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INTRODUCTION

Hello, I'm Dr. Mary Beth Walsh. I'm a practicing rheumotologist and CEO of the Winifred Masterson Burke Rehabilitation Hospital – a 150-bed, freestanding inpatient rehabilitation hospital in White Plains, New York. As chair of the American Hospital Association's Section for Long-Term Care and Rehabilitation, it is my privilege to present remarks today on behalf of the AHA.

During the recent effort to refine the "75% Rule," many concerns were raised by patients and providers about diminishing access to the intensive care provided by inpatient rehabilitation hospitals and units. While many care settings provide rehabilitative care, the 75% Rule has forced patients who are clinically appropriate for hospital-level rehabilitation to seek care in a non-inpatient setting setting. Unfortunately for these patients, no other setting provides an inpatient rehabilitation facility's unique combination of hospital-level medical management and intensive rehabilitation. This distinct package of services is provided by multi-disciplinary teams led by specialty-trained physicians – typically a physiatrist – and includes 24-hour registered nurse-level care as a core component of treatment.

PROBLEMS WITH THE 75% RULE

As discussed extensively in recent years, the 75% Rule raises many concerns. And while the fundamental flaws of this policy remain, some of our concerns have lessened with the move to a permanent 60 percent threshold. At the same

time, other policy challenges have emerged, which demand attention, on which I'll elaborate in a moment.

Our primary 75% Rule concerns include the following:

- The intended purpose of the 75% Rule – to distinguish inpatient rehabilitation hospitals and units from general acute hospitals – has been distorted. Instead of serving as a criterion for determining whether a site qualifies as an IRF, as was intended, the 75% Rule has been used inappropriately as coverage policy to determine whether to admit a particular patient to an IRF.
- The 75% Rule also has been used as a quota to deny individuals who meet the medical necessity criteria for admission to an IRF and, in some cases, has been inappropriately by CMS contractors to retroactively deny Medicare payment.
- It is inappropriate to rely on a diagnosis-based criterion to distinguish IRFs from general acute hospitals, when in fact IRFs provide care for a population that <u>also</u> is defined by other clinical characteristics – comorbidities and functional level being the most important.
- Skilled nursing facilities and home health agencies play important roles for patients needing less-intensive rehabilitation, but they are not equal substitutes for IRF-level care. In most communities, typical SNFs do not provide adequate levels of physician, therapy, or nursing care for patients with advanced functional needs and multiple comorbidities, treatments and medications.
- Another concern is the lack of comparative quality measures to indicate whether medically complex patients are receiving the level of medical and rehabilitation care they need. As a published researcher, I have first-hand knowledge of the limited comparative data on treatments and outcomes for complex rehabilitation patients who have traditionally been treated in IRFs and are now treated in other settings.

- And finally, the 75% Rule inappropriately extends access restrictions to additional patients by requiring all payers to comply with the rule, rather than limiting the rule to Medicare patients.

CONCLUSION

Where does that leave us? Some of these concerns were partially mitigated by the implementation of a permanent 60% threshold and the addition of the comorbidities provision. And while the rule's fundamental flaws remain and access today remains restricted – even under the new 60% Rule – other policy matters need to be urgently addressed. Research in some key areas that we hope will provide the policy building blocks of payment reform, which could include provocative and complex elements such as episode payment and bundled payment.

In addition, we remain concerned that, while the lower 60 percent threshold should grant greater flexibility to admit patients who met medical necessity criteria but fall outside of the designated 13 conditions, such admissions remain difficult due to aggressive denials by CMS-contracted auditors. A 2007 analysis of data from 72 IRFs by United BioSource and the AHA found an 80% denial rate by their 12 FIs, and a 63 percent overturn rate for appealed denials. CMS' most recent Recovery Audit Contractor update shows a 45% overturn rate for appealed denials.[1] And we know that thousands of RAC appeals, including numerous IRF appeals, are still in process.

We raise these concerns because, for many providers, the restrictions caused by the 75% Rule have been overshadowed by FI, RAC, and Medicare Administrative Contractor denials. And the second guessing of physician's treatment decisions and care delivered years prior, by auditors who typically have limited knowledge of IRFs and IRF policy, has become a top priority facing

[1] Using the data provided in CMS January 2009 RAC Demonstration Update, a 45.2% overturn rate is calculated by dividing the total number of appeals overturned in favor of the provider (40,115) by the total number of appeals (88,721).

the field in 2009 and beyond. Therefore, as the new 60% threshold makes facility compliance more reasonable, these denials and appeal challenges become more prominent.

Given the long effort to establish the permanent 60% threshold and the emergence of other pressing challenges for IRFs, the AHA encourages CMS not to undertake major refinement of the new "60% Rule." Modest changes to develop a functional component or to refine the IRF conditions of participation may be worthwhile, but the current policy achieves the goal of ensuring that IRFs are fundamentally different from general acute hospitals.

Instead, it is more important that CMS and the post-acute community focus our collective resources on developing a framework for a sound post-acute system that ensures access to high-quality, coordinated and efficient care at all points on the health care continuum. CMS has multiple demonstrations underway to test and develop new approaches, but we expect even more analysis and preparation will be needed to achieve a health system that produces better health outcomes with less waste – and that includes a common payment system for post-acute care. For example:

- An accurate and reliable common assessment instrument must be completed;
- Methods to safely and efficiently transition patients from hospitals to post-acute care, and other transitions, are also needed;
- Common post-acute quality measures must be developed that incentivize quality and efficiency for chronic disease patients using high volumes of care at multiple sites;
- More comparative analysis of IRF and SNF treatments, costs and outcomes is essential; and
- Episode frameworks should be developed and tested.

So, in closing, clearly, the post-acute care community has much work to do in conjunction with CMS before health reform, including a new post-acute paradigm, can advance. As we move forward, one of our overriding priorities must remain ensuring that patients who need advanced rehabilitation retain access to intensive, medical rehabilitation that maximizes recovery and function as soon as possible, in order to help them return to their homes and communities.