American Hospital Association

Liberty Place, Suite 700
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.**

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

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 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 Rebasing 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.

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