The Functional Assessment Specialists

Uniform Data System

for Medical Rehabilitation

Telephone
716.817.7800

Fax
716.568.0037

E-mail
info@udsmr.org

Web site
www.udsmr.org

Suite 300
270 Northpointe Parkway
Amherst, NY 14228

University at Buffalo
The State University of New York

Comments
Provided by Uniform Data System for Medical Rehabilitation (UDSMR)
January 29, 2009

In response to:

Centers for Medicare & Medicaid Services
Town Hall Meeting
Medicare Classification Criteria for Inpatient Rehabilitation Facilities

Monday, February 2, 2009

I. Main Contention

Access to medically necessary rehabilitation services for Medicare Beneficiaries (non- Managed Care) with a stroke impairment has been compromised since early 2005.

II. Support for this contention

An analysis of IRF-PAI data from 355,431 **stroke patients** admitted to a cohort of 650 certified Inpatient Rehabilitation Facilities (IRFs) between Quarter 1, 2004 and Quarter 3, 2008. Stroke was selected because it represents the largest Rehab Impairment Category (RIC) among IRF patients today.

The 650 IRFs, all of whom are UDSMR subscribers, represent a subset of our 850+ total current subscribers. This cohort of 650 IRFs was selected because they had submitted data to UDSMR continuously since Quarter 1, 2004 and is comprised of 521 units and 129 freestanding hospitals. These IRFs maintain 20,578 operating beds, and represent every CMS region and every state in the union.

A. Primary Observations from the Cohort Analysis

Comparing admissions of stroke patients by the 650 IRFs between the first three quarters of 2005, with the same three quarters in 2008, and stratifying the comparison on payer source, the data show the following:

1. There was an overall **decline of 13.5% in stroke admissions between the two time frames for Medicare beneficiaries** with payer code 02 (Medicare non-MCO). Average quarterly stroke admissions dropped from 12,491 cases to 10,800. Refer to Chart #1.

2. Over the same time frame, while fewer Medicare beneficiaries were being admitted to IRFs, there was an **increase of 12.1% in stroke cases covered by non-Medicare insurers.** Average quarterly stroke admissions for this group increased form 5,456 cases to 6,117.

3. Examining a third payer group, **Medicare MCO (code 51), our data show a 149% increase in stroke admissions over the same timeframe**. Cases admitted increased from a quarterly average of 817 to 2,038.

4. In addition to a quantitative impact on admission of Medicare beneficiaries with stroke to IRFs since 2005, **there has been a qualitative impact as well,** as evidenced by exploring changes in the stroke CMG mix between the first three quarters of 2005 and 2008 by payer source. Refer to Charts 2, 3 and 4.

   a. The data indicate that Medicare beneficiaries with a stroke that would classify them into CMG 101, 102, 103 or 104 in aggregate, are less likely to be admitted and treated in an IRF in 2008 relative to 2005. Those same patients are also less likely to be admitted and treated in an IRF relative to comparably severe stroke cases covered by some insurance other than Medicare. These results lend credibility to the contention of reduced access to medically necessary rehabilitation services for Medicare beneficiaries.

   b. Despite a declining total number of Medicare stroke cases admitted and treated in the cohort of 650 IRFs, the proportion of highly severe cases (CMG 109 and 110 combined) has increased from 35% in 2005 to 38.4% in 2008 (a 3.4% shift); this is greater than the increase of 2.6% observed for non-Medicare patients. These findings suggest an overall upward shift in the profile of Medicare admissions toward the more severe patients, with a concomitant decline in the less severe, which might still require and benefit from acute rehabilitation services.

While numerous other patient factors were compared across payer source and time in the analysis, including selected socio-demographics, severity (admission relative weight), tier distribution, FIM™ ratings at admission, discharge and FIM™ rating increase, length of stay and LOS efficiency, as well as discharge to community, there is not enough time in a "comment" venue to share, much less discuss the findings.

III. IRF Closures: Further Support of the Contention

We have one additional observation, apart from above mentioned cohort analysis, which we would like to share that would undoubtedly have a direct impact on patient access**, and that is the closure of IRF facilities in the past 3 years.**

UDSMR has an exit interview with every facility that withdraws from its' subscription service. Since 2006, 86 IRFs have closed their doors that were UDSMR subscribers. Closure of those 86 facilities, coming from 30 states scattered across every CMS region, represented the loss of Medicare patient access to 1647 acute rehabilitation operating beds.

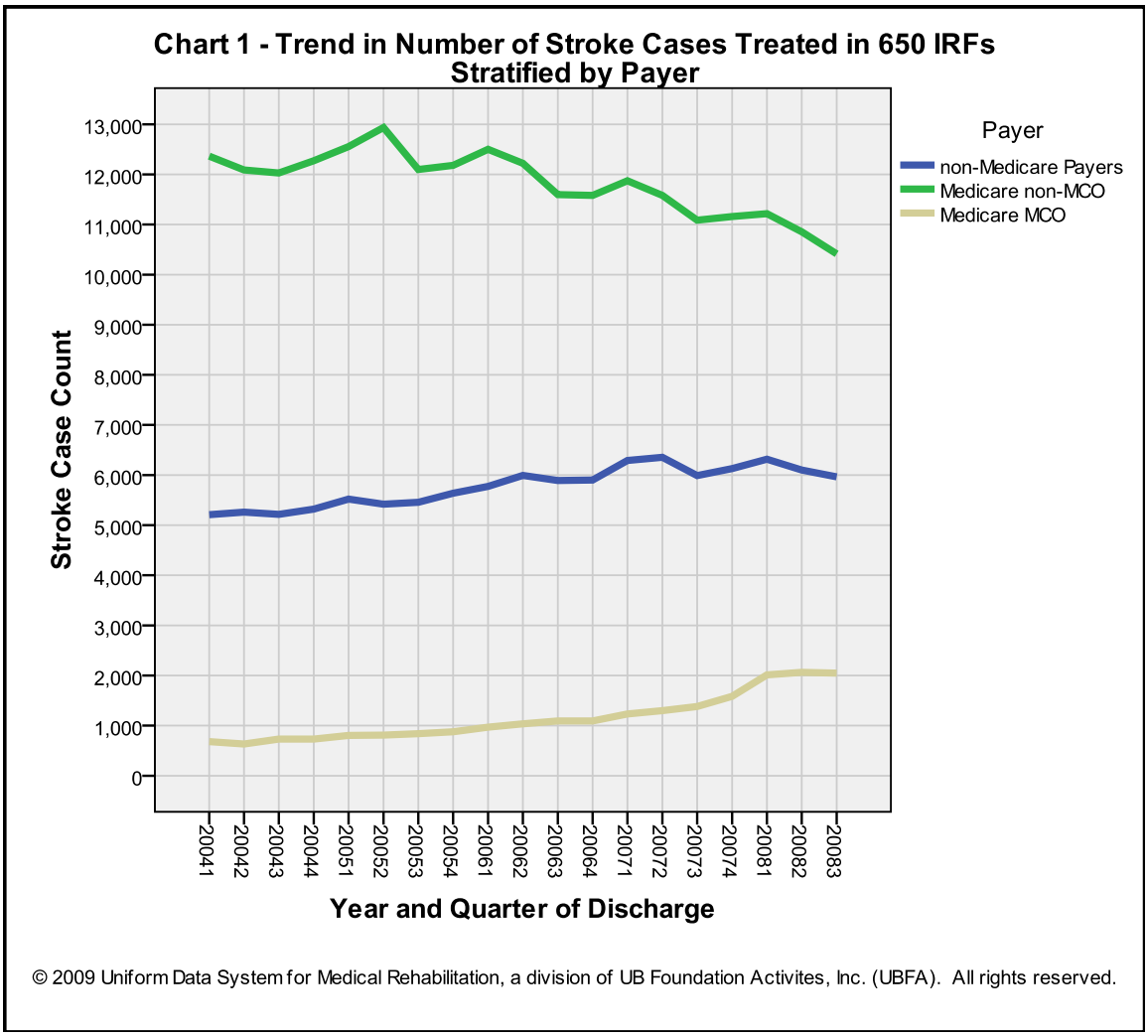
IV. UDSMR Request to be Included in Subsequent Discussions and Activities Related to the "75% Rule" Topic

On behalf of the 850+ IRFs subscribing to UDSMR in the USA, we would welcome an opportunity to be included in discussions related to the three "75% Rule" topics set out in the background for this Town Hall Meeting and would freely share our current observations and explore new analyses based on the outcomes of such discussions. It is clearly not in the best interests of our healthcare system to have access restricted for Medicare beneficiaries to medically necessary rehabilitation services, while other insurers provide access to and consider the same services as medically necessary and appropriate for their constituency. We believe this is in direct conflict with one of the IOM's aims for quality healthcare in the United States, namely that care be "Equitable".

Thank you for the opportunity to comment on this timely topic and we look forward to substantive inclusion on follow up activities to the "75% Rule" discussion.

Carl V. Granger, MD
Executive Director

Samuel J. Markello, PhD
Associate Director



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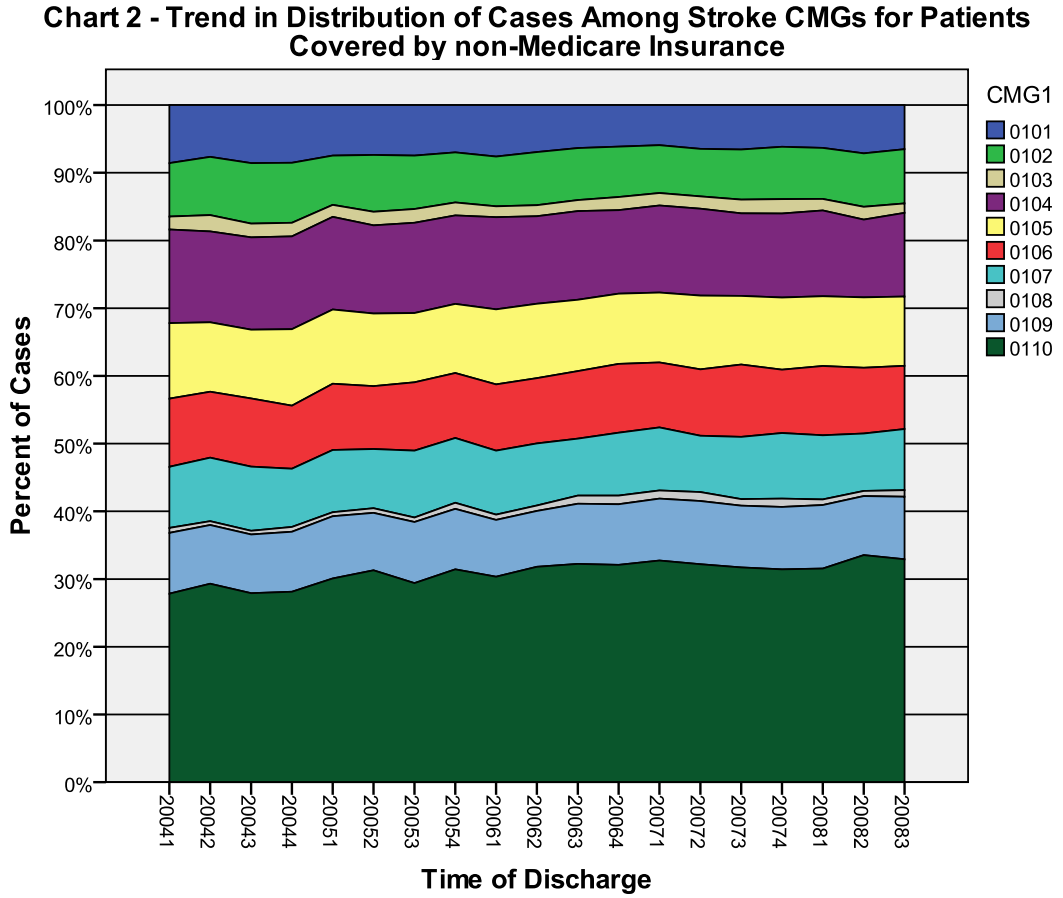

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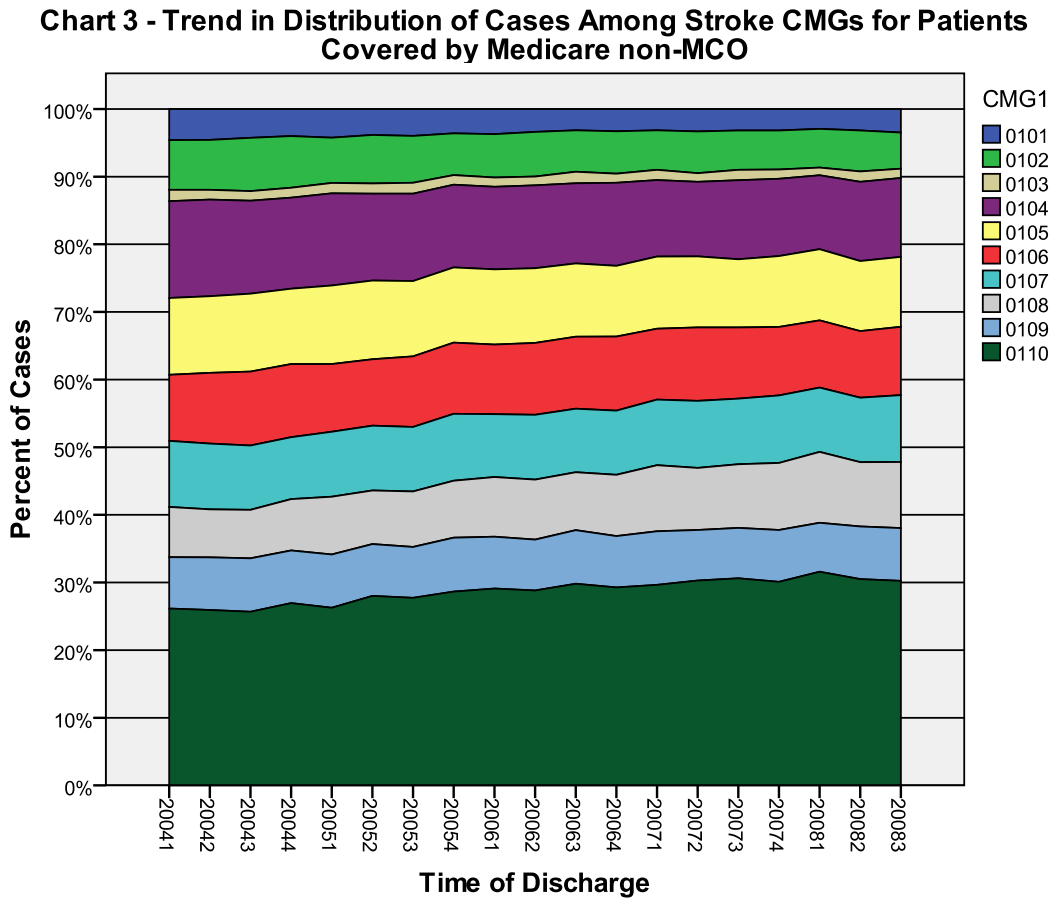

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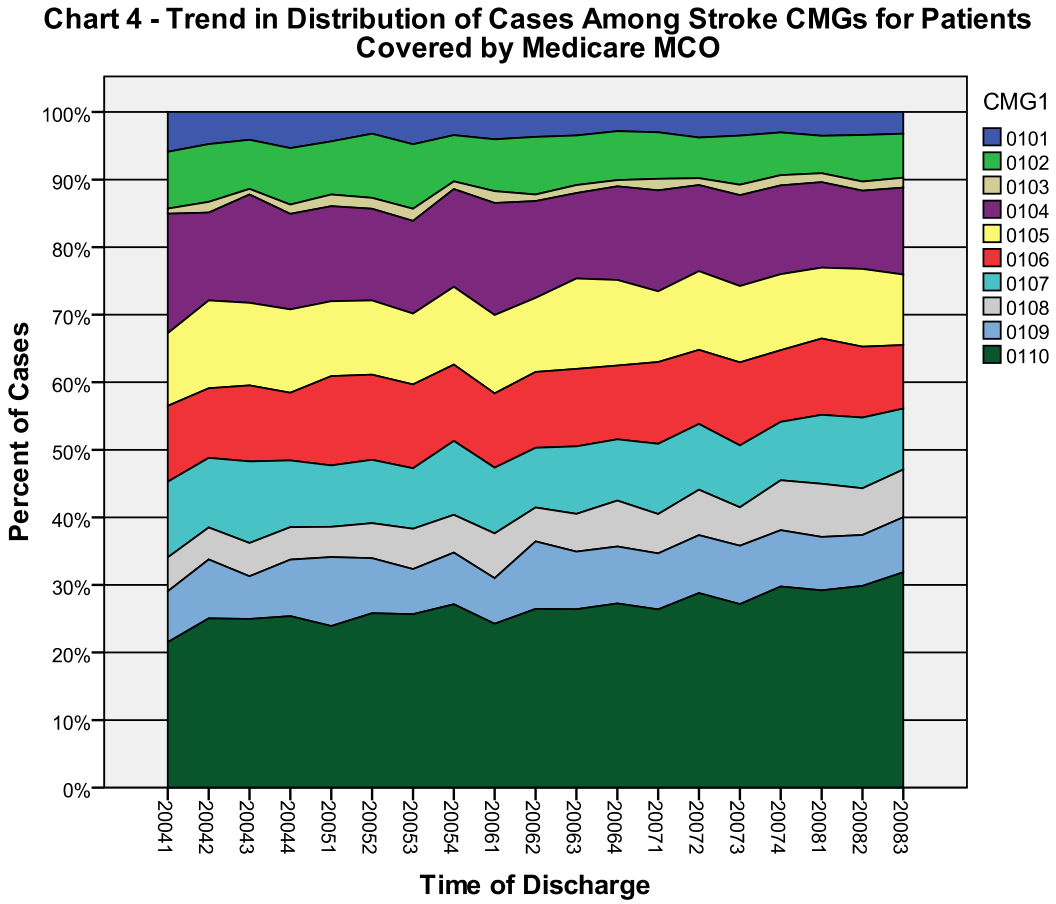

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