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QUESTIONS AND ANSWERS

PRESERVING ACCESS TO INPATIENT REHABILITATION SERVICES-- WHY POLICYMAKERS, MEDICARE BENEFICIARIES, AND THE DISABILITY COMMUNITY SHOULD BE CONCERNED WITH THE IMPACT OF CMS' SO-CALLED "75% RULE"

Access to intensive, coordinated rehabilitation services provided in inpatient rehabilitation facilities for Medicare beneficiaries and others is in jeopardy. These services are often the lifeline from the hospital back to a person's home, rather than placement in an institution. The purpose of this paper is threefold:

1. Provide a clear statement of the issue—why policymakers, Medicare beneficiaries, and the disability community should be concerned with the 75% Rule and why immediate action is necessary to preserve access to inpatient rehabilitation.
2. Provide background information about the inpatient rehabilitation entitlement, including rules for certifying inpatient rehabilitation hospitals and units and rules governing the admission of beneficiaries to such hospitals and units.
3. Describe the adverse impact of CMS' rules on beneficiaries, including the denial of medically reasonable and necessary rehabilitation services that will enable beneficiaries to return to their homes rather than being forced into nursing homes and how the administration of the 75% Rule is inconsistent with the principles of disability policy articulated in the Americans with Disabilities Act (ADA).

STATEMENT OF THE ISSUE

The Medicare program provides healthcare coverage for older Americans and certain persons with disabilities. The number of people with disabilities on Medicare below the age of 65 now totals over 6 million. Under Medicare, access to medically reasonable and necessary health care services is an "entitlement," which means that as long as a person meets the eligibility requirements, they are entitled to receive the benefits covered by the program.

Among the health care services recognized under Medicare is the provision of intensive, coordinated rehabilitation services provided by inpatient rehabilitation hospitals and rehabilitation units of acute care hospitals. A primary purpose of rehabilitation services provided in an inpatient rehabilitation facility is to enable a beneficiary to regain and/or maintain his or her maximum level of independent functioning as quickly as possible so that the individual can return to his or her own home and job (whenever feasible) rather than being placed in a nursing home.

In order to be certified as an inpatient rehabilitation hospital or unit, the provider must meet criteria established by CMS—the agency that administers the Medicare program.

Once a hospital or unit is certified, it is eligible for enhanced payment to cover the additional costs associated with providing intensive, comprehensive, and coordinated rehabilitation services through a multi-disciplinary team. Thus, to justify the enhanced payment made to inpatient rehabilitation hospitals and units, it is appropriate for public policy to be able to distinguish inpatient rehabilitation hospitals and units from other settings that receive a lesser payment, such as nursing homes or outpatient care.

Similarly, in order for a beneficiary to be admitted to an inpatient rehabilitation hospital, he or she also must meet strict criteria issued by CMS—the services must be reasonable and necessary based on an assessment of each beneficiary’s individual care needs. Thus, public policy guarantees access to these critical inpatient rehabilitation services for those beneficiaries who satisfy the strict criteria for admissions promulgated by CMS. These intense, coordinated inpatient rehabilitation services are often the lifeline from the hospital back to beneficiaries’ homes, rather than placement into institutions.

To the dismay of Medicare beneficiaries, the disability community, and a bipartisan group of Senators and Congressmen, CMS is implementing a rule (commonly referred to as the “75%” rule) as a means of certifying inpatient rehabilitation hospitals and units that is having the untenable effect of forcing inpatient rehabilitation hospitals and units to turn away beneficiaries who need, and are entitled to, inpatient rehabilitation services. In other words, because of the arbitrary, inflexible, overly bureaucratic 75% rule, beneficiaries’ access to medically reasonable and necessary inpatient rehabilitation services is being jeopardized, which is impacting their quality of life, particularly their ability to expeditiously return to their homes and live independently, rather than being forced into institutions.

The following provides a summary explanation of how the 75% rule is adversely impacting certain beneficiaries who need inpatient rehabilitation services. In order to be certified by CMS as a rehabilitation hospital or unit, a number of criteria must be met including the 75% Rule. This rule requires that providers maintain a particular percentage of patients receiving treatment for one or more of thirteen (13) conditions specified by CMS. In order to retain their certification, inpatient rehabilitation hospitals and units are being placed in the unacceptable position of turning away patients whose medical condition and rehabilitation needs meet the strict admissions criteria promulgated by CMS, but who do not happen to fall within one of the thirteen listed conditions. Practically speaking, inpatient rehabilitation hospitals and units are being forced to establish health care quotas—i.e., they must manage/limit the mix of the patients they treated based on the 75% Rule (a certification/payment rule) rather than on the basis of clinical judgment or rehabilitation need.

The following examples describe persons who do not fall within the 13 listed conditions and who, therefore, may be turned away by the inpatient rehabilitation facility to ensure that it maintains its certification.

- A patient who requires a hip or knee replacement and who also has one or more medical complications or “comorbid conditions” such as a severe heart and pulmonary condition, diabetes, and/or a pre-existing amputation on another limb.
- Cancer patients undergoing chemotherapy that need intensive rehabilitation to improve both motor and cognitive functioning and patients who have undergone extensive cardiac surgery.

Bipartisan bills have been introduced in the House and Senate to preserve access to safe and effective treatment provided in inpatient rehabilitation hospitals so that beneficiaries can return to the highest functional level possible, living in their homes and returning to their jobs (whenever feasible). The bills are entitled the “Preserving Access to Inpatient Rehabilitation Hospitals Act of 2007.” (S. 543 and H.R. 1459.) If enacted, the bills will lessen the negative impact of the 75% rule on patients and the providers who serve them. Specifically, the bills would accomplish the following objectives:

- Require a compliance rate of no greater than 60%, *i.e.*, 60% of the patient population in the facility must have one of the thirteen listed conditions, but all the patients must continue to meet strict admissions criteria established by CMS;
- Continue the use of medical complications (*i.e.*, “comorbidities”) in assessing the need for inpatient rehabilitation;
- Codify the current standards which has been in place for over 20 years for determining medical necessity of beneficiaries served in rehabilitation hospitals and units;
- Report to Congress with recommendations for classifying inpatient rehabilitation hospitals and units in a manner that does not force such hospitals and units to turn away needy beneficiaries (House bill only).

BACKGROUND INFORMATION

What is the purpose of inpatient rehabilitation for beneficiaries, including people with disabilities?

A primary purpose of inpatient rehabilitation services is to provide coordinated and intensive rehabilitation along with close medical supervision in order to enable a beneficiary to regain and/or maintain his or her maximum level of independent functioning so that the individual can live as independently as possible and return to work (whenever feasible and appropriate) rather than be placed in an institution such as a nursing home.

Under Medicare, what types of services are included during an inpatient rehabilitation stay?

Rehabilitation services authorized under Medicare include physical, occupational, and speech therapies, respiratory and recreational therapies, orthotic and prosthetic services (e.g., artificial limbs and orthopedic braces), social work services, and any other services considered to be reasonable and necessary for good patient care.

What is required of hospitals or units to qualify under CMS rules?

In general, inpatient rehabilitation hospitals and units provide specialized medical rehabilitation for persons who have had a significant injury, disease, or condition, and/or are recovering from surgery or medical treatment. Intense, comprehensive, coordinated care is provided in a specialized setting by a multi-disciplinary team of health care professionals that specialize in the medical, physiological, and psychosocial aspects of rehabilitative health care. Intensive rehabilitation services play a critical role in regaining lost function as a result of a disability, injury, or illness, thereby allowing individuals to improve their ability to function and live as independently as possible in their homes and communities.

What specific criteria must be met by rehabilitation hospitals and units?

In order to be considered an inpatient rehabilitation facility under Medicare, an entity must meet seven criteria as follows:

- Enter into a Medicare provider agreement,
- Adopt a preadmission screening procedure,
- Provide medical nursing and rehabilitation therapy services,
- Adopt a plan of treatment for each patient,
- Use a coordinated multidisciplinary team approach,
- Employ a medical director of rehabilitation with specified training or experience, and
- Demonstrate that during a 12-month period at least 75% of all its patients, including its Medicare patients, required intensive rehabilitation services for the treatment of at least one (1) of the thirteen (13) conditions listed in the rule. (This 75% requirement is currently at 60% and is being phased-in to 75% over the next two years.)

Why is the 75% Rule compliance percentage changing?

CMS revised the 20-year old 75% Rule in 2004 by issuing a final rule effective on July 1, 2004. In this final rule, CMS established over time, a transition period for implementation of the changes. In addition to lowering and then increasing the threshold over a three-year period, the transition period allows a patient to be counted toward the required threshold if the patient is admitted for either a primary or comorbid condition on the list in the rule. But at the end of the transition period, (*i.e.*, when the 75% compliance rate is reinstated) a patient cannot be counted toward the required threshold on the basis of a comorbidity on the list in the rule.

Based on congressional action, the certification threshold is currently 60%. The threshold is scheduled to increase to 65% beginning on July 1, 2007 and then to 75% beginning on July 1, 2008. These two policies combined (i.e., the comorbidities policy and the rising compliance percentages) will further restrict access to inpatient rehabilitation over the next several years.

What are the minimum criteria to qualify as a Skilled Nursing Facility (SNF) and what are the major differences between the criteria applicable to SNFs and inpatient rehabilitation hospitals and units (IRFs)?

1. Admission to a SNF must be approved by a physician (same as IRF requirement).
2. A comprehensive care plan must be developed by a physician and nurse with input from other staff but only “to the extent practicable.”
3. A physician must provide general supervision of the patient but this does not necessarily include management of therapy services. Rehab physicians are required to be available on a 24-hour basis in IRFs.
4. Physician visits are required once every 30 days (and once every 60 days after the first 3 months) and mid-level practitioners can substitute for physicians on an intermittent basis (IRF require a physician visit every two to three days).
5. Patient assessments are required quarterly or within 14 days of a significant change.
6. There is no requirement for interdisciplinary team conferences as opposed to IRFs.
7. Therapy providers can determine, independently of one another, when therapy will end (IRFs require a multidisciplinary team to make such decisions).
8. Twenty-four hour registered nursing staffing is not required (IRFs require 24-hour rehabilitation nursing availability).
9. Rehabilitation nursing is not required as it is in IRFs.
10. Rehabilitation therapy services must be available, if required by the patient’s plan. There is no requirement to provide prosthetic or orthotic services. Social services provided by a social worker must be provided.
11. There is no requirement that the patient be provided with 3 hours or any minimum amount of therapeutic services per day (IRFs require that the patient receive three hours of therapy per day, five days per week).
12. There is no requirement for a director of rehabilitation position (IRFs require a medical director).

What is the significance of a facility being certified by CMS as an inpatient rehabilitation facility?

If the facility is certified as an inpatient rehabilitation facility, it is entitled to an enhanced payment rate to defray the costs of providing the comprehensive, coordinated, multi-disciplinary services and supports under the direct supervision of specially trained physicians, nurses, therapists, and others.

Does the inpatient rehabilitation facility receive the same payment for all patients admitted to the facility?

No. Payment is based on case-mix groups (CMGs). The CMG determines the payment the inpatient rehabilitation facility will receive for each patient. Within each CMG the weighting factors are tiered based on the estimated effect of comorbidities that each patient may have. Each CMG has four payment tiers reflecting the level of complexity of patients with that particular condition.

What criteria are used to determine whether a particular individual requires intensive rehabilitation services provided in an inpatient rehabilitation facility?

The criteria for admission of a patient to an inpatient rehabilitation facility are very strict. There are two basic requirements that must be met for a patient to be admitted to an inpatient rehabilitation facility. First, the services must be reasonable and necessary (in terms of efficacy, duration, frequency, and amount) for the treatment of the patient's condition. Second, the services must be reasonable and necessary to furnish the care on an inpatient hospital basis, rather than in a skilled nursing facility or on an outpatient basis. Determinations of whether stays in inpatient rehabilitation hospitals and units are reasonable and necessary must be based on an assessment of each beneficiary's individual care needs.

In general, rehabilitative care in an inpatient rehabilitation facility, rather than in a skilled nursing facility or on an outpatient basis, is reasonable and necessary for a patient who requires a more coordinated, intensive program of multiple services than is found in an acute care hospital or skilled nursing facility. Further, a patient generally requires an inpatient rehabilitation facility level of care if he or she has either one or more conditions requiring intensive and multi-disciplinary rehabilitation care, or a medical complication in addition to their primary conditions, so that the continuing availability of a physician is required to ensure safe and effective treatment.

More specifically, before a person is admitted into an inpatient rehabilitation facility, he or she must require the following:

- **Close medical supervision** (24-hour availability) by a physician with specialized training or experience in rehabilitation.
- **Twenty-four hour availability of rehabilitation nursing** by a registered nurse with specialized training or experience in rehabilitation.
- Relatively **intense level of rehabilitation services** (general threshold is that the patient must require and receive at least three hours a day of therapy, with identified exceptions).
- **Multi-disciplinary team approaches** to delivery the program (usually consisting of a physician, rehabilitation nurse, social worker and/or psychologist, and those therapies involved in the patient's care).
- **Coordinated program** of care to assess progress or problems, consider resolutions and reassess validity of goals initially established.

- **Significant practical improvement** (rehabilitation team must conclude that a significant practical improvement can be expected within a reasonable period of time).
- **Realistic goals** including **self-care or independence** in the activities of daily living to allow an individual **to live in his or her home rather than in an institution, and where feasible, employment. Thus**, the aim of the treatment is achieving **the maximum level of function possible**.
- **Length of rehabilitation program** (coverage stops when further progress toward the established rehabilitation goal is unlikely or when further progress can be achieved in a less intensive setting).

Who is a typical person who does not fall within the 13 listed conditions but who needs inpatient rehabilitation services consistent with admissions criteria established by CMS?

There are many examples of beneficiaries who meet the strict criteria promulgated by CMS for admission to inpatient rehabilitation hospitals and units but who do not fall within the 13 listed conditions promulgated by CMS. For example, many cancer patients undergoing chemotherapy can improve both motor and cognitive function. Many patients who have undergone extensive cardiac surgery are scientifically documented to have decreased mortality, improved quality of life, and lower costs from cardiac-focused inpatient rehabilitation. Many patients with pulmonary conditions need pulmonary rehabilitation—for example, stays as brief as 10 days have been shown to improve exercise tolerance and abnormal breathing relative to their condition.

But the impact of the 75% Rule is broader and is having an impact on all kinds of people with disabilities as facilities that are forced to turn away medically necessary patient (in order to comply with the 75% Rule) are forced to downscale their programs (such as brain injury, spinal cord injury, and other specialized rehab programs) or even close their doors altogether.

Set out below is an additional profile of a beneficiary whose case had been recently denied payment for inpatient rehabilitation which is taken from an actual case heard by an Administrative Law Judge (ALJ). In this case, CMS' contractor had denied a claim by the beneficiary and the inpatient rehabilitation hospital for payment under Medicare. The ALJ reversed the decision and found that the payment was appropriate because the treatment was medically reasonable and necessary and consistent with the admissions criteria established by CMS.

- The beneficiary was an 85-year old woman who had undergone a total hip replacement. Her comorbid conditions included hypertension, hypothyroidism, cervical stenosis, trigeminal neuralgia, osteoporosis, osteoarthritis, and premature ventricular contraction. Sustained premature ventricular contractions may result death. Her history of cardiac arrhythmias required close monitoring. With close monitoring, she was able to successfully participate in therapy. By discharge from the rehab hospital, she had significantly improved her ability to function

independently. She was able to achieve her goal of returning to her home in only seven days due to this multi-disciplinary coordination of care.

Why support legislation that holds the compliance level at 60% rather than 75%? Isn't this still an arbitrary rule?

Yes. Whether the compliance percentage is set at 60% or 75%, the “75% Rule” is an arbitrary rule that should be replaced with a better way of determining which hospitals and units deserve extra payments because they are truly rehabilitation hospitals and units, providing beneficiaries with intensive, coordinated rehabilitative care. However, no well-defined alternative currently exists to the 75% Rule. Setting the compliance rate at 60% at least allows rehabilitation hospitals and units much greater latitude in admitting those beneficiaries who really need intensive rehabilitation, regardless of whether their condition meets one of the 13 identified by CMS.

ANALYSIS OF THE IMPACT OF THE 75% RULE

What is the relationship between the 75% rule and the responsibility to admit patients in need of inpatient rehabilitation services? What strategies are hospitals and units adopting to avoid losing their certification and what is the impact of these strategies on patients?

The operation of the 75% rule has the effect of denying medically reasonable and necessary inpatient rehabilitation services to beneficiaries who meet strict admission criteria but who do not happen to have one of the thirteen 13 conditions on the list.

If the facility accepts too many patients that need intense inpatient rehabilitation services in accordance with medical necessity criteria but who do not fall within the 13 arbitrary categories also established by CMS, the facility will lose its certification as a rehabilitation hospital or unit and will be shut down. To avoid such an outcome, the facility is forced to turn away needy patients based on the condition they have when they arrive at the hospital. For example, if the facility's patient census indicates that only 60% of patients in the inpatient rehabilitation facility meet the arbitrary 13 listed conditions and the remaining 40% do not (but do satisfy the medical necessity criteria for admission), the facility will be forced to only accept patients with one of the 13 conditions and turn away all others.

Practically speaking, inpatient rehabilitation hospitals and units are being forced to establish health care quotas—i.e., they must manage/limit the mix of the patients they treat based on the 75% rule (a certification/payment rule) rather than on the basis of clinical judgment or rehabilitation need. The rule further creates an absurd situation where access to inpatient rehabilitation is largely dependent on the point in time that a patient arrives at the facility, not whether the patient needs to be admitted. So, the same patient might be admitted in March, but not in November depending on how many other patients a particular hospital has treated whose conditions may not be listed under the 75% rule.

Does the 75% rule mean that 25% of the patients do not need to meet the criteria for admissions?

No. This is a major misunderstanding of Medicare policy. All patients admitted to an inpatient rehabilitation facility (100%) must meet the strict medical necessity criteria and if an audit finds that an individual patient did not meet the strict criteria, the beneficiary and facility will be denied payment by Medicare for that individual. It should be noted that CMS' contractors are pursuing a vigorous campaign to deny payment for patients who they claim do not meet medical necessity guidelines and those cases are being reversed at the ALJ level at a very high rate. In other words, in roughly over 90% of these cases, ALJs are finding that the admissions are appropriate and, therefore, payment for services rendered is being approved.

What is the impact of the 75% rule on the quality of life of beneficiaries denied admission to inpatient rehabilitation hospitals and units?

The effect of the 75% rule is that more people with disabilities will be denied medically reasonable and necessary inpatient rehabilitation services which they are entitled to under Medicare law. As a result, beneficiaries' ability to function independently will be adversely affected which in turn will adversely impact their ability to return to their homes and live as independently as possible. The alternative to an appropriate placement in an inpatient rehabilitation facility will be placement in skilled nursing homes, potentially inappropriate outpatient therapy, or nothing. Although inpatient rehabilitation generally costs more in the short term, a shorter length of stay and a more intense rehabilitation program usually produces better outcomes (return to home and job, where feasible), which results in improved quality of life and long-term savings.

What are the implications for a community if a facility loses its certification?

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

What is the impact of the 75% Rule in the broader disability rights context?

On July 26, 1990 President George H. W. Bush signed into law the Americans with Disabilities Act of 1990 (ADA), which has been described as the 20th century emancipation for people with disabilities. The ADA articulated four principles of disability policy for our nation. The four principles are:

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

The administration of the 75% rule by CMS is inconsistent with each and every principle articulated in the Americans with Disabilities Act.

Equal opportunity:

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

Full Participation

- Medicare rules are supposed to provide beneficiaries with the ability to access inpatient rehabilitation services that will enable them to return to their homes after experiencing medical interventions. This access is not absolute—a beneficiary must meet strict medical necessity criteria promulgated by CMS to be admitted into an inpatient rehabilitation facility.

- Access of a beneficiary who meets criteria for admission to an inpatient rehabilitation facility should never be negated by the operation of an arbitrary, inflexible, bureaucratic rule for certifying hospitals and units. And yet, the 75% Rule is having the effect of forcing inpatient rehabilitation hospitals and units to turn away needy beneficiaries to retain their certification *i.e.*, the rule is having the effect of denying beneficiaries the right to receive safe and effective treatment.

Independent Living and Economic Self-sufficiency

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

CONCLUSION

For these reasons, the Coalition to Preserve Rehabilitation urges Congress to adopt the "Preserving Access to Inpatient Rehabilitation Hospitals Act of 2007." (S. 543 and H.R. 1459.) The member organizations of the CPR encourage all Americans to make clear their support of this legislation for the benefit of people with disabilities and seniors in need of intensive, inpatient rehabilitation services.