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July 11, 2005

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Mark B. McClellan, M.D., Ph.D.
Administrator
CMS
CENT Bldg, Room C5-25-25
Mail Stop C5-11-24
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: 42 CFR Part 412; [CMS-1290-P] RIN 0938-AN43: Medicare Program: Inpatient Rehabilitation Facility Prospective Payment System for FY 2006

Dear Dr. McClellan:

Before proceeding with the heart of this letter, I would like to provide you with an Executive Summary that highlights our concerns and recommendations:

Executive Summary:

Concerns:

1. The 75% Rule still needs to be revised. As proposed, the current rule will:
   a. Catastrophically reduce inpatient rehabilitation facilities (IRFs).
   b. Arbitrarily exclude rehabilitation impairment categories (RICs).
   c. Create major "access to care" issues for patients.
2. The data used to calibrate proposed changes (2002 and FY 2003) does not reflect full enforcement of 75% Rule.
3. The proposed CMG classification system is problematic on a number of levels.
   a. System eliminates comparability over time.
   b. Weighted motor score index is complex (not transparent) and not sensitive to differences between RICs.
   c. Recoding of 0 to 2 (transfer to toilet) artificially elevates motor score, reduces payment, and is potentially biased against the severely impaired (e.g., spinal cord injury).
   d. System will be difficult and burdensome on IRFs to understand and to implement.
4. Quality of care will suffer.
5. The implementation of the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF PAI) in January 2002 induced distorting effects on FIM™ instrument ratings.

Recommendations:

1. CMS defers enforcement of the 75% Rule and should review and study the parameters that define an IRF.
   a. Include medical diagnosis, patient severity (admission FIM™ rating), and potential for improvement which can be predicted by the admission CMG.
2. CMS does not implement the proposed CMG classification system; furthermore, CMS does not even attempt to recalibrate it until the 75% Rule can be studied, altered, and implemented for a sufficient time period. This includes the new cut points, weighted motor index score, and recoding.
3. CMS works with UDSMR and other industry participants to capitalize on the valid, reliable, and predictive capabilities of the IRF PAI (FIM™ instrument) system in order to refine the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) so that it meets the needs of all stakeholders.
4. UDSMR demonstrates to CMS how these same efforts will benefit the IRF PPS and how they can be successfully applied to all of post-acute care functional assessment.
5. UDSMR demonstrates to CMS the distorting effects on the FIM™ instrument ratings that were induced when the IRF PAI was implemented in January 2002.

The Uniform Data System for Medical Rehabilitation (UDSMR) is a division of UB Foundation Activities, Inc., a not-for-profit corporation associated with the University at Buffalo, The State University of New York. For the past 18 years, UDSMR has provided rehabilitation facilities with outcomes reports and national benchmarks. Our intent has always been to contribute to the industry's ability to monitor and improve quality through measurement of functional status and outcomes of individuals and programs. Annually, more than 800 IRFs use our outcomes reporting services. Our database represents approximately 60-70 percent of the IRFs in the nation, and we currently house more than 1.6 million patient records (both Medicare and private insurance) that reflect rehabilitation outcomes information. As such, UDSMR is the world's largest government-independent repository of rehabilitation outcomes and IRF PAI data. Because of our longstanding leadership position in the industry, we are recognized as objective evaluators of the data that is used to measure the outcomes and quality of inpatient rehabilitation. Accordingly, industry associations, research groups, and others regularly call upon us to provide unbiased, factual information about trends and outcomes information in the United States. This information has been used to help develop policy on issues such as the 75% Rule.

UDSMR also created and developed the FIM™ instrument. From 1987 through 2001, use of this tool was voluntary. Several years ago, we entered into an agreement with CMS to provide the tool royalty-free to the agency, and it has since become the centerpiece of Medicare's IRF PPS. The agreement contained some risk for UDSMR as it related to our not-for-profit business. Thanks to our strong, ongoing working relationship with CMS, however, this decision has been mutually beneficial to all parties involved: CMS, UDSMR, and the field. To this day, the FIM™ instrument continues to be the industry standard assessment and reporting tool.

Finally, UDSMR staff members are the national experts in providing accurate rating information and training related to the IRF PAI and the FIM™ instrument. For the past 3 years, we have staffed the CMS-funded IRF PAI Help Desk. During this time, we have worked with CMS, answering questions and streamlining the process to ensure that IRFs receive accurate information so that they can file accurate reports and receive accurate payments in a timelier manner. This arrangement, too, has worked to the benefit of both CMS and the industry.

We are writing now to comment on the May 25, 2005, publication of the proposed rule regarding the Prospective Payment System for FY 2006. Given that UDSMR houses this large inpatient rehabilitation database and that our staff members are the clinical experts, we believe that the government will be interested in our assessment of the potential impact this proposed rule may have on IRFs and the patients they serve. We have recently applied the proposed changes from the May 25, 2005, proposed rule to our national outcomes database and have performed some global analyses of this data. The remainder of this letter presents the results of these analyses. We hope that this information will be instructive to the government and to the rehabilitation industry. Our comments are organized by section as identified in the proposed rule.

Background:

The proposed changes in 42 CFR Part 412 are significant and complex. They are based on analysis by the RAND Corporation using calendar year 2002 and FY 2003 data generated by the IRFs since the implementation of the IRF PPS. We recognize that CMS is responsible for monitoring and refining the IRF PPS, but we have serious concerns about the proposed rule from a number of perspectives.

First, because the data used to calibrate the proposed changes (a) was taken from a time period in which the 75% Rule was not being enforced and (b) is not reflective of changing practice, the proposed modifications may not have the intended effect. Alterations to the case mix groups (CMGs), relative weights, and expected lengths of stay (ELOS) are likely to be impacted by the changing case mix from pre-enforcement to full enforcement of the 75% Rule. As an example of how case mix is changing, see table 1 (next page). This data, which represents Medicare cases from the UDSMR database, is drawn from the 3 quarters prior to the beginning of the enforcement period and the 3 quarters immediately after the start of the partial enforcement period (July 1, 2004).

Table 1: 75% Rule Impact.

Time Frame	2003 Q4, 2004 Q1, and 2004 Q2	2004 Q3, 2004 Q4, and 2005 Q1	
RIC	**Patient Count**	**Patient Count**	
01 – STR	35,228	35,064	-164
02 – TBI	3,304	3,717	413
03 – NTBI	4,853	5,306	453
04 – TSCI	1,086	1,144	58
05 – NTSCI	7,641	7,601	-40
06 – Neuro	9,679	10,996	1,317
07 – LE/FX	27,171	27,104	-67
08 – LE/Rep	52,947	47,937	-5,010
09 – Ortho	12,442	11,729	-713
10 – Amp/LE	5,500	5,400	-100
11 – Amp/NLE	555	387	-168
12 – Osteo	3,326	2,172	-1,154
13 – Rheum	2,240	1,558	-682
14 – Cardiac	13,098	10,643	-2,455
15 – Pulmonary	4,853	3,616	-1,237
16 – Pain	4,137	3,707	-430
17 – MMT-NBSCI	2,291	2,052	-239
18 – MMT-BSCI	549	550	1
19 – GB	318	292	-26
20 – Miscellaneous	28,511	24,317	-4,194
21 - Burns	155	120	-35
Total	219,884	205,412	

This analysis included 616 facilities. Each facility had at least one case every month from January 2002 through March 2005. In order to allow for new facilities, withdrawals, and data submission problems, we limited our analysis to these 616 facilities (out of 848 total).

As you can see, the patient count has been reduced significantly in RICs 08, 12, 14, 15, and 20 (Joint Replacements, Osteoarthritis, Cardiac, Pulmonary, and Miscellaneous, respectively). These changes and the 75% Rule are associated; unfortunately, the changes were not available in the data set used by the RAND Corporation in its analysis.

Second, the significant changes to the CMG classification system will not result in a one-for-one "crosswalk" from the current to the proposed CMGs (e.g., a case that is classified as CMG 0107 under the current rule will not necessarily be classified as CMG 0107 under the proposed rule). This lack of a crosswalk will render CMG-adjusted trend reporting suspect and will force IRFs to spend "non-patient care" resources to alter all of their CMG-based clinical, financial, and managerial tools. Many facilities have used the current CMGs to develop "clinical pathways" or "care plans" that help them manage resources and quality. These programs are often used for quality improvement purposes; however, these tools will require major revisions based on the changes put forth in the Proposed Rule.

Lastly, although we do not want to interfere with CMS's ability to achieve its goals, we feel that such sweeping changes to the patient classification system will severely limit the industry's ability to monitor the effectiveness of the IRF PPS over time. Year-over-year comparisons will prove difficult, if not impossible, should such drastic changes be implemented as proposed. We are not suggesting that the patient classification system be immune to change; rather, we suggest that a more measured approach be taken.

Proposed Refinements to the Patient Classification System:

As we stated earlier, the major changes to the CMG definitions will result in a number of negative implications. With respect to the details of the refinements to the patient classification system, we have identified three areas of concern.

First, distorting effects on the FIM™ instrument ratings were induced when modifications in the rating of IRF PAI items was mandated in January 2002 (e.g., recording the lowest item rating over a 3-day period rather than the customary 24-hour period, use of a zero-level rating for "not observed," and redefining bladder assessment).

Second, alterations to the cut points used to define the CMGs (and the methodology of using a weighted motor score index) make comparisons of similar cases between the current rule and this proposed rule extremely difficult. Sample scenario 1 (next page) demonstrates how a case with a motor score of 39-41, which is currently categorized as CMG 0107 with a non-tiered FPP of $16,910.19, could be classified in the CMG range of 0102 – 0109 with a non-tiered FPP ranging from $9,898.56 to $22,970.47. At first glance, a case with a motor score of 39-41 (CMG 0107) would appear capable of ending up in only one proposed CMG: 0104. However, one must take into account the item weighting used to arrive at a weighted motor score index. Many combinations of item ratings can result in a composite motor score of 39-41, and the sheer number of these combinations results in a potential placement into one of many CMGs. The impact of this complexity will be akin to taking a hiking trip without a compass: few facilities will arrive at the desired destination.

Sample Scenario 1: Current CMG to proposed CMG conversion (patient and FPP distribution).

		Proposed CMG	0101	0102	0103	0104	0105	0106	0107	0108	0109	0110	
		Description	MI > 51.05	MI > 44.45 MI < 51.05 C > 18.5	MI > 44.45 MI < 51.05 C < 18.5	MI > 38.85 MI < 44.45	MI > 34.25 MI < 38.85	MI > 30.05 MI < 34.25	MI > 26.15 MI < 30.05	MI < 26.15 A > 84.5	MI > 22.35 MI < 26.15 A < 84.5	MI < 22.35 A < 84.5	
Current CMG	Description	Non-Tiered FPP	$8,037.83	$9,898.56	$11,666.88	$12,394.71	$14,876.95	$17,316.14	$19,986.98	$23,105.91	$22,970.47	$27,450.14	
0107	M 39-41	$16,910.19	*0*	*5*	*1*	*502*	*2079*						Net Change
			$0.00	-$35,055.15	-$5,243.41	-$2,266,770.96	-$4,227,105.96						-$8,540,013.96

This table includes Medicare cases from the UDSMR database discharged between April 1, 2004, and March 31, 2005 (N = 4038). Numbers in italics show the distribution of current CMG 0107 cases and their distribution across the proposed CMGs. The dollar amounts directly below these numbers show the difference in payment for these cases based on non-tiered FPPs. The case counts shown are the current distribution of Medicare cases in the UDSMR database for the most recent 12-month period. For example, 2079 of our Medicare cases for this data set that are currently classified as 0107 would be reclassified as 0105 with a reduction in non-tiered FFP of $2,033.24

Legend: M = Motor score, MI = Weighted motor score index, C = Cognitive score, A = Age.

To further illustrate how minor differences in scoring very similar patients can result in different CMG assignments and payments, see sample scenario 2.

Sample Scenario 2: Patient weighted motor score index comparison.

Two similar stroke patients, age 84, have the following admission motor item scores.

Item	Patient 1	Patient 2
Eating	5	5
Grooming	1	1
Bathing	1	1
Dressing: Upper Body	1	1
Dressing: Lower Body	1	1
Toileting	3	3
Bladder	1	1
Bowel	7	7
Transfers: Bed, Chair, Wheelchair	2	2
Transfers: Toilet	0	2
Locomotion: Walk, Wheelchair	2	1
Locomotion: Stairs	1	1

Under the current system, Patient 1 has a motor rating of 26 (because the 0 is converted to a 1), and Patient 2 has a motor score of 26. Both would be assigned to CMG 0112 and paid a non-tiered FPP of $25,935.44.

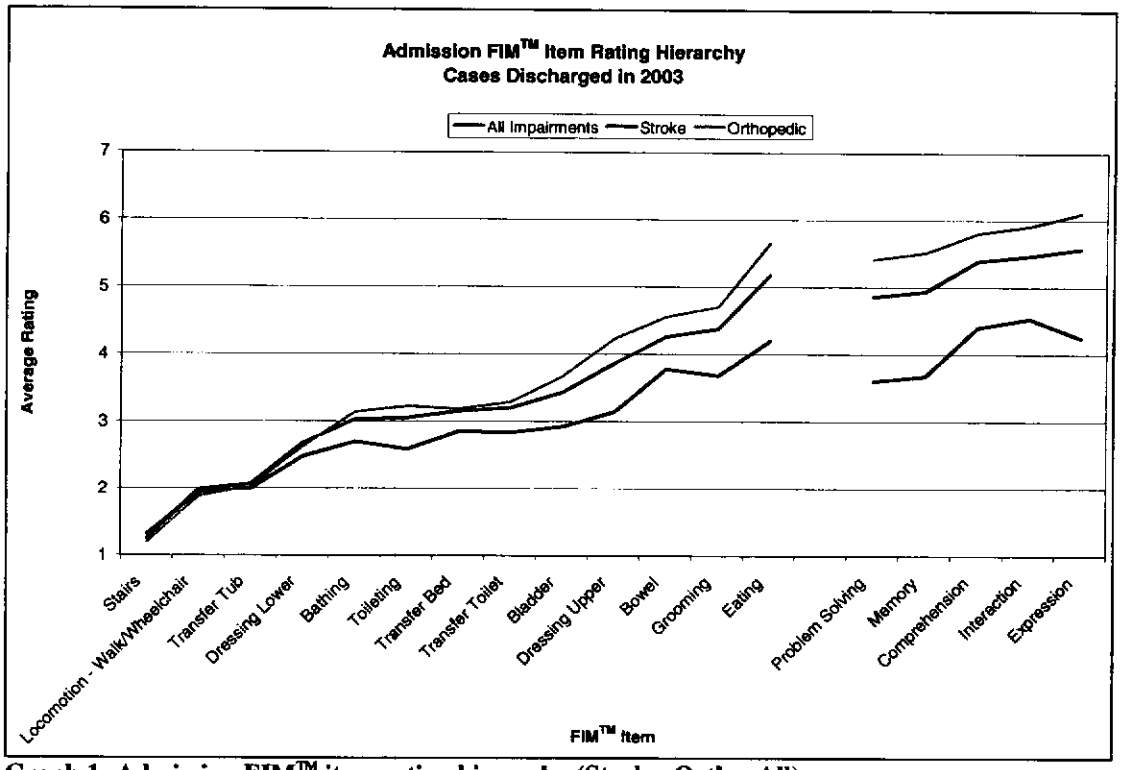
Under the Proposed Rule, Patient 1 has a weighted motor index of 23.2 (because the 0 is now coded as a 2), and Patient 2 has a weighted motor index score of 21.6. Patient 1 is assigned to Proposed CMG 0109 and is paid a non-tiered FPP of $22,970.47. Patient 2 is assigned to Proposed CMG 0110 and is paid a non-tiered FPP of $27,450.14.

Both patients originally had identical FIM™ motor ratings of 26 and required similar clinician assistance (minutes of care), yet one now is paid more, one is paid less. The entire difference is the result of two items – Transfers: Toilet and Locomotion: Walk, Wheelchair.

As this scenario clearly demonstrates, IRFs and industry stakeholders will have an impossible job trying to compare historical cases to similar cases under the new classification system. Thus, their efforts at maintaining quality improvement will be compromised.

Third, in addition to the change in cut points (defined by motor score, cognitive score, and age) that define the CMGs, the proposed rule includes a new methodology for calculating the motor score element of those cut points. CMS appears to be adding this new element, known as the "weighted motor score index," in order to more accurately ascribe costs at the item level. Although we understand the intent and the statistical approach used to determine this methodology, we recommend against its implementation for the following reasons:

1. The weighting system is overly complicated and difficult to implement because it lacks transparency. The IRFs are not equipped with the software and tools necessary to quickly and accurately calculate the weighted motor scores and subsequent CMGs. Forcing them to do so will create an undue burden on them.
2. The weighting formula was derived with all patients and RICs included, yet it will be applied only to the subset that survives the 75% Rule.
3. The items are weighted the same for all RICs even though the item "level-of-difficulty hierarchy" differs from RIC to RIC. Graph 1 (next page) compares admission FIM™ item ratings for stroke, orthopedic, and all cases for 2003 discharges.



Graph 1: Admission FIM™ item rating hierarchy (Stroke, Ortho, All).

4. The weightings may negatively impact a very reliable, objective, tested, and retested rating system.
5. Pre-admission screening and documentation tools used both to assess patient severity and appropriateness for rehab and to manage 75% Rule compliance by projecting the likely CMG will now be much more complicated.

Fourth, we disagree with the recommendation to recode the "Transfer to Toilet" item from 0 to 2. We believe that this change will artificially elevate patient motor scores, will reduce payments, and may be biased against severely impaired patients (e.g., spinal cord injury) who are incapable of transferring to a toilet upon admission to rehabilitation.

Throughout this comment letter, we have referred to the 75% Rule as a contributing or complicating factor in evaluating the impact of the proposed rule. At this point, we offer analysis and supporting data that will help make the case for a more measured approach to implementation of the proposed rule. Simply put, there are far too many changing parts to get a good handle on how the payment system is performing. **The measured approach we recommend is simple:**

1. Study and update the system for classifying an IRF (75% Rule), including clear guidelines for facilities, fiscal intermediaries, and industry stakeholders on how to achieve compliance. The guidelines:
   a. Should include a clear and finite list of conditions that match current IRF practices and patient demographics (prevalence of conditions).
   b. Should include a factor of patient severity (admission FIM™ rating).
   c. Should not create massive closures of facilities or "access to care" problems for patients.
2. Once the facility classification system is stable, update the patient classification system (CMGs), relative weights, expected lengths of stay, etc., in a way that allows CMS to meet its budgetary objectives.
3. Monitor and update the system annually to maintain budgetary objectives.

Table 2 (next page) comes from the April 2005 GAO report (GAO-05-366). Based on analysis of 2003 data, the GAO projects that a mere 6% of IRFs will meet the requirements of full implementation of the 75% Rule (75% threshold, no comorbidities).

Table 2: IRFs That Met Varying Threshold Levels for Medicare Patients Admitted with Any of 13 Conditions on List in Rule in Fiscal Year 2003

Compliance threshold	Percentage of IRFs that met threshold based on either primary condition or related comorbid conditions	Percentage of IRFs that met threshold based solely on primary condition
50 percent	85	39
60 percent	62	20
65 percent	50	14
75 percent	27	6

Source: GAO analysis of CMS IRF-PAI data.

Table 2: Percent of IRFs meeting 75% Rule thresholds.

Our analysis shows that, given current practice, only 9% of IRFs would meet the requirements of full implementation (75% threshold, no comorbidities). These figures do not even account for the impact of "medical necessity." We raise this point about the 75% Rule for two reasons. First, as we stated earlier, we are concerned that recommendations in the proposed rule have been calibrated on data collected prior to full enforcement of the 75% Rule. Consequently, the patient mix does not reflect the time period the proposed rule is intended to manage. Second, while the enforcement of the 75% Rule is being phased in and facilities are struggling to change practice to maintain compliance, we believe that the primary conditions included under the 75% Rule should be re-evaluated.

We do not believe that CMS intends to eliminate more than 90% of IRFs. Although we believe the facilities are making an effort to comply, a good number of them apparently will be unable to make it. We also believe that using the current 75% Rule as a way of defining IRFs, and excluding entire RICs (e.g., cardiac, pulmonary, etc.) in the process, is a hazardous approach. A better method should be developed to determine the appropriate level of care. The desired method should use patient severity (admission FIM™ rating) in conjunction with medical diagnosis, determination of care needs, and assessment of prognosis for functional improvement. This same approach could also incorporate the concept of "medical necessity" and eliminate any variation in application. Our research demonstrates how a patient's FIM™ rating closely correlates to the patient's expected minutes of care required for personal care tasks, and we will be happy to share this research with you.

In closing, we would like to remind the Secretary that CMS needs to be concerned with the impact of rulemaking not only from a financial standpoint, but also from a quality of care standpoint as well.

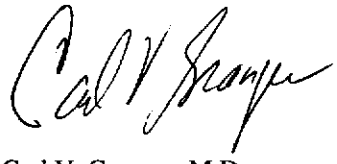
The inpatient rehabilitation industry has led the way for all of healthcare by voluntarily participating in a national benchmarking system with the intention of improving the quality of care. For more than 18 years, hundreds of IRFs from all over the country have been subscribing to our services and utilizing the FIM™ instrument, which has performed in a highly reliable and consistent manner. For example, average admission and discharge FIM™ ratings by RICs have been remarkably consistent even while (a) the onset time from acute hospital admission to IRF admission has been gradually decreasing (cost savings in transitioning); (b) the gain in FIM™ points per day in IRFs has been increasing, associated with reducing lengths of stay in IRFs (efficiency); and (c) a high rate of discharge to the community has been maintained. These trends are evidence that continuous quality improvement has been taking place.

<u>These favorable results are due to intensive concern for maintaining an easily understandable and uniform data system that has facilitated comparison by IRFs of the most relevant outcomes, both internally over time and externally against benchmarked regional and national data</u>. Changes induced by CMS at the initiation of the IRF PPS have already altered rating patterns of the FIM™ instrument at admission and discharge, which has problematized the interpretation of changes over time. To the extent that they affect the composition of the CMGs, the proposed changes in the rule now pose an even more serious threat. IRFs will be practically unable to develop rational methodologies for understanding and improving facility operations. We are concerned that a series of changes that lack accounting for all relevant factors could severely impact an excellent asset represented by the IRFs, resulting in an ineffectual and regressive situation.

Due to the number of variables associated with the current IRF PPS and the complexities in the proposed rule mentioned throughout this letter, we are still working on our financial analysis. We will submit our findings in a subsequent letter.

We would like to work with the Department (HHS), the Agency (CMS), and the IRFs to help refine the system to meet the needs of all involved, including the growing population of patients we all serve. We are grateful for the opportunity to provide these analyses to the Secretary on the proposed rule, and we welcome the opportunity to work with the government in order to provide unbiased research regarding the impact of federal regulation on IRFs. If you have questions about these comments or need further information, please contact us at (716) 817-7800.

Sincerely,



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

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

Leslie V. Norwalk, Esq.; CMS Deputy Administrator
Herb Kuhn; CMS Director
Tom Gustafson; CMS Deputy Director

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July 13, 2005

Department of Health & Human Services
Attention: CMS-1290-P
7500 Security Boulevard
Baltimore, MD, 21244-1850

To Whom It May Concern:

Please accept these written comments on the Center for Medicare and Medicaid Service's (CMS's) May 25, 2005 Notice of Proposed Final Rule, Refinements to Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) for FY 06: Proposed Changes to IRF PPS for FY 2006, Federal Register, Vol. 70, No 100, Pages 30188 - 30327.

California Rehabilitation Association (CRA), the Western Alliance for Rehabilitation (Alliance) and its members respect, understand and support the need to evaluate and refine the PPS system so that it continues to meet the needs of the patients, the providers and CMS. We are committed to working together and hope our comments are constructive. Thank you for the opportunity to submit input.

CRA currently represents 44 IRFs in California, and the Alliance represents over 65 IRFs in the Western United States. Collectively we serve over 21,000 acute inpatient rehabilitation admissions each year, of which approximately 65% are Medicare.

Please note these areas of concern and recommendation:

1. The change in proposed methodology for calculating a Functional Independence Measure (FIM) Motor score, using a system of weights for individual FIM items, is extremely complicated and places an undue burden on the providers without the necessary software support and documentation. This change will require an enormous retraining effort for staff to accurately calculate the weighted FIM Motor scores and will result in additional costs to the IRFs. The weighted FIM Motor scores have not been field tested to ensure the assigned weights reflect the expected resource use and differential item difficulty. The RAND Technical Expert Panel (TEP) recommended against using the weighted FIM Motor scores because it had not be thoroughly tested and was not feasible to implement.

We adamantly oppose this change and request you omit the weighted FIM Motor Score requirement, as recommended by the TEP.

2. The change in scoring of Toilet Transfers, recording a "2" for patients who are not tested or not observed, will discriminate against the more severely impaired spinal cord injury, amputation or neurological patients who are not capable of executing a Toilet Transfer without total assistance upon admission to the IRF. Subsequently the FIM Motor scores

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would increase, and providers may be compensated less for these severely impaired patients, while their costs are potentially higher. This will result in restricted access and reduced resources available for these more severely impaired patients.

We strongly oppose this change. Providers would not take the risk to perform this test on severely impaired patients, due to patient safety. We ask that scoring for Toilet Transfers, for patients who are not tested or observed, be reinstated as a score of "1."

3. There are major changes in Case Mix Groups (CMGs), definitions, relative weights and target length of stay (LOS). It appears that relative weights for stroke and traumatic brain injury have decreased more than other impairment groups, thereby further restricting access. Target (geometric mean) length of stay averages have dropped by as much as 33% in one year, forcing them to discharge patients into community settings much earlier than may be safe or medically appropriate. It is difficult to determine the potential impact; however, if re-weighted CMGs and shorter lengths of stays result in lower payment for conditions which do not adequately cover the cost of care, this may further restrict access to IRFs.

   In addition, the data used (FY 02 and 03) by CMS to calibrate proposed changes is not reflective of current practice with full enforcement of the 75% Rule.

We recommend that major changes, such as these, are phased in over a period of time, assuring access to critically needed care and safe discharges to the community.

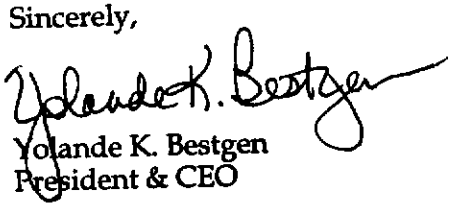
4. The proposed lower outlier threshold, ($4,911) will result in more cases potentially qualifying for outlier payments. The increased percentage of outlier cases and payments may unfairly and non-uniformly prompt increased probe audits from the fiscal intermediaries (FIs).

We recommend that CMS notify FIs to modify their probe and target audit screens to accommodate a higher percentage of outliers.

In closing, we want to reiterate that changing a majority of the factors in the IRF PPS system for FY06, all at the same time, may create uncertainty and potential damaging effects on the rehabilitation industry, further restricting access, which is already at risk. Please consider phasing in these changes over time, in order to allow the industry and CMS to assess the impact of these changes on access to rehabilitation services.

We thank you for considering our comments. If you have any questions, please contact Jeannie Grigg, Vice President of Corporate Services at 916.441.5844.

Sincerely,



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5

JUL 18 2005

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July 13, 2005

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

RE: MEDICARE PROGRAM; INPATIENT REHABILITATION FACILITY PROSPECTIVE PAYMENT SYSTEM FOR FY 2006, Federal Register, Vol. 70, No. 100, Wednesday, May 25, 2005.

Dear Dr. McClellan:

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

Abbott Northwestern Hospital, our largest hospital, located in Minneapolis, MN is recognized as one of the best hospitals in the country, as attested by U.S. News and World Report Best Hospitals in America. The Sister Kenny Rehabilitation Institute (SKRI) is a center of excellence at Abbott Northwestern. Sister Elizabeth Kenny established SKRI in 1942 in response to the polio epidemic. Her pioneering principles of muscle rehabilitation became the foundation of modern physical therapy. SKRI has 55 inpatient beds (at two sites) where acute, inpatient rehabilitation services are provided.

Thank you for this comprehensive rule. Your efforts to support providers and beneficiaries with this payment structure are recognized. We have reviewed and analyzed the impact of the proposed rule. First of all we commend CMS for its commitment to align payments to IRF's as closely as possible with the actual costs of treating patient. Our specific feedback on the proposed changes are noted below.

Proposed Refinements to the Patient Classification System

We support the proposed change that would move dialysis to a Tier One designation in recognition of its clearly higher costs.

However, we are concerned about the proposed changes to the CMGs and relative weights. CMS contracted with RAND to look at data from 2002 and 2003. As a result of their analysis, CMS is proposing the use of the weighted motor score index that increases the explanation of variance within each RIC by 9.5 percent, on average. You are also proposing to eliminate the use of the tub transfer score in determination of a patient's CMG.

Our concern with these proposed changes is that not enough review has been given by experts who have developed and researched the Functional Independence Measurement (FIM) items, of which the motor items are a part. The Proposed Rule mentions that a Technical Expert Panel (TEP) was convened to look at these proposed changes. Given the breadth of the proposed changes to determine the CMGs, and in the absence of any knowledge of who specifically made up the TEP and what specific input they gave, it is our advice that changes to the CMGs should be deferred until both more data can be included (such as use of 2004 data) and an open forum of recognized experts in the field of FIM can be convened to discuss and debate the proposed changes, especially when such changes result in inconsistencies.

If tub transfer scores, for example, offer no predictive value in determination of patient costs, then it would be logical that this item should be removed from the Inpatient Rehabilitation Facility – Patient Assessment Instrument (IFR-PAI) as an unnecessary expense to document and collect. This inconsistency should be resolved before any changes are implemented.

Another inconsistency can be found in Table 6 – Proposed Relative Weights for Case-Mix Groups (CMGs), p. 30213. The proposed relative weights have been changed to adjust payment based on RAND's analysis. The general schema is that Tier None has no relevant co-morbidities that should increase cost, and thus the relative weight within that CMG is the lowest. Tier 1 has the highest relative weight to compensate for the most expensive co-morbidities associated with it; Tier 2 less than Tier 1, and Tier 3 less than Tier 2. However, the accompanying Average Length of Stay for the Tiers does not follow this logical progression. For example, CMG 0103, the Length of Stay (LOS) given for Tier 2 is 20 days, whereas for Tier 1 it is 13 days. With LOS used as a proxy for costs, this is clearly an inconsistency – Tier 1, with the highest costs associated with it, should have the highest LOS. A quick look through Table 6 Average Length of Stay reveals a number of such inconsistencies, including where Tier None has a higher average LOS than Tier 1 (for example, CMG 0109).

It may be that there is a rational explanation for these inconsistencies, but none has been given. This leads one to wonder if the Proposed Relative Weights are not based as soundly on the data as they should be. Before this proposed rule is adopted, this apparent conceptual discrepancy should be explained and resolved.

Negative Financial Impact of the changes to the CMGs and the Proposed Relative Weights

According to the Proposed Rule, "the purpose of the CMG and tier changes is to ensure that the existing resources already in the IRF PPS are distributed better among IRFs according to relative costliness of the types of patients they treat." (Page 30219) CMS further states that it is attempting to ensure that the total estimated aggregate payments to IRFs do not change.

This is an empirical question that should be resolved in advance of implementation. Sister Kenny, cannot, of course, determine how the Proposed Rule will impact other IRFs in order to measure the aggregate effect. However, we have looked at our Medicare patients discharged to the community from one of our sites between January 2004 and March 2005, to determine the impact of the proposed changes in CMGs and relative weights. The impact is overall negative, with a net decrease in payments by 2.54% (using the proposed standard payment conversion factor, with proposed facility adjustments). Aside from this, the resulting decrease in payments is troubling because it is not uniform among RICs, nor it is uniform among CMGs within RICs. For example, payments would increase to current CMGs 0102 and 0113, but would decrease to almost all the other Stroke CMGs. Our non-traumatic spinal cord CMGs would have the greatest decrease in payments, followed by non-traumatic brain injury CMGs (except for 0301). For traumatic brain injury CMGs, 0203 payments would decrease and others would stay almost the same. Surprisingly, payments for most replacement of lower extremity CMGs would increase.

Because of the lack of uniformity in how payments would be impacted at just one IRF, we advise CMS to defer implementation of this Proposed Rule until the full impact on all IRFs can be further analyzed in light of more data. The resulting change in payments may be more than just a better redistribution among IRFs. Instead, patients' access to needed inpatient rehabilitation may be adversely impacted simply due to the CMG they may fall into (not even considering the 75% Rule). The concern is that the net changes in payments among the CMGs do not reflect a closer approximation of costs within and among RICs, and will instead drive what patients are admitted to IRFs in spite of their rehabilitation needs.

Proposed FY 2006 Federal Prospective Payment Rates

Allina strongly supports CMS's proposal to update the low-income patient (LIP) adjustment to account for differences in costs among IRFs associated with differences in the proportion of low-income patients they treat. We agree that this reflects variations in necessary costs of treatment among rehabilitation facilities. The update to this factor will more accurately reflect the cost of providing services to an increased percentage of low-income patients.

Additionally, Allina supports the adoption of the new CBSA-based labor market area definitions with the 2006 IRF PPS rule, without a transition period. Moving all facilities immediately to the CBSA-based labor markets will be administratively simpler than having a transition period for some or all facilities. We thank CMS for the analysis of various implementation approaches to provide the smoothest transition from MSAs to CBSAs, and agree with the implementation approach detailed in the proposed rule.

Provisions of the Proposed Regulations

There are a few revisions to the regulations we request CMS review to remove potential discrepancies and to ensure consistency within the regulations. These updates are listed below.

§412.25
In the update to the IPF PPS final rule, a reference to rehabilitation units was removed from §412.25(a), and was not replaced elsewhere in §412.25.

- 42 CFR 412.25(a), revision 2004:
  "Basis for exclusion. In order to be excluded from the prospective payment systems specified in §412.1(a)(1), a psychiatric or rehabilitation unit must meet the following requirements"
- 42 CFR 412.25(a), as modified in 69 FR 66976:
  "Basis for exclusion. In order to be excluded from the prospective payment systems as specified in § 412.1(a)(1) and to be paid under the prospective payment system as specified in 412.1(a)(2), a psychiatric unit must meet the following requirements."

We request that CMS address the removal of the rehabilitation unit from the requirements in §412.25(a), either by reinserting the phrase "or rehabilitation" in the text, or by creating a new section in §412.25 specifically for rehabilitation hospitals.

Discrepancies Regarding Change in Status of Excluded Units

There are various locations within the regulations governing excluded hospitals and hospital units that discuss requirements for change in excluded status. This includes §412.25(c) and §412.22(d). We request clarification to ensure that these regulations are in synch.

- §412.22 includes general rules for excluded hospitals and hospital units. §412.22(d) states that hospitals may only change status of either excluded or not excluded at the start of a cost reporting period.
- §412.25 lists the common requirements for excluded hospital units. §412.25(c)(2) permits the status of a hospital unit to be changed from excluded to not excluded at any time during the cost reporting period if the hospital notifies the appropriate parties within the appropriate timeframe.

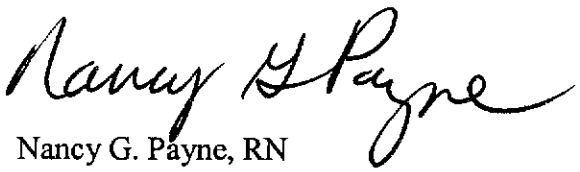
Allina would like CMS to address whether section §412.22(d) applies only to excluded hospitals, or to both excluded hospitals and excluded units. We also request that the CMS Internet Only Manual (100-4, Chapter 13, Section 3120) be updated with this clarifying information.

Errata

There are two (or more) errors in Table 3 of the Addendum - Inpatient Rehabilitation Facilities with Corresponding State and County Location; Current Labor Market Area Designation; and Proposed New CBSA-based Labor Market Area Designation: the Provider Numbers of Sister Kenny Rehabilitation Institute at Abbott Northwestern Hospital is 24T057, and at United Hospital it is 24T038 (we are unsure if the accompanying SSA and MSA codes also need to be corrected).

Thank you for your consideration of our comments on the proposed rule. If you have any questions about our comments please feel free to contact me at (612) 775-9744. We look forward to your response in the final rule.

Sincerely,



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