



American Hospital
Association

JUN 26 2007

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

June 21, 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:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 37,000 individual members, including 1,228 inpatient rehabilitation facilities, the American Hospital Association (AHA) 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.



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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 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.

We look forward to continued collaboration on this matter. If you have any questions about our comments, please feel free to contact me or Rochelle Archuleta, senior associate director for policy, at (202) 626-2320 or rarchuleta@aha.org.

Sincerely,



Rick Pollack
Executive Vice President

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UPMC | University of Pittsburgh
Medical Center

University of Pittsburgh Physicians
Department of Physical Medicine & Rehabilitation

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Kaufmann Medical Building
Suite 201
3471 Fifth Avenue
Pittsburgh, PA 15213-3321
412-648-6848
Fax: 412-692-4410

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 FY2008, Federal Register, vol. 72, No. 88, May 08, 2007

CMS-1551-P

Dear CMS colleagues:

I would like to contribute my expert testimony regarding the proposed final regulations for inpatient rehabilitation facility (IRF) eligibility for Medicare beneficiaries.

75 Percent Rule Policy

My colleagues and I have published several recent articles in peer reviewed journals to study the effects of rehabilitation site on recovery of function in elderly Medicare beneficiaries who sustained a hip fracture. These clinical studies have been funded by the National Institutes of Health.

Our team examined the effects of post-acute rehabilitation provided in either an IRF or skilled nursing facility (SNF) in elderly patients who were living in the community at time of hip fracture. We measured functional status using the validated Functional Independence Measure Motor Scale (mFIM) from acute care hospitalization through 6 months post hospital discharge. We also measured other covariates such as depression, readmissions to acute care and mortality.

We found significantly improved functional outcomes at three and six months for those individuals receiving care at an IRF compared to treatment in a SNF. We also found that length of stay was significantly longer in the SNF compared to IRF^{1,2}. While we did not directly examine costs during the continuum of care, based upon length of stay differences, the relative costs differences between sites would be minimal. We believe that the increased intensity of rehabilitation services contributed to a faster trajectory of recovery thus allowing patients to return home sooner. Follow-up complications were not different between treatment sites, but mortality was less in the IRF group, although we were not fully powered to determine if this was statistically significant. I have referenced our articles at the end of this letter for your perusal.

In another study, we examined elderly hip fracture patients with comorbidities that included severe depression, apathy, or cognitive impairment at the time of acute

care transfer³. While these comorbidities are different than those listed in the CMS proposed regulations, our findings add important insights regarding the impact of excluding comorbidities when determining eligibility for IRF care.

We found that elderly hip fracture patients with major depression, apathy and cognitive impairment who received care at an IRF performed significantly better compared to those sent to SNF. In addition, IRF treated patients with comorbidities had equal outcomes to non-depressed and non-apathetic IRF patients, who had superior outcomes compared to all SNF treated patients. These findings strongly suggest that IRFs provide superior functional outcomes to Medicare beneficiaries who have underlying comorbidities that are separate from the CMS approved diagnosis (in this case hip fracture).

I am concerned that if the "75% rule" is fully implemented, the absence of qualifying comorbidities will negatively impact Medicare beneficiaries recovering from disabling conditions. As an academic clinician, I welcome the opportunity to work with CMS and other funding agencies within the NIH to conduct clinical trials to determine how we can improve existing criteria for those patients in need of intensive rehabilitation services. Future outcomes research should aim to identify characteristics of those patients who most appropriately need intensive rehabilitation. I strongly object to the use of the null hypothesis as proof that no evidence exists to support the efficacy of inpatient rehabilitation for Medicare beneficiaries who lack approved diagnoses. Clearly, we need data-driven decision-making to ensure the highest functional outcomes that include return to community living.

Sincerely,



Michael C. Munin, M.D.
Associate Professor
Department of Physical Medicine and Rehabilitation
University of Pittsburgh School of Medicine

Literature Cited

1. Lenze EJ, Skidmore ER, Dew MA, Butters MA, Rogers JC, Begley A, Reynolds CF, Munin MC. Does depression, apathy or cognitive impairment reduce the benefit of inpatient rehabilitation for elderly hip fracture patients? *Gen Hosp Psychiatry* 2007;29:141-146
2. Munin MC, Begleya, Skidmore ER, Lenze EJ. Influence of rehabilitation site on hip fracture recovery in community-dwelling subjects at six-month follow-up. *Arch Phys Med Rehabil* 2006; 87: 1004-1006.
3. Munin MC, Seligman K, Dedw MA, Quear T, Gruen G, Reynolds CF, Lenze EJ. Effect of rehabilitation site on functional recovery after hip fracture. *Arch Phys Med Rehabil* 2005; 86: 367-372.