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To: **John F.** Morrall III/OMB/EOP@EOP

cc:
Subject: Regulatory Reform & Improvements ; Fed Register, Vol **67,** Num. ***60,3/28/02***

Dear Mr. Morrall,

We submit the attached suggestions to the Office of Information and Regulatory Affairs as requested by the notice given in the Federal Register, Volume 67, Number 60, March 28, 2002.

The attached pages contain our suggestions regarding Inpatient Rehabilitation Facilities which are regulated **by** the Center for Medicare and Medicaid Services (CMS) under the U.S. Department of Heath and Human Resources.

Specifically, our comments address;

Citation	Statue	Name of Regulation
42 U.S.C. § 1395ww(d).	42 CFR 412.23(b)(2)	The 75% Rule
42 U.S.C. § 1395ww(d).	42 CFR 412.30(c)	The Converted Bed Rule
42 U.S.C. § 1395ww(d).	42 CFR 412.25(c)	The Exemption Date Rule
42 U.S.C. § 1395ww(d).	42 CFR 412.29(f)(1)	The Medical Director Rule

Thank you for accepting our comments and extending this invitation for public input. Please feel free to contact me at 314-659-2610 if you wish to discuss any of these matters.

Sincerely,

Tom Davis
RehabCare Group, Inc.
President, Inpatient Services

Attach

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May 24,2002

Mr. John Morrall
Office of Information and Regulatory Affairs
Office of Management and Budget
NEOB, Room 10235
17th Street, N.W.
Washington, D.C. 20503

Regarding; OIRA's Invitation Seeking Comments on Regulatory Reform & Improvements
Federal Register, Volume 67, Number 60, Thursday, March 28,2002

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TD/rtl

Regulating Agency: **U.S. Department of Health and Human Services**
Centers for Medicare and Medicaid Services (CMS)
Citation: **42 CFR 412.23(b)(2)**
Authority: **42 U.S.C. § 1395ww(d).**

Description of Problem: Regarding Inpatient Rehabilitation Services (IRF);

The 75% Rule should be eliminated or modified. The current rule in effect denies access to treatment to patients who would benefit from intensive rehab services. The current Inpatient Rehabilitation Facilities Prospective Payment System (Rehab PPS) regulations and related Case Mix Groups (CMG's), which define rehab appropriate condition, render the 75 / 25 rule to be out dated and not reflective of current rehabilitative medical practice.

Situation
The so-called "75% rule" is one of a handful of regulations that exempt rehabilitation hospitals and units from the DRG reimbursement system. This regulation stipulates that in a 12 month cost report year a minimum of *75%* of the patients discharged must have one of ten clinical conditions. Administrators and managers of rehabilitation programs faced with increasing demand for the service they provide are forced to limit access to potential rehabilitation patients with clinical conditions outside the ten conditions mentioned above as a means to maintain their program above the *75%* level.

Industry data from 1996-2000, accumulated by RAND (see footnote below) 'and UDS, suggests that many rehab units, are having great difficulty meeting the *75* / 25 rule. In addition, industry trends indicate that there are several rehab conditions outside the *75%* category which are increasing in frequency. These conditions, which benefit from intensive rehab services, include cardiac, pain, pulmonary and (RIC 20) other disabling conditions. They totaled 20.4% of all rehab discharges in 1999 and were only 10.1% in 1994. This increase likely reflects advancements in medical care and an aging population, both of which are trends expected to continue. Some patients with conditions not included in the 75% category are currently being denied rehab services in a failing effort to maintain the 75% ratio. With increasing frequency of the alternate conditions, even more patients will be denied rehab services in the future if the 75% rule is left in place.

Backmound
The 75/25 Rule was originally formed at a time when rehab was not well defined. CMS (then HCFA) first chose 8 (later expanded to 10) condition categories which it felt were clearly rehab appropriate and mandated that they comprise 75% of discharges. Other conditions, which CMS at the time felt may or may not be typical for rehabilitation programs, were allowed to comprise the remaining 25% of discharges. If a unit provided rehab and discharged patients that had a diagnostic ratio of 75/25, the unit was deemed to be primarily engaged in rehab services.

When implementing IRF PPS, CMS has now defined all conditions that are routinely admitted to a rehab program. Each condition has been assigned a code that makes up the reimbursement system known as Case **Mix** Groups (CMG's). The list of conditions has

[1] RAND Report, Sept. 1997 prepared for CMS and RAND Draft Preliminary Data, Phase 1 Study, prepared for CMS

been essentially "brought up to date" and because it is based in part on MedPar data it is more of an indication of the recipients of today's rehabilitative medicine.

The development of the CMG listing by CMS is de facto the list of patients who are appropriate for rehab. Medical care has changed and it is now more broadly inclusive of patient types. The CMG list is the validation of modem utilization. The continuation of the 75% rule in its current state serves only to maintain a system that denies access to Medicare beneficiaries for rehabilitation services.

Proposed Solution:

1. Eliminate the 75% Rule - or -
2. Modify the Rule to relate the *75%* rule to Rehab PPS. HHS has been presented a proposal that if *75%* of inpatient rehabilitation services furnished to Medicare patients during a provider's most recent reporting period fell into 20 of the 21 RIC's, the provider would be deemed to have met the 75% Rule. This proposal was first presented to HMS by the American Rehabilitation Providers Association in an April 2, 2002 letter and then later reaffirmed in an April 17,2002 letter to HHS by a coalition of industry trade associations.

Estimate of Economic Impacts: Immaterial

Patients that are currently being denied access to IRFs due to the 75% Rule are likely currently receiving inappropriate or less than optimal treatment at acute care hospitals, skilled nursing units, nursing homes or long term acute care hospitals. Allowing these patients additional access to IRFs would enable them to receive more appropriate care and merely shift these patients, and their costs, from other care settings to IRFs.

Regulating Agency: **U.S. Department of Health and Human Services**
Centers for Medicare and Medicaid Services (CMS)
Citation: **42 CFR 412.30(c)**
Authority: **42 U.S.C. § 1395ww(d).**

Description of Problem: Regarding Inpatient rehabilitation Services (IRFs)

The Converted Bed Rule should be eliminated. Hospitals are financially penalized if they open or expand a rehab unit using converted beds. There is no such financial penalty if rehab units are opened or expanded using new beds. (See footnote below for definitions of new & converted beds/units) Therefore an inequity exists between the treatment of new and converted beds. **As** a result of this inequity and financial penalty, hospitals don't open or expand rehab units if they only have beds available for conversion. This results in fewer rehab beds which then in effect denies patients access to intensive rehabilitation services.

Situation
Hospitals who open or expand rehab units with converted beds are required to show that the unit treated an inpatient population that satisfies the 75/25 Rule for a full 12 month cost reporting period. During this 12-month period the hospital is only allowed reimbursement under the patient's original DRG and is denied participation in IRF PPS. Only after satisfying the 75/25 Rule for a full 12-month reporting period are the converted beds allowed to participate in the Inpatient Rehabilitation Facility Prospective payment System (Rehab PPS).

In contrast, hospitals that open or expand rehab units with new beds are allowed to participate in Rehab PPS immediately. The hospital only needs to certify that these new beds will meet the 75/25 rule in the coming 12-month period.

As a result, there is an inequity between new rehab beds & converted rehab beds. New beds begin receiving Rehab PPS reimbursement immediately, while converted beds receive no rehab reimbursement during their first 12 months. Faced with this financial penalty, hospitals don't open or expand rehab units if they only have beds available for conversion. This results in fewer rehab beds which then in effect denies patients access to intensive rehabilitation services.

Background[2]
Originally the converted bed rule applied to new beds as well. However CMS later acknowledged that waiting 12 months to establish compliance with the 75/25 Rule was "unnecessarily harsh" (49 Fed Reg at 34,733). Relief was granted to new rehab hospitals and units by allowing them to certify in writing that they will meet the 75/25 rule in their initial cost reporting period. Such relief was not granted to converted beds. **As** a result,

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[2] Brief Definitions:
New Units- if the hospital has obtained state & Medicare approval for an increase in its hospital bed capacity that is greater then *50%* of the number of beds in the unit.
New Beds – if the hospital has obtained state & Medicare approval for an increase in its hospital bed capacity that is greater than *50%* of the number of beds it **seeks** to add to the unit.
Converted Beds / Units - if not defined as new, then it is considered to be converted.

this inequity between the treatment of new and converted beds was created. The result is just as "harsh" for converted beds, and there is no reason to discriminate beds in this way.

Proposed Solution

Eliminate the Converted Bed Rule

Estimate of Economic Impacts: Immaterial

Patients that are currently being denied access to IRFs due to the 75% Rule are likely currently receiving inappropriate or less than optimal treatment at acute care hospitals, skilled nursing units, nursing homes or long term acute care hospitals. Allowing these patients additional access to IRFs would enable them to receive more appropriate care and merely shift these patients, and their costs, from other care settings to IRFs.

Regulating Agency: **U.S. Department of Health and Human Services**
Centers for Medicare and Medicaid Services (CMS)
Citation: **42 CFR 412.25(c)**
Authority: **42 U.S.C. § 1395ww(d).**

Description of Problem: Regarding Inpatient Rehabilitation Facilities (IRFs)

The Exemption Date Rule should be eliminated. This rule is rendered obsolete due to Inpatient Rehabilitation Prospective payment System (Rehab PPS). Elimination of this rule will allow hospitals to open rehab units in a more timely manner, thus improving patient access to intensive rehabilitation services and reduce the hospital's administration burden.

Situation
The Exemption Date Rule requires that rehab hospitals and units only be approved by Medicare effective at the hospital's annual cost reporting date. Inpatient rehabilitation is the only hospital service that is not allowed to open or expand during a cost reporting period. This impacts the timely opening and expansion of rehab units, which impacts patient's access to rehabilitation services.

Backmound
Historically the exemption date rule was required by CMS because IRFs were reimbursed under a cost based system. CMS needed to ensure that rehab costs were accurately captured within cost report to facilitate reimbursement. The intent of CMS was to enhance the accuracy of a rehab unit's cost report by disallowing mid-year rehab unit openings.

However, with the advent of Rehab PPS, reimbursement is no longer cost based. Rehab units could open / expand mid year and receive appropriate Rehab PPS reimbursements regardless of what the rehab unit's cost report reflects. **A** compelling reason to wait until an exemption date to open or expand a rehab unit no longer exists.

Proposed Reform
Eliminate the Exemption Date Rule.

Estimate of Economic Impacts: Immaterial
Patients that are currently being denied access to IRFs due to the 75% Rule are likely currently receiving inappropriate or less than optimal treatment at acute care hospitals, skilled nursing units, nursing homes or long term acute care hospitals. Allowing these patients additional access to IRFs would enable them to receive more appropriate care and merely shift these patients, and their costs, from other care settings to IRFs.

Regulating Agency: **U.S. Department of Health and Human Services**
Centers for Medicare and Medicaid Services (CMS)
Citation: **42 CFR 412.29(f)(1)**
Authority: **42 U.S.C. § 1395ww(d).**

Description of Problem: Regarding Inpatient Rehabilitation Facilities (IRFs)

The Medical Director Rule should be amended to allow for resources to be determined based on rehab unit size. The current rule is inflexible and mandates wasted resources at smaller units.

Situation
All rehab units, regardless of size, are required to have medical directors providing a minimum of 20 hours of service / week. This is a one-size fits all approach. Clearly medical director resources needed to meet patient and administrative needs vary based on unit size. Smaller units are overstaffed when medical directors serve 20 hours. Allowing medical director resource requirements to appropriately vary with unit size would "right size" medical directorships, thus eliminating wasted costs at smaller sized units while maintaining quality patient care.

Background
Initially both rehab hospitals and units needed to have full time medical directors. Realizing that rehab units were smaller than rehab hospitals, CMS revised the requirements for rehab medical directors, mandating a minimum of 20 hours per week.

An extension of this logic would recognize that within rehab units, smaller units are overstaffed with a 20-hour medical director, which adds unnecessary costs and burdens to the system.

Proposed Reform

Amend the Medical Director Rule to require;

Beds	**Medical Director Hours**
10 & under	10
10 – 15	12
15 – 20	16
20 or more	20 minimum

Estimate of Economic Impacts: No Impact

Amending the Medical Direrctor Rule as suggested above will only reduce costs of providers and will add no additional costs to the Medicare programs. In the long run, however, Medicare costs may decrease slightly if CMS reduces reimbursements in light of reduced provider costs.