Association of American Medical Colleges
2450 N Street, N.W., Washington, D.C. 20037-1127
T 202 828 0400 **F** 202 828 1125
www.aamc.org

Jordan J. Cohen, M.D.
President

VIA ELECTRONIC SUBMISSION
AND HAND DELIVERY

July 18, 2005

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
Room 445-G
200 Independence Ave, SW
Washington, DC 20201

Attention: 1290-P

Dear Administrator McClellan:

The Association of American Medical Colleges (AAMC) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled *"Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for FY 2006."* 70 Fed. Reg. 30188 (May 25, 2005). The AAMC represents approximately 400 major teaching hospitals and health systems; all 125 accredited U.S. allopathic medical schools; 94 professional and academic societies; and the nation's medical students and residents.

This year's proposed rule would make significant changes to the inpatient rehabilitation facility (IRF) prospective payment system (PPS). I write to convey the Association's strong support of the proposals to a) include a teaching hospital adjustment, and b) increase the low-income patient adjustment.

At the outset, I would like to commend the CMS staff for the clarity and completeness of the discussion of the IRF PPS and the proposed changes. Such a well-written document makes it much easier to understand the changes proposed, which allows us to provide more meaningful comments.

THE PROPOSED IRF PPS TEACHING ADJUSTMENT

CMS is proposing a payment adjustment for teaching inpatient rehabilitation facilities. (70 Fed. Reg. at 30241-244). We believe such an adjustment is well-justified and long overdue. Including it in the final rule will ensure payment equity across all providers, which will go a long way to maintaining a stable and fair Medicare inpatient rehabilitation prospective facility payment system.

Over half of the AAMC's Council of Teaching Hospitals and Health Systems (COTH) acute non-Federal members have rehabilitation units and a major rehabilitation teaching hospital also is a COTH member. These facilities play a special role in the provision of rehabilitation services. Often they possess the sophistication and infrastructure to manage the rehabilitation phase of treatment for patients with the most complex diseases and conditions. These facilities also differ from other providers because they are sites for clinical education for all types of health professional students and residents, and offer an environment in which clinical research can flourish.

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 RAND 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 are involved and facilities with larger teaching programs generally treat more costly patient populations. Such a finding has been borne out in both the inpatient acute 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 the 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 acute PPS, in which changes to the indirect medical education (IME) adjustment requires legislative action, CMS has ample opportunity to modify the 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 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 decisionmaking and include a teaching adjustment in the final rule.

II. CMS SHOULD RECONSIDER THE IME RESIDENT CAP PROPOSALS

To be consistent with the acute inpatient and psychiatric prospective payment systems, CMS is proposing to include a cap on the number of residents that could be counted for the IRF PPS teaching adjustment. The cap would be based on the number of residents reported by the IRP on the "final settlement of the IRF's most recent cost reporting period ending on or before November 15, 2003." (70 Fed. Reg. at 30243). Unlike the other payment systems, however, the proposed rule, if finalized, would preclude IRFs from entering into IME affiliation agreements. Such agreements allow facilities to aggregate their caps and redistribute them among themselves, so long as the aggregate number is not exceeded. In other words, one facility's cap may only increase if the other facility agrees to a corresponding reduced cap.

We have several concerns about CMS's proposals.

A. The Caps Should be Based on More Recent Data

We believe the cap determinations should be based on more recent data. We recognize CMS's desire to use historical data so that hospitals will not seek to increase their resident counts prior to application of the cap. However, under the Balanced Budget Act (BBA) legislation establishing the acute care caps, to ensure that the caps would be based on the most accurate historical resident count data possible, Congress required that CMS use data from hospital cost reports ending on or before December 31, 1996--nine months prior to the October 1, 1997

[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.

effective date. We see no reason why CMS should not employ a comparable standard and base the IRF caps on cost reporting periods ending in 2004, rather than 2003.

B. CMS Should Rescind the Proposal to Ban IME Cap Affiliation Agreements

In the proposed rule, CMS states that, "contrary to the policy for IME FTE resident caps under the IPPS, we would not allow IRFs to aggregate the FTE resident caps used to compute the IRF PPS teaching status adjustment through affiliation agreements." (70 Fed. Reg. at 30243). The Agency attempts to justify this policy by stating that it wants to "avoid incentives for IRFs to add FTE residents in order to increase their payments" and "to avoid the possibility of hospitals transferring residents between IPPS and IRF training settings in order to increase Medicare payments." (Ibid.)

As part of the BBA legislation establishing the resident caps for acute care hospitals, Congress specifically included a provision allowing hospitals to aggregate their resident caps. (SSA section 1886(h)(f)(H(ii)). The regulations implementing this provision allow for hospitals to combine their resident caps and redistribute them across the hospitals so long as the aggregate cap is not exceeded. This flexibility was permitted because of the recognition that hospitals often rotate residents to other facilities for educational reasons, such as exposing them to particular patient populations or clinical experiences, and these rotation arrangements can vary from year to year. The aggregation policy allows hospitals some flexibility in their resident caps to account for these changing rotation arrangements.

There is no reason to deviate from this Congressionally-sanctioned policy in the IRF prospective payment system. Residents who specialize in rehabilitation (known as "physiatrists") are required to train in a variety of clinical experiences, not just rehabilitation (see 2005-2006 Graduate Medical Education Directory (the "Green Book") at 375, "the clinical portion of the curriculum must include a sufficient variety, depth, and number of clinical experiences"). These medical education clinical requirements are why teaching institutions need the flexibility that the affiliated group agreement grants them.

Moreover, we disagree strongly with the proposed rule perception that teaching hospitals would arbitrarily assign residents to rehabilitation units merely to increase their Medicare payments. First, to substantially affect payments would require residents to spend significant time in the rehabilitation units. Unlike inpatient acute hospitals, these units are essentially "single specialty"-- rehabilitation. So while residents of other specialties may do a training rotation in the rehabilitation unit, their own specialty-specific educational requirements do not provide for significant training periods in these units. Second, rehabilitation units are generally self-contained, not having large numbers of patients or beds. Thus, the number of residents that can be accommodated is quite limited. Third, given that there are exponentially more cases in the acute inpatient portion of the hospital compared to the rehabilitation unit, and that overall teaching adjustment payments in both settings depend on the number of cases treated, it would not make financial sense for a hospital to move residents arbitrarily to a rehabilitation unit.

But perhaps most importantly, CMS's concern that teaching hospitals might inappropriately rotate rehabilitation residents to other locations or rotate other residents to rehabilitation units is without merit in principle. It is contrary to the fundamental commitment that the academic medicine community makes to ensuring that the educational needs of future physicians are met. This overriding and widespread commitment to medical education dominates the decisionmaking process of teaching hospitals.

C. CMS Should Use the IRF Resident Count as Reported on the Medicare Cost Reports

In computing the teaching adjustment, RAND used resident counts from the Medicare cost reports. For rehabilitation hospitals, this count is for the entire hospital; for units, the count is for the time residents spend in the rehabilitation unit. Specifically, the proposed rule states that RAND used the following variables from the cost report:

- Rehabilitation hospitals: Worksheet S-3, line 25, column 9 [Note that there appears to be a typographical error in the proposed rule in that no Part was listed for worksheet S-3. We presume that the correct cost report cite is Worksheet S-3, Part 1]

- Rehabilitation units of acute care hospitals: Worksheet S-3, Part 1, line 14 (or 14.01)

70 Fed. Reg. at 30242

CMS requests comments on "the most valid and reliable method of counting residents for purposes of a proposed teaching status adjustment." (70 Fed. Reg. at 30244). The proposed rule also states that:

> We are particularly interested in ensuring that the FTE resident counts used for the proposed IRF teaching status adjustment do not duplicate resident counts used for purposes of the IPPS IME adjustment and that hospitals do not have incentives to shift residents from the acute care hospital to the hospital's rehabilitation unit for purposes of computing the proposed IRF teaching adjustment.
>
> 70 Fed. Reg. at 30244.

We believe that CMS should use the cost report variables specified above to determine the IRF resident counts. For acute care hospitals, the cost report distinguishes between the time residents spend in the IPPS portion of the hospital and the rehabilitation unit. These counts are not duplicates. This result is verified by the Intern-and-Resident Information System (IRIS) files, which are used by fiscal intermediaries to ensure that resident counts are accurate and not duplicated across hospitals.

Historically, there has been no incentive to increase inappropriately the resident count in the rehabilitation unit because currently hospitals receive no IME payments associated with these counts. Moreover, given that CMS plans to impose an IRF resident cap based on historical resident counts, hospitals have no payment incentive to shift additional residents from the

inpatient acute portions of the hospital to their rehabilitation units. Such a shift would result in no payments because the additional residents would exceed the cap count and thus not be eligible for teaching adjustment payments. [2]

THE LOW-INCOME PAYMENT ADJUSTMENT

The IRF PPS currently includes a payment adjustment to account for differences in costs among IRFs associated with differences in the proportion of low-income patients (LIP) they treat. Based on the analyses conducted by RAND, CMS proposes to increase the LIP adjustment. We support this proposal and believe the adjustment should be increased in the final rule.

IRF DATA

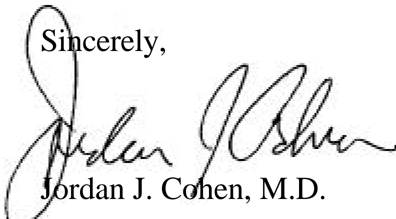
Currently, CMS does not publish patient level data on IRF PPS case-mix group assignments. This greatly hampers the provider community and other researchers from doing empirical research on the IRF patient classification system and payment model which, in turn, hampers our ability to provide meaningful comments on proposed changes to the payment system. We urge CMS to publish these data.

* * * * * * * * * * * *

Thank you for this opportunity to present our views. We would be happy to work with CMS on any of the issues discussed above or other topics that involve the academic health care community.

If you have questions concerning these comments, please feel free to call Robert Dickler, Senior Vice President, Health Care Affairs, or Karen Fisher, Senior Associate Vice President. These individuals may be reached at (202) 828-0490.

Sincerely,



Jordan J. Cohen, M.D.

cc: Robert Dickler, AAMC
Karen Fisher, AAMC

[2] And, as discussed above, hospitals do not arbitrarily assign residents to various portions of the hospital. Such assignments are largely based on the education requirements associated with the resident's specialty.