American Hospital Association

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Mark McClellan, M.D., Ph.D.
Administrator, Centers for Medicare & Medicaid Services
Attn: CMS—1540—P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

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

Dear Dr. McClellan:

On behalf of our 4,800 member hospitals and health care systems, and our 35,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the fiscal year (FY) 2007 proposed rule for the inpatient rehabilitation facility prospective payment system (IRF PPS).

Among other changes, the Centers for Medicare & Medicaid Services (CMS) proposes providing an inflationary update at the statutorily required market-basket rate of 3.4 percent, a 2.9 percent across-the-board reduction to adjust for coding increases, and several adjustments to the changes made in last year's system refinement that significantly revised the IRF PPS. The AHA strongly urges CMS to withdraw the negative 2.9 percent coding adjustment. We are very concerned that the negative 2.9 percent coding adjustment and other proposals in this rule are based on substandard and limited analysis of old data that do not reflect the current environment. We urge CMS to update its data and analysis in subsequent rules. Our detailed comments follow.

Volatile Regulatory Environment for IRFs

As with the FY 2006 changes to the IRF PPS, the AHA is very concerned that CMS is again basing its proposals on old data that fail to account for the serious challenges currently facing IRFs. The FY 2007 proposed rule ignores significant changes being caused by the phase-in of the "75% Rule," which began in July 2004, by using data from 1999 through 2004. The Moran Company's June 2006 report on the impact of the 75% Rule, "Utilization Trends in Inpatient Rehabilitation: Update through QI 2006," estimates that approximately 37,000 fewer patients were treated by IRFs during the first year of 75% Rule implementation (under a 50 percent threshold from July 2004 through June 2005). The Moran Company's review of

claims data through March 2006 estimates that during the second year of the 75% Rule phase-in (under a 60 percent threshold from July 2005 through June 2006) approximately 62,000 fewer patients will access IRFs. The combined impact of these analyses – a reduction of 100,000 patients accessing IRFs in the first two years of the 75% Rule phase-in – is ignored in this proposed rule. These estimates exceed by 14 times CMS' estimate that 7,000 fewer patients would be treated in IRFs during the first two years of 75% Rule phase-in. We expect further reductions once the threshold moves to 65 percent in July 2007.

The proposed rule also fails to recognize other significant changes faced by IRFs in recent months due to several local coverage determinations (LCDs), notably the LCDs being enforced by Mutual of Omaha and Tri-Span fiscal intermediaries (FIs). Medical necessity reviews are being conducted by these and other FIs on both a pre-payment and post-payment basis. Mutual of Omaha's 2006 probe audits are producing shocking denial rates, ranging from 25 percent to 90 percent, and are denying Medicare payment for a broad array of diagnoses, including cases within the 75% Rule's qualifying conditions. The IRFs undergoing these audits are in compliance with the 75% Rule, and many of these FI denials are being appealed.

The 75% Rule by itself has not led to IRF closures. However, its impact in combination with the LCD enforcement has already produced closures in 2006, with more pending. LCD-related disruptions are greatest in communities where inconsistent medical necessity standards are being imposed, such as Boston, St. Louis and Shreveport. IRFs in these communities are struggling with an uneven regulatory playing field that is causing confusion for patients and referring physicians who cannot understand the inconsistent levels of access among local IRFs.

Given the current instability faced by IRFs due to the 75% Rule, LCDs and the FY 2006 1.9 percent across-the-board cut in Medicare payments, we urge CMS to withdraw the negative 2.9 percent coding adjustment.

In future rulemaking, CMS should use the most recent payment and claims data and publicly disseminate it along with the paid, current and proposed case-mix groups and associated IRF patient-assessment instrument data, as they do with annual rulemaking for the inpatient PPS.

Proposed Changes to the CMG Relative Weights

CMS is proposing to reweight the IRF PPS case-mix groups (CMG) to account for proposed changes to the comorbidity codes used to calculate Medicare payments per patient. The agency states that it "propose[s] to update the CMG relative weights for FY 2007 to ensure that they continue to reflect as accurately as possible the costs of treatment for various types of patients in IRFs." Yet CMS also fails to rebase the CMG weights, as it annually does for the diagnosis-related groups of the inpatient PPS by incorporating the latest claims data. **We urge CMS to rerun the recalibration of the weights so that it includes not only the proposed new comorbidity codes, but also utilizes the latest available data, rather than using the same 2002 and 2003 data used for the FY 2006 proposed and final rules, and issue them in an interim final rule for FY 2007.**

Proposed 2.9 Percent Coding Reduction

In FY 2006, CMS implemented a 1.9 percent across-the-board payment cut to offset coding increases from 1999 to 2002. The RAND Corporation had estimated coding increases ranging from an increase of 1.9 percent to 5.8 percent. However, RAND questioned the accuracy of its own coding analysis, and CMS acknowledged the inconclusive finding in setting the reduction at the low end of the range in the FY 2006 rule.

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

Questions have recently been raised pertaining to the transition to restructured and rebased CMGs in FY 2006. Early analyses by the Lewin Group and others indicate this transition likely produced a 3 percent decrease in overall case mix and, subsequently, Medicare payments to IRFs during FY 2006. The effect of transitioning to the new CMGs was neither discussed nor accounted for in the budget neutrality adjustments in the FY 2006 final rule. This reduction was distinct from the FY 2006 coding-related cut of 1.9 percent. Final analysis of this matter is pending and we urge CMS to evaluate this work closely. It would be appropriate for CMS to discuss its findings on this sensitive matter in an interim final rule for FY 2007.

The proposed 2.9 percent cut raises another question: Why should CMS impose further adjustments to the IRF PPS based on data from 1999 through 2002 when the payment system was refined by restructuring and reweighting the CMGs in FY 2006? The comprehensive FY 2006 refinement should serve as a new baseline for this payment system and analysis using information after the refinement would be needed to substantiate further reductions.

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

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

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

CMS has already made sufficient, if not excessive, downward adjustments with the implementation of the IRF PPS and its 2006 refinement. IRF case mix, average length of stay and costs per stay are increasing. **The AHA strongly urges CMS to withdraw the proposed 2.9 percent coding reduction.**

Research on Medical Rehabilitation

CMS believes that less-intensive settings save money for the Medicare program, especially for joint-replacement patients, but this is as yet unproven. The work done by the Government Accountability Office and the National Institutes of Health on the 75% Rule was helpful in identifying what further research is needed in order to modernize the 75% Rule, more clearly define the role of IRFs relative to other post-acute care providers and better understand the cost effectiveness of IRFs and other post-acute providers. The IRF field is stepping forward to help fill the void in the medical literature on comparative analysis of medical rehabilitation costs and outcomes. CMS should do the same by providing research funding in this area.

Post-acute Care Demonstration

The AHA is very supportive of the post-acute care demonstration authorized by the *Deficit Reduction Act of 2005*. The AHA is uniquely positioned to provide insights on the demonstration given our broad membership, which includes 1,500 home health agencies, 1,200 SNFs, 1,200 IRFs, 150 long-term care hospitals and more than 5,000 outpatient departments. We have been in contact with the many CMS departments involved in developing and implementing the demonstration and continue to urge the agency to adopt a balanced position that fairly considers the unique merits of each post-acute provider group. We support this effort, which may ultimately help align Medicare payments more closely with the clinical characteristics of post-acute patients.

We thank CMS for the opportunity to comment on this proposed rule. Please address any comments or questions to me or Rochelle Archuleta, senior associate director of policy, at 202-626-2320 or rarchuleta@aha.org.

Sincerely,

Rick Pollack
Executive Vice President