

Rehabilitation Policy Roundtable

Background and Analysis of Major Threats to Rehabilitation

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*Peter W. Thomas, Esq.
Powers, Pyles, Sutter and Verville, PC
Co-Chair, Health Task Force
Consortium of Citizens with Disabilities*



Rehabilitation Roundtable is Timely

■ National Rehabilitation Week

- In 1991, President George H.W. Bush proclaimed the third week in September recognizing the importance of rehabilitation on the lives of people with disabilities, chronic conditions, and those who have sustained serious injuries.
- Fourteen years later, access to rehabilitation services has never been under greater threat.

■ Hurricane Katrina exposed serious deficiencies in policies impacting people with disabilities and chronic conditions.

Charge of Roundtable

Purpose

- To examine the multiple threats to rehabilitation access and assess their current and potential impact, particularly when taken in combination with one another.

Goal

- To collectively recognize the magnitude of the threat and achieve consensus on the need for those who rely on rehabilitation services the most to mount a commensurate and sustained response.

Convergence of Policies Impacting Rehabilitation

- Convergence of Legislative and Regulatory Initiatives that Could Severely Impact the Lives People with Disabilities
 - Medicaid Cuts and Rehabilitation Changes
 - Inpatient Rehabilitation:
 - 75% Rule
 - Restrictive Local Coverage Determinations
 - Outpatient Rehabilitation Restrictions: Impending Therapy Caps
 - Rehabilitation Device Restrictions: Power Wheelchairs In the Home Restriction

Impact of Rehabilitation Trends

- With less access to rehabilitation, this series of federal policies may very well deprive people with disabilities of access to the most appropriate rehabilitation services
- Long Term Impact:
 - Drive people with disabilities toward nursing homes and other less intensive levels of rehabilitation care.
 - Lead to decreases in functional improvement and independent living among people with disabilities, chronic conditions and serious injuries.
 - Undermine existing federal policies designed to improve functional status, community reintegration and independent living including the Olmstead Supreme Court decision, the Americans with Disabilities Act, and the New Freedom Initiative.

Medicaid Cuts

- FY 2006 Budget includes reconciliation instructions to Senate Finance and House Energy and Commerce Committees to find \$10 billion and \$14.7 billion respectively in savings from entitlement programs under their jurisdiction.
- Expected that reconciliation language will include approximately \$10 billion in Medicaid cuts.
- In early August, the Bush Administration provided Congress with draft Medicaid reform legislation.
- Includes a redefinition of rehabilitation services under Medicaid.

Administration's Medicaid Rehab Proposal

Administration's "redefinition language" would:

- Require that "rehabilitation services" demonstrate "specific, measurable outcomes" that show restoration of function;
- Eliminate federal matching funds for rehabilitation therapies that maintain or prevent deterioration of function, rather than "restore function;"
- Prevent Medicaid coverage if such services are provided by or are an "administrative function" of any other Federal, State or local program.

Inpatient Rehabilitation: 75% Rule

- In May 2005, the Government Accountability Office issued a report entitled *"Medicare: More Specific Criteria Needed to Classify Inpatient Rehabilitation Facilities"* that addressed the shortcomings of the so-called 75% Rule
- The GAO recommended that additional study would help inform which conditions needed to be refined and/or added to the list typically considered appropriate for an inpatient level of care.
- Despite this report, the HHS Secretary permitted the 75% rule to be implemented as it currently stands.

Inpatient Rehabilitation: 75% Rule Implementation

- The rule is currently being phased in and having far greater impact than CMS expected on both Medicare or Non-Medicare patients.
- Starting in 2007, CMS will require 75% of an inpatient rehabilitation facilities' (IRFs) patients to have a condition that falls into one of thirteen (13) typical diagnoses for rehabilitation care such as stroke, spinal cord injury, or brain injury
- IRFs not meeting these criteria will lose their classification as rehabilitation hospitals or units, which is indicative of this more intensive rehabilitation setting.
 - IRFs will either be forced to significantly reduce the scope of their rehabilitation programs or close altogether, denying people with disabilities access to medical rehabilitation in favor of cheaper, less-intensive settings such as nursing homes.

Inpatient Rehabilitation: IRFs

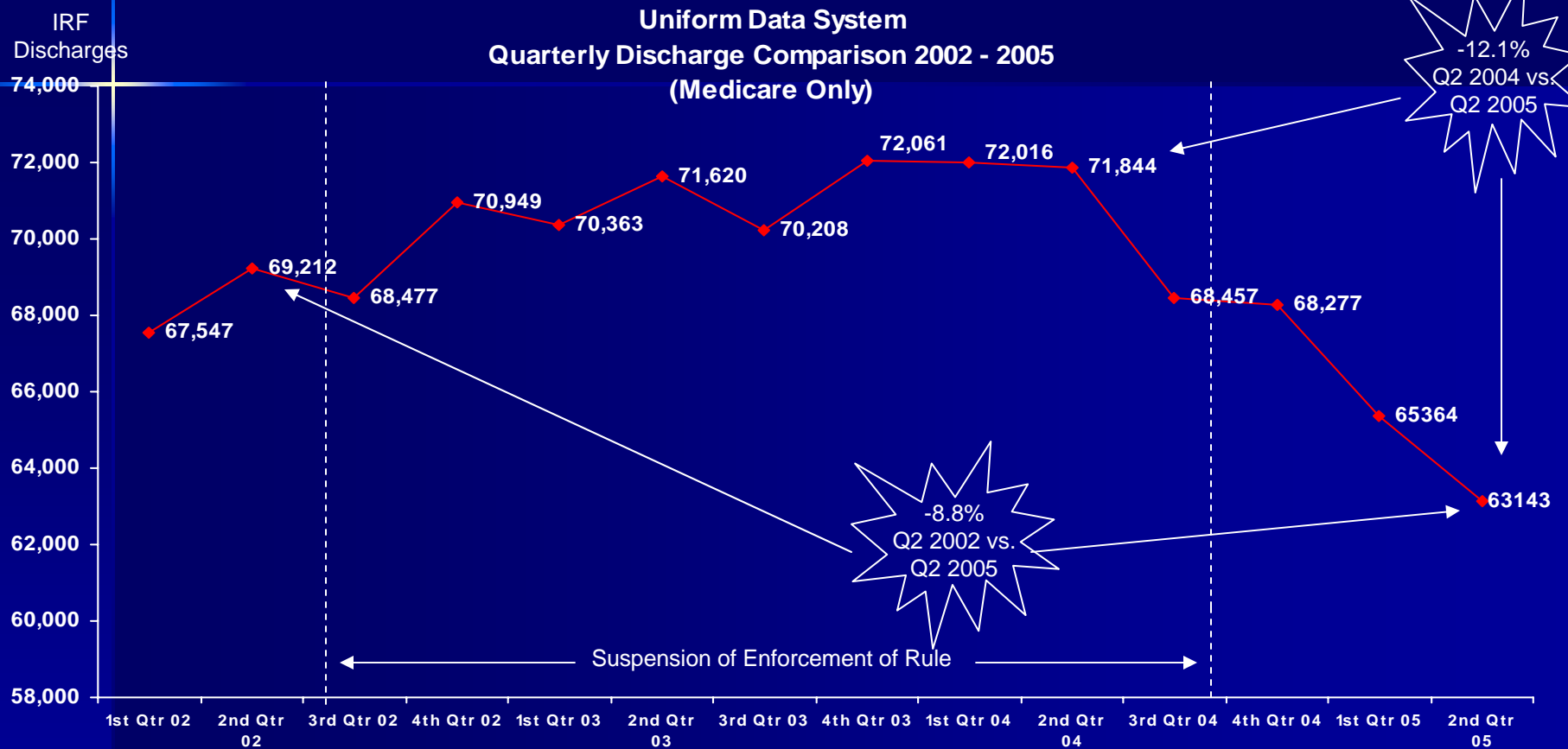
- Inpatient Rehabilitation Facilities Provide:
 - Specialized treatment for persons who have had a significant impairment of function as a result of injury, disease or condition, and/or recovery from surgery or medical treatment.
 - Close medical supervision coupled with an intensive rehabilitation program to restore health status, function and independence in the home and integration back into the community.
 - Care in a specialized setting by a team of health professionals that specialize in one or more aspects of rehabilitation often led by a rehabilitation physician known as a physiatrist.

Inpatient Rehabilitation: Comparison to Nursing Homes

- Compared with skilled nursing facilities or nursing homes, IRFs generally have shorter lengths of stay and better functional outcomes have been demonstrated in patients with conditions such as stroke, spinal cord injury and brain injury.
- Inpatient rehabilitation setting usually has a higher short-term cost for the Medicare program.
 - The 13 “accepted” conditions of the current 75% Rule fail to account for many patients who need a relatively intense level of rehabilitation care but do not have a qualifying condition.

Inpatient Rehabilitation: Denied Access to Care

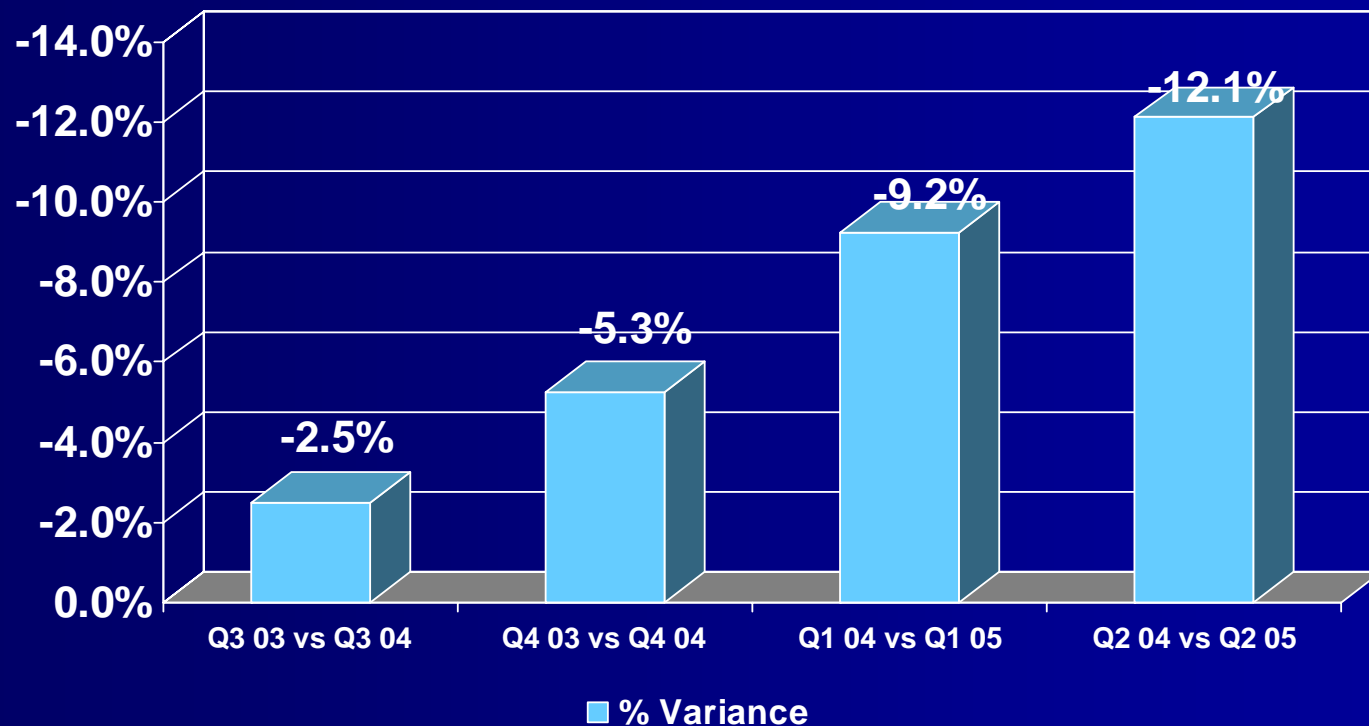
- Recent data from the Uniform Data Set for Medical Rehabilitation and eRehabData ® indicates that patients who do not qualify under the 75% Rule are often denied access to inpatient rehabilitation. (See Moran Report):
 - CMS's original estimate of patients to be denied access to inpatient rehabilitation in the first year of implementation was 1,750 patients.
 - Based on data from the first and second quarters of 2005 compared to 2004, almost 40,000 patients are expected to be denied access to inpatient rehabilitation this year alone.
 - Discharges from inpatient rehabilitation facilities are down by 12.1% compared to one year ago.



- Percentages reflect variance from corresponding prior year quarter.
- Data derived from facilities reporting discharges in each quarter (598). Data represents approximately 62% of Medicare IRF discharges
- This summary information was provided by UDS_{MR}, for the benefit of the rehabilitation field, and is used with prior written permission of UDS_{MR}

Updated August 16, 2005 Preliminary

Percentage Volume Variance of Similar Prior Periods (Medicare Only)



- Data derived from facilities reporting discharges in each quarter. Data from 598 IRFs representing approximately 62% of Medicare IRF discharges.
- Discharge data was provided by UDS_{MR}, for the benefit of the rehabilitation field, and is used with prior written permission of UDS_{MR}.

Impact of 75% Rule

- 75% Rule = Quota System = Denied Access = Nursing Home
 - CMS is inappropriately using a hospital *classification tool* as an instrument to assess the *medical necessity* of inpatient rehabilitation for specific patients, an application that was never intended.
 - Use of the 75% Rule in this manner puts a premium on when a patient presents to an inpatient setting.
 - If the hospital is close to the 75% compliance level, then that patient might be sent to a SNF or nursing home, rather than receiving the intensity of rehabilitation they require.
 - Practically speaking, rehabilitation hospitals must now manage their mix of patients based on a payment rule rather than clinical judgment or rehabilitation need.
 - Medicare entitlement becomes a program that is more akin to the Veterans Administration, where limited funding can delay care for long periods of time.

Local Coverage Determinations (LCDs)

- Under the Medicare statute, Medicare contractors administer and pay claims for inpatient rehabilitation
 - Fiscal Intermediaries (FI's) may issue Local Coverage Determinations
- FI's have the discretion to make determinations of "medical necessity" for inpatient rehabilitation
 - 3 FIs have issued restrictive final LCDs in the past 9 months
 - Arguably, these LCDs are in conflict with federal regulations and policy manuals
 - Can be challenged legally, but this is time consuming and costly
- **Major Issue:** LCDs force Medicare beneficiaries into less intensive settings, i.e., nursing homes

Impact of LCDs

- Unfairly restrict access to medical rehabilitation by denying coverage for patients who need comprehensive inpatient rehabilitation based on “rules of thumb” and “diagnostic screens.”
- Coupled with 75% Rule, these policies together act as a virtual **100% Rule**, inappropriately denying access to inpatient rehabilitation.

Outpatient Rehabilitation—Therapy Caps

- Balanced Budget Act of 1997 imposed \$1,500 per patient, per year caps on outpatient therapy (not hospital or SNF-based)
 - \$1,500 – Combined Physical Therapy and Speech
 - \$1,500 – Occupational Therapy
- Congress has enacted moratoria on implementation of the caps since 1997, except for several months in 2001
 - Moratorium expires December 31, 2005
 - Legislation will be required to extend moratorium

Impact of Therapy Caps

■ Immediate Impact

- Arbitrary limitations on outpatient therapy services
- Increased expenses for beneficiaries needing additional therapy
- Decreased efficiency in providing therapies (outpatient hospital therapies not capped)
 - Example: Some “polyarthritis” conditions (listed in 75% rule) require intensive 3-week outpatient physical therapy to fail *before* admission to inpatient rehabilitation. Thus, therapy caps will prevent coverage after inpatient treatment

■ Long Term Impact

- Decreased access to therapy services in outpatient environment
- Increased reliance on Skilled Nursing Facilities/ nursing homes and outpatient hospital departments to provide therapy services

Rehabilitation Device Developments (Wheelchair Coverage Restrictions)

- Power Wheelchair Benefit Under Assault:
 - CMS has issued a series of new coverage policies that will clearly have the impact of restricting access to appropriate mobility devices for people with mobility impairments.
- Policy not breaking down barriers to community living as is the goal of the New Freedom Initiative
 - Medicare policy for wheelchairs and other mobility devices strictly limits coverage to devices that are medically necessary “in the patient’s home.”
- This policy renders all mobility devices that assist a person in performing routine community activities not medically necessary.

Conclusion: Policies Combine to Force People with Disabilities into Nursing Homes and Be Less Independent

- Macro Perspective: Impact of Medicaid cuts, the 75% Rule, Local Coverage Determinations, therapy caps and restrictions in rehabilitation device coverage is clear:
 - Taken together, this set of policies will drive people with disabilities toward less intensive and less appropriate settings of care.
 - Ultimately, nursing homes and other less intensive settings will become the norm for rehabilitation care, not just for Medicare beneficiaries but for all individuals in need.
- Longer lengths of stay in institutional settings
- Lesser levels of intensity of rehabilitation interventions
- Greater dependency and recidivism to institution-based care
- Less ability of PWDs to live independently in their homes and communities.

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