



**Statement to the Ways and Means Health Subcommittee  
Submitted for the Written Record**

**Hearing on “Payments to Certain Medicare Fee-for-Service Providers”  
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My name is Anne Sommers and I am policy counsel to the American Association of People with Disabilities or “AAPD,” the nation’s largest individual membership organization for people with disabilities.

My written testimony is being submitted on behalf of AAPD as well as the Coalition to Preserve Rehabilitation (referred to as “CPR”), a group of over 25 national organizations representing consumers and clinicians that formed to try to breathe new life into the Medicare rehabilitation benefit. The CPR is run by a steering committee comprised of five consumer/disability groups including AAPD, National Council on Independent Living, Dana and Christopher Reeve Foundation, National Spinal Cord Injury Association, and Center for Medicare Advocacy. Fighting inappropriate restrictions in access to intensive, coordinated rehabilitative care provided in inpatient rehabilitation hospitals and units is one of the CPR’s top three priorities.

The restrictions in access to inpatient rehabilitation of the past few years have largely been discussed in terms of the impact on *providers*. But I would like to stress the negative impact that Medicare policies such as the so-called “75% Rule” and restrictive medical necessity policies have on *patients*, most of whom have a serious injury, a condition that comes with aging, a disability, or a chronic condition.

Access to intensive rehabilitation services is vital in order for these people to return to full function, live as independently as possible in their homes and communities, and if appropriate, return to work. With over 6 million people with disabilities on Medicare, this is an issue that cuts across all age groups and impacts access to rehabilitation for all people, not just those on Medicare.

I am the recipient of intensive rehabilitation provided in an inpatient setting. I was born with extremely shallow hip sockets, but we didn’t know that until I was much older. Doctors had incorrectly assessed my difficulties walking as a problem localized to my knees and feet. But as a result of my hip condition, as a young child, I walked with difficulty with both my legs inverted almost to the point of my knees knocking with each step. I was fitted with corrective shoes and leg braces as well as a corrective bar, which I wore between my legs when I slept at night.

By the time I finished high school, the integrity of both hip sockets had so eroded that I was walking with the assistance of a cane and eventually Canadian crutches. I had since moved to Richmond, VA, and had located an excellent orthopedic specialist who pinpointed the hip condition almost immediately just after watching me walk down the hallway of his medical office.

In 1998, I had my first of two radical hip reconstructive surgeries – this one on my right hip. I spent the days following the 8-hour surgery undergoing intensive rehabilitation in an inpatient setting. I then received physical therapy for many more weeks at my home to complete my rehabilitation. In 2001, I had the same operation on my left hip. Again, I spent nine days receiving intensive rehabilitation in an inpatient setting, followed by many weeks of PT in my home.

The inpatient care I received was intense and well coordinated. The providers were thorough and always encouraging and the outcome of my rehabilitation was amazing. I am completely independently ambulatory. I have not used braces or crutches for over five years now. I've recently become an attorney and am now fully employed counseling AAPD on policy issues that impact people with disabilities.

Inpatient care and PT had other surprising effects. Never having previously competed in sports, I didn't realize how much I'd like the "push" that I got during rehabilitation. After the weeks of PT ended, I started attending a gym, and it was within 3 years' time that I began competitively power lifting, which is squatting, deadlifting, and benchpressing.

In 2004 and 2005, I accumulated five state records in VA and was twice named the VA state champ at 114lbs. My best deadlift in a competition is 319lbs. Many people have noticed my 16" scars on each leg during my competitions and have heard the back story. That's how I earned the name "Mighty Mouse" by several of the judges in the USAPL federation.

The Coalition to Preserve Rehabilitation, including AAPD, believes the 75% Rule is an arbitrary way of determining who gets access to intensive, inpatient rehabilitation care. The impact of this restriction is essentially a quota system that leads to arbitrary judgments about who is admitted to intensive rehabilitation and who is diverted into nursing homes and lesser intense levels of care. Practically speaking, in order to retain their qualification as an inpatient rehabilitation hospital or unit, some of these facilities must manage or limit the mix of patients they treat based on the 75% Rule rather than on the basis of clinical judgment and rehabilitation need.

On a related issue, restrictive Local Coverage Determinations ("LCDs") only exacerbate the restrictions in access by using "rules of thumb" rather than the individual needs of a

particular patient to determine in what setting they are treated. This is short-sighted and will likely cost Medicare more in the long run.

I understand that CMS believes joint replacement patients rarely, if ever, require the intensive rehabilitation that occurs in the inpatient setting. This is a dangerous generalization and I'm a living example of why making these decisions based on diagnosis alone is not a wise policy.

Recently, the nursing home industry seems to be suggesting that they offer comparable care at lower cost to Medicare. The CPR coalition simply does not agree. Some patients require a more intensive, coordinated rehabilitation program with close medical supervision, and it simply costs providers more to provide rehabilitation in this inpatient setting. The long term payoff in many instances, of course, is a life of better health and greater function, a higher quality of life, and independent living.

CPR believes that medical and rehabilitation *need alone* should determine which patients have access to inpatient rehabilitation, not arbitrary rules, such as the 75% Rule, which define what constitutes a rehabilitation hospital or unit.

However, in the absence of a better mechanism to achieve this, CPR certainly believes that the Rule should not continue to be phased-in, as is currently planned on July 1<sup>st</sup>, resulting in greater restrictions in access to inpatient rehabilitation. That is why members of the CPR support the Preserving Patient Access to Inpatient Rehabilitation Hospitals Act of 2007 (S. 543 and H.R. 1459).

In addition to holding the Rule from being fully phased-in, this legislation would also set in statute the federal standard for medical necessity of inpatient rehabilitation, the same standards that CMS has used by regulations for over two decades.

*We strongly urge Congress to take immediate action and pass this legislation before July 1, 2007 to ensure that the 75% Rule does not continue to inappropriately deny beneficiaries access to inpatient rehabilitation services needed to maximize their independence and return to their homes and communities.*

I am attaching a May 15<sup>th</sup> letter for the record addressed to Chairman Stark and Ranking Member Camps from 22 CPR members regarding access to inpatient rehabilitation and this important legislation, H.R. 1459.

Thank you for the opportunity to submit this statement for the record.