production of residents and for quality patient care in the future. The AAPM&R and the AAP supported the inclusion of a teaching adjustment in the original IRF PPS and determined that the failure to include such an adjustment resulted from the paucity of data related to IRF teaching programs. We recommended that CMS continue to have research done on the cost per case of IRF teaching programs relative to the cost per case of other IRF programs since we believed teaching programs to have greater costs per case. Those costs now are shown to be greater in teaching hospitals thus justifying an adjustment as proposed.

Another policy reason for this proposal is the need to keep PM&R residency training adequately supported and to support other programs for the training of rehabilitation professionals conducted by the IRF teaching institutions which will benefit from this adjustment. The adjustment would assist in supporting these programs. The 1998 "Review and Update of the 1995 Physical Medicine and Rehabilitation Workforce Study: The Supply of and Demand for Physiatrists" conducted by The Lewin Group also reaffirmed the current shortage of physiatrists, and estimated a growing demand for PM&R physician services through 2017. It estimated that supply, at current rates, was slowing but might equal demand in the period 2000 through 2017 under current conditions. But it noted the failure of adequate Medicare financing for Graduate Medical Education as a factor which could result in demand exceeding the available supply since supply would be adversely affected by possible reduced funding. The number of residents in training in 2004 is lower than the average number in training in the years 1995 through 2000. This shows that the problem of maintaining an adequate workforce

capacity is in fact becoming more exacerbated, and strongly argues for adequate reimbursement for teaching facilities to maintain their programs to meet the demand for PM&R physicians in the future.

Currently, there are approximately 80 residency training programs approved in the field of PM&R and an estimated 1,140 residents were in training in 2004. The programs graduate between 300 to 350 residents each year and those residents are necessary to meet the expanding demand for rehabilitation services and to provide quality care. The adjustment will assist the programs to produce these required numbers. The updated Lewin Group study also indicates that PM&R is likely to remain a shortage specialty through the period 2015-2020. Consequently, as a matter of sound public policy, it makes sense to support the training capacity of psychiatrists.

2003 Data Compared to 1999

The AAPM&R and the AAP believe the 2003 Rand data and analyses much more accurately represent the current economic situation of IRFs with teaching programs than do the Rand 1999 data. The Rand 1999 analysis was weaker than the current one because we believe it missed data from many IRF teaching institutions since the PM&R residents were identified as residents of a parent institution and not the IRF. Since 2000, the AAPM&R and the AAP have been of the opinion that IRF teaching hospitals and units bore higher costs per case than other IRFs. This belief is based largely on anecdotal information and our professional opinion that more costly cases are seen in the teaching hospitals and units than in other IRFs. It is also based on the opinion that the IRFs are very similar to acute care facilities and therefore IRF teaching programs merit comparable treatment to the acute teaching hospital. Along with their rehabilitation needs, patients in IRFs have complicated medical conditions similar to conditions seen in acute hospitals, especially since the enactment of the Diagnosis Related Group (DRG) PPS in 1983. Rehabilitation units with residency training activities are part of acute hospitals and free standing facilities are generally part of a health care system that integrates acute care and rehabilitation. These relationships suggest the similarity of the level of care and complexity of cases treated in the two settings. It is reasonable to assume therefore that the costs per case of teaching IRFs would be greater than those of non teaching IRFs as teaching hospitals in the acute system have greater costs per case than non teaching hospitals on average.

The difference in the data of 1999 and 2003 may also have resulted from the impact of IRF-PPS on case mix with more costly cases being sent to teaching facilities since the inception of the IRF PPS. The AAPM&R and the AAP do not think the current data are "volatile" as CMS worries. Instead, we believe the 2003 data are much more likely to be accurate than the earlier data.

A Reservation on the Provisions Implementing the Adjustment

The provisions implementing the IRF teaching status adjustment generally follow the provisions of the DRG PPS for Indirect Medical Education adjustments in both the formula for determining the amount of the adjustment and the terms applicable to qualifying teaching programs. These terms are similar to those applicable to DRG PPS

teaching hospitals and include caps on numbers of residents which may be counted for purposes of the IRF PPS adjustment. In one area, however, the two differ and there seems to be no rationale for the difference. IRF teaching programs would not be able to use affiliation agreements with related institutions in which training is carried out to establish their residency count for purposes of the payment formula. The DRG PPS teaching hospitals may use such affiliation agreements for their count. Affiliation agreements permit teaching programs to expand the settings in which residents are trained in order to have training reflect current practices in medical care. Agreements could be entered into with outpatient clinics, pain centers, SNFs or other hospitals. To not allow aggregation of residents to include those trained in affiliated organizations would discourage that training. Such agreements are used in other settings and the AAPM&R and the AAP believe they should be permitted in the IRF teaching setting. It would seem that the caps on base year residents would serve to limit the economic exposure of the Medicare program to satisfy the worry relative to over expanding programs. The AAPM&R and the AAP therefore recommend that IRF teaching programs be permitted to use affiliation agreements in the count of residents for purposes of the IRF PPS teaching adjustment.

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We appreciate the opportunity to review and comment on the proposed regulation and ask that you contact Suzanne Butler at the AAPM&R at 312-464-9700 if you have any questions.

Sincerely,



Bruce M. Gans, MD
President



Robert Rondinelli, MD, PhD
President



American Academy of
Physical Medicine and Rehabilitation



July 18, 2005

Mark McClellan, MD, PhD
Administrator
The Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1290-P
P.O. Box 8010
Baltimore, MD 21244-8010

Dear Administrator McClellan:

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We appreciate the opportunity to review and comment on the proposed regulation and ask that you contact Suzanne Butler at the AAPM&R at 312-464-9700 if you have any questions.

Sincerely,



Bruce M. Gans, MD
President



Robert Rondinelli, MD, PhD
President

Submitter : Mr. James T. Kirkpatrick
Organization : Massachusetts Hospital Association
Category : Health Care Professional or Association

Date: 07/18/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1290-P-54-Attach-1.DOC

July 18, 2005

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1290-P
PO Box 8010
Baltimore, MD 21244-8010

Re: CMS-1290-P, Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for FY 2006; Proposed Rule

Dear Dr. McClellan:

The Massachusetts Hospital Association welcomes the opportunity to comment on the proposed rule related to the Federal Fiscal Year (FFY) 2006 Prospective Payment System (PPS) for Inpatient Rehabilitation Facilities (IRF).

Proposed FY 2006 Federal Prospective Payment Rates - Reduction to the Standard Payment Rate

MHA is strongly opposed to the proposal to reduce the standard payment amount by 1.9% to eliminate what the agency feels is the effect of coding changes that do not reflect real changes in case mix. This adjustment is based on an analysis of calendar year 2002 data which indicated that payments had increased because of changes in the classification of patients in IRFs. The analysis, conducted by the RAND Corporation, attempted to quantify the amount of the case mix change that was due to real changes in patient characteristics and the amount that was due solely to changes in coding practices.

RAND compared the 1999 data (currently used to construct the IRF PPS weights) with 2002 data (the first year of implementation for the PPS). RAND determined that the case mix for IRFs increased by 3.4% from 1999 to 2002. As CMS notes, 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.*

The implementation of any new prospective payment system, such as the IRF PPS, and ongoing changes to the admission criteria under federal regulations will result in provider behavior changes that are reflected in changes in patient characteristics as measured by the case mix. According to CMS, the IRF PPS may have provided incentives for IRFs to admit patients with greater impairments, lower function, or more comorbidities. Case mix changes due to these factors should be counted as "real changes" and are appropriately reflected in increased payments. CMS should not implement an adjustment for coding improvements that might inappropriately reduce payments without a more complete analysis that will definitively differentiate between coding changes and real patient changes.

Simultaneous with the proposed 1.9% reduction to the rate, CMS is proposing revisions to the case mix groups (CMGs) based on an analysis of data from 2002 and 2003. The proposed revisions include redefinitions of comorbidities to exclude some diagnosis codes that CMS believes are not related to increased costs and reassignment of other codes to provide lower payments that more accurately reflect observed costs. We address the proposed CMG changes elsewhere in this letter. However, the proposed 1.9% reduction for coding changes must be considered in relation to the CMG revisions. The CMG revisions would reduce payments for cases with reported comorbidities that the CMS analysis determined

to be overpaid compared to actual costs. CMS justifies 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)”. The proposed revision of the CMGs combined with the 1.9% reduction to the standard rate would adjust twice for the same coding changes. We believe that the proposed CMG revisions based on specific codes that were identified as problems by a systematic analysis are more equitable than an across-the-board 1.9% rate reduction that is based on circumstantial evidence.

Further, the attempt to differentiate between coding changes and real patient changes is complicated by ongoing changes in IRF admission practices under changes incorporated in the final IRF designation criteria and the Fiscal Intermediary’s Local Coverage Decision (LCD) policies that result from facility attempts to comply with the “75% rule”. CMS does reference the 75% rule regarding the 1.9% reduction to the standard payment rate. CMS states that “. . . we chose the amount of the proposed reduction in the standard payment amount in order to recognize that IRFs current cost structures may be changing as they strive to comply with other recent Medicare policy changes, such as the criteria for IRF classification commonly known as the ‘75 percent rule.’” We appreciate that CMS acknowledges the need to consider this factor when determining the amount of the coding reduction. However, given the significant changes in IRF patient admission patterns that will result from the implementation of the 75% rule, CMS should not make an adjustment for coding changes at this time.

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 does not reflect current IRF admission practices.

Proposed Refinements to the Patient Classification System

The current CMGs and comorbidity tiers are based on data from 1998 and 1999. CMS proposes refinements to the patient classification system based on an analysis of data from 2002 and 2003. CMS indicates that this refinement significantly improves the alignment between Medicare Payments and actual IRF costs.

MHA supports the updates and refinements proposed by CMS. The data from 1998 and 1999 does not accurately reflect the characteristics of patients treated in IRFs. Data from 2002 and 2003 are from periods subsequent to the implementation of the IRF-PPS and will provide for more accurate classification of patients.

As stated in the section of our comments regarding the 1.9% reduction to the standard rate, we believe that the proposed refinements to the CMGs and comorbidity tiers provide a reasonable and equitable adjustment for changes in coding practices. We urge CMS to adjust for coding changes through systematic refinements to the patient classification system and eliminate the 1.9% across-the-board reduction from the final rule.

As we have stated above, IRFs are making several ongoing changes to their operations and admission practices in order to be compliant with the CMS 75% rule requirements. In addition, providers are required to ensure that their compliance with the 75% rule also mirrors coverage determination by the FI through their LCD policies. Unfortunately, these LCD policies do not

mirror the changes or requirements contained in the CMS criteria. For those states that have multiple FIs operating in the state are seriously disadvantaged by having different LCD policies. Having conflicting policies among your contractors results in Medicare patients being treated differently.

Therefore, MHA urges CMS to ensure that any changes to the patient classification system must be addressed in each FI's LCD policy, and to further ensure that there is an attempt to consolidate or conform the LCD policies for multiple Fiscal Intermediaries that are operating in the same state subject to any such changes in the classification system.

Proposed Revisions of the IRF PPS Geographic Classification

MHA is strongly opposed to any changes in the IRF PPS labor market areas without a transition for hospitals that are harmed by the changes from the current Metropolitan Statistical Areas (MSAs) to the inpatient PPS called Core-based Statistical Areas (CBSAs). CMS provided a one-year transition for IPPS hospitals that were harmed by the redefinition of the wage index areas, allowing these hospitals experiencing a wage index decrease to receive a blend of 50% of the wage index based on the new definitions and 50% based on the old boundaries. Given that these hospitals are required to compete in the same market area for existing labor resources, CMS must provide the same relief for IRF hospitals as it does for IPPS hospitals. Without this transition, IRFs will be given a significant disadvantage in their budget process with this proposal without notice or a hold harmless exception like the transition.

The redefinition of wage areas will have significant impacts on IRFs that are similar to the impacts on inpatient PPS hospitals. We urge CMS to provide the same transition for hospitals that are harmed by the full CBSA transition as was applied to the inpatient PPS.

Low-Income Patient Adjustment

IRFs receive an adjustment to the Federal prospective payment rate to account for differences in costs associated with the treatment of low-income patients. Based on the RAND analysis of 2003 data, CMS is proposing to update the formula used to calculate the LIP and thereby increase these payments.

MHA supports this proposal which will provide more accurate and equitable payment to IRFs that serve low-income patients.

Proposed Teaching Status Adjustment

In the past, CMS has considered, but has not adopted an adjustment for IRFs to account for the higher indirect operating costs experienced by facilities that participate in Graduate Medical Education programs. A RAND analysis of 2003 data found that the indirect teaching cost variable is significant in explaining the higher costs of IRFs that have teaching programs. Therefore, CMS is proposing to establish a facility level teaching adjustment for IRFs.

MHA supports implementation of an IRF teaching adjustment. This adjustment would increase payment equity by compensating for the higher costs experienced by facilities with teaching programs. Both the inpatient PPS and the inpatient psychiatric PPS recognize the need for such an adjustment and the inpatient rehabilitation PPS should be consistent with these systems.

While the proposal includes a teaching adjustment, CMS expresses several concerns and is soliciting comments on the proposed IRF teaching adjustment. CMS is concerned that the results of the RAND analysis based on 2003 data contradicts the prior analysis of the 1999 data used to construct the initial IRF PPS, which found no significant relationship between teaching and increased costs. As we state in our comment supporting the CMS proposal to refine the patient classification system, data from 2003 represents a period subsequent to the implementation of the IRF-PPS and provides for more accurate analysis of IRF costs under the PPS.

CMS further suggests that the results of the RAND analysis might reflect an aberration based on only a single year's data and suggests that analysis of future data from 2004 or later might provide a more accurate result. CMS should not postpone or delay the implementation of a teaching adjustment in hopes of receiving later data that will provide more accurate results. A decision to postpone implementation is in effect a decision to continue to use results based on 1999 data rather than use results based on 2003 data. In the proposed rule, CMS clearly indicates the limitations and data problems that are associated with the 1999 data. That is the reason that CMS has proposed several of the major policy changes that are contained in this rule.

Moreover, the proposed increase in the low-income patient adjustment is based on the same data and analysis as was used for the proposed teaching adjustment. MHA supports both of these proposed adjustments which will increase payment equity and more accurately reflect the costs incurred by IRFs. We do not believe that CMS should selectively apply the results of the RAND analysis in some instances but reject the results in others.

We urge CMS to implement the proposed teaching adjustment in FFY 2006 along with the increases in the low-income patient adjustment and the rural location adjustment.

Proposed Update to the Outlier Threshold Amount

CMS has established an IRF PPS outlier policy for cases that require more costly care. The methodology is designed to result in outlier payments that are 3% of total IRF payments. CMS proposes to decrease the outlier threshold from \$11,211 in FFY 2005 to \$4,911 in FFY 2006, thereby increasing the number of cases that will qualify for outlier payments. CMS estimates that this change is required to maintain outlier payments at 3% of total IRF PPS payments.

MHA supports the proposed revision to the outlier threshold that will ensure that IRFs receive compensation for the treatment of high cost patients.

Please contact me at (781) 272 8000 ext. 173 or jkirkpatrick@mhalink.org if you have any questions.

Sincerely,



James T. Kirkpatrick
Vice President, Health Care Finance and Managed Care

Submitter : Ms. Susan Johnson
Organization : Iowa Methodist Medical Center
Category : Hospital

Date: 07/18/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attached

CMS-1290-P-55-Attach-1.DOC

July 21, 2005

The Honorable Dr. Mark McClellan
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention CMS -1290-P P.O. Box 8016
Baltimore, MD 21244-8010

Ref: CMS 1290-P Medicare Program: Inpatient Rehabilitation Facility Prospective Payment System for FY 2006: Proposed Rule (69 *Federal Register* 30188).

Dear Dr. McClellan,

I am writing to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule for the FY 2006 Inpatient Rehab Facility (IRF) prospective payment system (PPS) published in the May 25, 2005 *Federal Register*. I represent Iowa Methodist Medical Center in Des Moines, Iowa which has a 54 bed acute rehab unit.

Although the system calls for a market basket update of 3.1 percent, this rule proposes many adjustments that will result in a **reduction of 2.3 percent** from the FY 2005 standard payment rate. My comments are as follows:

Proposed Reduction of the Standard Payment Amount to Account for Coding Changes
CMS is proposing to make a 1.9 percent reduction to the base rate to compensate for the increase they are seeing in the case mix. We strongly disagree with the logic of reducing payments as a result of more accurate coding that better matches reimbursement with costs of providing care. Until implementation of the IRF PPS there was very little education provided to IRFs and medical review of IRF claims was minimal. Only recently have Medicare contractors begun reviewing IRF medical records and providing education on proper documentation and coding.

An across-the-board reduction penalizes all acute rehab providers without providing an opportunity for provider education. We recommend that CMS establish review and education guidelines to be used by intermediaries in working with IRFs. This process would also benefit the transition to enforcement of the 75% rule. If the intermediaries were given standard guidelines for reviewing IRF medical documentation and educating provider staff, providers would have a better understanding of CMS expectations and would be more compliant in documenting, coding, and billing for IRF services.

We also disagree with CMS' theory that IRFs have an incentive to admit more costly cases due to the fact that payment is tied to diagnosis codes, and the more medically complex a patient is, the higher reimbursement the IRF will receive. A case-mix classification system is designed to tie payment to the complexity of the patient. Please consider the following arguments that support our contention that IRFs are not upcoding or intentionally admitting only the more complex patients:

- By enforcing the "75 percent rule", many of the less costly and less complex patients are not in one of the categories that would qualify to meet the 75 percent rule

requirements. As IRF providers focus on working toward achievement of the 75 percent rule, it is logical that the average acuity level of their patients will increase.

- Implementation of the transfer provision discourages early transfer of more complex cases to IRFs.
- Finally, CMS has not considered changes in the delivery of inpatient rehabilitation care as evidenced by its refusal to redefine the conditions included in the 75 percent rule policy. Medicare patients are living longer today than was expected in 1983, and are surviving longer with conditions that were generally considered fatal in earlier years. Very minor changes have been made to this policy recently, and those changes do not adequately recognize the spectrum of patients that can benefit from care in an IRF.

I would like to take this opportunity to comment that CMS is over-stepping its authority by applying the 75 percent rule to the entire patient volume of IRFs. CMS uses data from Medicare beneficiaries that have received care in an IRF to make a presumption that the entire IRF patient population meets the 75 percent criteria. Employers, private health plans, and finally, patients, have the right to choose what they will and will not pay for. CMS should not be setting policy for non-Medicare services.

Proposed Changes to Move Dialysis to Tier One

We are supportive of the proposal to move dialysis to comorbidity tier one to better recognize the resources necessary to provide care and rehabilitation to these frail patients.

Labor-Related Share

We disagree with the proposal to increase the labor-related share for IRF payments. While it is likely true that IRFs have slightly higher labor-related costs than acute inpatient hospitals, the labor share is already high at 72.359 percent.

Because our wage index is below 1.0, this increased labor-related share will result in an additional payment reduction for a unit that has a very high Medicare utilization. This proposal will unfairly shift IRF reimbursement to areas with higher wage indices.

Until CMS develops an IRF-specific wage index, no changes should be made to the labor-related share based on data from a different type of provider. We recommend that CMS withdraw this proposal and wait until more research is completed and use IRF-specific data to determine whether it is necessary, or appropriate to increase the labor-related share.

Wage Index

We encourage CMS to begin developing instructions for the collection of IRF data in conjunction with the provider community. Implementing an IRF-specific wage index would allow CMS to establish geographic reclassification criteria for IRFs and would better recognize the employment mix among labor markets. An IRF wage index would also more appropriately distribute Medicare payments nationwide.

It is unclear why CMS is proposing to use the hospital wage index from a year other than the most recent year for which wage index data is available. All other payment systems apply the most current hospital wage index and we believe that CMS should apply the 2006 hospital wage index to adjust the labor-related share of the IRF base rate.

Low-Income Patient Adjustment

We support the proposal to increase the low-income patient adjustment from 4.7 percent to 6.2 percent. IRF stays can be costly to already financially strapped Medicare beneficiaries and this proposal will help offset some of the uncompensated care IRFs provide.

Teaching Status Adjustment

In general, we support a teaching status adjustment as it is more costly to care for patients in a teaching environment. We do not support a limit that basically prevents us from making any program changes in the way interns and residents are rotated. The redistribution of resident FTEs should alleviate many hospitals concerns related to the resident caps, and thus remove any incentives to shift resident FTEs into acute rehab units. It is unlikely that hospitals would shift residents into acute rehab units for this reason due to program required rotations. However, if a specific resident has an interest in Rehab Medicine, it would be beneficial if hospitals could appropriately allocate that resident's time to the IRF.

Quality of Care in IRFs

As CMS expands its efforts to reward high quality care in the IRF setting, we urge the agency to take this opportunity to include measuring the quality of care provided to Medicare beneficiaries that do not fall into one of the 13 specified categories for purposes of the 75 percent rule criteria. The agency also wishes to move toward a performance measurement model that coordinates an approach to payment for post-acute services that reaches across settings and focuses on quality of care for the overall post-acute episode, regardless of provider type. This model would require CMS to transition from provider-specific payment approaches to patient-centric approaches based on patient characteristics and outcomes. This concept provides another opportunity to revisit the 75 percent rule when reviewing the entire post-acute care episode.

For the Medicare program to become a purchaser of value, it must focus on improving the health outcomes for program beneficiaries and more effectively manage the disperse resources that Congress provides. Any design of paying for the post-acute care episode based on patient characteristics and outcomes must embrace the following principles:

Payment incentives should:

- Reward providers for improving quality and providing effective care.
- Evaluate the consumption of resources in achieving desired health outcomes, as this is necessarily required in measuring effective care.
- Use a system of rewards that increases payments and reduces regulatory burdens for successful providers.
- Be aligned between institutional providers and physicians.

Performance measures should be:

- Based on measures of adherence to quality improving processes.
- Selected to insure that all IRFs have an opportunity to participate and succeed.
- Selected to minimize the data collection burden for providers.

Thank you for your review and consideration of these comments. If you have questions, please contact me 515-241-6290.

Sincerely,

Susan Johnson

Reimbursement Manager

cc: Brenda Long
Dr. Robert Rondinelli
Iowa Hospital Association