

Rehabilitation Policy Roundtable Discussion

Background Memorandum September 22, 2005

In 1991, President George H.W. Bush proclaimed the third week in September as National Rehabilitation Week, recognizing the importance of rehabilitation on the lives of people with disabilities, chronic conditions, and those who have sustained serious injuries. Yet fourteen years later, access to rehabilitation services has never been more at risk. The purpose of the Rehabilitation Policy Roundtable is to examine the multiple threats to rehabilitation access and assess their current and potential impact, particularly when taken in combination with one another. The goal of the Roundtable is 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.

Earlier this summer, Secretary of Health and Human Services Michael Leavitt declined to address serious shortcomings in the so-called "75% Rule" for inpatient medical rehabilitation, allowing a flawed rule to continue being implemented. In August 2005, a proposal to redefine "rehabilitation services" under the Medicaid program created serious concern within the Medicaid disability and rehabilitation population. This proposal was offered as part of a broader effort to reduce spending under Medicaid by approximately \$10 billion over five years.

Local Coverage Determinations (LCDs) are being issued by Medicare's fiscal intermediaries that seriously restrict the types and severity of patients that will qualify for inpatient rehabilitation while Congress considers whether to let a moratorium on outpatient rehabilitation therapy caps lapse, thereby limiting the amount of therapy available to the Medicare patients who need it most, effective the first of the new year. Access to rehabilitation devices is also at risk as the Medicare program issues highly restrictive medical policies on mobility devices and confines coverage of such devices to only those that are medically necessary for use in the beneficiary's home.

The confluence of these policies is beginning to have a troubling impact which will likely become more acute in the months and years to come. 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 available and, over the long term, drive people with disabilities toward nursing homes and other less intensive levels of rehabilitation care. Such a trend will likely lead to decreases in functional improvement and independent living among people with disabilities, chronic conditions, and serious injuries.

Such a trend would also 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

Congress is preparing to pass a reconciliation bill this fall that could cut Medicaid by \$10 billion over 5 years. HHS established a Commission to advise Congress on short term cuts and long term Medicaid reform. A controversial Administration proposal to redefine the definition of “rehabilitation services” which is discussed below, was not included in the final Commission recommendation. However, this does not prevent Congress from including it in a Medicaid bill later this year or in the future.

On August 5, 2005, Health and Human Services (HHS) Secretary Michael Leavitt provided Congress with draft Medicaid legislation in connection with the reconciliation instructions Congress is currently considering. Contained in this draft legislation is language that addresses the “Definition of Rehabilitation Services.” As written, this language could severely restrict access to many of the rehabilitation services that individuals with disabilities depend on to be healthy, functional and independent.

Specifically, the Administration’s legislative language would now require that “rehabilitation services” demonstrate “specific, measurable outcomes” that show restoration of function. This language would restrict rehabilitation therapies that are provided to *maintain* function or *prevent further deterioration* in function, rather than *restore* functional status. These are often referred to as “habilitation” rather than rehabilitation services. Habilitation programs serve a critical purpose for many with severe physical disabilities; however, this new requirement could essentially eliminate any maintenance services currently provided under Medicaid as covered rehabilitation services.

The Administration’s proposal would also prevent Medicaid from covering rehabilitation services if such services are provided by or are an “administrative function” of any other Federal, State or local program. By including this provision, the Administration appears to be suggesting an end to federal matching funds for many rehabilitation services associated with education, mental health treatment, substance-abuse, vocational rehabilitation, foster care, and assistive living.

Many of these targeted services are vital to the continuum of care for people with disabilities and could not be provided without the help of federal Medicaid matching funds. By displacing the cost of such services onto other programs, this rehabilitation proposal would clearly curtail access to rehabilitation services—the proposal was estimated to save Medicaid approximately \$2 billion over five years. If adopted, the proposal would also threaten the success of other federal and local programs where coordination between programs is essential in order to meet the comprehensive needs of an often medically complex population.

75% Rule

In May 2005, at the request of Congress, the Government Accountability Office issued a report entitled, “More Specific Criteria Needed to Classify Inpatient Rehabilitation Facilities,” which 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 rule to be implemented as it currently stands.

As a result, starting in 2007, the Centers for Medicare and Medicaid Services (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. This, in turn, will mean that such 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 less expensive, less-intensive settings such as nursing homes.

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. They provide close medical supervision coupled with an intensive rehabilitation program to restore health status, function and independence in the home and community. Care is provided in a specialized setting by a team of health professionals that specialize in one or more aspects of rehabilitation and is usually led by a rehabilitation physician known as a physiatrist.

When 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. However, the 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.

Patients who do not qualify under the 75% Rule are increasingly being denied access to inpatient rehabilitation as recent data from the Uniform Data Set for Medical Rehabilitation and eRehabData[®] indicates. CMS's original estimate of patients to be denied access to medical rehabilitation in the first year of implementation was 1,750 patients. However, based on data for the first year the rule has been in effect, approximately 30,000 Medicare patients alone and over 40,000 Medicare and non-Medicare patients combined have been denied access to inpatient rehabilitation this year alone. Discharges from inpatient rehabilitation facilities are down by at least 12.1% compared to one year ago.

The practical impact of the 75% Rule is that people with disabilities are being admitted to inpatient rehabilitation on what amounts to a quota system. 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 the time at which 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. This essentially turns the Medicare

entitlement into a program that is more akin to the Veterans Administration, where limited funding can delay care for long periods of time.

Currently large numbers of Medicare beneficiaries are being denied access to inpatient rehabilitation, IRF programs are being curtailed, and IRF closures will begin to occur soon. Rehabilitation provider capacity is being seriously degraded at the very time demand, through the “baby boom” generation, is increasing. More people with disabilities will go without inpatient rehabilitation and instead be sent to SNFs, nursing homes, outpatient therapy, home health care, or nothing at all.

Local Coverage Determinations

Another serious issue impacting people with disabilities who require medical rehabilitation are Local Coverage Determinations (LCDs) by Medicare contractors known as “fiscal intermediaries” that, when combined with the 75% Rule, impose even greater restrictions on access to inpatient care.

Under Medicare law, fiscal intermediaries (FIs) may issue LCDs that set criteria for the coverage of medical services. Ultimately, FIs have the discretion to make determinations of “medical necessity” for inpatient rehabilitation. These medical necessity determinations, much like those made by private health insurance companies to restrict or deny higher cost medical care, often unfairly define coverage for inpatient medical rehabilitation based on “rules of thumb” and “diagnostic screens,” even though Medicare law prohibits FIs from doing so.

Recently, three FIs covering multiple states throughout the country have issued extremely strict final LCDs for inpatient rehabilitation. For instance, some of these LCDs explicitly state that inpatient rehabilitation is “rarely” or “never” appropriate for a particular type of patient, even though this decision should be in the hands of the physician in consultation with the rehabilitation team. LCDs often force Medicare beneficiaries into less intensive settings, i.e., nursing homes, and, much like the 75% Rule, unfairly restrict access to a relatively intense level of rehabilitation care. When coupled with the 75% Rule, these policies together act as a virtual **100% Rule**, superseding the clinical judgment of the treating physician and therapists and inappropriately denying access to inpatient rehabilitation care.

Rehabilitation Therapy Caps

The Balanced Budget Act of 1997 imposed annual caps of \$1,500 per patient on outpatient therapies that are not provided in a hospital outpatient department. The first cap is a combined \$1,500 limit for outpatient physical and speech therapy combined. The second cap is a \$1,500 limit on outpatient occupational therapy. Congress has enacted moratoria on implementation of the caps since 1997, except for several months in 2001. No beneficiary to date has seen a significant impact on their outpatient therapy, but the current Congressional moratorium expires on December 31, 2005. Federal legislation will be required to extend this moratorium.

The outpatient therapy caps are arbitrary limitations on outpatient therapy services, driven primarily by budget considerations. Nowhere in published literature or medical practice is a one-

size-fits-all cap on therapy services supported at any level. The most pernicious aspect of these caps is that they disproportionately affect people who need more therapy services than the cap will allow. In other words, this policy deprives therapy services from those who need them most. It is also questionable whether Medicare will see reduced costs with these caps since outpatient hospital-based therapy is not capped under the law, only inconveniencing already functionally limited beneficiaries from receiving optimal care.

The therapy caps may also contribute to reducing or eliminating access to inpatient rehabilitation for some arthritis-related conditions listed in the 75% Rule. The rule now requires the patient to fail an intensive 3-week course of outpatient physical therapy *before* admission to inpatient rehabilitation is permissible. The cost of the intensive pre-hospital session will exhaust a beneficiary's therapy benefit for the year, shifting future therapy costs onto beneficiaries. Over the long term, the caps will decrease access to therapy services in outpatient settings and increase reliance on nursing homes and outpatient hospital departments to provide therapy services.

Rehabilitation Device Developments

As a result of fraudulent activity in the power wheelchair benefit under the Medicare program, 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. In addition, rather than breaking down barriers to community living as is the goal of the New Freedom Initiative, the new Medicare policy for wheelchairs and other mobility devices strictly limits coverage to devices that are medically necessary "in the patient's home." This policy potentially renders all mobility devices that assist a person in performing routine community activities not medically necessary.

Analysis

When the impact of Medicaid cuts, the 75% Rule, Local Coverage Determinations, therapy caps and restrictions in rehabilitation device coverage is viewed from a macro perspective, the threat to people with disabilities, chronic conditions, and serious injuries becomes 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. With this trend will come longer lengths of stay in institutional settings, lesser levels of intensity of rehabilitation interventions, and ultimately, greater dependency and recidivism to institution-based care.

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