THE CONGRESSIONALLY-MANDATED STUDY OF MEDICAL CLASSIFICATION CRITERIA FOR INPATIENT REHABIILTATION FACILITIES

COMMENTS PRESENTED BY THE COALITION TO PRESERVE REHABILITATION

FEBRUARY 9, 2009

The undersigned members of the Coalition to Preserve Rehabilitation (CPR) submit the following comments relating to the congressionally-mandated study of medical classification criteria for inpatient rehabilitation hospitals and units. CPR is a coalition of national consumer, clinician, and membership organizations with the goal of preserving access to appropriate rehabilitation services so that individuals with disabilities, injuries, or chronic conditions may regain and/or maintain their maximum level of independent function. The comments set out below are written from the perspective of patients, those ultimately impacted by the "75% Rule." If you have any questions regarding the testimony, please contact Bobby Silverstein (Bobby.Silverstein@ppsv.com) or Peter Thomas (Peter.Thomas@ppsv.com).

BACKGROUND

In December 2007, Congress passed the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA). Section 115 made key reforms to the Medicare policy known as the 75% Rule. The 75% Rule required inpatient rehabilitation hospitals and units to admit at least 75% of their patients within 13 diagnostic categories (compliance threshold) for the facility to be paid as an inpatient rehabilitation provider. CPR and others advocated for reforming this rule because it had the effect of denying medically necessary care for patients who were not within one of the 13 diagnostic categories even though such care was determined essential based on individualized assessment of need. For many individuals, the effect of this policy was unnecessary confinement in nursing homes, rather than expeditious return to their homes. The new law permanently sets the compliance threshold at 60%, replacing the previous 75% requirement. In addition, the legislation makes permanent the ability to include patients who meet certain comorbidity standards as counting toward the 60% threshold.

Section 115 of MMSEA also directs the Secretary of Health and Human Services to submit a report to Congress that includes:

- An analysis of Medicare beneficiaries' access to medically necessary rehabilitation services, including the potential effect of the fully-implemented 75% rule on access to care;

- An analysis of alternatives or refinements to the 75% rule policy for determining criteria for inpatient rehabilitation hospital and unit designation under the Medicare program; and

- An analysis of the conditions for which individuals are commonly admitted to inpatient rehabilitation hospitals and units that are not included as a listed condition under the existing 75% rule in order to determine the appropriate setting of care and variations in patient outcomes and costs across settings of care for treatment of such conditions.

In designing the study, conducting the analysis, and preparing the report, Section 115 also directs the Secretary to consult with, among other groups, physicians; administrators of inpatient rehabilitation, acute care hospitals, skilled nursing facilities and other settings providing rehabilitation services; Medicare beneficiaries**,** trade organizations representing inpatient rehabilitation hospitals and units and skilled nursing facilities; and the Medicare Payment Advisory Commission.

It is our understanding that CMS has contracted with RTI International to assist CMS in preparing the Report to Congress. This congressionally mandated study/report may play a significant role in determining the permanent/long-term viability of the new congressionally-established 60 percent rule. Thus, it is essential that the study's findings, conclusions, and recommendations be based on a valid, reliable, unbiased review of the data by RTI International and ultimately the Secretary.

GUIDING PRINCIPLES

The study should reflect the following guiding principles:

1. The establishment of criteria that enables CMS to distinguish IRFs from other settings must facilitate and not impede achievement of the goals of our nation's law impacting persons with disabilities as set forth in the Americans with Disabilities Act—equality of opportunity, full participation, independent living and economic self-sufficiency.

2. Under the Medicare program, older Americans and certain persons with disabilities are entitled to receive medically reasonable and necessary health care services.

3. Based on an individualized assessment of need, for a relatively small, but distinct number of patients, medically reasonable and necessary health care services entail the provision of intensive, coordinated rehabilitation services provided by a multi-disciplinary team in inpatient rehabilitation hospitals and rehabilitation units in acute care hospitals.

4. In order to be excluded from the acute care inpatient hospital Prospective Payment System (PPS) specified in 42 CRF § 412.1(a)(1) and instead receive enhanced payments under the Inpatient Rehabilitation Facility (IRF) PPS, it is appropriate for CMS to establish

criteria/conditions that enable it to distinguish IRFs from other settings that receive lesser payments.

5. In order to be admitted to an inpatient rehabilitation hospital or rehabilitation unit in an acute care hospital, it is appropriate for CMS to establish criteria—the services must be reasonable and necessary based on an assessment of each beneficiary's individual care needs. Thus, it is appropriate for public policy to limit access to those beneficiaries who satisfy the criteria for admission.

6. Medicare patients' entitlement to medically reasonable and necessary health care services, including intensive inpatient rehabilitation services, must not be impeded by the operation of policies designed to classify facilities as IRFs for purposes of payment. Thus, the standards for qualifying a facility as an IRF should not be commingled with the standards for medical necessity for individual patients. The concept of specifying classification criteria (the 75% Rule) and the concept of specifying criteria for admission (medical necessity) must be treated as separate and distinct concepts.

7. Criteria that enable CMS to distinguish IRFs from other settings for purposes of establishing enhanced payments should recognize the totality of patients' conditions (e.g., the patients' impairment, age, comorbidities, and functional capabilities (motor and cognitive)) on their need for inpatient rehabilitation. The criteria should not only address levels of functioning but should also address the need for close medical supervision to stabilize medical conditions.

8. Rehabilitation medicine and medical rehabilitation care has substantially changed since the inception of the 75% rule and the impact of coverage and payment rules on beneficiary access to timely and appropriate care.

9. The "75%" rule should not be viewed in isolation from other policies and practices adopted by CMS e.g., recent administrative review activities implemented by the fiscal intermediaries, the recovery audit contractors, and other Medicare contractors and other government enforcement agencies.

SCOPE AND FOCUS OF THE STUDY

The study should address the following issues:

1. The study should include an assessment of the effect the 75% rule had on access to care for Medicare beneficiaries i.e., an assessment of the effect of the 75 percent rule had on IRFs being forced to turn away patients (denying patients access to medically necessary rehabilitation services for arbitrary reasons).

2. The study should include an assessment of the impact the 75% rule and other restrictions had on the overall stability of the inpatient rehabilitation hospital system (*i.e.,* closures and shrinkages of inpatient rehabilitation programs) with an eye on future capacity to serve an increasingly elderly and disabled population.

3. The study should provide a comparison of the quality, cost, effectiveness, and patient outcomes of inpatient rehabilitation services among different post-acute settings, including whether the Medicare program and Medicare beneficiaries may incur higher costs of care for the *entire episode* of illness or disability because of factors such as—

    - Readmission to acute care hospitals that could have been avoided with an IRF stay; and
    - Extended lengths of stay in post-acute settings other than IRFs upon denial of admission to such an intensive rehabilitation setting due to the 75% rule.

4. The study should include an assessment of patient outcomes across settings of care from a functional perspective, including the measurement of:

    - Improved functional status generally from a short and long term perspective;
    - The ability to walk independently for significant distances;
    - The ability to transfer independently;
    - Return to home (more rapid discharge to home); and
    - Faster rate of initial recovery from the acute medical event.

5. The study should include an assessment of the utility, equity, and propriety of using a function-based system rather than a diagnosis-based compliance percentage for purposes of IRF payment classification. A function-based system recognizes the totality of patients' conditions (e.g., the patients' impairment, age, comorbidities, and functional capabilities (motor and cognitive)) on their need for inpatient rehabilitation. The criteria should not only address levels of functioning but should also address the need for close medical supervision to stabilize medical conditions.

6. To the extent that a conclusion is reached by CMS to retain a compliance percentage, we recommend that the 60% Rule be retained unless the study can demonstrate by clear and convincing evidence that an alternative compliance percentage should be used. Prior to the enactment of MMSEA, CPR and others identified serious problems with the administration of the 75% Rule. These problems, particularly denial of access for medically necessary services, cannot be ignored.

7. To the extent that a conclusion is reached to retain comorbidities, we recommend that the treatment of comorbidities be modified. The CMS regulation specifies that a patient's *comorbidity* (listed in the regulations) can be used to determine if a provider meets the compliance threshold provided certain applicable requirements were met. In §421.602, a comorbidity is defined as a specific patient condition that is secondary to the patient's principal diagnosis. A patient's principal diagnosis is the primary reason for the patient being admitted to an IRF and this diagnosis is used to determine if the patient had a medical condition that can be counted towards meeting the compliance threshold. In order for an inpatient with a comorbidity to be included in the inpatient population that counts toward the applicable percentage, the following criteria must be met [§412.23 (b) (2) (i)]:

- The patient is admitted for inpatient rehabilitation for a condition that is not one of the 13 listed conditions;
- The patient also has a comorbidity that falls within one of the 13 listed conditions;
- The comorbidity has caused a significant decline in the functional ability of the individual such that, even in the absence of the admitting condition, the individual would require the intensive rehabilitation treatment that is unique to inpatient rehabilitation facilities paid under the IFR PPS and that cannot be appropriately performed in another setting.

CPR believes that the current comorbidity provision is far too narrow in its scope and that CMS should substantially modify and make permanent an appropriate comorbidity policy. The current policy makes little sense in that a comorbid condition can only qualify a patient under the regulations if that condition would independently qualify that patient for coverage under the Rule. This policy fails to recognize the interplay of comorbid conditions on the totality of clinical circumstances of each patient and the medical judgment that comes into play when determining whether a particular patient needs to be admitted to an inpatient rehabilitation hospital or unit.

In sum, by limiting consideration of a patient's comorbidities to a list of 13 conditions and by requiring such comorbidities to independently qualify a patient for inpatient rehabilitation, the 75% Rule artificially segregates into parts the overall health and functional status of patients. The current policy fails to recognize the totality of patients' conditions on their need for inpatient rehabilitation care.

ESTABLISHMENT OF WORKING GROUP OF EXPERTS

CMS should convene a group of experts, including experts from the groups CMS originally relied on when it prescribed the 13 listed conditions, to determine how best to address the various policy issues raised by this study. The original medical conditions specified in the 75% rule was partly based upon information contained in a document entitled "Sampling Screening Criteria for Review of Admissions to Comprhensive Medical Rehabilitation Hospitals/Units," a product of the Professional Standards Review Organization of the American Academy of Physical Medicine and Rehabilitation. In addition, CMS received input from the National Association of Rehabilitation Facilities and the American Hospital Association [69 Fed. Reg. 25753 (May 7, 2004)].

For example, the group should review the 13-currently-listed treatment categories and whether additional conditions should be added to the list and review the comorbidity policy. The group could also determine how best to use data available from the IRF-PAI, including impairment, functioning, and comorbidities (all comorbidities, not comorbidities limited to the 13 listed conditions) to objectively determine, for purposes of classification only (not medical necessity) types of conditions that will typically require intensive inpatient rehabilitation in IRFs because rehabilitation in general can be delivered in a variety of settings. This determination could focus on developing objective criteria that not only address levels of functioning but that also address the need for close medical supervision to stabilize medical conditions.

We thank you for the opportunity to comment.

Sincerely,

American Association of People with Disabilities

American Academy of Physical Medicine and Rehabilitation

American Therapeutic Recreation Association

Amputee Coalition of America

The Arc of the United States

Association of Academic Physiatrists

Association of Rehabilitation Nurses

ACCSES

ADAP Advocacy Association

Brain Injury Association of America

Center for Medicare Advocacy, Inc.

Christopher and Dana Reeve Foundation

Easter Seals

National Association for the Advancement of Orthotics and Prosthetics

National Council on Independent Living

National Council for Community Behavioral Healthcare

National Multiple Sclerosis Society

Paralyzed Veterans of America

United Cerebral Palsy

United Spinal Association