

Submitter : Mr. Rick Pollack

Date: 06/21/2007

Organization : American Hospital Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1551-P-5-Attach-1.DOC

#5



**American Hospital
Association**

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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.



Leslie Norwalk, Esq.
June 21, 2007
Page 2 of 2

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



MICHIGAN HEALTH & HOSPITAL ASSOCIATION

Advocating for hospitals and the patients they serve.

June 22, 2007

Ms. Leslie Norwalk, Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1551-P
Post Office Box 8011
Baltimore, MD 21244-8012

RE: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Fiscal Year 2008; Proposed Rule.

Dear Ms. Norwalk:

On behalf of Michigan's 145 nonprofit hospitals, the Michigan Health & Hospital Association (MHA) appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services regarding the fiscal year (FY) 2008 proposed rule for the inpatient rehabilitation facility prospective payment system (IRF PPS).

75 Percent Rule

The CMS uses the "75% rule" to classify a hospital or unit of a hospital as an IRF. This criterion sets a minimum percentage of a facility's total inpatient population that must meet one of 13 medical conditions for the facility to be classified as an IRF. This minimum percentage is known as the "compliance threshold."

Prior to FY 2005, the 75% rule applied to 10 medical conditions. However, in FY 2005, the CMS revised the 75% rule, increasing the number of medical conditions to 13, at the same time the CMS temporarily lowered the compliance threshold, creating a transition period to the full compliance threshold of 75%. In addition, the CMS temporarily allowed patients with certain comorbid conditions to be included in the inpatient population that counts toward the required compliance threshold if certain requirements are met.

During 2006, the CMS implemented a provision of the Deficit Reduction Act of 2005(DRA) that revised the 75% rule compliance thresholds. The provision essentially extended the 60% compliance threshold for an additional 12 months, requiring an IRF with a cost reporting period starting on or after July 1, 2008 (instead of July 1, 2007) to meet the full compliance threshold of 75%. The CMS also permitted an extension of cases with certain comorbidities to be used in

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Mark McClellan, M.D., Ph.D.

July 6, 2006

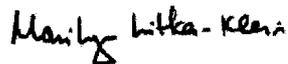
Page 2 of 2

determining the compliance threshold for this same time period. "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. . ."

The MHA remains concerned about the impact of this rule on IRFs and patient access to medically-necessary IRF services. We also believe that this outdated rule continues to undermine the physician care plan that includes an IRF as the most appropriate setting for post-acute care based on an individual patient's medical condition and needs. **The MHA urges the CMS to maintain the minimum threshold at the current 60 percent rather than increasing it to 65 percent.**

Again, the MHA appreciates the opportunity to provide comments to the CMS regarding this proposed rule. Please contact me if you have any questions or require additional information at 517-703-8603 or via email at mklein@mha.org.

Sincerely,



Marilyn Litka-Klein
Senior Director, Health Policy & Delivery

Submitter : Ms. Julianna Perez
Organization : Ms. Julianna Perez
Category : Other Health Care Professional

Date: 06/22/2007

Issue Areas/Comments

75 Percent Rule Policy

75 Percent Rule Policy

CMS-1551-P

Caption: 75 Percent Rule Policy

Comment:

All post-acute facilities (Long Term Care Hospitals, Inpatient Rehabilitation Facilities, Swing-Beds, Skilled Nursing Facilities and Home Health Agencies) can treat a patient with the following modalities: Physical, Occupational and Speech Therapy. Each can treat a range of diagnoses. The decision that IRF (or any other type of facility) must only treat 13 conditions when Physical Medicine is part of the treatment plan denies patients access to care. The use of Physical Medicine should be available to all patients who need this type of treatment regardless of their diagnosis or injury or the site of service.

Patients have the right to access care regardless of the setting in which the care is given. Treatment needs to be organized around the characteristics of care needs, rather than around the settings where care is delivered.

In the Policy Council Document, dated September 28, 2006, Post-Acute Care Reform Plan (CMS SNF-PPS website address: http://www.cms.hhs.gov/SNFPPS/Downloads/pac_reform_plan_2006.pdf) reform is discussed across the continuum.

In the plan, DRA of 2005 mandated a Demonstration Project to revise the assessment, gather and analyze data from each type of setting with a Report to Congress in the year 2011 which will -lead to a comprehensive, site-neutral PAC payment reform.1

Assessment should include patient outcomes - including measurement of return to the community and patient satisfaction - including patient's preference in PAC setting.

Cases must not be excluded from any of the post-acute facilities unless excluded from all facilities. As such: if fracture of tibia is excluded in a Rehab setting because this diagnosis does not meet the 75 Percent Rule, it should also be excluded from a Skilled Nursing Facility or Home Health setting. Based on this project, it is incompatible to continue the 75 Percent Rule in an IRF setting unless the 75 Percent Rule was in place at each type of post-acute setting if the treatment plan includes the Physical Medicine modalities: Physical Therapy, Occupational Therapy, and Speech Therapy.

If rehab facilities are not allowed to treat patients with certain diagnoses (to maintain their percentage of compliance); then it is impossible to determine if the rehab setting is appropriate for the patient, because there will not be an adequate sample of patients from the IRF setting in comparison to the other settings which do not have the 75 Percent Rule.

In conclusion, the 75 Percent Rule currently in effect for IRF-PPS should be eliminated entirely, or
. it should be added to each PAC PPS for treatment that includes Physical Medicine, or
. delayed until the demonstration project has been completed, the report to congress filed, the most appropriate reimbursement system selected including ample time for implementation.

1 SNF-PPS Policy Council Document, dated September 28, 2006, Post-Acute Care Rreform Plan

CMS-1551-P-7-Attach-1.PDF

**Policy Council Document
September 28, 2006
Post-Acute Care Reform Plan**

Introduction

In May of 2005, the CMS Administrator formed the Policy Council to serve as a vehicle for the Agency's senior leadership to develop strategic policy directions and initiatives to improve our nation's health care system. One of the Council's first priorities was to develop a plan for post-acute care (PAC) reform. The Council developed a set of post-acute care reform principles and based on these principles developed a vision for post-acute care to guide current and future reform activities.

The Deficit Reduction Act (DRA) of 2005 was signed into law on February 8, 2006. Section 5008 of the DRA mandated a demonstration that supports post-acute care payment reform and is consistent with the Agency's vision for post-acute care. Implementation of the DRA demonstration thus became a key element of the Agency's strategy for PAC reform.

This document presents CMS' post-acute care reform plan. It describes: the current problems in the post-acute care system; CMS' principles and vision for post-acute care reform and various short and medium-term steps toward that goal.

Overview of the Current Problems in the Post-Acute Care System

Medicare currently covers PAC services in the following provider settings: Skilled Nursing Facilities (SNFs), home health (HHA), Long-Term Care Hospitals (LTCHs) and Inpatient Rehabilitation Facilities (IRFs).¹ To date, Medicare's PAC benefits and payment policies have focused on phases of a patient's illness as defined by a specific site of service, rather than on the characteristics or care needs of the beneficiary. Thus, payments across PAC settings may differ considerably even though the clinical characteristics of the patient and the services delivered may be very similar.

Currently each of the PAC provider settings has its own prospective payment system. Three of these payment systems rely on standardized data collected by providers using different assessment instruments (e.g., MDS 2.0, OASIS, and IRF-PAI) developed for multiple purposes, including assessment, quality improvement, and payment. However, the information is collected in different data formats, which are often not compatible and make it difficult to readily compare beneficiaries and their use of items and services across PAC settings. No assessment instrument is mandated for LTCHs. (Please see Attachment A for additional background information on the existing PAC assessment instruments and payment systems.)

Principles for Post-Acute Care Reform

As a first step in addressing the current problems in the post-acute care system, the PAC Workgroup developed a set of principles for reform which were approved by the Policy Council. These principles are summarized below:

¹ PAC services are also provided in other settings such as hospital outpatient departments, CORFs, free-standing outpatient therapy practices, inpatient psychiatric facilities, and through the hospice benefit. This paper, however, focuses on PAC services provided through SNFs, HHAs, IRFs and LTCHs.

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- Increasing consumer choice and control of PAC services by Medicare beneficiaries, their family members and caregivers.
- Providing high-quality PAC services in the most appropriate setting based upon patient needs – which requires getting patients into the right PAC setting at the right time, as well as measuring patients' progress and the quality of care provided in PAC settings.
- Developing effective measures (including process measures) in order to drive the PAC system toward the delivery of high-quality care in the most effective manner and, thus, improve payment efficiency.
- Providing a seamless continuum of care for beneficiaries through improved coordination of acute care, post-acute care and long-term care services, including better management of transitions between care settings.

CMS' Vision for Post-Acute Care in the 21st Century

The central concept of CMS' vision for post-acute care is that the system will become patient-centered; that is, the system will be organized around the individual's needs, rather than around the settings where care is delivered. As such, the vision defines post-acute care in terms of the populations who need care. Specifically, post-acute care is care that is provided to individuals who need additional support to assist them in recuperating following an acute illness or serious medical procedure. A more beneficiary-centered system of post-acute care services has the potential to improve quality of care and continuity of care in a cost efficient way.

The person-centered post-acute care system of the future will:

- optimize choice and control of services;
- ensure that placement decisions are based on patient needs with both the patient and family receiving honest and useful information about the patient's situation and prognosis;
- provide coordinated, high quality care with seamless transitions between settings;
- reward excellence by reflecting performance on quality measures in payment;
- recognize the critical role of family care giving; and
- utilize health information technology.

Path to Achieving Reform

Demonstration Under Section 5008 of the Deficit Reduction Act of 2005 (DRA)

Section 5008 of the Deficit Reduction Act of 2005 (DRA) mandates a PAC payment reform demonstration. Under this provision, the Secretary is to establish a demonstration program by January 1, 2008 that would, for diagnoses or diagnostic conditions specified by the Secretary:

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- use a comprehensive assessment at hospital discharge to help determine appropriate PAC placement based upon patient care needs and patient clinical characteristics;
- gather data on the fixed and variable costs for each individual and on care outcomes in various PAC settings; and
- use a standardized assessment instrument to measure functional status and other factors during treatment and at discharge across PAC settings.

The demonstration is mandated for a three-year period. It is to include a sufficient number of sites to ensure statistically reliable results. Within 6 months after the completion of the demonstration, the Secretary is required to report to Congress on the results and make appropriate recommendations. Six million dollars is made directly available from the Hospital Insurance trust fund for the costs of the demonstration.

CMS has developed a plan to implement the DRA demonstration (see Attachment B). The uniform assessment instrument that is being developed under the DRA demonstration will be comprehensive, inter-operable, and implemented on a internet-based platform. In addition to its use within the demonstration, the uniform assessment instrument will be made available for use in 2008 by hospitals outside of the demonstration on a voluntary basis as a tool for improving care transitions to PAC settings. The assessment and cost data collected under this demonstration will lead to comprehensive, site-neutral PAC payment reform.

Budget Proposals

The FY 2007 President's Budget included a proposal to reduce the excessive difference in payment between Inpatient Rehabilitation Facilities (IRFs) and Skilled Nursing Facilities for total knee and hip replacements. CMS will continue to look for opportunities to propose policies which move the program in the direction of our ultimate goal of site neutral payment for PAC services.

Pay-for-Performance Activities

CMS currently has activities underway with regard to pay-for-performance for both the home health and the SNF settings. For HHAs, in 2007 CMS will begin pay-for-reporting. HHAs that submit the required quality data (i.e, for 2007, CMS has proposed using 10 OASIS quality measures that are currently being reported through the CMS Home Health Compare website) would receive payments based on the full proposed home health market basket update of 3.1 percent for CY 2007. If a HHA does not submit quality data, the home health market basket percentage increase will be reduced by 2 percentage points to 1.1 percent for CY 2007. Pay-for-reporting will eventually transition to pay-for-performance. With regard to SNFs, CMS anticipates implementing a 3-year Nursing Home Value Based Purchasing Demonstration under which participating nursing homes will be offered financial incentives to provide high quality care and or to improve the level of care that they provide.

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Electronic Health Records and Personally Controlled Health Records

Over the long term, interoperable, widely deployed Electronic Health Records will play a major role in coordination of post acute care. The creation of a uniform assessment instrument for all post-acute patients can be built into the functionality of an EHR, alleviating the need to reconfigure the data every time the data move to a new setting. Availability of clinical and functional status patient information across multiple settings will be the most immediate benefit. However, EHRs also have the potential to streamline the collection and reporting of quality data and to support a range of evidence based quality improvement initiatives. In the shorter term, Personally Controlled Health Records (PCHRs, or simply PHRs) will allow patients and their caregivers to take individual responsibility for the portability of their medical history. A portable, patient controlled PHR can be updated after each encounter, allowing the patient to take an active role in reducing the medical "paper chase."

Conclusion

In fiscal year 2005, Medicare spent \$42 billion on post acute care services. Although this spending represents 13 percent of all Medicare benefit spending, the value that beneficiaries and tax payers are receiving is unclear. The post-acute care product is not well defined. Differences in assessment instruments make precise comparisons across settings difficult if not impossible. Optimal care transitions are hindered by the absence of a smooth flow of patient information from the acute to the post acute setting. Economic incentives resulting from the intricacies of the four separate payment systems interfere with the PAC placement decisions being made on a patient-centered basis.

With the implementation of the DRA payment reform demonstration, CMS will address both patient care and analytic needs through the development of a uniform patient assessment instrument to be used at hospital discharge and across PAC settings. Combining the patient assessment data and the facility cost data will provide the analytic input for PAC payment reform which will ultimately lead to a site neutral payment system. Incorporating pay for performance mechanisms into this new system will provide new incentives for providers to strive for excellence in the provision of PAC services. The uniform assessment instrument and the reformed payment system will improve care transitions and the overall quality of PAC care and foster PAC placement decisions that are patient-centered, reflecting patient needs.

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**Attachment A: Background Information on
Medicare's Current Post-Acute Care Payment Systems and Assessment Instruments**

Medicare has four separate prospective payment systems for each post-acute care (PAC) provider setting. Three of these payment systems rely on standardized data collected by providers using assessment tools developed for multiple purposes, including assessment, quality improvement, and payment.

- All skilled nursing facilities perform patient assessments using a standard Minimum Data Set (MDS).
- All certified home health agencies perform patient assessments using the Outcome and Assessment Information Set (OASIS)
- All Inpatient Rehabilitation Facilities use the IRF Patient Assessment Instrument (IRF-PAI).

To date, Medicare's PAC benefits and payment policies have focused on phases of a patient's illness as defined by a specific site of service, rather than on the characteristics or care needs of the beneficiary. Thus, payments across PAC settings may differ considerably even though the clinical characteristics and care needs of the patient and the services delivered may be very similar.

Furthermore, while the existing assessment instruments used in PAC settings allow providers to collect data in a standardized way, even when providers collect similar information on a single patient, each instrument collects the information using unique metrics and stores the information in different data formats, which are often not compatible and make it difficult to readily compare beneficiaries and their use of items and services across PAC settings. For example, providers across Medicare sites of service commonly collect information on a patient's diagnosis. Some settings collect and store this information as a code while others store the same information as a checklist of conditions. Also, while all of the PAC assessment tools include measures relating to patients' functional status, cognitive status, diagnoses, and comorbidities, they differ considerably in terms of the timeframes covered, scales used to differentiate patients, and definitions of the measures. The following is a summary of some of the major differences between the current PAC assessment tools.

	MDS 2.0	IRF-PAI	OASIS
Post-Acute Care Setting	Medicare or Medicaid certified nursing homes, i.e., Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs)	Inpatient Rehabilitation Facilities	Medicare-Certified Home Health Agencies
Frequency of Administration	Conducted close to (but not necessarily at) admission and periodically throughout the patient's stay – on days 5, 14, 30, 60, & 90 (but not at discharge)	Typically administered on the third day of the admission and at discharge	Routinely at admission, every 60 days, and discharge; Other assessments determined by change in patient health status
Timeframes Covered	Generally captures the patient's condition over the past 7 days recording the most support	Captures the patient's status on that day	Generally captures the patient's status within the last 24 hours; some

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	MDS 2.0	IRF-PAI	OASIS
	needed during that time		functional status items capture status in the prior 14 days – records an assessment of ability rather than actual performance at time of assessment
Time Required to Complete	90 minutes	25 minutes	90 minutes – Start of Care (SOC) version; 60 minutes – Resumption of Care (ROC), Follow-Up (FU), Significant Change in Condition (SCIC), and Discharge (DC) versions; 15 minutes – Transfer version
Scales Used to Differentiate Patient Functionality and Acuity	3-6 point scale	7 point scale	3-5 point scale
Functional Status Definitions	Evaluates whether and how frequently the patient needed assistance to engage in a given task, such as walking or getting dressed, as well as the type of help involved (e.g., weight bearing or verbal encouragement)	Includes the distances walked Distinguishes what share of the dressing a patient performs	Records the patient's ability to walk safely, once in a standing position
Diagnosis and Comorbidity Definitions	Uses a checklist of diagnoses or comorbidities	Uses ICD-9 codes to record diagnoses or comorbidities	Requires the use of the highest level of specificity for all digits of the ICD-9 Does not require the use of all 5 digits of the ICD-9-CM code
Cognitive Status Definitions	Considerable variation, including whether the tools distinguish between short-term vs. long-term memory, how depression and delirium are evaluated, and the types of decisions patients are able to make		

Skilled Nursing Facilities (SNF) Per Diem Payments based on Resource Utilization Groups (RUG)

SNFs provide short-term skilled nursing and rehabilitative care to people with Medicare who require such services on a daily basis in a SNF setting after a medically necessary hospital stay lasting at least three days. SNFs use the Minimum Data Set 2.0 (MDS 2.0) instrument to obtain a comprehensive assessment of each resident's functional capabilities and help nursing home staff identify health problems.² The MDS captures health assessment data with the use of a

² <http://www.cms.hhs.gov/quality/mds20/>

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checklist of conditions. SNFs receive per diem payments for each admission, which are case-mix adjusted using a resident classification system, Resource Utilization Groups (RUG) III, based on data from MDS 2.0 and relative weights developed from staff time data. Patients are classified into RUG-III groups based on need for therapy (i.e., physical, occupational, or speech therapy), special treatments (e.g., tube feeding), and functional status (e.g., ability to feed self and use the toilet). Patient status is reviewed periodically to update the RUG-III grouping.

Home Health Agency (HHA) 60-Day Episode Payments Based on National Rate

To qualify for Medicare home health visits, people with Medicare must be under the care of a physician, have an intermittent need for skilled nursing care or need physical therapy/speech therapy, or have a continuing need for occupational therapy. The beneficiary must be homebound and receive home health services from a Medicare approved HHA. Health assessment information is captured by HHAs in the Outcome and Assessment Information Set (OASIS). Under the home health PPS, Medicare pays higher rates to home health agencies to care for beneficiaries with greater needs. Payment rates are based on relevant data from patient assessments using the OASIS instrument. Home health services are measured in 60-day units called episodes and the amount of payment for an episode is the national base rate, adjusted for case-mix and for labor/wages in the area where the patient resides. The base payment covers the cost of visits and routine supplies, which is based upon a model with 1997 costs. The standardized payment amount model is updated annually using the home health market basket percentage.

Inpatient Rehabilitation Facility (IRF) Per Discharge Payments Based on Case-Mix Groups

For classification as an IRF, a percentage of the IRF's total patient population during the IRF's cost reporting period must match one or more of thirteen specific medical conditions. Currently, CMS is in the midst of a multi-year transition. On July 1, 2005, CMS began requiring that 60 percent of the total population match the thirteen medical conditions. Health assessment data are captured at IRFs with the use of the IRF Patient Assessment Instrument (IRF-PAI), which utilizes a 5 digit ICD-9 code. Payments under the IRF PPS are made on a per discharge basis. Under this system, payment rates are based on case-mix groups (CMGs) that reflect the clinical characteristics of the patient and the anticipated resources that will be needed for treatment.

Long-Term Care Hospital (LTCH) Per Discharge Payments based on Diagnosis Related Groups (LTC-DRGs)

To qualify as a LTCH, a facility must have an average inpatient length of stay greater than 25 days. These hospitals typically provide extended medical and rehabilitative care for patients who are clinically complex and may suffer from multiple acute or chronic conditions. Services may include comprehensive rehabilitation, respiratory therapy, cancer treatment, head trauma treatment, and pain management. LTC-DRGs are used under the LTCH PPS to classify patients into distinct diagnostic groups based on clinical characteristics and expected resource needs. LTC-DRGs, are based on the existing DRGs used under the hospital inpatient PPS that have been weighted to reflect the resources required to treat the medically complex patients treated at LTCHs. Unlike other post-acute care settings, there is no existing requirement for an assessment instrument for the LTCH setting.

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**Attachment B:
Timeline for Implementation of DRA Section 5008 Demonstration and Related PAC
Reform Activities**

Late October, 2006	Award contract for development of assessment instrument		
Early December, 2006		Award contract for: development of cost data collection tool; collection of assessment and cost data; and analysis of data.	
December 2006 – July 2007	Obtain Industry and expert input on Assessment Instrument through Town Hall Meeting and Technical Advisory Panels		
January 2007	Award contract for development of internet application for the assessment instrument		
Spring 2007	Begin recruiting providers for DRA demonstration		
Summer 2007	Alpha and beta testing of assessment instrument and application		
Jan 2008	Demonstration begins in one market		
April 2008	Full scale implementation of demonstration begins		Possible use of assessment instrument by providers outside of the demonstration on voluntary basis
July 2011	Report on demonstration delivered to Congress		

Submitter : Mrs. Marlene Claar

Date: 06/25/2007

Organization : Three Rivers Health

Category : Nurse

Issue Areas/Comments

75 Percent Rule Policy

75 Percent Rule Policy

I feel changing this percentage would affect many people who would benefit from a short stay at an inpatient rehab facility. We currently turn away people whom we know this service would help, and that is a difficult thing to do when you are trained to help people. I think we need to be available to assist all patients who need it.

Submitter : Mrs. Roshunda Drummond-Dye
Organization : American Physical Therapy Association
Category : Health Care Professional or Association

Date: 06/25/2007

Issue Areas/Comments

75 Percent Rule Policy

75 Percent Rule Policy

See attached comments

CMS-1551-P-9-Attach-1.PDF



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June 25, 2007

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Submitted via electronic submission

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 the American Physical Therapy Association (APTA), I am submitting the following comments regarding the Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal year (FY) 2008 Proposed Rule. The APTA is a professional association that represents the interest of over 69,000 physical therapists, physical therapist assistants, and students of physical therapy. APTA members furnish services to Medicare beneficiaries in inpatient rehabilitation facilities, and therefore, we are very concerned about proposed changes to the system.

Physical therapy is the profession devoted to restoration, maintenance, and promotion of optimal physical function. Physical therapists are licensed health care professionals who diagnose and manage movement dysfunction and enhance physical and functional status in all age populations. Physical therapists help patients maintain health by preventing further deterioration or future illness. In the inpatient rehabilitation facility (IRF) setting, physical therapy is critical to patients with a number of conditions.

APTA commends CMS for its efforts to update the prospective payment system to accurately reflect the costs of treatment in the inpatient rehabilitation setting. Although we feel that CMS has made progress, there are a few issues that we would like to address.

The 75 Percent Rule Policy

As with previous rules, APTA is still very concerned about the implementation of the classification criteria percentage for inpatient rehabilitation facilities, known as the “75% rule”. The criterion sets a minimum percentage of the facility’s total inpatient population that must meet one of thirteen medical conditions listed in the regulation in order for the facility to be classified as an IRF. This minimum percentage is known as the “compliance threshold”. The FY 2008 proposed rule discusses the revised “75% rule” phase-in implementation as mandated by the Deficit Reduction Act (DRA) which extends the full compliance threshold of 75 % until July 1, 2008. APTA contends that the “75% rule” continues to reduce admissions based on outdated, restrictive, and ineffective diagnosis-based criteria.

When Medicare first implemented the inpatient acute care hospital prospective payment system (PPS) in 1983, the regulation included a set of rules by which an IRF could exclude itself from the Inpatient Acute Care PPS. These rules included the original version of what we call the “75% rule” today. The “75% rule” was a methodology adopted by CMS for the purpose of establishing that the IRF was primarily engaged in providing intensive rehabilitation services as opposed to general medical and surgical services that related to ancillary rehabilitation services.

Although the original eight specified conditions have been expanded over the past 23 years to thirteen conditions, this policy still remains archaic and does not take into account the changing needs of patients. Physical therapists working in inpatient rehabilitation facilities often treat patients with complex orthopedic diagnoses, organ transplants, cancer, pain, and cardiopulmonary conditions that are not included in the current specified conditions. For certain conditions, the rehabilitation hospital is the best setting for the patient to receive the level of intense rehabilitation needed for their condition.

The practice of medicine and rehabilitation, current imaging techniques, and the use of modern day pharmaceutical therapy has dramatically changed since the original implementation of the “75% rule”. Medicare beneficiaries are living longer, and many of them must manage multiple chronic conditions. When an injury and/or surgery is added to a beneficiary’s list of pre-existing conditions, intensive rehabilitation is necessary to restore the person to maximum function levels.

For example, beneficiaries undergoing life-saving organ transplants or procedures for cardiopulmonary ailments that did not exist when these criteria were established are among those who are in the greatest need of the multi-disciplinary services that an IRF provides. It would not be medically prudent or in the best interest of the patient to provide these life-saving interventions, while at the same time failing to provide the necessary post-acute care rehabilitation care so that patients can return to their maximum function levels.

CMS’ current proposal, as described in the FY 2008 proposed rule, jeopardizes the care of a significant number of patients who require treatment in an inpatient rehabilitation facility. While we understand the need to manage treatment and streamline Medicare costs in the inpatient rehabilitation setting, we believe CMS needs to rethink the implementation

of the “75% rule” and develop a policy that ensures that individual needs are at the center of the decision concerning the Medicare beneficiary’s post-acute care.

In addition, CMS should, on an ongoing basis, periodically review its policy and classification criteria for IRFs to ensure that IRF Prospective Payment System is current, comprehensive in coverage, and reflects the most recent data regarding patient admissions and treatment in the IRF setting.

APTA thanks CMS for the opportunity to comment on this proposed rule, and we look forward to working with the agency to craft patient-centered reimbursement policies that reflect quality health care. If you have any questions regarding our comments, please contact Roshunda Drummond-Dye, Associate Director of Regulatory Affairs, at (703) 706-8547 or roshundadrummond-dye@apta.org.

Sincerely,

A handwritten signature in black ink, appearing to read "G. David Mason". The signature is written in a cursive, flowing style.

G. David Mason
Vice President, Government Affairs

CMS-1551-P-10

**Prospective Payment System for Inpatient Rehabilitation Facilities
for FY 2008**

Submitter : Thomas Hogenson

Date & Time: 06/26/2007

Organization : Mecosta County Medical Center

Category : Hospital

Issue Areas/Comments

75 Percent Rule Policy

75 Percent Rule Policy

We believe that the ratio cited in the "75/25" rule is too stringent in view of the 60-65% level which appears to represent the market in most locales. Mecosta County Medical Center offers a high level of sustainable services under these figures, care which is only available 50 or more miles distant from our rural community. Seeking to balance payments by diagnosis when our facility is adequately functional at the more realistic level would deny necessary care to hundreds in our service population each year and create needless expense of physical, time, financial and emotional reserves of our patients and their families. The availability of the physical rehabilitation inpatient setting at our Medical Center also adds a stabilizing influence on the provision of inpatient services overall and is a valuable adjunct to our total service profile within the region we serve. We strongly advocate for retention of the nominal 60-65% status quo in constructing admission census criteria for inpatient physical rehabilitation services. Respectfully,

Thomas J. Hogenson, RN
Public Relations Manager
Mecosta County Medical Center
605 Oak St.
Big Rapids MI 49307
thogenson@mcmcbr.com

**CMS-1551-P-11 Prospective Payment System for Inpatient Rehabilitation Facilities
for FY 2008**

Submitter : Mr. Richard Buhowski

Date & Time: 06/26/2007

Organization : Helen Hayes Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1551-P-11-Attach-1.DOC

June 26, 2007

Department of Health and Human Services
Attention: CMS-1551-P
P.O. Box 8012
Baltimore, MD 21244-8012

Subject: Helen Hayes Hospital's Comments regarding CMS Proposes Payment, Policy
Changes for Inpatient Rehabilitation Facilities in Fiscal Year 2008

To Whom it May Concern:

This letter is in response to CMS's request for comments regarding the Proposed Rule – Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2008 – as published in the Federal Register May 8, 2007. Our comments regarding file code CMS-1551-P specifically relate to the item identified as “75 Percent Rule Policy” and the continued use of comorbidities to calculate the compliance percentage required for classification as an IRF.

Background

Helen Hayes Hospital (HHH) is owned and operated by the New York State Department of Health and is JCAHO and CARF accredited. Founded in 1900 as one of the nation's first free-standing physical rehabilitation facilities, Helen Hayes Hospital's highly skilled, medical therapeutic teams focus on a singular goal: helping individuals recover from polytraumatic, catastrophic injuries and disabling disorders. A modern, state-of-the-art facility paired with an unparalleled depth and range of programs and services means the specialty hospital is well equipped to restore the mobility and independence of its patients. HHH is nationally recognized for its numerous specialty services and extensive continuum of care, which includes an acute inpatient population, a subacute population and outpatient services as well as outpatient day hospital services and a transitional living setting for TBI patients.

HHH provides intensive rehabilitation care by disability-specific, multidisciplinary treatment teams experienced in managing the diverse needs of medically complex patients. The teams are directed by board certified specialty physicians, including on-staff neurologists, physiatrists, cardiologists, psychiatrists, psychologists, and neuropsychologists, pulmonologists, otolaryngologists, dental and oral surgeons, urologists, and others. Our physical, occupational and recreational therapists, rehabilitation technologists, rehabilitation nurses, audiologists and speech pathologists and prosthetists and orthotists specialize in treating brain and spinal cord injury, stroke, joint replacement, fractures, amputation, and other conditions.

1) 75% Rule Policy

We wish to make clear our position regarding implementation of the 75% Rule, specifically that 75% of an IRF's patients must fall into one or more of 13 qualifying conditions. It is our opinion that the need for acute rehabilitation services should not be diagnosis based, but based upon the needs of the patient. When CMS developed CMGs for all impairments, rather than just compliant impairments, it acknowledged that patients of all types benefit from acute, intensive physical rehabilitation services, such as those offered here at Helen Hayes Hospital. The Moran Group, in their September 2006 study, found that the enforcement of the 75% Rule yields a correlation between the 75% Rule implementation and a decline in IRF admissions that is "difficult to be believed a coincidence." We believe that the steady decline in IRF cases is indicative of Medicare beneficiaries' restricted access to Inpatient Rehabilitation Facilities. "The observed caseload decline is obviously the direct consequence of the policy," states the Moran study. The 75% rule policy is detrimental and harmful to Medicare beneficiaries who would otherwise benefit from acute physical rehabilitation services that Inpatient Rehabilitation Facilities provide. The benefits of these services are supported by industry wide outcome data that CMS collects for each discharge. CMS in many of its initiatives supports high-quality, evidence-based practice, and the outcome data of Medicare beneficiaries in an IRF clearly supports the value of this approach for maximizing function and recovery. We would suggest CMS revise its current policy and the 75% Rule and instead allow for admissions to an IRF to be based upon the medical needs of the patient rather than a diagnosis.

2) Use of Co-Morbid Conditions to Determine 75% Rule Compliance

As indicated above, we strongly believe that admission to an Inpatient Rehabilitation Facility be determined by the needs of the patient rather than a diagnosis driven system. However, given the continued implementation of the 75% rule, we believe it is inappropriate to eliminate the use of co-morbid conditions to determine 75% rule compliance.

We strongly support the continued use of co-morbid conditions to calculate the compliance percentage of an IRF. To continue to allow this practice does not pose a hardship as the current use of technology makes it fairly easy, for all involved, to determine which co-morbidities affect the compliance rate.

A review of our cases for calendar year 2006 indicates that a select percentage of our total discharges were compliant due to a co-morbid condition. These co-morbid conditions included multiple sclerosis, Parkinson's disease, and other neurological disorders such as residual weakness from a stroke or a critical illness myopathy. Of note, we did not find any cases of osteoarthritis that would make a joint replacement case compliant. Review of calendar year 2007 cases, thus far, indicates a higher acuity of our patients due to compliant co-morbidities. It is our belief that access to acute rehabilitation services currently offered to these more impaired, higher acuity patients is imperative. Access, which is presently not limited since the co-morbid condition results in a compliant case, may mean the difference between a short stay in acute rehab versus a much longer and more dependent stay in a nursing home. If these impaired patients are strictly limited to admission to a nursing home, chances are high that they will not leave the long-term facility. Furthermore, they will not make gains as quickly, they will not have the 24-hour physician care to manage the current medical condition nor will they have the intensive therapy and rehabilitation nursing to support the pre-morbid neurological rehab needs.

Most of Helen Hayes Hospital cases did not go into outlier status; however, when compared to similar CMGs, the co-morbid condition did impact the costs of the case. The IRF stay was beneficial for the patient who received the appropriate services at the level of care required and for Medicare as good outcomes were achieved in a fiscally prudent manner.

Based upon review of these cases, we strongly support the access to acute inpatient rehabilitation services for patients who present with co-morbid conditions and request that admissions presently with the co-morbid conditions continue to be included as compliant cases.

We hope you take these comments into consideration.

If you require further information, please do not hesitate to contact me at (845) 786-4202.

Sincerely,

Richard Buhowski
Chief Financial Officer

RB/jk

C: M. Ramirez

**CMS-1551-P-12 Prospective Payment System for Inpatient Rehabilitation Facilities
for FY 2008**

Submitter : Mrs. Nancy Payne

Date & Time: 06/26/2007

Organization : Allina Hospitals and Clinics

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-1551-P-12-Attach-1.DOC

Allina Hospitals & Clinics
Compliance and Regulatory Affairs
PO Box 43 Mail Route 10105
Minneapolis, MN 55440-0043



June 26, 2007

Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare and 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: 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 Allina Hospitals & Clinics (Allina), I appreciate the opportunity to comment on the proposed rule concerning the Inpatient Rehabilitation Facility Prospective Payment System (IRF-PPS). Allina is a family of hospitals, clinics and care services that believes the most valuable asset people can have is their good health. We provide a continuum of care, from disease prevention programs, to technically advanced inpatient and outpatient care, medical transportation, pharmacy, home care, hospice and palliative care services. Allina serves communities around Minnesota and western Wisconsin.

Abbott Northwestern Hospital, our largest hospital, located in Minneapolis, Minnesota is recognized as one of the best hospitals in the country. The Sister Kenny Rehabilitation Institute (SKRI or Sister Kenny) is a center of excellence of Abbott Northwestern Hospital. Sister Elizabeth Kenny established SKRI in 1942 in response to the polio epidemic. Her pioneering principles of muscle rehabilitation became the foundation of modern physical therapy. SKRI comprises two hospital-based inpatient rehab facilities totally 55 beds, two spine centers, 20 outpatient physical therapy clinics, and many other specialty clinics. We treat over 1300 rehab inpatients a year, and more than 70,000 outpatients.

Over the last number of years we have commented with opposition on the 75% Rule. We continue to have grave concerns about the any further transition to a threshold that we feel will create significant access issues for a very vulnerable patient population.

75 Percent Rule Policy

We are very 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. We oppose this proposal on several grounds: 1) it would further restrict access to patients who need, and would significantly benefit from, inpatient rehabilitation; 2) the proposal

lacks medical and/or scientific basis; 3) the financial impact of the proposal has not been studied; and 4) the proposal is silent about the continued use of certain etiologic diagnoses to exclude compliance with the Rule, thus rendering it unequal and unfair in application alone.

1) **Restriction of Patient Access**

Using data supplied to our facility by a national vendor, we have estimated that elimination of the use of certain comorbidities to meet the 75 percent compliance threshold would result in a decrease of at least another 4-5% of patients who we cannot treat if we are to remain compliant.

The patient population that will be most severely affected will be those patients suffering from cancer, cardiac, pulmonary, or pain conditions. These are the very conditions not covered by the 75% rule since its inception almost 25 years ago. There have been many changes in medicine and rehabilitation since that time which this proposal ignores, including the decreased mortality rate for certain health care conditions.

2) **Proposal Lacks Medical or Scientific Basis**

CMS does not cite any scientific studies to support its proposal to eliminate the use of comorbidities. This proposal would further restrict access to inpatient rehabilitation and will affect the lives of thousands of people around the country, including those who live the communities we are dedicated to serve. One would at least hope and expect that it would be grounded in sound medical basis, however, none is offered here.

Because the comorbidities listed cover such a wide range of conditions, to decide that none of them are valid rehabilitation conditions seems capricious at best. For example, the ICD-9 code for Guillian Barre is listed as a valid comorbidity to determine compliance. What is the basis for excluding this when we have successfully treated numerous patients with this condition?

We can only assume that CMS wants to arbitrarily go back to the time period when these comorbidities were not used. It may even be alleged that the use of certain comorbidities to determine compliance was only a temporary provision to lessen the impact of the gradual implementation of the 75% rule. The real question is, however, lessen the impact on whom? It certainly impacts the operation of inpatient rehabilitation facilities. But the real impact is on the lives of people who can and do benefit from the skilled rehabilitation services we provide. That impact should only be undertaken on the basis of sound medical and scientific analysis and is consistent with the recommendations of the Medicare Payment and Advisory Commission (MedPAC) on the 75% rule.

3) **Financial Impact of Proposal**

The proposal ignores where the patients will go who cannot receive our services due to our need to meet the arbitrary requirements of the 75 percent rule. One would assume either that their length of stay in the acute care hospital will increase until they are able to go home or that many patients will be discharged to nursing homes. This ignores initial research that has been conducted at Burke Rehabilitation Hospital by the recently created ARA Research Institute that found that, for patients with single knee or hip replacement, patients who went to an inpatient rehabilitation facility, as opposed to a skilled nursing facility, were less likely to require re-hospitalization, had shorter lengths of stay, and were more likely to be discharged home.

Although the results of this study are preliminary, they do suggest that further study of the issue is warranted to determine the financial impact of the proposal before implementation.

4) **The Proposal is Unequal and Unfair in Application**

When the list of comorbidities was released in the 2004 Final Rule, included were certain etiologic diagnoses which took a patient out of the count in meeting the 75 percent threshold. No medical or scientific evidence was provided for this list. Thus, for example, a patient with a non-traumatic spinal cord injury, which is ordinarily sufficient to meet compliance, was determined to be non-compliant if the etiologic diagnosis was spinal stenosis.

We have successfully treated many patients who have had spinal stenosis. This proposal is silent regarding whether these patients will continue to be excluded after comorbidities or are no longer included in determining the compliance threshold. This issue needs to be addressed in the final rule. One could argue that just as the use of certain comorbidities to determine compliance was temporary, so too is the use of certain etiologic diagnoses. A more effective approach is to use medical and scientific evidence to guide the determination which will affect the quality of life for many Medicare beneficiaries.

Termination of the comorbidities provisions would have significant negative impact on a 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 FY2008 IRF-PPS final rule to **permanently include** comorbidities among qualifying cases. Additionally, we ask CMS to work more closely with research institutes, such as the ARA Research Institute, in developing the evidence base necessary for sound decision making.

We support 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 our inpatient rehabilitation programs. Systematic, timely review and modernization of the qualifying conditions should be conducted by CMS in collaboration with independent researchers; clinical experts including referring physician, physiatrists, rehabilitation nurses and therapists; and inpatient rehabilitation providers.

Thank you for your consideration of our comments on the proposed rule. If you have any questions about please feel free to contact me at (612) 262-4912. We look forward to your response in the final rule.

Sincerely,



Nancy G. Payne, RN
Director Regulatory Affairs

Submitter : Mr. Thomas Jendro
Organization : Illinois Hospital Association
Category : Health Care Provider/Association
Issue Areas/Comments

Date: 06/27/2007

GENERAL

GENERAL

See Attachment

CMS-1551-P-13-Attach-1.DOC



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- Peter Murphy
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- Mark Newton
Chicago
- David Ochs
Pontiac
- David Schertz
Rockford
- Conrie Schroeder
Pittsfield

June 27th, 2007

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

ATTN.: CMS-1551-P

Re: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2008; Proposed Rule, Federal Register, Volume 72, No. 88, Tuesday, May 8, 2007

Dear Ms. Norwalk:

On behalf of our approximately 200 member hospitals and health care systems, the Illinois Hospital Association (IHA) is taking this opportunity to formally comment on the proposed rule establishing new policies and payment rates for hospital inpatient rehabilitation for fiscal year 2008. IHA commends the Centers for Medicare and Medicaid Services (CMS) for its thorough analysis in the development of this rule; however, the Association does have some concerns with several of the provisions. Therefore, in accordance with instructions in the rule, the Illinois Hospital Association presents the following comments for your consideration:

75% Rule Policy:

- In accordance with recommendations by the Medicare Payment Advisory Commission (Med PAC), CMS should identify the clinical characteristics of those patients who currently fall outside of the qualifying conditions and are appropriate for hospital-level rehabilitation. IHA shares MedPAC's view that the 75% 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; doing so would reduce the number of denied medical necessity admissions for patients who seek care in rehabilitation hospitals and hospital units. CMS staff should coordinate timely review of these qualifying conditions with industry experts, including physicians, physiatrists, rehabilitation nurses, therapists and providers.

- IHA is also concerned about the pending termination of the Rule's temporary "co-morbidities provision," which allows classification of Medicare inpatients as meeting the 75% if certain, secondary medical characteristics are present. The provision is scheduled to sunset on July 1st, 2008 when full phase-in of the 75% rule is implemented. Under this temporary provision, a patient meets the 75% rule requirement is that patient is admitted for a co-morbid condition that falls within one of the thirteen qualifying conditions and also causes a significant decline in the patient's functional ability. According to CMS' own analysis, approximately 31,000 patients meet the rule's criteria because of this provision. Termination of this provision would negatively impact this large number of patients with complicating medical conditions who require medical oversight by a physician and the specialized, advanced nursing care and therapy given in rehabilitation hospitals and units. **Therefore, the Illinois Hospital Association urges CMS to permanently include co-morbidities as qualifying cases in the final FY 2008 rule.**

High Cost Outliers Under the IRF-PPS:

- CMS has proposed an increase in the outlier threshold amount to \$7,522 in FY 2008 from \$5,534 in FY 2007. The agency justifies this increase because estimated outlier payments in FY 2005 were 3.8% of total IRF-PPS payments, exceeding the statutory limit of 3%. However, CMS does concede that it is still examining the reasons for this increase. **Therefore, IHA recommends that CMS continue examining the causes for the increase and if further analysis suggests that the threshold increase is still valid, CMS should publish these reasons as part of the final rule.**

Ms. Norwalk, thank you again for the opportunity to comment. The Illinois Hospital Association also welcomes the opportunity to work with your agency in the continued development and refinement of the Medicare payment system for all providers.

Sincerely,

Thomas A. Jendro
Senior Director-Finance
Illinois Hospital Association
(630) 276-5516
tjendro@ihastaff.org

Submitter : Mr. Christopher Lee
Organization : Madonna Rehabilitation Hospital
Category : Hospital

Date: 06/27/2007

Issue Areas/Comments

75 Percent Rule Policy

75 Percent Rule Policy

See Attachment.

CMS-1551-P-14-Attach-1.DOC

#74

March 23, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1551-P
P.O. Box 8012, Baltimore, MD 21244-8012.

Re: Comments and Recommendations on the Proposed FY 2008 Amendments to the Inpatient Rehabilitation Hospitals and units Prospective payment System (IRF PPS), CMS-1551-P; 72 F.R. 26229 *et Seq.*, May 8, 2007

To Whom It May Concern:

Madonna Rehabilitation Hospital submits these comments on proposed amendments published on May 8, 2007, CMS-1551-P; 72 F.R. 26229 *et Seq.* These amendments have the potential to have negative implications for Madonna and the persons it serves.

Madonna Rehabilitation Hospital is a not-for-profit Catholic facility located in Lincoln, Nebraska and is sponsored by Diocesan Health Ministries, a division of the Catholic Dioceses of Lincoln. Originally founded in 1958 as an 111-bed facility by Benedictine Sisters whose mission was to "take care of the sick as Christ", the hospital has since grown to 303 beds on a 24 acre campus dedicated to the provision of rehabilitation care. Madonna is considered a local, regional and national provider of comprehensive post-acute care services including IRF.

In regards to the **75 Percent Rule Policy**, pg. 26233, Madonna supports permanent retention of the comorbidities. We note and appreciate that CMS has specifically requested comments and data regarding the use of comorbidities as they relate to the 75% rule exclusion criterion. We support retention of comorbidities in determining compliance with the threshold percentage and believe that eliminating comorbidities may have a negative affect on access to rehabilitation for Medicare beneficiaries.

Retaining comorbidities in the calculation is especially important given that the threshold will increase from 65% to 75% for cost reporting periods beginning on or after July 1, 2008. This increase may be even greater than 10% if comorbidities are eliminated. According to CMS's own analysis, 7% of patients throughout the industry were admitted under the presumptive compliance methodology in 2005 as patients with qualifying comorbidities. Based on analysis of Madonna's eRehab data from the most recent complete compliance periods between March 1, 2006 and February 28, 2007, as well as compliance information provided to us by our Fiscal Intermediary Mutual of Omaha, we believe that use of comorbidities could potentially cause as much as a 12.72% difference in calculating the compliance percentage. When this is combined

with the 10% increase in the compliance threshold, the cumulative affect for many facilities may be 17%, but could actually range up to 22.72% based on Madonna's data. Since this would, in effect, create an "88% rule", it is likely that even more Medicare beneficiaries will be denied access to rehabilitation.

Madonna projects that as many as 30 patients could be turned away from our facility in FY08 based on the compliance threshold increasing to 75% and the elimination of comorbidities. In addition to restricting access for these individuals, the financial impact to the facility is calculated to be \$418,500. Although this may not initially appear to be a large number, this represents a very significant impact to a free-standing, not-for-profit facility. Each year Madonna provides millions in services which are subsidized by the facility, not reimbursed, or reimbursed below cost. As a facility which exists on very small margins, an impact of over \$400,000 can significantly affect Madonna's ability to provide these community benefits. Not only will the Medicare beneficiaries who are turned away be negatively affected, but the community at large.

Comorbidities are a significant contributing factor in the medical necessity of an intensive inpatient rehabilitation program. Many of the patients admitted to IRFs could not be adequately treated in an alternate setting due to their comorbidities and the resulting medical and functional complexity. For instance, Madonna admitted a patient with a previous spinal cord injury and complete C5 level quadriplegia. He had been living alone in a college dorm, going to school, and living independently with intermittent personal assistance care provided by a home health agency. He developed pneumonia with respiratory failure and was subsequently hospitalized for eight days in acute care. While recovering from pneumonia, he also developed diabetic symptoms requiring monitoring of his blood glucose levels and delivery of insulin injections. He had a history of pressure sores, which was significant given the new potential diagnosis of diabetes and its impact on skin as well as his limited mobility and sensation. The patient required respiratory therapy three times daily. Because of the level of his spinal cord injury, he also required neuromuscular re-education of the upper chest musculature, range of motion to increase chest expansion, and instruction in adaptive techniques for deep breathing, quad cough, and pulmonary toilet. The patient had a history of skin breakdown, and had poor sensation, and interruption in his normal daily routine of up/down schedule. Therefore, he required skilled interventions and training to do pressure relief techniques, build back to his normal up/down schedule, and to evaluate his seating and positioning system to prevent further skin breakdown.

These skilled therapy techniques were delivered by an Occupational Therapist and reinforced by nursing, respiratory therapy, and physical therapy. 24-hour respiratory therapy, skilled therapies, assistive technology, and rehab nursing staff trained in the treatment of persons with C5 quadriplegia are not available in less intensive settings. The nursing staff had to have knowledge of rehabilitation of persons with quadriplegia in order to effectively treat and provide appropriate education for this patient in the areas of skin care, diabetic management, and pulmonary care. This required use of specialized adaptive equipment as well as adaptive techniques given his level of spinal cord injury.

Rehabilitation was necessary in an inpatient hospital setting due to the complex nature and combination of pulmonary and potential skin issues combined with the fact that he had quadriplegia, was living independently in the community, and wished to return to that level of

function. Utilizing all these specialized resources, the patient was able to return to his previous independent living setting.

Once the 75% Rule, as it stands today, is fully implemented, this patient's primary admitting diagnosis would not meet the 13 conditions even though his comorbidities clearly required an IRF setting. If comorbidities are removed from the calculation of 75% Rule compliance, this patient could only be admitted to Madonna if we were already well within the compliance threshold.

This real-life case, and many like it, serves to demonstrate that the comorbidities should be retained because of the inherent limitations of any diagnosis based system which is insensitive to the special needs of individual patients. To eliminate comorbidities further exacerbates the issues of access to care in IRFs that are inherent in this rule. The debate over the 75% rule centers on the fact that the rule has moved away from its original purpose of defining an IRF, as compared to an acute care hospital, to embrace issues of medical necessity. The result is that the rule is being used as a crude measure of medical necessity. Until these issues of medical necessity are further researched, debated and resolved, the rule should recognize the clinical relevance of patients who present with complex clinical elements and need care, be it by a primary qualifying condition under the 13 conditions or as a qualifying comorbidity.

Finally the use of comorbidities should be retained indefinitely, at a minimum until current research examining the use of comorbidities and their severity is concluded. Madonna is a strong supporter of clinically based rehabilitation research. Madonna is a member of AMRPA and is currently a participating site in AMRPA sponsored research. This research will seek to determine the outcomes of patients with non-qualifying primary conditions who are treated in different settings, primarily IRFs and SNFs. In addition, Madonna sent a representative to Washington D.C. in February 2007 to attend a research symposium, titled "State of the Science", sponsored by AMRPA and other organizations. Work groups at this symposium began the process of outlining the research necessary to provide answers to crucial questions regarding such things as medical necessity and the role that comorbidities play. The case study presented earlier in this letter presents a powerful anecdotal argument for retaining comorbidities. However, Madonna is also dedicated to producing research data which will provide an objective basis upon which to base important health policy decisions. Madonna believes that comorbidities should be retained for the present time, current research should be concluded, and the resulting data used to make a more informed decision on the use of comorbidities.

Recommendations:

1. Madonna Rehabilitation Hospital respectfully recommends that CMS retain the current comorbidities under the 75% rule exclusion policy and make it permanent.
2. Madonna also recommends, based on the preliminary findings of research sponsored by AMRPA, prior RAND research, and in response to CMS's request for comment, that CMS add the following comorbidities to the current list of ICD-9-CM codes:
 - Obesity
 - Anemia
 - Depression
 - Thrombophlebitis
 - Chronic Skin Ulcers
 - Osteomyelitis

- Hypertension
3. Alternatively, we would recommend that any functionally compromised patient who needs rehabilitation services and has a cluster of common conditions, specifically a cardiac complication, pulmonary complication, diabetes, obesity and/or metabolic syndrome, be considered to fall within the comorbidities policy.
 4. Not all comorbidities are currently an alternate for qualification as operationally defined by CMS under its presumptive methodology. Madonna recommends that the presumptive methodology policy for qualification under the comorbidity policy become the comorbidity policy and that the regulation be amended to read:

“A patient with a comorbidities, as defined at § 412.602, may be included in the inpatient population that counts towards the required applicable percentage if—

- A. The patient is admitted for inpatient rehabilitation for a condition that is not one of the conditions specified in paragraph (b)(2)(iii) of this section;
- B. The item(s) in the IRF PAI requesting data on comorbid conditions falls into ICD-9-CM Codes set forth by CMS.”

Sincerely,

Christopher A. Lee, PT, M.S.P.T.
Director of Rehabilitation Operations

Paul A Dongilli, Jr., Ph.D., FACHE
Executive Vice President and Chief Operations
Officer

Submitter : Mr. Christopher Lee
Organization : Madonna Rehabilitation Hospital
Category : Hospital

Date: 06/27/2007

Issue Areas/Comments

75 Percent Rule Policy

75 Percent Rule Policy

See attachment.

CMS-1551-P-15-Attach-1.DOC

March 23, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1551-P
P.O. Box 8012, Baltimore, MD 21244-8012.

Re: Comments and Recommendations on the Proposed FY 2008 Amendments to the Inpatient Rehabilitation Hospitals and units Prospective payment System (IRF PPS), CMS-1551-P; 72 F.R. 26229 *et Seq.*, May 8, 2007

To Whom It May Concern:

Madonna Rehabilitation Hospital submits these comments on proposed amendments published on May 8, 2007, CMS-1551-P; 72 F.R. 26229 *et Seq.* These amendments have the potential to have negative implications for Madonna and the persons it serves.

Madonna Rehabilitation Hospital is a not-for-profit Catholic facility located in Lincoln, Nebraska and is sponsored by Diocesan Health Ministries, a division of the Catholic Dioceses of Lincoln. Originally founded in 1958 as an 111-bed facility by Benedictine Sisters whose mission was to “take care of the sick as Christ”, the hospital has since grown to 303 beds on a 24 acre campus dedicated to the provision of rehabilitation care. Madonna is considered a local, regional and national provider of comprehensive post-acute care services including IRF.

In regards to the **75 Percent Rule Policy**, pg. 26233, Madonna supports permanent retention of the comorbidities. We note and appreciate that CMS has specifically requested comments and data regarding the use of comorbidities as they relate to the 75% rule exclusion criterion. We support retention of comorbidities in determining compliance with the threshold percentage and believe that eliminating comorbidities may have a negative affect on access to rehabilitation for Medicare beneficiaries.

Retaining comorbidities in the calculation is especially important given that the threshold will increase from 65% to 75% for cost reporting periods beginning on or after July 1, 2008. This increase may be even greater than 10% if comorbidities are eliminated. According to CMS’s own analysis, 7% of patients throughout the industry were admitted under the presumptive compliance methodology in 2005 as patients with qualifying comorbidities. Based on analysis of Madonna’s eRehab data from the most recent complete compliance periods between March 1, 2006 and February 28, 2007, as well as compliance information provided to us by our Fiscal Intermediary Mutual of Omaha, we believe that use of comorbidities could potentially cause as much as a 12.72% difference in calculating the compliance percentage. When this is combined

with the 10% increase in the compliance threshold, the cumulative affect for many facilities may be 17%, but could actually range up to 22.72% based on Madonna's data. Since this would, in effect, create an "88% rule", it is likely that even more Medicare beneficiaries will be denied access to rehabilitation.

Madonna projects that as many as 30 patients could be turned away from our facility in FY08 based on the compliance threshold increasing to 75% and the elimination of comorbidities. In addition to restricting access for these individuals, the financial impact to the facility is calculated to be \$418,500. Although this may not initially appear to be a large number, this represents a very significant impact to a free-standing, not-for-profit facility. Each year Madonna provides millions in services which are subsidized by the facility, not reimbursed, or reimbursed below cost. As a facility which exists on very small margins, an impact of over \$400,000 can significantly affect Madonna's ability to provide these community benefits. Not only will the Medicare beneficiaries who are turned away be negatively affected, but the community at large.

Comorbidities are a significant contributing factor in the medical necessity of an intensive inpatient rehabilitation program. Many of the patients admitted to IRFs could not be adequately treated in an alternate setting due to their comorbidities and the resulting medical and functional complexity. For instance, Madonna admitted a patient with a previous spinal cord injury and complete C5 level quadriplegia. He had been living alone in a college dorm, going to school, and living independently with intermittent personal assistance care provided by a home health agency. He developed pneumonia with respiratory failure and was subsequently hospitalized for eight days in acute care. While recovering from pneumonia, he also developed diabetic symptoms requiring monitoring of his blood glucose levels and delivery of insulin injections. He had a history of pressure sores, which was significant given the new potential diagnosis of diabetes and its impact on skin as well as his limited mobility and sensation. The patient required respiratory therapy three times daily. Because of the level of his spinal cord injury, he also required neuromuscular re-education of the upper chest musculature, range of motion to increase chest expansion, and instruction in adaptive techniques for deep breathing, quad cough, and pulmonary toilet. The patient had a history of skin breakdown, and had poor sensation, and interruption in his normal daily routine of up/down schedule. Therefore, he required skilled interventions and training to do pressure relief techniques, build back to his normal up/down schedule, and to evaluate his seating and positioning system to prevent further skin breakdown.

These skilled therapy techniques were delivered by an Occupational Therapist and reinforced by nursing, respiratory therapy, and physical therapy. 24-hour respiratory therapy, skilled therapies, assistive technology, and rehab nursing staff trained in the treatment of persons with C5 quadriplegia are not available in less intensive settings. The nursing staff had to have knowledge of rehabilitation of persons with quadriplegia in order to effectively treat and provide appropriate education for this patient in the areas of skin care, diabetic management, and pulmonary care. This required use of specialized adaptive equipment as well as adaptive techniques given his level of spinal cord injury.

Rehabilitation was necessary in an inpatient hospital setting due to the complex nature and combination of pulmonary and potential skin issues combined with the fact that he had quadriplegia, was living independently in the community, and wished to return to that level of

function. Utilizing all these specialized resources, the patient was able to return to his previous independent living setting.

Once the 75% Rule, as it stands today, is fully implemented, this patient's primary admitting diagnosis would not meet the 13 conditions even though his comorbidities clearly required an IRF setting. If comorbidities are removed from the calculation of 75% Rule compliance, this patient could only be admitted to Madonna if we were already well within the compliance threshold.

This real-life case, and many like it, serves to demonstrate that the comorbidities should be retained because of the inherent limitations of any diagnosis based system which is insensitive to the special needs of individual patients. To eliminate comorbidities further exacerbates the issues of access to care in IRFs that are inherent in this rule. The debate over the 75% rule centers on the fact that the rule has moved away from its original purpose of defining an IRF, as compared to an acute care hospital, to embrace issues of medical necessity. The result is that the rule is being used as a crude measure of medical necessity. Until these issues of medical necessity are further researched, debated and resolved, the rule should recognize the clinical relevance of patients who present with complex clinical elements and need care, be it by a primary qualifying condition under the 13 conditions or as a qualifying comorbidity.

Finally the use of comorbidities should be retained indefinitely, at a minimum until current research examining the use of comorbidities and their severity is concluded. Madonna is a strong supporter of clinically based rehabilitation research. Madonna is a member of AMRPA and is currently a participating site in AMRPA sponsored research. This research will seek to determine the outcomes of patients with non-qualifying primary conditions who are treated in different settings, primarily IRFs and SNFs. In addition, Madonna sent a representative to Washington D.C. in February 2007 to attend a research symposium, titled "State of the Science", sponsored by AMRPA and other organizations. Work groups at this symposium began the process of outlining the research necessary to provide answers to crucial questions regarding such things as medical necessity and the role that comorbidities play. The case study presented earlier in this letter presents a powerful anecdotal argument for retaining comorbidities. However, Madonna is also dedicated to producing research data which will provide an objective basis upon which to base important health policy decisions. Madonna believes that comorbidities should be retained for the present time, current research should be concluded, and the resulting data used to make a more informed decision on the use of comorbidities.

Recommendations:

1. Madonna Rehabilitation Hospital respectfully recommends that CMS retain the current comorbidities under the 75% rule exclusion policy and make it permanent.
2. Madonna also recommends, based on the preliminary findings of research sponsored by AMRPA, prior RAND research, and in response to CMS's request for comment, that CMS add the following comorbidities to the current list of ICD-9-CM codes:
 - Obesity
 - Anemia
 - Depression
 - Thrombophlebitis
 - Chronic Skin Ulcers
 - Osteomyelitis

- Hypertension
3. Alternatively, we would recommend that any functionally compromised patient who needs rehabilitation services and has a cluster of common conditions, specifically a cardiac complication, pulmonary complication, diabetes, obesity and/or metabolic syndrome, be considered to fall within the comorbidities policy.
 4. Not all comorbidities are currently an alternate for qualification as operationally defined by CMS under its presumptive methodology. Madonna recommends that the presumptive methodology policy for qualification under the comorbidity policy become the comorbidity policy and that the regulation be amended to read:

“A patient with a comorbidities, as defined at § 412.602, may be included in the inpatient population that counts towards the required applicable percentage if—

A. The patient is admitted for inpatient rehabilitation for a condition that is not one of the conditions specified in paragraph (b)(2)(iii) of this section;

B. The item(s) in the IRF PAI requesting data on comorbid conditions falls into ICD-9-CM Codes set forth by CMS.”

Sincerely,

Christopher A. Lee, PT, M.S.P.T.
Director of Rehabilitation Operations

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Executive Vice President and Chief Operations
Officer