

**Submitter :** Mr. Robert Shircliff

**Date:** 06/29/2007

**Organization :** Jewish Hospital and St. Mary's Healthcare

**Category :** Hospital

**Issue Areas/Comments**

**75 Percent Rule Policy**

75 Percent Rule Policy

Jewish Hospital and St. Mary's Healthcare encourages CMS to continue to permanently include the specific comorbidities listed in the Proposed Rule under the 75 percent rule compliance threshold, and to postpone further changes to the 75 percent rule until post-acute payment reform moves forward.

Please see our complete comments in the attached file.

CMS-1551-P-18-Attach-1.PDF

**Jewish Hospital &  
St. Mary's HealthCare**

6/28/2007

BY EXPRESS MAIL

Leslie Norwalk, Administrator (Acting)  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1551-P  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-8012.

June 28, 2007

**re: 75 Percent Rule Policy**

Dear Administrator Norwalk,

Thank you for this opportunity to comment on the 2008 Proposed Rule for the Inpatient Rehabilitation Facility Prospective Patient System (the Proposed Rule). Jewish Hospital & St. Mary's HealthCare (JHSMH) appreciates CMS's efforts to ensure beneficiary access to appropriate and effective rehabilitation services. In this light, we encourage CMS to continue to include all appropriate patients when applying the 75 percent rule to a facility's patient population.

JHSMH is a major regional health network headquartered in Louisville, Kentucky that includes 71 health care facilities with more than 1,900 licensed beds, over 42,000 discharges and almost 100,000 emergency room visits annually. JHSMH employs more than 8,100 people, who provide a complete array of health care services in Kentucky and southern Indiana including: hospitals, behavioral health, assisted living, home health care, outpatient care, nursing home care, occupational health and rehab medicine.

Frazier Rehab and Neurological Institute is a 135 bed Inpatient Rehabilitation Facility on the campus of Jewish Hospital in downtown Louisville. It is one of six sites participating in a comparative effectiveness study on cardio-pulmonary rehabilitation. The study is intended to compare outcomes for similar patients receiving cardio-pulmonary care as an IRF inpatient with outcomes for patients receiving cardio-pulmonary care in a Skilled Nursing Facility. This study is part of the industry's effort to refine the list of 13 conditions eligible for intensive rehab care through rigorous data collection examining real life clinical situations.

In addition, JHSMH shares ownership in Southern Indiana Rehab Hospital (SIRH) with two county owned facilities in southern Indiana, Clark Memorial Hospital and Floyd Memorial Hospital. SIRH, a 60 bed facility, is the only hospital providing acute rehab services for the residents of Southern Indiana.

JHSMH appreciates CMS's continuing efforts to ensure that Medicare beneficiaries have access to high quality care in the most appropriate setting. We believe that the services offered at Frazier Rehab are unsurpassed with respect to quality and effectiveness, and support continuing CMS efforts to recognize the value of intensive inpatient rehabilitation services.

As described in the Proposed Rule, Inpatient Rehabilitation Facilities are paid on a fee schedule that is distinct from the Inpatient Prospective Payment System. Eligibility for the IRF fee schedule is based on the so-called "75 percent rule" that requires a particular case mix at the facility (the actual percentage requirement may not be 75 percent, and is referred to as the "compliance threshold"). Thirteen conditions that typically require intensive services (e.g. stroke, traumatic brain injury) form the core of the 75 percent rule determination. Since July 1, 2004, CMS has also included patients with certain comorbidities towards the required case mix.

In November 2005, September 2006, and June 2007, CMS issued reports about the policy objectives for the 75% rule, the results of its initial implementation, and an analysis of the need for post acute care reform. These documents are part of an effort to infuse Medicare's post-acute reimbursement and policy systems with the policy and analytic rigor that has long characterized Medicare's acute care systems. The latest report confirms that the current implementation of the 75% rule has effectively served the goal of encouraging patient care in the most appropriate setting.

As a comprehensive regional network offering all covered services to Medicare beneficiaries, Jewish Hospital and St. Mary's Healthcare is in a unique position to understand the complexities and shortcomings of care coordination, appropriate reimbursement, and quality outcomes following acute hospitalization discharge. From this perspective, we make the following comments.

**CMS should permanently include comorbidities that meet the current criteria when applying the 75 percent rule to identify inpatient rehabilitation facilities.**

In order for a patient with a primary diagnosis that would not count towards the compliance threshold to be included based on a comorbidity, a number of conditions must be met:

- the comorbidity must fall in one of the rule's thirteen conditions.
- the comorbidity must have caused significant decline in functional ability in the individual such that, *even in the absence of the admitting condition*, the individual would require the intensive rehabilitation treatment that is unique to IRFs and *cannot be appropriately performed in another care setting*.

Under current regulations, the inclusion of these select comorbidities for the purposes of establishing IRF status under the 75 percent rule will end for cost reporting periods on or after July 1, 2008.

The purpose of the 75 percent rule is to distinguish between IRFs and hospitals paid under the IPPS, in order to match appropriate care with appropriate reimbursement. We believe that the current criteria for the 75 percent rule serve the goals of encouraging care in appropriate settings,

and matching payment to patient needs, rather than site of services. The June 2007 CMS report supports this perspective, stating,

the ongoing implementation of the 75 percent rule continues to have the desired effect of ensuring that the most appropriate Medicare beneficiaries have access to care in IRFs, while those with lower acuity cases are increasingly being served in settings that are both less intensive and less costly.

This positive development would be threatened if comorbidities are excluded from determination of the compliance threshold. The comorbidity criteria are narrowly drawn in order to reach a limited set of secondary diagnoses that have significantly limited the patient's functional abilities. By definition, these patients "require the intensive rehabilitation treatment that is unique to IRFs and cannot be appropriately performed in another care setting." Treatment in less appropriate facilities is likely to negatively impact patient outcomes.

If the 75 percent rule is modified by excluding consideration of comorbidities, these *higher* acuity cases are more likely to be discharged to less intensive settings despite their actual care needs. The beneficiaries with these comorbidities would see a new barrier to access to the facilities best suited to treat their condition. Jewish Hospital & St. Mary's HealthCare strongly encourages CMS to permanently include comorbidities that meet the current criteria when applying the 75 percent rule to identify inpatient rehabilitation facilities.

**CMS Should Suspend Further Changes to the 75% Rule Until More Coordinated Post-Acute Care Reform is Implemented.**

Regrettably, CMS (formerly HCFA) developed the multiple payment systems for post-acute care without a beneficiary-centered vision or a notion of coordination or integration. For more than two decades it has used separate, uncoordinated organizational entities to design and manage contracts with different vendors to develop these systems. Each post-acute care setting is characterized by separate assessment systems, payment categories, service terminologies, outcome measures, and coding procedures. CMS's Policy Council recognized these issues in its Post-Acute Care Reform Plan, published September 28, 2006, and presented a path for rationalization of post-acute payment.

The Reform Plan sets out a series of steps, that include a demonstration program, industry and expert input, and a gradual implementation of various technology tools to facilitate the improvements. A central piece of the Plan is the implementation of a single post-acute assessment instrument in order to facilitate a patient-centered payment system.

JHSMH supports these reforms, but recognizes that they will result in dramatic changes to the reimbursement landscape for post-acute care. Recognizing this risk of volatility, and in light of the June 2007 report describing the success of the 75 percent rule as currently implemented, we recommend that CMS suspend further implementation of the 75 percent rule until the single post-acute assessment instrument is implemented.

We believe there is insufficient cause to raise the compliance threshold above the current 60% level, especially in light of the absence of outcome, access, or quality data. This is the prudent

course for CMS due to the anticipated financial volatility associated with payment reform, as well as the enrollment of the first wave of baby boomers.

Finally, as CMS develops the FY 2008 Final Rule and other payment system reforms, we hope they will consider carefully the complex impact payment changes can have on other provider segments. For instance, while changes in admissions and discharges to IRFs under the 75% rule appear to have reduced aggregate payments to IRFs, these reductions may be cancelled out by increased admission of rehab patients to LTCHs, with much higher standard payment rates. Also, many private payers follow Medicare policy with respect to payment, amplifying the potential impact of CMS decisions. These complex dynamics make rational payment reform even more urgent, as the volatility can only harm beneficiaries' care needs and outcomes.

### **Conclusion**

In conclusion, JHSMH encourages CMS to continue to permanently include the specific comorbidities listed in the Proposed Rule under the 75 percent rule compliance threshold, and to postpone further changes to the 75 percent rule until post-acute payment reform moves forward. We appreciate this opportunity to comment on the 2008 Proposed Rule. Please don't hesitate to contact us if you have any questions, or if we can provide any further information about the impact of this rule on our patients.

Sincerely,



Robert L. Shircliff  
President and CEO  
Jewish Hospital and St. Mary's Healthcare

cc: Ronald Abrams, Chairman  
Jewish Hospital and St. Mary's Healthcare  
Board of Trustees

**CMS-1551-P-19**

**Submitter :** Ms. Patricia Blaisdell  
**Organization :** California Hospital Association  
**Category :** Hospital

**Date:** 06/29/2007

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-1551-P-19-Attach-1.PDF



**CALIFORNIA  
HOSPITAL  
ASSOCIATION**

**Center for Medical  
Rehabilitation Services**

July 2, 2007

Leslie V. Norwalk, Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Hubert H. Humphrey Building, Room 445 –G  
200 Independence Avenue, SW  
Washington, DC 20201

**Re: CMS-1551-P: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Fiscal Year 2008; Proposed Rule**

Dear Ms. Norwalk:

The California Hospital Association (CHA) respectfully submits comments on the proposed rule for inpatient rehabilitation facility (IRF) prospective payment system (PPS) refinements for Federal fiscal year (FY) 2008. CHA submits comments on behalf of its nearly 500 hospital and health system members, including approximately 70 inpatient rehabilitation programs.

The proposed rule includes annual payment rate updates. In addition, CMS requests comments regarding the 75 percent rule policy, in particular the use of co-morbidities beyond the end of the rule's implementation transition period, which ends July 1, 2008. CHA appreciates the opportunity to comment on these items.

**The Role of IRFs**

Inpatient Rehabilitation Facilities play a unique role in the continuum of care for Medicare beneficiaries recovering from disabling injuries or illnesses. The focus of inpatient rehabilitation is to facilitate independence in daily activities, most often allowing the patient to return to a community setting. The close medical management, 24 hour rehabilitation nursing, and intensive therapy services available only in the IRF setting are essential to the individual's ability to transition to and remain at a less costly level of care.

**Data-related Concerns**

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For the FY 2008 IRF PPS proposed rule, we note that CMS proposes to continue the use of data that reflect IRF cases from 2003. Since that time, there have been substantial changes in IRF operations secondary to the introduction of PPS and the implementation of the revised 75% rule. These changes have in turn led to related changes to admissions practices and cost structures. The use of outdated claims data from 2003 is not an accurate reflection of current inpatient case

mix and cost of care. We encourage CMS to adjust its internal protocols to ensure that future rulemaking uses the most recent payment and claims data available

### **75% Rule; Use of Qualifying Co-morbidities**

CHA supports CMS's efforts to identify criteria to distinguish IRFs from other components of the post-acute continuum of care. We share CMS's commitment to developing mechanisms to support the appropriate use of these services as well as other levels of care in the patient care continuum. It is essential that the unique care that IRFs provide be utilized appropriately, so that these valuable services remain available to Medicare beneficiaries who require them.

A distinguishing characteristic of IRFs is its unique concept of medical necessity. Unlike many other areas of medical care, the need for IRF services is not driven by the presence or absence of specific diagnoses or the need for a particular intervention or medical procedure. Rather, medical necessity of IRF care can be determined only by physician assessment of the patient's functional status and potential for increased independence in the context of their presenting medical condition. Patients admitted to rehabilitation hospitals or units usually have had a recent onset or significant exacerbation of a serious illness or injury due to one or more medical conditions. Impairments result in reduced abilities to perform activities of daily living and ambulation.

For this reason, any system that attempts to define patient need or candidacy for IRF services on the basis of diagnosis alone is inappropriate and will not serve the needs of beneficiaries or of the Medicare program. While CMS has made positive efforts to revise the "75% rule", it remains an outdated and inaccurate measure for IRFs. Furthermore, while the intent of the 75% Rule was to aide CMS in distinguishing IRFs from other levels of care, its re-interpretation and implementation has led to patients being "in" or "out" based on their presenting diagnosis, as facilities are forced to make admission decisions in consideration of their case mix and 75% Rule threshold compliance, rather than upon individual patient need and ability to benefit.

Of particular concern is the pending termination of the 75% rule's co-morbidities provision, which enables inpatient rehabilitation facilities to count patients with qualifying co-existing secondary medical diagnoses toward compliance. This provision is set to expire on July 1, 2008.

CMS's own analysis found that 7 percent of cases admitted to IRF from July 1, 2005 through June 30, 2006, representing approximately 31,000 individuals, fell into this category. This large group is made up of patients that present with specific rehabilitation needs in the context of complicating medical conditions. As such, these individuals often require closer medical management during their rehabilitation course than might be required by patients who have similar primary diagnoses but who do not have significant complicating co-morbidities. The rehabilitation physician and nursing care available only in the IRF setting is critical to the ability of these individuals to return to the community and to achieve maximum independence. We urge CMS to amend the 75% Rule in the FY 2008 inpatient rehabilitation PPS final rule to permanently allow for the inclusion of qualifying comorbidities among cases counted toward compliance.

According to several recently published studies, patients with single joint replacements and other medical complications have superior functional outcomes in an IRF compared to less intensive settings.

In these studies, the IRF group had shorter lengths of stay and superior outcomes to those treated in a skilled nursing facility. Additionally, 75% of the skilled nursing patients required home care services versus 41% of the IRF patients.<sup>i,ii,iii</sup>

We appreciate the opportunity to provide input on these important issues on behalf of our providers and the disabled and senior citizens they serve. If you have any questions or would like to discuss our comments, please contact Pat Blaisdell at (916)552-7553, or [pblaisdell@calhospital.org](mailto:pblaisdell@calhospital.org).

Sincerely,



Patricia L. Blaisdell  
Vice President, Medical Rehabilitation Services

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<sup>i</sup> Walsh, M. B., Herbold, J. Outcome after rehabilitation for total joint replacement at IRF and SNF. Am. J. Phys. Med. Rehabil., vol 85 (1), 1 – 5, January 2006.

<sup>ii</sup> Munin, M. C., Begley, A., Skidmore, E. R., Lenze, E. J. Influence of rehabilitation site on hip fracture recovery in community-dwelling subjects at 6-month follow-up. Arch Phys Med Rehabil., vol 87, 1004 – 1006, July 2006.

<sup>iii</sup> Silverstein, B., Findley, P.A., Bode, R. K. Usefulness of the Nursing Home Quality Measures and Quality Indicators for assessing skilled nursing facility rehabilitation outcomes. Arch Phys Med Rehabil., vol 87, 1021 -1025, August 2006.

**Submitter :** Mr. John Sullivan

**Date:** 06/29/2007

**Organization :** Sisters of Mercy Health System

**Category :** Health Care Provider/Association

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-1551-P-20-Attach-1.PDF



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**SISTERS OF MERCY  
HEALTH SYSTEM**

June 26, 2007

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1551-P  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-8012

**RE: "Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2008"**

The Sisters of Mercy Health System (Mercy) is a 19-hospital system operating in Missouri, Kansas, Oklahoma, and Arkansas. We have a significant number of Medicare certified rehabilitation programs and rely heavily on Medicare as a major payor for those services. We are writing to provide comments in areas of concern relating to the proposed rule. Thank you for considering our comments.

Specifically, we offer the following comments:

**High-Cost Outliers Under the IRF PPS**

If the estimated costs of a case are higher than the adjusted outlier threshold, CMS makes an outlier payment for the case equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold, similar to the outlier payment calculation for hospital acute care stays. CMS sets the outlier threshold in order to maintain outlier payments equal to approximately three percent of all estimated payments. For fiscal year (FY) 2006, CMS set the outlier threshold at \$5,129. The outlier threshold for FY 2007 is \$5,534 and \$7,522 for FY 2008. This represents a 46.7% increase over two years.

Using updated FY 2005 claims and Inpatient Rehabilitation Facility (IRF)-Patient Assessment Instrument data, CMS estimated that IRF outlier payments as a percentage of total estimated payments for FY 2007 increased from 3.0% percent (using FY 2004 data) to 3.8% (using FY 2005). They are investigating the reasons for the change in estimated outlier payments between FY 2004 and FY 2005, and will evaluate all possible reasons for this change. It is difficult for Mercy to understand how CMS can increase the outlier threshold, from FY 2007 to FY 2008, by 36% without understanding the reason(s) for the percentage

increase. This leads us to believe CMS does not fully understand the methodology used to set the outlier threshold in **prior** fiscal years.

Until CMS can validate and understand the rationale for such a significant increase in the outlier threshold, Mercy respectfully recommends the FY 2008 threshold be at least held constant at the FFY 07 level of \$5,534.

**75 Percent Rule Policy**

We are very concerned about the end of the transition period for the implementation of the classification criteria percentage for inpatient rehabilitation facilities, more commonly known as the 75 percent rule. The FFY 08 proposed rule states that for cost reporting periods beginning on or after July 1, 2008, comorbidities will not be eligible for inclusion in the calculations used to determine if the provider meets the 75 percent compliance threshold.

Our concern is that the 75 percent rule will limit beneficiary's access to necessary rehabilitation services, which are vital to the treatment of their condition. The current 13 medical conditions, listed in the regulations, in order for the facility to be classified as and IRF, do not include elective joint replacement, cardiopulmonary conditions, and severe medical debilitation. Patients with these conditions will be forced to reside in a nursing home when in fact they could have returned home after rehabilitation services.

We strongly recommend that CMS either freeze the compliance threshold at 60 percent or expand the list of qualifying medical conditions to include all of the existing comorbidities on a permanent basis; this will expand the current list of 13 conditions to include a more diversified list of qualifying diagnoses and conditions.

Thank you again for considering our comments. Should you have additional questions, please contact Ron Trulove at 314-364-3504.

Sincerely,



John Sullivan  
President / CEO  
Sisters of Mercy Health System

**Submitter :**

**Date: 07/02/2007**

**Organization :** American Academy of PM

**Category :** Health Care Professional or Association

**Issue Areas/Comments**

**75 Percent Rule Policy**

75 Percent Rule Policy

See attached comment letter.

CMS-1551-P-21-Attach-1.DOC



www.aapm.org

President  
President-Elect  
Vice-President I  
Secretary  
Treasurer  
Past President  
Member-at-Large

June 28, 2007

Leslie Norwalk, Esq.  
Acting Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
**Attn: CMS-1551-P**  
P.O. Box 8015  
Baltimore, MD 21244-8015

**Re: Medicare program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2008; CMS-1551-P 75 Percent Rule Policy**

President AACP  
ABA Director  
President  
President-Elect  
Council of Academies of PM&R  
Council of State PM&R Society Presidents  
Executive Director

Dear Ms. Norwalk:

The American Academy of Physical Medicine and Rehabilitation (AAPM&R) appreciates the opportunity to submit comments on the *Inpatient Rehabilitation Facility Prospective Payment System for FY 2008*, as set forth in the May 8, 2007 *Federal Register*.

AAPM&R is the national medical specialty society of more than 7,000 board certified physical medicine and rehabilitation physicians, also called physiatrists. Approximately 90% of all physiatrists practicing in the United States are members of AAPM&R. Physical medicine and rehabilitation (PM&R), recognized as a board-certified medical specialty in 1947, focuses on restoring function to people with problems ranging from simple physical mobility issues to those with complex cognitive involvement. Physiatrists also treat patients with acute and chronic pain and musculoskeletal disorders, neurological disorders and those in need of prostheses, orthoses and mobility devices.

**75 Percent Rule Policy**

CMS has asked for comments as to whether it should continue its current policy of allowing patients with certain comorbidities to count for purposes of the 75 percent compliance threshold. AAPM&R strongly supports the continued use of comorbidities in determining whether an admission can be counted toward the applicable threshold. Patients with a comorbidity that is



Leslie Norwalk, Esq.  
June 28, 2007  
Page 2

one of the thirteen diagnoses listed in 42 CFR Section 412.23(b)(2)(iii) are among the most vulnerable and mostly likely to need treatment in an inpatient rehabilitation facility that has the capacity for complex rehabilitation management. To the extent that the 75 percent rule is intended to identify patients “typically” in need of inpatient rehabilitation, the fact that a given comorbidity is a secondary diagnosis rather than primary, should be of little consequence provided that the comorbidity causes or contributes to the individual’s decline in functional ability.

In this regard, AAPM&R believes that the criteria for determining whether a comorbidity may be used for determining compliance with the 75 percent rule is too restrictive and should be modified. As set forth in the May 7, 2004 Federal Register, those criteria are that the patient must:

- Be admitted for inpatient rehabilitation for a condition other than those listed in §412.23(b)(2)(iii); and
- Have a comorbidity that is listed in § 412.23(b)(2)(iii) which has caused “significant decline in functional ability . . . such that even in the absence of the admitting condition, the individual would require the intensive rehabilitation treatment that is unique to inpatient rehabilitation facilities paid under the IRF PPS .” (emphasis added)

We believe it should be sufficient that the comorbidity has caused significant decline in function. The additional requirement that the comorbidity be an independent basis for admitting the patient to an IRF fails to recognize that it is most typically the comorbidity or secondary condition in combination with the primary diagnosis and not by itself that establishes the need for inpatient rehabilitation. The criterion, as written, would exclude from the 75 percent count many patients with extremely complex medical and rehabilitation needs who are clearly appropriate candidates for inpatient rehabilitation. Therefore, we recommend modification of this criterion by elimination of the language underlined above.

Leslie Norwalk, Esq.  
June 28, 2007  
Page 3

However, at the very least, the existing policy should be continued until a better method can be developed for identifying patients who need and can benefit from inpatient rehabilitation.

In this regard, AAPM&R believes that the current diagnosis-based structure for classifying patients is a flawed mechanism to properly identify patients who need and can tolerate an intensive inpatient rehabilitation program. The 75 Percent Rule is insensitive and inadequate as a tool to determine a patient's appropriate rehabilitation treatment setting. Its use is having the deleterious effect of denying admission to highly needy patients (major organ transplant patients, for example, for whom no category exists), while allowing many patients in "compliant" categories to be included, despite the fact that their care needs might be a lesser priority, and possibly be acceptably provided in an appropriately organized and qualified skilled nursing facility (if such an appropriate facility exists in the patient's community).

Further, it is causing rehabilitation units and hospitals to close and occupancy rates are declining at an alarming rate. This is the impact while the rule is only being "phased in" and compliance only required at the 60% level.

AAPM&R recommends that CMS convene an expert group of physicians, hospital executives, beneficiary representatives and policy makers, and charge them with creating a new system that:

- a) creates a functional definition of the rehabilitation hospital or unit that relies upon facility characteristics to distinguish them from acute care hospitals for reimbursement purposes;
- b) establishes a basic set of medical necessity determination criteria that accurately help to parse individuals into either hospital, SNF, or dual-admissible categories;
- c) defines the essential characteristics and responsibilities of a SNF that is organized as a substitute for hospital level services and establishes regulations to monitor and measure their

Leslie Norwalk, Esq.  
June 28, 2007  
Page 4

- d) performance as hospitals must do (level the clinical playing field); and
- e) establishes a price-neutral reimbursement rate for those patients who truly are clinically appropriate for either setting, to remove financial incentives as a driver for good patient centered decision making.

Concurrent to the expert panel's activities, AAPM&R recommends several interim actions that should be initiated by CMS and maintained until new rules are put into effect:

- a) freeze the 75% Rule criterion at the 60% level;
- b) place a moratorium on the addition of any new rehabilitation programs into the Medicare program; and
- c) continue to hold in abeyance enforcement of the 75% Rule for non-compliant facilities.

In addition, AAPM&R is aware that Medicare Fiscal Intermediaries are using the 75 percent rule list of 13 diagnoses as a proxy for coverage decisions and are, in some cases, automatically denying coverage of inpatient admissions that are not on the list of 13. This reflects a misunderstanding of the 75 percent rule and causes inappropriate denials of coverage. Therefore, we request that in the final rule, CMS include language clarifying that the 75 percent rule is not relevant and should not be used in determining whether an individual beneficiary's inpatient stay is covered and that many patients whose diagnoses are not among those that count for purposes of the 75 percent rule are appropriate for inpatient rehabilitation.

Further, we request that CMS clarify that Medicare fiscal intermediaries, Medicare administrative contractors, recovery audit contractors, and other government agents should, in making coverage determinations, use and apply the criteria established in HCFA Ruling 85-2, as issued on July 31, 1985 as the sole basis for determining the medical necessity of services provided by

Leslie Norwalk, Esq.  
June 28, 2007  
Page 5

inpatient rehabilitation hospitals and units to Medicare beneficiaries. In this regard, any local coverage determinations or other medical review policies should be suspended until the group of national clinical experts on inpatient rehabilitative care is convened and fully examines the issues associated with medical necessity criteria. These recommendations are all consistent with those set forth in an AMA Resolution approved by the AMA House of Delegates and their most recent meeting in June of 2007. (See AMA HOD Resolution 134.)

In the meantime, until a comprehensive review can be undertaken, we ask that in interpreting the requirements of HCFA Ruling 85-2, that AAPM&R's own guidelines - *Standards for Assessing Medical Appropriateness Criteria for Admitting Patients to Inpatient Rehabilitation Hospitals or Units* - be used by Medicare contractors in making coverage determinations. That document can be accessed on the AAPM&R website at:  
<http://www.aapmr.org/zdocs/hpl/MIRC0906.pdf>.

We appreciate the opportunity to comment on this important issue. If you have any questions please contact Rebecca Burke, JD, at (202) 872-6751 or [Rebecca.Burke@ppsv.com](mailto:Rebecca.Burke@ppsv.com).

Sincerely,



Joel M. Press, MD  
President

**Submitter :** Mr. Richard Snyder  
**Organization :** Oklahoma Hospital Association  
**Category :** Hospital

**Date:** 07/02/2007

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-1551-P-22-Attach-1.DOC



4000 Lincoln Boulevard  
Oklahoma City, OK 73105  
(405) 427-9537  
www.okoha.com

Craig W. Jones, FACHE  
President

July 2, 2007

Leslie Norwalk, Esq.  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W., Room 445-G  
Washington, DC 20201

***RE: CMS-1551-P, Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2008: Proposed Rule***

Dear Ms. Norwalk:

On behalf of our nearly 150 member hospitals, health systems and other health care organizations, the Oklahoma Hospital Association (OHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule for the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS). The OHA along with the American Hospital Association (AHA) urge regulatory action on the "75% rule".

The Centers for Medicare and Medicaid Services (CMS) should identify the clinical characteristics of patients who are appropriate for hospital-level inpatient rehabilitation, as recommended by the Medicare Payment Advisory Commission (MedPAC). OHA shares MedPAC's view that the Rule's current diagnosis-based structure is inadequate to "identify all patients who need, can tolerate, and benefit from intensive rehabilitation." **CMS should revise the Rule's criteria based on key clinical indicators of medical necessity for inpatient rehabilitation patients. Patients needing the intense resources available in an IRF, are being inappropriately diverted to a less-intensive setting due to the Rule's current constraints.**

In addition, we also believe there should be a systematic, timely review of the key clinical indicators of medical necessity for IRF level of care conducted by CMS in collaboration with independent researchers; clinical experts including referring physicians, physiatrists, rehabilitation nurses and therapists; and inpatient rehabilitation

providers. This review would allow for ongoing modernization of the Rule's criteria as standards of medical practice and health care advance in the coming years.

The OHA along with the AHA are also concerned about the pending termination of the "75% Rule's" comorbidities provision, which enables inpatient rehabilitation patients to count under the rule based on selected, secondary medical characteristics. This provision is set to expire on July 1, 2008 when the "75% Rule" is fully phased-in. Under this temporary provision, a patient may count toward "75% Rule" compliance if he/she is admitted for a comorbidity that falls within one of the 13 qualifying conditions and causes a significant decline in the patient's functional ability. CMS' own analysis found that 7 percent of cases from July 2005 through June 2006 – approximately 31,000 patients – qualified under the "75% Rule" through the comorbidities provision.

Termination of the comorbidities provision would have a significant negative impact on this large group of patients with complicating medical conditions, now receiving rehabilitation. It is precisely the clinical expertise and resources found now only in an IRF, the close medical supervision by a physician, the specialized, advanced rehabilitative nursing care, and therapy services, that permit these patients to receive rehabilitation in conjunction with the ongoing medical management of their multiple, complex comorbidities. Given the compromised health status and functional level of this population, it would be inappropriate and unsafe for them to receive services outside of an IRF. **OHA urges CMS to amend the "75% Rule" in the Federal Fiscal Year 2008 IRF PPS final rule to permanently include comorbidities among qualifying cases.**

Thank you for the opportunity to submit these comments. If you have any questions, please feel free to contact me at [rsnyder@okoha.com](mailto:rsnyder@okoha.com) or (405) 427-9537.

Sincerely,

OKLAHOMA HOSPITAL ASSOCIATION



Richard K. Snyder  
CFO & VP Finance and Information Services

**Submitter :** Kenneth Raske

**Date:** 07/02/2007

**Organization :** Greater New York Hospital Association

**Category :** Health Care Provider/Association

**Issue Areas/Comments**

**75 Percent Rule Policy**

75 Percent Rule Policy

See attachment.

CMS-1551-P-23-Attach-1.PDF

#23



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**Greater New York Hospital Association**

555 West 57th Street / New York, N.Y. 10019 / (212) 246-7100 / FAX (212) 262-6350  
Kenneth E. Raske, President

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July  
Two  
2007

**VIA ELECTRONIC MAIL**

Leslie Norwalk, Esq.  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W., Room 445-G  
Washington, DC 20201

**RE: CMS-1551-P: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Fiscal Year 2008; Proposed Rule (Vol. 72, No. 88), May 8, 2007**

Dear Ms. Norwalk,

Greater New York Hospital Association (GNYHA), which represents approximately 50 inpatient rehabilitation providers in the metropolitan New York region, including hospitals in New York, Connecticut, New Jersey, and Rhode Island, appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS's) inpatient rehabilitation facility prospective payment system (IRF PPS) proposed rule for fiscal year (FY) 2008.

Our comments will focus on the so-called "75% rule," which requires that a certain percentage of a facility's patients (all payers) have a diagnosis classified in one of 13 conditions. The rule is being phased-in, and under current law, beginning with cost reporting periods July 1, 2007, the required compliance percentage will be 65%, while for cost reporting periods beginning July 1, 2008, the compliance percentage will be 75%. On July 1, 2008, when the compliance threshold reaches 75%, a temporary provision that considers patient comorbidities in determining compliance with the rule will expire.

**The 75% Rule**

GNYHA continues to be very concerned about the impact of the 75% rule on access to inpatient rehabilitation services for Medicare beneficiaries, as well as other payers since the rule applies to facilities' entire patient population. As the rule is phased-in, facilities are increasingly restricted from admitting patients with "non-compliant" diagnoses, regardless of their medical necessity for inpatient rehabilitation care and, as a result, patients who require inpatient rehabilitation services may not be receiving care in the most appropriate setting.

The 75% rule was implemented in the early 1980s in order to distinguish inpatient rehabilitation services from other levels of post-acute care for the purposes of determining Medicare reimbursement. It is important to note, however, that in addition to the 75% rule, inpatient rehabilitation facilities must fulfill strict facility and medical necessity criteria that ensure that they are treating medically complex patients that require intensive multidisciplinary care, rather than patients with low-level rehabilitation needs that could be treated in other post-acute care settings.

In order to meet the facility requirements, facilities must provide the following: a preadmission screening to determine a patient's ability to participate in and benefit from an intensive rehabilitation program; clinical care by a multidisciplinary medical team that meets regularly to discuss patient treatment plans; and 24-hour coverage by a rehabilitation physician and nurse.

The medical necessity guidelines address the functional status and clinical condition of patients who qualify for treatment in an inpatient rehabilitation facility, as well as the intensity of the treatment that the patients must receive, as follows:

- The patient's condition must necessitate intensive, multidisciplinary care in an inpatient hospital setting in order to significantly improve their functional status.
- The patient must be able to receive at least three hours per day of intensive physical and/or occupational therapy at least five days per week.

Patients who cannot participate or benefit from the intensive levels of therapy provided in an inpatient rehabilitation facility and who do not require the medical treatment and oversight available are referred to other post-acute care settings. The facility and medical necessity criteria ensure that the care provided to patients in inpatient rehabilitation facilities is intensive, multidisciplinary, and medically appropriate.

Unlike the medical necessity guidelines described above that considers the patient's acuity and clinical condition in determining their appropriateness for inpatient rehabilitation services, facility compliance with the 75% rule is purely based on patient diagnosis. Patients with a diagnosis not included in one of the 13 conditions may also benefit from inpatient rehabilitation, but the current 75% rule does not recognize this fact. As we noted above, this is a major concern because as the 75% rule is phased-in, facilities are increasingly restricted from admitting patients with "non-compliant" diagnoses, regardless of their medical necessity for inpatient rehabilitation care and, as a result, patients who require inpatient rehabilitation care may not be receiving care in the most appropriate setting.

*To address this key issue with the current 75% rule, GNYHA recommends that CMS consult with a panel comprised of clinicians specializing in rehabilitation, representatives of inpatient rehabilitation facilities, and other experts, to identify the clinical characteristics of the patients with "non-compliant" diagnoses, including their associated comorbidities, that require treatment in a inpatient rehabilitation facility and modify the 75% rule regulation to reflect the findings.*

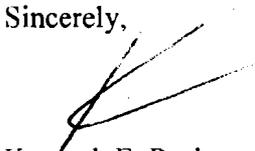
### **Expiration of the Comorbidity Provision**

In the proposed rule, CMS specifically requests comments on whether it should extend the temporary comorbidity provision that is set to expire on July 1, 2008. We are very concerned that the expiration of this provision will inappropriately restrict patients with complex medical needs from receiving needed inpatient rehabilitation care. The comorbidity provision allows a patient to be counted in the "compliant" category if they are admitted with a comorbidity classified in one of the 13 qualifying conditions that causes a significant decline in the patient's functional ability and requires intensive rehabilitation treatment. Eliminating this provision would jeopardize access for the Medicare beneficiaries that qualify for inpatient rehabilitation services under the comorbidity provision. The medical necessity and appropriateness of a patient for inpatient rehabilitation cannot be determined based on the primary diagnosis alone, but must also consider the full clinical profile of the patient.

*We strongly recommend that CMS revise the 75% rule regulation to make the comorbidity provision permanent. In addition, we request that CMS review the list of qualifying comorbidities to determine if there are additional codes that are appropriate for inclusion on the list of qualifying codes.*

If you have any questions about our comments, please do not hesitate to call Elisabeth Wynn, Assistant Vice President for Finance, at (212) 259-0719.

Sincerely,



Kenneth E. Raske  
President

**Submitter :** Mr. Loren Dyer  
**Organization :** Tampa General Hospital  
**Category :** Hospital  
**Issue Areas/Comments**

**Date:** 07/02/2007

**GENERAL**

GENERAL

See attachment

CMS-1551-P-24-Attach-1.DOC

July 02, 2007

Leslie Norwalk, Esq.  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W., Room 445-G  
Washington, DC 20201

***RE: (CMS-1551-P) Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Fiscal Year 2008; Proposed Rule (Vol. 72, No. 88), May 8, 2007***

Dear Ms. Norwalk:

I am writing on behalf of Tampa General Hospital. We appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule for the fiscal year (FY) 2008 inpatient rehabilitation facility prospective payment system (PPS). In particular, we would like to urge regulatory action on the "75% Rule."

Tampa General Hospital (TGH) serves a 12-county region with a population in excess of 4 million, in West Central Florida. TGH serves as the primary teaching hospital for the University of South Florida (USF) College of Medicine. Since 1971, the College of Medicine has graduated nearly 1,700 physicians and prepared 2,000 doctors in specialty residency programs. Ranked among the nations top 100 research universities, USF and TGH are committed to developing advances in medicine through both clinical practice and research.

CMS should identify the clinical characteristics of patients who currently fall outside of the qualifying conditions and are appropriate for hospital-level inpatient rehabilitation, as recommended by the Medicare Payment and Advisory Commission (MedPAC). We share MedPAC's view that the Rule's current diagnosis-based structure is inadequate to "identify all patients who need, can tolerate, and benefit from intensive rehabilitation." CMS should expand the qualifying conditions based on key clinical indicators of medical necessity for inpatient rehabilitation patients who today are inappropriately diverted to a less-intensive setting due to the Rule's constraints. Doing so would reduce inappropriately denied admissions for medically necessary patients seeking care in the nation's inpatient rehabilitation hospitals and units. Systematic, timely review and modernization of the qualifying conditions should be conducted by CMS in collaboration with independent researchers; clinical experts including referring physicians, psychiatrists, rehabilitation nurses and therapists; and inpatient rehabilitation providers.

Leslie Norwalk, Esq.  
July 02, 2007  
Page 2 of 2

We also are concerned about the pending termination of the 75% Rule's co-morbidities provision, which enables inpatient rehabilitation patients to count under the rule based on selected, secondary medical characteristics. This provision is set to expire on July 1, 2008 when the 75% Rule is fully phased-in. Under this temporary provision, a patient may count toward 75% Rule compliance if he/she is admitted for a co-morbidity that falls within one of the 13 qualifying conditions and causes a significant decline in the patient's functional ability. CMS' analysis found that 7 percent of cases from July 2005 through June 2006 – approximately 31,000 patients – qualified under the 75% Rule through the co morbidities provision.

Termination of the co-morbidities provision would have a significant negative impact on this large group of patients with complicating medical conditions that require medical oversight by a physician and the specialized, advanced nursing care and therapy services found in inpatient rehabilitation hospitals and units. Given the compromised health status and functional level of this population, it would be inappropriate to deny them access to the inpatient rehabilitation setting.

We urge CMS to amend the 75% Rule in the FY 2008 inpatient rehabilitation facility PPS final rule to permanently include co-morbidities among qualifying cases.

Tampa General looks forward to continued collaboration on this matter.

Sincerely,

Loren M. Dyer  
Director of Revenue & Reimbursement

**Submitter :** Mr. Stephen Harwell  
**Organization :** Healthcare Association of New York State  
**Category :** Health Care Provider/Association

**Date:** 07/02/2007

**Issue Areas/Comments**

**GENERAL**

GENERAL

See attachment

CMS-1551-P-25-Attach-1.DOC

#25



Healthcare Association  
of New York State

July 2, 2007

Leslie Norwalk, Esq.  
Acting Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1551-P  
7500 Security Boulevard  
Baltimore, Maryland 21244-8012

**Re: CMS-1551-P, Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2008; Proposed Rule**

Dear Ms. Norwalk:

The Healthcare Association of New York State (HANYS), on behalf of our more than 550 hospitals, nursing homes, home health agencies, and other health care providers, welcomes the opportunity to comment on the proposed rule related to the Medicare Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS). HANYS along with the American Hospital Association (AHA) urge regulatory action on the "75% Rule."

The Centers for Medicare and Medicaid Services (CMS) should identify the clinical characteristics of patients who are appropriate for hospital-level inpatient rehabilitation, as recommended by the Medicare Payment Advisory Commission (MedPAC). HANYS shares MedPAC's view that the Rule's current diagnosis-based structure is inadequate to "identify all patients who need, can tolerate, and benefit from intensive rehabilitation." **CMS should revise the Rule's criteria based on key clinical indicators of medical necessity for inpatient rehabilitation patients. Patients needing the intense resources available in an IRF, are being inappropriately diverted to a less-intensive setting due to the Rule's current constraints.**

In addition, we also believe there should be a systematic, timely review of the key clinical indicators of medical necessity for IRF level of care conducted by CMS in collaboration with independent researchers; clinical experts including referring physicians, physiatrists, rehabilitation nurses and therapists; and inpatient rehabilitation providers. This review would allow for ongoing modernization of the Rule's criteria as standards of medical practice and health care advance in the coming years.

Ms. Leslie Norwalk  
July 2, 2007

Page Two

HANYS along with the AHA are also concerned about the pending termination of the "75% Rule's" comorbidities provision, which enables inpatient rehabilitation patients to count under the rule based on selected, secondary medical characteristics. This provision is set to expire on July 1, 2008 when the "75% Rule" is fully phased-in. Under this temporary provision, a patient may count toward "75% Rule" compliance if he/she is admitted for a comorbidity that falls within one of the 13 qualifying conditions and causes a significant decline in the patient's functional ability. CMS' own analysis found that seven percent of cases from July 2005 through June 2006 – approximately 31,000 patients – qualified under the "75% Rule" through the comorbidities provision.

Termination of the comorbidities provision would have a significant negative impact on this large group of patients with complicating medical conditions, now receiving rehabilitation. It is precisely the clinical expertise and resources found now only in an IRF, the close medical supervision by a physician, the specialized, advanced rehabilitative nursing care, and therapy services, that permit these patients to receive rehabilitation in conjunction with the ongoing medical management of their multiple, complex comorbidities. Given the compromised health status and functional level of this population, it would be inappropriate and unsafe for them to receive services outside of an IRF. **HANYS urges CMS to amend the "75% Rule" in the Federal Fiscal Year 2008 IRF PPS final rule to permanently include comorbidities among qualifying cases.**

HANYS appreciates having the opportunity to comment on the proposed rule. If you have any questions regarding our comments, please contact me at (518) 431-7777 or [sharwell@hanys.org](mailto:sharwell@hanys.org).

Sincerely,

Stephen Harwell  
Vice President  
Economics, Finance, and Information

**Submitter :** Ms. Robert Reske  
**Organization :** University of Michigan Health System  
**Category :** Hospital  
**Issue Areas/Comments**

**Date:** 07/02/2007

**GENERAL**

GENERAL

See Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE AND MEDICAID SERVICES  
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

**Submitter :** Mr. David McClure  
**Organization :** Tennessee Hospital Association  
**Category :** Health Care Provider/Association

**Date:** 07/02/2007

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-1551-P-27-Attach-1.DOC



July 2, 2007

Leslie Norwalk, Esq.  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W., Room 445-G  
Washington, DC 20201

***RE: CMS-1551-P, Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Fiscal Year 2008; Proposed Rule***

Dear Ms. Norwalk:

The Tennessee Hospital Association (THA), on behalf of our over 200 healthcare facilities, including hospitals, inpatient rehabilitation facilities, home care agencies, nursing homes, and health-related agencies and businesses, and over 2,000 employees of member healthcare institutions, such as administrators, board members, nurses and many other health professionals, appreciates the opportunity to submit comments on the Centers for Medicare & Medicaid Services (CMS) on the fiscal year (FY) 2008 inpatient rehabilitation facility prospective payment system proposed rule..

**75 Percent Rule Policy**

The Tennessee Hospital Association is in agreement with the recommendation of the American Hospital Association; in particular, we would like to urge regulatory action on the "75% Rule."

CMS should identify the clinical characteristics of patients who currently fall outside of the qualifying conditions and are appropriate for hospital-level inpatient rehabilitation, as recommended by the Medicare Payment and Advisory Commission (MedPAC). We share MedPAC's view that the Rule's current diagnosis-based structure is inadequate to "identify all patients who need, can tolerate, and benefit from intensive rehabilitation." CMS should expand the qualifying conditions based on key clinical indicators of medical necessity for inpatient rehabilitation patients who today are inappropriately diverted to a less-intensive setting due to the Rule's constraints. Doing so would reduce inappropriately denied admissions for medically necessary patients seeking care in the nation's inpatient rehabilitation hospitals and units. Systematic, timely review and modernization of the qualifying conditions should be conducted by CMS in collaboration with independent researchers; clinical experts including referring physicians, physiatrists, rehabilitation nurses and therapists; and inpatient rehabilitation providers.

We also are concerned about the pending termination of the 75% Rule's comorbidities provision, which enables inpatient rehabilitation patients to count under the rule based on selected, secondary medical characteristics. This provision is set to expire on July 1, 2008 when the 75% Rule is fully phased-in. Under this temporary provision, a patient may count toward 75% Rule compliance if he/she is admitted for a comorbidity that falls within one of the 13 qualifying conditions and causes a significant decline in the

Leslie Norwalk, Esq.  
July 2, 2007  
Page 2 of 2

patient's functional ability. CMS' analysis found that 7 percent of cases from July 2005 through June 2006 – approximately 31,000 patients – qualified under the 75% Rule through the comorbidities provision.

Termination of the comorbidities provision would have a significant negative impact on this large group of patients with complicating medical conditions that require medical oversight by a physician and the specialized, advanced nursing care and therapy services found in inpatient rehabilitation hospitals and units. Given the compromised health status and functional level of this population, it would be inappropriate to deny them access to the inpatient rehabilitation setting. We urge CMS to amend the 75% Rule in the FY 2008 inpatient rehabilitation facility PPS final rule to permanently include comorbidities among qualifying cases.

The THA appreciates the opportunity to submit these comments. If you have any questions about our remarks, please feel free to contact me or David McClure, vice president of finance, at (615) 256-8240 or [dmcclure@tha.com](mailto:dmcclure@tha.com).

Sincerely,

Craig Becker, FACHE  
President

cc: Rick Pollack, AHA, Executive Vice President

**Submitter :** Dr. Francis Bonner  
**Organization :** Rehabilitation Hospital of South Jersey  
**Category :** Hospital

**Date:** 07/02/2007

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-1551-P-28-Attach-1.DOC

#28



**REHABILITATION HOSPITAL  
of SOUTH JERSEY**

1237 W. SHERMAN AVENUE  
VINELAND, NEW JERSEY 08360

TOLL-FREE; 1-800-691-RHSJ  
PHONE: 856-696-7100 FAX; 856-696-9040

WWW.RHSJ.COM

***BY ELECTRONIC DELIVERY***

Leslie Norwalk, Acting Administrator  
Centers for Medicare & Medicaid Services  
Room 445-G  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W.  
Washington, DC 20201

**Re: CMS-1551-P (Medicare Program; Inpatient  
Rehabilitation Facility Prospective Payment System for  
Federal Fiscal Year 2008)**

Dear Administrator Norwalk:

Mediplex Cumberland Rehabilitation Hospital, d/b/a the Rehabilitation Hospital of South Jersey (RHSJ), appreciates this opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) fiscal year (FY) 2008 proposed rule regarding inpatient rehabilitation facility (IRF) reimbursement under the Medicare prospective payment system (PPS) (the "Proposed Rule").<sup>1</sup> RHSJ is an IRF located in Cumberland County, New Jersey, that provides high-quality, comprehensive physical restoration services and is reimbursed under the Medicare IRF PPS.

RHSJ's comments on the Proposed Rule are limited to the wage index, which is used by CMS to adjust an IRF's wage and wage-related costs to reflect the relative hospital wage level in the IRF's geographic area, as compared to the national average wage level. As you are aware, the wage index has a significant effect on a hospital's Medicare reimbursement, because labor costs constitute the majority of hospital costs. The wage index that would apply to RHSJ for FY 2008 under the Proposed Rule is substantially lower than the wage indices that would apply to the neighboring hospitals with which RHSJ competes for professional staff, including the only acute care hospital in the same Core-Based Statistical

<sup>1</sup> 72 Fed. Reg. 26,230 (May 8, 2007).

Area (CBSA),<sup>2</sup> seven other acute care hospitals in the region, and the nearest IRF. As a result of this material difference between RHSJ's wage index and the wage indices of all neighboring hospitals, RHSJ has been substantially disadvantaged in its efforts to compete for and retain skilled staff.

As described in more detail below, we request that CMS exercise its broad discretion under section 1886(j)(6) of the Social Security Act (the Act) and change the methodology for setting the FY 2008 wage index for RHSJ and the very small number of IRFs that are likely to be similarly situated. Specifically, we propose a change in the wage index applied to IRFs in CBSAs with only one acute care hospital on which to determine the wage index and that acute care hospital has been reclassified, redesignated or receives the rural floor. We urge CMS to make this change in the FY 2008 IRF PPS final rule.

## **I. The Medicare Wage Indices Applied to RHSJ and Neighboring Facilities**

The proposed FY 2008 wage index for RHSJ is substantially below the proposed wage index for the acute care hospital located directly across the street, as well as the other facilities with which RHSJ competes for staff. We describe below the effects on RHSJ of these wage index "cliffs" between neighboring hospitals and counties and the implications for patient access to IRF care in South Jersey.

RHSJ is the only rehabilitation facility in Cumberland County, New Jersey. Despite being located only 35 miles from Philadelphia, Cumberland County is a largely rural county. In addition to serving Cumberland County, RHSJ also serves the surrounding counties of Salem, Gloucester and Cape May, New Jersey, which do not have any IRFs. RHSJ provides physical restoration services of an intensity and scope that are not available in sub-acute or nursing home programs. Patients at RHSJ receive three hours of physical therapy per day as well as access to all services that the patient would receive from an acute care hospital, including cancer care, hemodialysis, and radiology services.

RHSJ opened in March 2003 and has been reimbursed under the IRF PPS since that time. The hospital is licensed for 30 inpatients, with a temporary extension from the State of New Jersey to 34 beds, and serves about 20-25 outpatients per day.

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<sup>2</sup> A CBSA is a geographic entity defined by the Office of Management and Budget (OMB). OMB standards designate and define two types of CBSAs: Metropolitan Statistical Areas (MSAs) and Micropolitan Statistical Areas. 70 Fed. Reg. 47,880, 47,918 (Aug. 15, 2005).

RHSJ is located directly across the street from a 262-bed acute care facility, the South Jersey Healthcare (SJH) Regional Medical Center, which is the only acute care hospital in the same CBSA (47220). RHSJ is also located within 25 miles of four other acute care hospitals (Burdette Tomlin Memorial Hospital, Memorial Hospital of Salem County, Kessler Memorial Hospital and Kennedy Memorial Hospitals-Washington Township) and within 37.5 miles of three additional hospitals (Shore Memorial Hospital, AtlantiCare Regional Medical Center, and Underwood-Memorial Hospital). The nearest IRF is Bacharach Institute for Rehabilitation, located in Atlantic County, which is contiguous with Cumberland County. This IRF is located less than an hour away from RHSJ, and has an outpatient rehabilitation facility located within five miles of RHSJ.

RHSJ must draw its therapy staff from across southern New Jersey and southeastern Pennsylvania because there is no natural base of trained therapists in Cumberland County. Only 24% of RHSJ's physical therapists live in Cumberland County, with most commuting at least 20 miles. Other professional staff commute from a wide area as well. Only 50% of RHSJ's other professional staff live in Cumberland County.

RHSJ has seen extraordinary growth in salaries for therapy staff. Its salaries have increased over 10% per year for the last two years in an effort to remain competitive with salaries at competing facilities. Several of RHSJ's current therapists are supplied by staffing agencies, which puts even greater pressure on the hospital's finances because of the higher rates charged by these agencies.

RHSJ must compete for professional staff with SJH Regional Medical Center, the other seven hospitals located in the region, the IRF in Atlantic County and its local outpatient facility, and several private physical therapy staffing agencies. Although RHSJ competes for the same workforce as these facilities, the wage index to be applied to RHSJ for FY 2008 is substantially lower than those of its competitors. Table 1 sets forth the wage indices to be applied to RHSJ, Bacharach Institute for Rehabilitation, SJH Regional Medical Center, which has been reclassified to CBSA 48664 for FYs 2008-2010, and other neighboring acute care hospitals for FY 2008:

**Table 1. Proposed Wage Indices for FY 2008 for RHSJ and Neighboring Hospitals<sup>3</sup>**

<b>Provider</b>	<b>Wage Index</b>	<b>% Higher than RHSJ Wage Index</b>
RHSJ	0.9832	***
Bacharach Institute for Rehabilitation	1.1831	20%
SJH Regional Medical Center	1.0752	9%
Burdette Tomlin	1.0864	10%
Shore Memorial Hospital	1.2095	23%
AtlantiCare Regional Medical Center	1.2095	23%
Underwood Memorial Hospital	1.0777	10%
Kessler Memorial Hospital	1.2095	23%
Memorial Hospital of Salem County	1.0752	9%
Kennedy Memorial Hospitals	1.0522	7%

These county-level “cliffs” in the wage indices put RHSJ at a severe disadvantage in hiring and retaining therapy staff, particularly as compared

<sup>3</sup> Sources: Table 1 of the Proposed Rule, “Hospital Case-Mix Indexes For Discharges Occurring in Federal Fiscal Year 2006; Hospital Wage Indexes For Federal Fiscal YEAR 2008; Hospital Average Hourly Wages For Federal Fiscal Years 2006 (2002 Wage Data), 2007 (2003 Wage Data), and 2008 (2004 Wage Data); Wage Indexes And 3- Year Average of Hospital Average Hourly Wages – (Correction)” and “FY 2008 Wage Index Final Rule Worksheet S-3 Wage Data File” available at <http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp#TopOfPage> and Table 2 of the CMS proposed rule regarding the hospital inpatient PPS for FY 2008, 72 Fed. Reg. 24,680 (May 3, 2007).

to Bacharach Institute for Rehabilitation, the IRF located in adjacent Atlantic County.

In addition to being at a competitive disadvantage for FY 2008 due to its low wage index, RHSJ was at a competitive disadvantage for earlier years for the same reason. For example, for FY 2007, RHSJ's wage index was 0.9827, while the neighboring SJH Regional Medical Center received the statewide rural floor of 1.1402, which was 16% higher than the wage index applied to RHSJ. The wage index for the IRF in Atlantic County was 1.1615 – a full 18% higher than the wage index applied to RHSJ. The other acute care hospitals in the region had wage indices ranging from 1.1402 to 1.1692, or 16 to 19% higher than the wage index applied to RHSJ.

If RHSJ is not able to compete for therapists and other professional staff, patients in Cumberland and surrounding counties will be unable to get access to the high-quality IRF services that the hospital provides. RHSJ estimates that application of the current wage index policy is costing RHSJ hundreds of thousands of dollars or more each year. The effects on RHSJ's operations and access to IRF services in Cumberland County are substantial:

- **Turnover:** The rate of staff turnover at RHSJ was 38% in 2006, which is up substantially from prior years. Exit interviews with departing staff cite rate of pay as the reason for the resignation in almost every case. Even with the recent wage increases, physical therapists still leave because of the very competitive market for therapy staff. This competitive market also affects turnover of other staff. Because of the upward pressure on wages for therapy staff, RHSJ has not been able to raise salaries for non-therapy staff since 2005.
- **Reduced Access to IRF Services:** If RHSJ cannot staff the full number of beds for which it is licensed, patients in Cumberland County cannot get access to the hospital's high quality IRF services. The hospital's goal is to have a staff of 15 therapists per day. It is currently five therapists short of this goal. RHSJ estimates that over a four-month period, 69 inpatients have been unable to get access to its inpatient therapy services due to staffing shortages. RHSJ has also had to close outpatient programs because of staffing constraints. For example, the hospital has not been able to open its day program for patients with head injuries.

## II. IRF PPS Wage Index Policy

As CMS has itself recognized, "acute care hospitals compete in the same labor market areas as IRFs."<sup>4</sup> Where the wage index applicable to an

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<sup>4</sup> 70 Fed. Reg. at 47,927.

IRF is substantially lower than the wage indices applicable to neighboring acute care hospitals, the IRF will be significantly disadvantaged in its ability to compete for staff. This is precisely what is happening to RHSJ, which is across the street from a competing facility that currently receives a wage index that is 16% higher than the wage index applied to RHSJ.

As noted above, there is only one acute care hospital in RHSJ's CBSA (47220). In discussing its methodology for setting the IRF wage index, the agency has acknowledged the potential problems in relying on a single hospital to create a wage index.<sup>5</sup> In its IRF PPS final rule for FY 2006, CMS noted that, where there are few hospitals in a labor market area, "the wage indices for IRFs in those areas could become relatively unstable as they might change considerably from year to year."<sup>6</sup> It also noted the "increase[d] . . . potential for dramatic shifts in those areas' wage indices from one year to the next because a single hospital . . . could have a disproportionate effect on the wage index of the area."<sup>7</sup> In light of these concerns, CMS decided to treat all Micropolitan Areas, which OMB defines as areas with at least one urban cluster with a population of at least 10,000 but less than 50,000, and which tend to include fewer hospitals, as part of the statewide rural labor market area.

The risk of volatility and potential inaccuracy in relying on data submitted by a single hospital to establish an area wage index, particularly where that hospital's costs may be idiosyncratic, was also highlighted at the March 2007 meeting of the Medicare Payment Advisory Commission (MedPAC) on wage index reform as well as in MedPAC's June 2007 report to Congress.<sup>8</sup> These problems may be exacerbated where, as in CBSA 47220, the only acute care hospital in the CBSA has been reclassified or is reimbursed based on the statewide rural floor, rather than its own reported wage data. Because such hospitals are reimbursed based on a higher wage index, they may be less concerned about their own wage data, and may arguably have less need to ensure a high degree of accuracy in reporting the data on which the wage index for their CBSA is based.

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<sup>5</sup> Id. at 47,921.

<sup>6</sup> Id. at 47,920.

<sup>7</sup> Id. at 47,921.

<sup>8</sup> See MedPAC, Report to the Congress: Promoting Greater Efficiency in Medicare 129 (June 2007) ("Areas with only one or two hospitals may also see volatility in the wage index if wages change suddenly—for example, because of a new labor agreement or because of errors in reporting costs and hours."); Transcript of MedPAC Public Meeting, March 8, 2007 at 332, 341-42. See also id. at 336 ([I]n a one hospital MSA, there's really not any assurance that what gets reported is that the underlying labor costs. Or it could be very idiosyncratic to that particular hospital.").

### III. Recommended Change to Current IRF PPS Wage Index Policy

In section 1886(j)(6) of the Act, Congress gave CMS broad authority to develop an appropriate IRF wage index. CMS has recognized the breadth of its discretion under section 1886(j)(6): “[CMS] has broad authority under 1886(j)(6) to update the wage index on the basis of information available to [CMS] (and updated as appropriate) of the wages and wage-related costs incurred in furnishing rehabilitation services.”<sup>9</sup> CMS has exercised its discretion to adjust the IRF wage index on a number of occasions. For example, CMS exercised this authority in circumstances where the data for determining the wage index were inadequate, such as with respect to Micropolitan Areas. CMS also exercised its broad latitude regarding the IRF wage index for urban IRFs located in geographic areas with no corresponding wage data. In the FY 2006 IRF PPS final rule, CMS determined that urban IRFs in geographic areas without hospital wage data would receive a wage index based on the average wage index for all urban areas in the state.<sup>10</sup>

Most recently, CMS has proposed to exercise its extremely broad discretion with respect to the IRF wage index for IRFs in rural areas where there are no rural hospital wage data. In the IRF PPS proposed rule for FY 2008, CMS said that, for such facilities, it intends to use the average wage index for all CBSAs that share a border with the CBSA of such facility as “a reasonable proxy for the rural area within a State.”<sup>11</sup> CMS determined that this approach would be the best imputed proxy because it would (1) use pre-floor, pre-reclassified hospital data, (2) be easy to evaluate, (3) use the most local data, and (4) be easily updateable from year-to-year.

CMS similarly should exercise its discretion under the Medicare statute to adjust the wage index for IRFs located in a CBSA with only one acute care hospital on which to determine the wage index, and that acute care hospital has been reclassified, redesignated or receives the rural floor. We recommend that the agency apply the statewide urban average wage index to each IRF in such circumstances. Alternatively, RHSJ recommends that CMS apply to each such IRF the average wage index for all CBSAs contiguous with that of the IRF.

Application of the statewide urban average wage index to IRFs in CBSAs with only one acute care hospital on which to determine the wage index, where the acute care hospital has been reclassified, redesignated or receives the rural floor, is well within CMS’s broad authority under section 1886(j). Consistent with the factors identified by CMS, the statewide urban average wage index is a reasonable proxy because it would use pre-floor, pre-

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<sup>9</sup> 70 Fed. Reg. at 47,927.

<sup>10</sup> Id. at 47,927.

<sup>11</sup> 72 Fed. Reg. at 26,244.

reclassified hospital data, would be easy to evaluate, would use data from the hospital's own state, and would be easily updateable. We note that this is the same solution that CMS has adopted to apply to urban hospitals in CBSAs without any wage index data.

Alternatively, CMS could apply to IRFs such as RHSJ the same policy that the agency has proposed for rural areas where there are no rural hospital wage data; that is, CMS could use the average wage index for all contiguous CBSAs. CMS has already determined that this approach meets its criteria for the best imputed proxy where there are no hospital wage data, and we believe that it is also a reasonable proxy where there are data only for a single acute care hospital and that hospital has been reclassified, redesignated, or receives the rural floor.

Either of these alternatives would provide a narrowly-tailored solution for RHSJ's situation that would likely apply to a very limited universe of IRFs. Based upon our analysis, we estimate that only about six IRFs in the nation would be similarly situated with RHSJ and, therefore, eligible for an increase in their wage index. CMS stated in the FY 2006 IRF PPS final rule that there are only 49 Metropolitan Statistical Areas with only one hospital.<sup>12</sup> Under our recommendation, this group would be limited further to only those areas in which the acute care hospital has been reclassified or is subject to the rural floor *and* in which an IRF is located. Based on our analysis of the IRF and IPPS wage index data files, we estimate that for FY 2007 there were only seven to nine IRFs located in CBSAs with only one acute care hospital, where the provider number of the IRF is different from the provider number of the acute care hospital. For this group, we found that six of the acute care hospitals had been reclassified, redesignated, or received the rural floor. Thus, although we are not able to determine precisely how many IRFs would be affected by our recommended change, these estimates strongly suggest that RHSJ's recommendation would apply to a very small number of IRFs.<sup>13</sup>

In developing our recommendation for addressing RHSJ's problem, we concluded that it would not be necessary to change the wage index policy other than for IRFs located in a CBSA with one acute care hospital, where the acute care hospital has been reclassified, redesignated or receives the rural floor. In CBSAs with two acute care hospitals, even if both of those hospitals have been reclassified, redesignated or receive the rural floor, there is an "averaging effect," which "allows for more data points to be used to calculate the representative standard of measured labor costs within a market area."<sup>14</sup> As CMS has recognized, "[i]n labor market areas with a

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<sup>12</sup> 70 Fed. Reg. at 47,921.

<sup>13</sup> We were not able to derive an estimate for FY 2008 because the final IRF data files for FY 2008 were not available. We have no reason to believe, however, that the number of affected IRFs would be significantly different for FY 2008.

<sup>14</sup> 70 Fed. Reg. at 47,921.

single hospital,” there is no “counterbalancing averaging” of wage costs.<sup>15</sup> We also do not believe that this policy change should extend to IRFs that share the same provider number as the acute care facility, because these IRFs do not have the same concerns about data quality and accuracy. Unlike RHSJ, an IRF that is affiliated with an acute care facility should have some ability to control the Medicare cost data submitted by that acute care facility as well as recourse if there is a concern that the data do not accurately reflect the facility’s wage costs.

#### **IV. CMS Can Make RHSJ’s Recommended Change in the FY 2008 Final Rule Without the Need for Any Additional Notice and Comment**

Incorporation of the limited change RHSJ has recommended into the final rule without undergoing additional notice and comment is consistent with the requirements for notice in section 553 of the Administrative Procedure Act (APA).<sup>16</sup> Although CMS did not explicitly propose this specific change to the IRF wage index, notice was adequate because the proposed rule suggested a related modification, and it thereby raised for consideration the general issue of changes to the IRF wage index to correct for inadequate data in particular circumstances.<sup>17</sup> Furthermore, CMS had previously expressed both a concern that wage indices based on data from a small number of hospitals would be unstable and inequitable and a desire to calculate wage indices that more accurately reflect the true nature of local labor costs.<sup>18</sup> To minimize instability and inequity, CMS adjusted its formula for calculating wage indices for IRFs located in Micropolitan Areas in a manner similar to what is proposed here – by using a statewide wage index.<sup>19</sup> Accordingly, because CMS had previously made comparable changes to the IRF wage index for related reasons, interested parties in the present circumstance were put on notice that CMS might consider similar changes even absent an explicit proposal.

The case law confirms that in circumstances such as these, the notice provided is adequate under the APA. Courts generally inquire whether the final rule is a “logical outgrowth” of the proposed rule, the rulemaking proceedings, or the comments received; if so, notice is deemed sufficient and an additional notice and comment period is not required.<sup>20</sup> If, however, the

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<sup>15</sup> Id.

<sup>16</sup> 5 U.S.C. § 553 (2006).

<sup>17</sup> 72 Fed. Reg. at 26,244 (proposing to revise the methodology used to determine wage indices for rural areas without hospital wage data).

<sup>18</sup> 70 Fed. Reg. at 47,920-21.

<sup>19</sup> Id. at 47,921.

<sup>20</sup> See, e.g., Ne. Md. Waste Disposal Auth. v. E.P.A., 358 F.3d 936, 951-52 (D.C. Cir. 2004) (“an agency satisfies the notice requirement, and need not conduct a further round of public comment, as long as its final rule is a ‘logical outgrowth’ of the rule it originally

final rule “deviates too sharply” from or is the opposite of the proposed rule, “affected parties will be deprived of notice and an opportunity to respond to the proposal.”<sup>21</sup> Because courts encourage administrative agencies to modify proposed rules in response to comments<sup>22</sup> as well as to use new information learned during the comment period in formulating the final rule,<sup>23</sup> a final rule satisfies the “logical outgrowth” test so long as “at least the ‘germ’ of the outcome is found in the original proposal.”<sup>24</sup> Furthermore, courts are willing to generalize from specific examples in proposed rules to conclude that final rules that include changes that fall within the same general category as the specific examples in the proposed rule satisfy the logical outgrowth test.<sup>25</sup>

Modifying the wage index for the limited set of IRFs that are in a CBSA with only one acute care hospital, where that acute care hospital has been reclassified, redesignated, or receives the rural floor, is a logical outgrowth of the Proposed Rule. The Proposed Rule contained a proposal to change the methodology for calculating the IRF wage index for situations in which the data that would otherwise be used were inadequate.<sup>26</sup> Thus, interested parties “should have anticipated” that CMS was contemplating exercising its discretion to adjust the IRF wage index, generally, for particular situations in which relevant data were substandard.<sup>27</sup> The particular change to the IRF wage index recommended by RHSJ is similar to the specific change proposed by CMS because it, too, seeks to correct for inadequate data. Therefore, because this particular change to the IRF wage index is related to CMS’s own proposed change and is within the same general category of changes, it is a logical outgrowth of the Proposed Rule, and additional notice and comment is not required prior to final promulgation.<sup>28</sup>

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proposed”) (quoting First Am. Discount Corp. v. Commodity Futures Trading Comm’n, 222 F.3d 1008, 1015 (D.C. Cir. 2000)).

<sup>21</sup> Small Refiner Lead Phase-Down Task Force v. E.P.A., 705 F.2d 506, 547 (D.C. Cir. 1997). See also Env’tl. Integrity Project v. E.P.A., 425 F.3d 992, 997 (D.C. Cir. 2005) (“This flip-flop complies with the APA only if preceded by adequate notice and comment.”).

<sup>22</sup> Ne. Md. Waste Disposal, 358 F.3d at 951.

<sup>23</sup> American Coke and Coal Chemicals Inst. v. E.P.A., 452 F.3d 930, 939 (D.C. Cir. 2006) (citing BASF Wyandotte Corp. v. Costle, 598 F.2d 637, 642-46 (1<sup>st</sup> Cir. 1979)).

<sup>24</sup> National Ass’n of Psychiatric Health Sys. v. Shalala, 120 F. Supp. 2d 33, 39 (D.D.C. 2000) (quoting Natural Res. Defense Council v. Thomas, 838 F.2d 1224, 1242 (D.C. Cir. 1988)).

<sup>25</sup> See, e.g., Small Refiner, 705 F.2d at 546-48 (D.C. Cir. 1983).

<sup>26</sup> 72 Fed. Reg. 26,230, 26,244 (May 8, 2007).

<sup>27</sup> Ne. Md. Waste Disposal, 358 F.3d at 952 (quoting City of Waukesha v. E.P.A., 320 F.3d 228, 245 (D.C. Cir. 2003)).

<sup>28</sup> See National Ass’n of Home Builders v. United States Army Corps of Eng’rs, 453 F. Supp. 2d 116, 126 (D.D.C. 2006) (when interested parties were aware that the final rule would be more protective of the environment, a final rule that was more protective than the proposed rule was a “logical endpoint” and was therefore a logical outgrowth of the proposed rule).

Finally, although MedPAC has submitted a report to Congress on the Medicare wage index that includes recommendations regarding alternative methods for computing the wage index, CMS should not delay making RHSJ's recommended narrowly-tailored change to IRF wage index policy for FY 2008. MedPAC has recommended that Congress repeal the existing wage index statute and give the Secretary authority to establish new wage index systems.<sup>29</sup> This legislative change may never be enacted; moreover, even if it is enacted, it may take years to implement. In the meantime, the current IRF wage index policy is causing significant financial harm to RHSJ. Its wage index is substantially lower than the wage indices that apply to the acute care hospital directly across the street and the inpatient rehabilitation hospital located less than an hour away, as well as other hospitals in the region. The limited administrative solution that we propose is well within CMS's authority, would apply to only a small number of IRFs, and is very much consistent with the one of the apparent goals of the MedPAC recommendations, as discussed at the March and April public meetings: to reduce the inherent unfairness where one provider receives the pre-reclassification wage index while a neighboring or adjacent hospital-based provider receives a higher wage index.

\* \* \*

RHSJ greatly appreciates the opportunity to comment on the proposed wage index for RHSJ for FY 2008, and we sincerely hope that CMS will give thoughtful consideration to our comments and will incorporate our recommendation into its final rule. Thank you for your attention to this very important matter.

Respectfully submitted,

*Francis J. Bonner, Jr. MD.*

Francis J. Bonner, Jr., MD  
Medical Director/CEO

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<sup>29</sup> See MedPAC, Report to the Congress: Promoting Greater Efficiency in Medicare 144 (June 2007).

**Submitter :** Mr. Bruce Hart  
**Organization :** Mary Free Bed Rehabilitation Hospital  
**Category :** Health Care Provider/Association

**Date:** 07/02/2007

**Issue Areas/Comments**

**75 Percent Rule Policy**

75 Percent Rule Policy

July 2, 2007

Re: Comments to file code CMS-1551-P

I am writing concerning the Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Fiscal Year 2008; Proposed Rule. The proposal fails to make meaningful changes to the outdated 75% Rule and its associated negative effects on rehabilitation providers and patients.

Mary Free Bed Hospital & Rehabilitation Center is an 80-bed, freestanding rehabilitation hospital located in Grand Rapids, Michigan. It is an integral part of the West Michigan healthcare community and serves approximately 1,100 inpatients annually. The hospital is known for excellent clinical outcomes, high levels of customer satisfaction, shortened lengths of stay and significantly lower than average case costs. The Medicare program covers about 40% of Mary Free Bed inpatient admissions.

Patients are referred for inpatient rehabilitation based on their overall medical condition, as well as their functional losses. Their need for medical supervision and the ability to tolerate and benefit from intensive daily therapy plays the determining role in the admission decision. The multidisciplinary team treating the patients includes physiatrists, rehabilitation nurses who monitor them 24 hours per day, and physical and occupational therapists. A broad range of other therapists is available and provides care as may be necessary. These clinicians are essential to the treatment of medically complex cases and the achievement of optimal patient outcomes. The daily application of at least 3 hours of therapy facilitates the most efficient recovery, which is not available in other sites such as skilled nursing facilities.

Mary Free Bed is the primary provider of rehabilitation services in the West Michigan community. Our most significant concern with the proposal to continue phase in of the 75% rule, is that, the Medicare beneficiaries and other patients will lose access to necessary care. We believe other providers and their patients share our concern. Many Medicare patients will be discriminated against as a result, and achieve below average recoveries, independence and quality of lives.

Mary Free Bed urges CMS to maintain the threshold at the 60% level rather than continuing the phase in to 75%. Thank you for your consideration of our concerns with the proposed rule. Please contact me with any questions you might have regarding the information above.

Sincerely,  
Bruce M. Hart  
Director of Finance  
616-242-0490-bruce.hart@maryfreebed.com

**Submitter :** Bobby Silverstein  
**Organization :** Coalition to Preserve Rehabilitation  
**Category :** Consumer Group

**Date:** 07/02/2007

**Issue Areas/Comments**

**75 Percent Rule Policy**

75 Percent Rule Policy

Please see the attached comments from the Coalition to Preserve Rehabilitation (CPR) regarding the 75 Percent Rule Policy.

CMS-1551-P-30-Attach-1.DOC



Leslie V. Norwalk, Esq.  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1551-P, Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-8012

**RE: Comments by the Coalition to Preserve Rehabilitation on the 75% Rule Policy**

Dear Ms. Norwalk:

The undersigned members of the Coalition to Preserve Rehabilitation (CPR) submit these comments relating to the 75 Percent Rule Policy. CPR is a coalition of national consumer, clinician, and membership organizations with the goal of preserving access to appropriate rehabilitation services so that individuals with disabilities, injuries, or chronic conditions may regain and/or maintain their maximum level of independent function. The comments set out below are written from the perspective of patients, those ultimately impacted by the 75% Rule.

Our comments are organized into four sections. First, we set out the principles that guided our analysis. Second, we provide an overview of our concerns regarding the operation of the 75 Percent Rule. Third, we identify the specific policies in the current regulations implementing the 75 Percent Rule policy that create problems and that can be addressed through regulation (and do not require legislation). Finally, we set out our recommendations.

**Guiding Principles**

In preparing our comments, we were guided by the following principles.

First, under the Medicare program, older Americans and certain persons with disabilities are entitled to receive medically reasonable and necessary health care services. Among the health care services recognized under the Medicare program is the provision of rehabilitation services. For some patients, rehabilitation services are appropriately provided in acute care hospitals; for others, rehabilitation services are appropriately provided in outpatient settings or part of home health care or in skilled nursing facilities. For a relatively small, but distinct number of patients, medically reasonable and necessary health care services entail the provision of intensive, coordinated rehabilitation services provided by a multi-disciplinary team in inpatient rehabilitation hospitals and rehabilitation units in acute care hospitals.

Second, in order to be excluded from the acute care inpatient hospital Prospective Payment System (PPS) specified in 42 CFR § 412.1(a)(1) and instead receive enhanced payments under the Inpatient Rehabilitation Facility (IRF) PPS, it is appropriate for CMS to establish criteria/conditions that enable it to distinguish IRFs from other settings that receive lesser payments. In other words, it is crucial to Medicare to maintain criteria ensuring that only facilities providing intensive rehabilitation services are identified as IRFs. To justify the enhanced payment, IRFs must be able to demonstrate through objective criteria/conditions their uniqueness and distinctiveness because rehabilitation services in general can be delivered in a variety of other settings, such as acute care hospitals, skilled nursing facilities, outpatient or home health care. It is appropriate to adopt conditions that enable CMS to distinguish those hospitals and units which provide intensive rehabilitation services coupled with close medical supervision.

Third, in order to be admitted to an inpatient rehabilitation hospital or rehabilitation unit in an acute care hospital, it is appropriate for CMS to establish criteria—the services must be reasonable and necessary based on an assessment of each beneficiary's individual care needs. Thus, it is appropriate for public policy to limit access to those beneficiaries who satisfy the criteria for admission. It is appropriate for CMS to limit access to patients for whom services are reasonable and necessary (in terms of efficacy, duration, frequency, and amount) for the treatment of the patient's condition. It is also appropriate that the services must be considered reasonable and necessary to furnish the care on an inpatient basis, rather than in a less intensive setting, i.e., the patient must have one or more conditions requiring intensive and multi-disciplinary rehabilitation care, or a medical complication in addition to their primary conditions, so that the continuing availability of a physician is required to ensure safe and effective treatment.

Fourth, and most importantly, Medicare patients' entitlement to medically reasonable and necessary health care services, including intensive inpatient rehabilitation services, must not be impeded by the operation of policies designed to classify facilities as IRFs for purposes of payment. Further, the policies designed to classify facilities must facilitate, not impede achieving our nation's goals regarding people with disabilities.

### **Overview of Concerns**

CPR strongly believes that the operation of the current 75 Percent Rule, which is one of six conditions a facility must satisfy in order to be considered an IRF for purposes of enhanced payment, has the effect of denying medically reasonable and necessary rehabilitation services to beneficiaries who meet strict admission criteria but who do not happen to have one of the thirteen conditions on the list included in the regulations. If the facility accepts too many patients that need intense inpatient rehabilitation services in accordance with medical necessity criteria but who do not fall within the 13 conditions, the facility will lose its certification as a rehabilitation hospital or unit and will be forced to shut down.

To avoid such an outcome, the facility is forced to turn away (and thus deny) medically reasonable and necessary services to needy Medicare patients based on the condition they have when they arrive at the hospital. Practically speaking, inpatient rehabilitation hospitals and units are being forced to establish health care quotas, i.e., they must manage/limit the mix of patients they treat based on the 75% Rule (a classification payment rule) rather than on the basis of clinical judgment or rehabilitation need.

CPR believes that the administration of the 75 Percent Rule is inconsistent with and is thwarting efforts to achieve the goals of disability policy articulated in the Americans with Disabilities Act, the Rehabilitation Act of 1973, as amended, and Executive Order No. 13217 (42 U.S.C. 12131 note; relating to community-based alternatives for individuals with disabilities issued by President Bush).

The goals of the ADA include:

- Equality of opportunity (treat people as individuals based on facts, not arbitrary and pernicious categories and provide effective services and supports in the most integrated setting appropriate);
- Full participation (empower people to make informed choices)
- Independent living, not dependency and isolation; and
- Economic self-sufficiency.

The administration of the 75% Rule by CMS is inconsistent with each and every principle articulated in the Americans with Disabilities Act and the Rehabilitation Act of 1973, as amended.

Equal opportunity:

- Medicare rules are supposed to facilitate the ability of every individual beneficiary to receive medically reasonable and necessary inpatient rehabilitation services to which he or she is entitled based on an individualized assessment of need, consistent with medical necessity criteria.
- A beneficiary who satisfies the criteria for admission to an inpatient rehabilitation facility (based on facts applicable to that individual) should not be denied admission simply because he or she fails to fall within an arbitrary list of 13 conditions promulgated by CMS. And yet, this is precisely what is happening because of the operation of the 75% Rule.
- Persons denied admission to inpatient rehabilitation hospitals and units are being forced into other settings. They are being denied access to comprehensive, coordinated inpatient rehabilitation services provided by a multidisciplinary team that will enable them to be reintegrated into their community and return to their own homes and jobs (whenever feasible) with the maximum ability to function independently.

Full Participation

- Medicare rules are supposed to provide beneficiaries with the ability to access inpatient rehabilitation services that will enable them to return to their homes after experiencing medical interventions. This access is not absolute—a beneficiary must meet strict medical necessity criteria promulgated by CMS to be admitted into an inpatient rehabilitation facility.
- Access of a beneficiary who meets criteria for admission to an inpatient rehabilitation facility should never be negated by the operation of an arbitrary, inflexible rule for classifying hospitals and units. And yet, the 75% Rule is having the effect of forcing inpatient rehabilitation hospitals and units to turn away needy beneficiaries to retain their certification, *i.e.*, the rule is having the effect of denying beneficiaries the right to receive safe and effective treatment.

## Independent Living and Economic Self-sufficiency

- For some beneficiaries who require intense, comprehensive, coordinated inpatient rehabilitation services provided by a multidisciplinary team, access to inpatient rehabilitation hospitals and units is the lifeline from treatment to independent living in one's own home rather than in a nursing home and return to work, to the extent feasible. And yet, the operation of the 75% Rule is having the effect of denying certain beneficiaries the outcome of independent living and potential employment.

Implementation of the 75% Rule is also threatening the overall stability of the rehabilitation hospital system, thereby threatening access to intensive inpatient rehabilitative care for all individuals in need of this care, including Medicare beneficiaries and individuals with disabilities who are not beneficiaries. If the rule continues to be implemented as planned over the next two years, many rehabilitation hospitals and units will be unable to meet the criteria mandated by the rule, and upon losing their certification, will likely close or dramatically shrink their rehabilitation programs. This would have a devastating impact on all individuals with disabilities and chronic conditions, not just Medicare patients, who depend on inpatient rehabilitative care to restore their health status, function, and independence in their home and community. This reduced capacity in the rehabilitation field comes at the very time that demographics suggest an increased need for inpatient rehabilitation in future years across the country.

### **Specific Concerns with the Current Regulations and Recommendations: Comorbidities**

Consistent with authority granted to the Secretary of HHS by Section 1886 (j) of the Social Security Act, CMS has established criteria for classifying a hospital or unit of a hospital as an "inpatient rehabilitation hospital." One key criterion specifies that a minimum percentage of a facility's total inpatient population must require intensive rehabilitation services for the treatment of at least one of 13 medical conditions listed in §412.23(b) (2) (iii) in order for the facility to be classified as an IRF. In addition, for cost reporting periods beginning on or after July 1, 2004, and before July 1, 2008, a patient with a comorbidity, as defined at §412.602, may be included in the inpatient population that counts toward the required applicable percentage if certain requirements are met. The minimum percentage is commonly referred to as the "compliance threshold."

Prior to the May 7, 2004 final rule, §412.23 (b) (2) stipulated that the compliance threshold was 75%. Therefore, the compliance threshold was commonly referred to as the "75% Rule." In addition, prior to May 7, 2004, the regulation specified 10 medical conditions. In the May 7, 2004 final rule, the number of total conditions was increased to 13 [§412.23 (b) (2) (iii)] but the new conditions replaced a much broader orthopedic condition, resulting in fewer orthopedic patients being admitted to inpatient rehabilitation hospitals or units. The final rule also temporarily lowered the compliance threshold while at the same time specified a transition period at the end of which IRFs would once again have to meet a compliance threshold of 75%. Also, the final rule specified that during the compliance threshold transition period a patient's *comorbidity* (listed in the regulations) could be used to determine if a provider met the compliance threshold provided certain applicable requirements were met.

In §421.602, a comorbidity is defined as a specific patient condition that is secondary to the patient's principal diagnosis. A patient's principal diagnosis is the primary reason for the patient being admitted to an IRF and this diagnosis is used to determine if the patient had a medical condition that can be counted towards meeting the compliance threshold. In order for an inpatient with a

comorbidity to be included in the inpatient population that counts toward the applicable percentage, the following criteria must be met [§412.23 (b) (2) (i)]:

- The patient is admitted for inpatient rehabilitation for a condition that is not one of the 13 listed conditions;
- The patient also has a comorbidity that falls within one of the 13 listed conditions;
- The comorbidity has caused a significant decline in the functional ability of the individual such that, even in the absence of the admitting condition, the individual would require the intensive rehabilitation treatment that is unique to inpatient rehabilitation facilities paid under the IFR PPS and that cannot be appropriately performed in another setting.

In accordance with the May 7, 2004 final rule, IRFs would have to meet a compliance threshold of 75% for cost reporting period starting on or after July 1, 2007. However, Section 5005 of the Deficit Reduction Act of 2005 (Public Law 109-171) modified the applicable time periods when the various compliance thresholds must be met. Due to the DRA, the transition period was extended to include cost reporting periods starting on or after July 1, 2004 and before July 1, 2008. The regulations were revised to reflect the new compliance thresholds during the transition period and the new end date of the transition (July 1, 2008). In addition, during this transition period, CMS permitted a comorbidity that meets the criteria described above for the cost reporting periods beginning before July 1, 2008 instead of July 1, 2007.

However, after this phase-in period (i.e., for cost reporting periods beginning on or after July 1, 2008) comorbidities will **not** be eligible for inclusion in the calculations used to determine if the provider meets the 75% compliance threshold.

#### **CPR Position on the 75% Rule and Comorbidities:**

*CPR strongly opposes the inclusion of any compliance threshold (e.g., 13 conditions in the current regulations) under the 75 Percent Rule as a means to help distinguish/classify IRFs from other facilities for purposes of payment. CPR believes that medical and rehabilitation need alone i.e., the patient's overall function, should determine access to inpatient rehabilitation, not arbitrary compliance thresholds that are used as a means to classify/define what constitutes a rehabilitation hospital or unit. However, we recognize that legislation, not regulation, is necessary to fix the compliance threshold issue.*

CPR recognizes that CMS has the authority to modify the list of 13 conditions included in the regulations as well as to modify the comorbidity policy. Our comments regarding the comorbidity provision are set out below.

CPR believes that the current comorbidity provision is far too narrow in its scope and that CMS should substantially modify and make permanent the comorbidity policy. Our proposed approach is guided by the following criteria: First, the revised provision must be consistent with and reflect the same policy rationale originally used to adopt the 13 conditions. Second, the provision must rely on objective data readily available to the agency. Third, the specific parameters of the revised provision should reflect input from expert opinions from the types of groups originally consulted by the agency.

In explaining the policy rationale for the inclusion of a compliance threshold consisting of the 13 listed conditions, CMS explained that a defining feature of an inpatient rehabilitation facility is the proportion of patients treated for conditions that “**typically**” require intensive inpatient rehabilitation. The intent of the 75% Rule is to ensure that these facilities are “unique” compared to other facilities in that they provide “intensive” rehabilitative services in an inpatient setting. The “uniqueness” of these facilities is the justification for paying them under a separate payment system. In other words, CMS explained that it is “imperative to identify conditions that would typically require intensive inpatient rehabilitation services because rehabilitation in general can be delivered in a variety of settings, such as acute care hospitals, skilled nursing homes, and outpatient settings.” Also, CMS explained that requiring an IRF to treat a patient population that has a high concentration of the conditions listed in the regulations is one of the means chosen to ensure that the treatment setting is appropriately classified to justify payment of the level of services furnished. [69 Fed. Reg. 25753, 25755, 25759-25770-25771 (May 7, 2004)]

In sum, the 75% Rule is used as an objective standard to justify the higher payment standard and requiring IRFs to treat a patient population that has a high concentration of conditions listed is one means chosen to ensure that the treatment setting is appropriate. Consistent with this policy objective, the current regulations include the 13 listed conditions and then restate the same list as secondary conditions (comorbidities).

We believe that CMS should ascertain whether a facility has a high concentration of typical conditions relying on the best available data, not solely on 13 arbitrary conditions suggested in the 1980s. The original medical conditions specified in the 75% rule was partly based upon information contained in a document entitled “Sampling Screening Criteria for Review of Admissions to Comprehensive Medical Rehabilitation Hospitals/Units,” a product of the Professional Standards Review Organization of the American Congress of Rehabilitation Medicine. In addition, CMS received input from the National Association of Rehabilitation Facilities and the American Hospital Association [69 Fed. Reg. 25753 (May 7, 2004)]. In short, the Secretary relied in part on the opinions of experts in the field.

Since that time major policy changes have occurred, including the adoption of the Prospective Payment System for IRFs. When CMS adopted PPS for IRFs, it needed to rely on the existence of patient-specific objective data. Thus, at the time a Medicare patient is admitted, the IRF must use the patient assessment instrument (PAI). Based on the IRF-PAI, a patient classification system is used to classify patients into mutually exclusive case-mix groups. These case-mix groups are identified based on the patient’s impairment, age, comorbidities, functional capabilities (motor and cognitive), and other factors that may improve the ability of the functional-related groups to estimate variations in resource use. Data from admission assessments are used to classify a Medicare patient into an appropriate case-mix group. An appropriate weight is assigned to each case-mix group that measures the relative difference in facility resource intensity among the various case-mix groups [See 42 CFR §412.602, §412.606, §412.620]. In short, objective criteria now exists that will enable CMS to ascertain a high concentration of typical conditions relying on the best available data, rather than relying solely on 13 arbitrary conditions suggested in the 1980s.

#### **Conclusion:**

We recommend that the comorbidity provision be substantially modified. CMS should convene a group of experts, including experts from the groups CMS originally relied on when it prescribed the

13 listed conditions, to determine how best to revise the comorbidity component of the 75% Rule. The group should determine how best to use data available from the IRF-PAI, including impairment, functioning, and comorbidities (all comorbidities, not comorbidities limited to the 13 listed conditions) to objectively determine, for purposes of classification only (not medical necessity) “types of conditions that will typically require intensive inpatient rehabilitation in IRFs because rehabilitation in general can be delivered in a variety of settings” [69 Fed. Reg. 25770-25771 (May 7, 2004)]. This determination should focus on developing objective criteria that not only address levels of functioning but that also address the need for close medical supervision to stabilize medical conditions.

Quite simply, by limiting consideration of a patient’s comorbidities to a list of 13 conditions and by requiring such comorbidities to independently qualify a patient for inpatient rehabilitation, the CMS policy artificially segregates into parts the overall health and functional status of patients. The current policy utterly fails to recognize the totality of patients’ conditions on their need for inpatient rehabilitation care. At the very least, and in the absence of a better alternative, CMS should permanently recognize the impact that comorbidities have in qualifying patients under the 75% Rule or any other mechanism that purports to identify who requires an intensive level of rehabilitation care. Optimally, however, CMS would revisit the comorbidity policy and use the objective mechanisms available to it to devise a more appropriate policy that better meets the needs of seniors and people with disabilities under Medicare.

Thank you for your consideration.

Sincerely,

**American Association of People with Disabilities**  
**American Academy of Physical Medicine and Rehabilitation**  
**American Occupational Therapy Association**  
**American Physical Therapy Association**  
**American Therapeutic Recreation Association**  
**Amputee Coalition of America**  
**Association of Academic Physiatrists**  
**ACCSES**  
**Brain Injury Association of America**  
**Center for Medicare Advocacy, Inc.**  
**Christopher and Dana Reeve Foundation**  
**Easter Seals**  
**National Association of Social Workers**  
**National Association for the Advancement of Orthotics and Prosthetics**  
**National Council for Community Behavioral Healthcare**  
**National Council on Independent Living**  
**National Multiple Sclerosis Society**  
**National Spinal Cord Injury Association**  
**Paralyzed Veterans of America**  
**The Arc of the United States**  
**United Cerebral Palsy**  
**United Spinal Association**

**Submitter :** Ms. Cheri Rinehart

**Date:** 07/02/2007

**Organization :** The Hospital

**Category :** Health Care Professional or Association

**Issue Areas/Comments**

**75 Percent Rule Policy**

75 Percent Rule Policy

see attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE AND MEDICAID SERVICES  
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

**Submitter :** Mr. Mark Rovinski  
**Organization :** Mark W. Rovinski, CPA LLC  
**Category :** Other Health Care Professional

**Date:** 07/02/2007

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

The use of a CBSA with only one hospital to develop the wage index for an IRF isn't always appropriate "See attached"

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE AND MEDICAID SERVICES  
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

**Submitter :** Ms. Stephen Miller  
**Organization :** Kentucky Hospital Association  
**Category :** Hospital

**Date:** 07/02/2007

**Issue Areas/Comments**

**GENERAL**

GENERAL

See attachment

CMS-1551-P-33-Attach-1.DOC

July 2, 2007

Leslie Norwalk, Esq.  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Hurbert H. Humphrey Building  
200 Independence Avenue, S.W., Room 445-G  
Washington, DC 20201

***RE: (CMS-1551-P) Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Fiscal Year 2008; Proposed Rule (Vol. 72, No. 88), May 8, 2007***

Dear Ms. Norwalk:

On behalf of our 126 member hospitals, including 18 inpatient rehabilitation services facilities, the Kentucky Hospital Association (KHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule for the fiscal year (FY) 2008 inpatient rehabilitation facility prospective payment system (PPS). In particular, we would like to urge regulatory action on the "75% Rule."

CMS should identify the clinical characteristics of patients who currently fall outside of the qualifying conditions and are appropriate for hospital-level inpatient rehabilitation, as recommended by the Medicare Payment and Advisory Commission (MedPAC). We share MedPAC's view that the Rule's current diagnosis-based structure is inadequate to "identify all patients who need, can tolerate, and benefit from intensive rehabilitation." CMS should expand the qualifying conditions based on key clinical indicators of medical necessity for inpatient rehabilitation patients who today are inappropriately diverted to a less-intensive setting due to the Rule's constraints. Doing so would reduce inappropriately denied admissions for medically necessary patients seeking care in the nation's inpatient rehabilitation hospitals and units. Systematic, timely review and modernization of the qualifying conditions should be conducted by CMS in collaboration with independent researchers; clinical experts including referring physicians, physiatrists, rehabilitation nurses and therapists; and inpatient rehabilitation providers.

We also are concerned about the pending termination of the 75% Rule's comorbidities provision, which enables inpatient rehabilitation patients to count under the rule based on selected, secondary medical characteristics. This provision is set to expire on July 1, 2008 when the 75% Rule is fully phased-in. Under this temporary provision, a patient

Leslie Norwalk, Esq.  
July 2, 2007  
Page 2 of 2

may count toward 75% Rule compliance if he/she is admitted for a comorbidity that falls within one of the 13 qualifying conditions and causes a significant decline in the patient's functional ability. CMS' analysis found that 7 percent of cases from July 2005 through June 2006 – approximately 31,000 patients – qualified under the 75% Rule through the comorbidities provision. The Moran Group, a Washington, DC-based health research and consulting firm, recently found that **nearly 88,000 patients were unable to receive care in rehabilitation hospitals and units during the first two years of the 75% Rule phase-in** – an assessment that far exceeds CMS' estimate that only 7,000 fewer patients would be treated. CMS' policies have severely reduced access beyond what was intended.

Termination of the comorbidities provision would have a significant negative impact on this large group of patients with complicating medical conditions that require medical oversight by a physician and the specialized, advanced nursing care and therapy services found in inpatient rehabilitation hospitals and units. Given the compromised health status and functional level of this population, it would be inappropriate to deny them access to the inpatient rehabilitation setting. We urge CMS to amend the 75% Rule in the FY 2008 inpatient rehabilitation facility PPS final rule to permanently include comorbidities among qualifying cases.

If you have any questions about our comments, please feel free to contact me at 502-637-9920 or smiller @kyha.com.

Sincerely,

Stephen Miller  
Vice-President/Finance

**Submitter :** Dr. Carl Granger  
**Organization :** Uniform Data System for Medical Rehabilitation  
**Category :** Health Care Professional or Association

**Date:** 07/02/2007

**Issue Areas/Comments**

**75 Percent Rule Policy**

75 Percent Rule Policy

See attachment

**GENERAL**

GENERAL

See Attachment

CMS-1551-P-34-Attach-1.PDF



June 30, 2007

The Functional Assessment Specialists

Leslie V. Norwalk, Esq.
Administrator
Centers for Medicare and Medicaid Services
Room 445-G, Hubert H. Humphrey Building
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Re: 42 CFR Part 412; [CMS-1551-P] RIN 0938-AO63: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for FY 2008

Dear Administrator Norwalk:

We are writing now to comment on the May 8, 2007, publication of the proposed rule for the Inpatient Rehabilitation Facility Prospective Payment System for Federal fiscal year 2008.

For the past 20 years, Uniform Data System for Medical Rehabilitation (UDSMR) has provided rehabilitation facilities with education, training, outcome/QI reporting, and national benchmarks. Annually, more than 850 inpatient rehabilitation facilities (IRFs) voluntarily use our services to improve the efficiency, effectiveness, and quality of their care. 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 have been recognized as objective evaluators of the data that is used to measure the outcomes and quality of inpatient rehabilitation. Industry associations, research groups, and others regularly call upon us to provide unbiased, factual information about trends and outcomes information in the United States.

Given that UDSMR houses and continually analyzes this large inpatient rehabilitation database for random and special cause variation, and that UDSMR has the clinical expertise to evaluate the impact of external factors on IRF case characteristics and treatment outcomes, we are compelled to express our assessment of the potential impact this proposed rule may have on these IRFs and the patients they serve. We trust that our comments will be given serious consideration by the Centers for Medicare and Medicaid Services and will provide sufficient data-driven evidence to warrant further research and deferral of any policy changes or enforcement until such research can be completed.

Our comments follow and are organized by section as identified in the proposed rule.

75 Percent Rule Policy

In this section of the proposed rule, the agency restated one of its criteria for classification of a hospital or unit within a hospital as an IRF with respect to medical conditions and comorbid conditions. The agency also restated the following with respect to comorbid conditions: "For cost reporting periods beginning on or after July 1, 2008, comorbidities will not be eligible for inclusion in the calculations used to determine if the provider meets the 75 percent compliance threshold specified in § 412.23(b)(2)(ii)." Given that facilities are currently operating in the compliance threshold transition period, we decided to look at the impacts of current policy on the subscribers whose data is housed in our database. Of the 1,200-plus facilities classified as IRFs in 2006, 866 actively participated in UDSMR's database.

Table 1 (next page) shows the number of facilities that would not meet the compliance threshold at 60% (the current level) and 75% (the 2008 level) based on the presumptive eligibility test. These figures are based on data from calendar year 2006.

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

Threshold	Comorbid Conditions INCLUDED	Comorbid Conditions EXCLUDED
60%	13	114
75%	296	463

**Table 1: Number of IRF facilities that would not meet the compliance threshold for 2008.** The data comes from UDSMR's database and covers discharges between January 1, 2006, and December 31, 2006.

Information in this table was restricted to **689** facilities that met the following criteria:

1. The facility is a current/active participant in UDSMR's database.
2. The facility is currently participating in the IRF PPS. (Non-IRFs and PPS-exempt Maryland facilities were excluded.)
3. The facility had at least one Medicare case in each and every month of 2006.
4. At least 50 percent of the cases discharged from the facility were Medicare cases.

When this information is viewed from a total case perspective, it is apparent that a large number of cases are dependent on comorbid conditions to count toward the compliance threshold. (See table 2.)

	All Payers			Medicare Only*		
	Total Cases	Cases with Qualifying Comorbid Conditions	Percentage of Cases with Comorbid Conditions	Total Cases	Cases with Qualifying Comorbid Conditions	Percentage of Cases with Comorbid Conditions
All Cases	412,263	23,601	5.7	276,816	17,608	6.4
Cases Not Qualifying under 75% Rule via IGC or Etiologic Diagnosis	152,699	23,601	15.5	114,354	17,608	15.4

\* Based on primary payer code 02.

**Table 2: Impact of eliminating comorbid conditions as a qualifying criteria for admission to IRFs for acute rehabilitation.** The data is based on a total of 866 IRFs that contributed data to UDSMR in 2006. Maryland IRFs are excluded.

If the qualifying comorbid conditions (as currently configured) are eliminated, many of these cases will be denied access to IRFs. The impact of eliminating these cases is even larger than the approximately 15% indicated in table 2, since the facilities will be left with fewer cases with which to meet the compliance threshold.

Facilities are already feeling the impact of these tightening measures. In 2006, 32 IRFs that subscribed to UDSMR closed; most cited an inability to meet the 75% Rule requirements. To date in 2007, we have received another 10 closures.

Given the devastating picture that these tables portray—and the fact that CMS is soliciting comments supporting current policy or other options, including the use of some or all of the existing comorbidities in calculating the compliance percentage for an additional fixed period of one or more years, or even on a permanent basis—we at UDSMR offer the following.

1. We recommend that CMS maintain the current threshold (60%) and inclusion of the current comorbid conditions until such time as scientific and clinical research can be done to facilitate solid clinical and fiscal policy.
2. UDSMR, as a university-based, not-for-profit organization, extends an offer to CMS to work directly with the agency on such research. Utilizing the agency's parameters, guidelines, and timelines, we can provide the sound research and evidence-based clinical summary data that will allow CMS to move forward in the right direction.

In light of these comments and questions, and the uncertain impact of the elimination of the qualifying comorbid conditions, we recommend that CMS defer implementation of any changes to, or elimination of, the current list of conditions. We believe that a set of qualifying comorbid conditions should exist, and we welcome an opportunity to work with the agency to establish a set that is medically sound for admission to an IRF. We offer this assistance to CMS in the spirit of placing the appropriate patient in the appropriate venue of care at the appropriate time for the appropriate cost in the post-acute care continuum.

In closing, we are grateful for the opportunity to provide comments to the Secretary on the proposed rule. We welcome the opportunity to work with the government to provide unbiased research regarding the impact of federal regulation on IRFs. If there are any questions about these comments, or if further information is needed, 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

**Submitter :**

**Date: 07/02/2007**

**Organization :** Centerre Healthcare

**Category :** Other Health Care Provider

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-1551-P-35-Attach-1.PDF

July 1<sup>st</sup> 2007

Leslie V. Norwalk, Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Service  
Attention: CMS-1551-P  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-8012

**Re: Medicare Program; Proposed Changes to the Inpatient Rehabilitation Facility Prospective Payment System "IRF PPS" for FY 2008**

Dear Mrs. Norwalk:

Centerre Healthcare appreciates the opportunity to comment on the proposed changes to the Inpatient Rehabilitation Facility-Prospective Payment System for Fiscal Year 2008. In summary, we respectfully request CMS

- continue to allow a comorbid condition to qualify as one of the listed medical conditions until such time as results from current research on this complex issue are available to help refine healthcare policy
- hold the compliance threshold at 60% due to the significant decline of cases admitted to IRF and the changes in mix in the Inpatient Rehabilitation Facilities as a result of the May 2004 final rule changes.
- cap outlier payments applicable to hospital exceeding 10% of total PPS payments and lower the pool

**75 Percent Rule Policy, p. 26233**

- I. **Preserve the "comorbid" conditions as qualifying conditions until such time as results from current research on this complex issue are available to refine healthcare policy**

We appreciate CMS soliciting comments on comorbid conditions. When the Centers for Medicare & Medicaid Services (CMS) implemented the revised and expanded classification criteria for inpatient rehabilitation facilities (IRFs) in the May 7, 2004 final rule, the rule expanded the number of qualifying medical conditions that are listed in the regulations to include stroke, spinal cord injury, congenital deformity, amputation, major multiple traumas, fracture of the femur, brain injury, three types of arthritis, neurological disorder, and burns. The revised regulations also added certain joint replacement cases as a new qualifying

July 1, 2007

Page 2

medical condition, and allowed a facility in certain circumstances to count toward the percentage threshold patients who have a secondary medical condition that meets one of the qualifying diagnoses. Transmittal 221 (Change Request 3334, June 25, 2004) further defined the requirements for counting a comorbidity as one of the qualifying medical conditions:

***140.1.2-Counting A Comorbidity As One Of The Listed Medical Conditions***

***(Rev. 221, 06-25-04)***

A comorbidity is a specific patient condition that is secondary to the patient's principal diagnosis that is the primary reason for the inpatient rehabilitation stay. A patient with a comorbidity may be counted as part of the inpatient population that counts towards the required applicable percentage specified above in §140.1.1B if:

- A. The patient is admitted for inpatient rehabilitation for a medical condition that is not one of the conditions specified above in §140.1.1C;
- B. The patient has a comorbidity that falls in one of the medical conditions specified above in §140.1.1C; and
- C. The comorbidity has caused significant decline in functional ability in the individual such that, even in the absence of the admitting condition, the individual would require the intensive rehabilitation treatment that is unique to inpatient rehabilitation facilities paid under the IRF PPS, and that cannot be appropriately performed in another care setting covered under Medicare.

For cost reporting periods beginning on or after July 1, 2007, a patient's comorbidity is not included in the inpatient population that counts towards the 75 percent specified above in §140.1.1B.

In medicine, comorbidity describes the effect of all other diseases an individual patient might have other than the primary disease of interest. As such, one cannot segregate or isolate a condition as if it existed independently. According to the Wikipedia encyclopedia found at [www.en.wikipedia.org/wiki/comorbidity](http://www.en.wikipedia.org/wiki/comorbidity) the term "comorbid" currently has two definitions: 1) to indicate a medical condition existing simultaneously but independently with another condition in a patient (this is the older and more "correct" definition) 2) to indicate a medical condition in a patient that causes, is caused by, or is otherwise related to another condition in the same patient (this is a newer, nonstandard definition and less well-accepted). The On Line Medical Dictionary defines "comorbidity" as the presence of coexisting or additional diseases with reference to an initial diagnosis or with reference to the index condition that is the subject of study. Comorbidity may affect the ability of affected individuals to function and also their survival; it may be used as a prognostic indicator for length of hospital stay, cost factors, and outcome or survival. Both of these definitions recognize the presence of one or more disorders (or diseases) in addition to a primary disease or disorder and the effect of such additional disease or disorder.

We are concerned the literal application of the CMS definition of comorbidity, that is "even in the absence of the admitting condition", could lead those persons reviewing such a case to disregard the complexity of coexisting medical conditions often seen in the aging population. From our experience, it is not uncommon for a patient to have a principle or etiologic diagnosis and up to 8-10 additional coexisting or "comorbid" conditions. The

evidence of such would be available on claims filed and on the IRF-PAI section for "comorbid" conditions. When treating the patient as a whole, one cannot segregate or isolate a single condition and disregard the other significant health issues that contribute to the overall medical management requirements of an individual.

Furthermore, from our preliminary internal analysis, those cases with a qualifying comorbid condition represent a higher severity as measured by the relative weight assigned to the case and reflected in the Case Mix Index (CMI). We understand current research in this important area may substantiate such a hypothesis and may provide evidence that such cases represent an increased complexity, or severity and as such should continue to meet the criteria as one of the listed medical conditions. We respectfully urge the Secretary to extend the inclusions of comorbid conditions as compliant cases provided they meet certain conditions as described in 412.602 until additional research is available to offer evidence to support healthcare policy.

**II. Hold the compliance threshold at 60% due to the significant decline of cases admitted to IRF and the changes in mix in the Inpatient Rehabilitation Facilities as a result of the May 2004 final rule changes.**

CMS' June 8, 2007 Update on IRF PPS, reported there have been significant decreases in claims volume between 2003 and 2005. Categories reported with the most significant decline included lower extremity joint replacement, cardiac, osteoarthritis, pain syndrome and miscellaneous. However, the decline was not limited to these five categories. Our analysis indicates there is, and continues to be a decline in other categories of IRF admissions, even at the current 60% compliance threshold. From our analysis, we also notice that Stroke, and Spinal Cord Traumatic and Non Traumatic volumes are decreasing compared to 2004 levels.

**Distribution of Discharges by IRF Impairment Category**

RIC	Desc	2004	2005	2006	2004	2005	2006	% Var 2006 vs 2004
1	Stroke	16.6%	18.3%	20.0%	84,660	82,713	82,565	-2.5%
2	Brain Dys, T	1.6%	2.0%	2.3%	8,160	9,200	9,641	18.1%
3	Brain Dys, NT	2.3%	2.9%	3.5%	11,730	13,079	14,420	22.9%
4	Spine, T	0.6%	0.6%	0.7%	3,060	2,706	2,884	-5.8%
5	Spine, NT	3.7%	3.8%	3.9%	18,870	17,138	16,068	-14.8%
6	Neuro	5.1%	5.8%	6.6%	26,010	26,158	27,192	4.5%
18	MMT W B	0.2%	0.3%	0.3%	1,020	1,353	1,236	21.2%
19	GB	0.1%	0.1%	0.2%	510	451	824	61.6%
	Nervous System	30.2%	33.9%	37.8%	154,020	152,799	154,830	0.5%

Appendix C, Center for Medicare & Medicaid Services June 8, 2007, Page 16

Note: this table multiplies the Mix% in Appendix C by the Total cases for the Corresponding years in figure 4, page 7

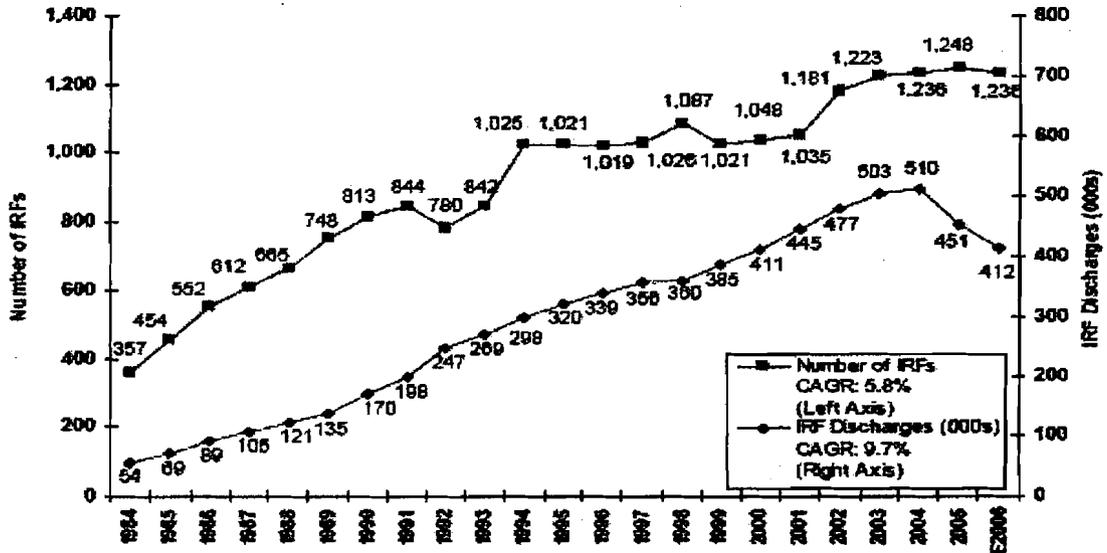
	2004	2005	2006
Total IRF Cases	510,000	451,000	412,000

Figure 4, page 7 Center for Medicare & Medicaid Services June 8, 2007

We believe that the volume decline will continue consistent with the last two years unless the compliance threshold is held at 60%. The chart below was taken from the CMS

June 8, 2007 update on IRF PPS and shows the dramatic decline in IRF patient volume with the compliance level implemented to 60%. We urge CMS to freeze the threshold at 60% in order to stabilize this significant downward trend.

Figure 4: Growth in number of IRFs and IRF Discharges, 1984 – 2006\*



Source: CMS/CMM and the Iowa Foundation for Medical Care (IFMC).

High Cost Outliers under IRF PPS, p. 26249

**III. Cap outlier payments applicable to those hospitals exceeding 10% of total IRF-PPS payments and lower the pool**

The proposed rule has proposed to increase the outlier threshold from \$5,534 to \$7,522. The rationale for this increase is an effort on the part of CMS to have total outlier payments reflect approximately 3% of the total IRF-PPS payments. Our analysis of the rate setting file for FY2008 shows that 278 hospitals receive 5% or more of their total IRF-PPS payments as a result of outlier payments. This translates into 23% (278/1234) of the IRF hospitals are receiving 60% of the total outlier pool.

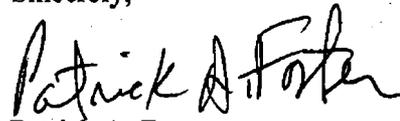
Table 1

% to Total Outlier Payments	Total IRFS	% IRF's to Total IRF's	FY08 Estimated Average Weight Per Discharge	FY 2008 Estimated Outlier Payments	% of Total Outlier Payments	FY 2008 Estimated Total PPS Payment	% Outlier Payments to Total PPS Payments
Less than 5%	956	77%	1.0386	83,652,656	40%	5,691,263,122	1.5%
5% Or More	278	23%	1.0324	123,989,913	60%	1,229,529,204	10.1%
	1234	100%	1.0376	207,642,569	100%	6,920,792,326	3.0%

Centerre recommends CMS consider a 10% cap on outlier payments to total PPS payments or some other methodology as a means of containing the outlier payment disproportion amongst IRF hospitals. While we appreciate the fact that there is a mechanism to pay for services of patients that stay far longer than intended, more accountability should be put on the hospitals to strengthen their internal services and management of cases with potential for high outlier payments. We believe such practices are consistent with the general industry and therefore in addition to limiting total outlier payments to any individual hospital to a 10% cap, any remaining dollars in the IRF-PPS pool should be applied to the Base rate calculation.

On behalf of Centerre Healthcare, we thank CMS for this opportunity to comment.

Sincerely,



Patrick A. Foster  
President and CEO Centerre Healthcare