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Proposed Limitation of Inpatient Rehabilitation for Medicare Beneficiaries: Delivery System Implications of the "75% Rule"

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Proposed Limitation of Inpatient Rehabilitation for Medicare Beneficiaries: Delivery System Implications of the "75% Rule"

In May of 2003, the Centers for Medicare and Medicaid Services (CMS) issued a notice of proposed rulemaking regarding Medicare funding for inpatient physical rehabilitation. CMS proposed strictly enforcing a 20-year-old rule, which would save CMS an estimated $213 million. Ironically, the savings would negatively impact services designed to move patients to independence after disabling illness or injury.

The acute hospital inpatient prospective payment system developed in the 1980s excluded inpatient physical rehabilitation. Instead, the organization that is now CMS defined inpatient rehabilitation facilities through adaptations to a previous report from the rehabilitation field. This definition distinguishing inpatient rehabilitation providers from other acute care settings was published in the January 1984 Federal Register. Inpatient rehabilitation providers were defined as hospitals or units that primarily provided intensive rehabilitation services and where 75% of the patients served had one of 10 diagnoses. This became known as the "75% Rule." The 10 diagnoses were stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, hip fracture, brain injury, polyarthritis, neurological disorders, and burns. This 1984 list has never been updated.

Conversely, medical/surgical outcomes and the method of payment for inpatient rehabilitation have changed considerably. Joint replacement is more common, and candidates are likely to have multiple comorbidities that would have barred them from the procedure 20 years ago. Organ transplant with long-term survival has increased dramatically. Survival of cancer and of demanding cancer-controlling regimens has also increased. When Medicare payment for inpatient rehabilitation moved to a prospective payment system in 2002, CMS identified a rehabilitation payment rate for 21 diagnoses. This payment system was designed over twelve years, initiated by the rehabilitation field and facilitated by research of the RAND Corporation through CMS contracts. This research found that contemporary patients in rehabilitation hospitals and units can be divided into 21 discreet diagnostic and impairment payment categories. These categories reflect the wide range of patients currently able to benefit from inpatient rehabilitation.

In recent years, the CMS fiscal intermediaries failed to enforce the 75% Rule for the maintenance of rehabilitation hospital provider status. They appeared to accept the CMS Hospital Manual individual patient medical necessity criteria to identify appropriate inpatient rehabilitation candidates. Section 211 of the Hospital Manual articulates the expectation that patients served in inpatient rehabilitation be able to realize practical gain from those services in a reasonable period of time, that they require the services of an interdisciplinary team including medical and nursing supervision, and that they have a reasonable chance to return to the community following their rehabilitation stay.[1] However, in the early 2000s, the CMS Administrator mandated fiscal intermediaries enforce the 75% Rule and use a revised interpretation of the polyarthritis category to exclude those who received total joint replacements.

If this revision to the rule is enforced, approximately 87% of the 1,210 facilities in

the country will lose their certification as inpatient rehabilitation providers by 2007.[2] While the rule concerns Medicare beneficiaries specifically, enforcement will affect availability of services for all rehabilitation candidates. When surveyed in 2003, almost one-quarter of the rehabilitation facilities in the United States indicated they would close if the regulation takes effect.[2] The intention of CMS is to move care of these patients to alternate settings through longer acute care stays, discharge to homecare or discharge to skilled nursing facilities.

The proposed shift of care setting will have consequences for consumers and for the healthcare system. Loss of acute rehabilitation services will result in increased numbers of patients discharged from acute care to skilled nursing care. Alternatively, individuals may be discharged to homecare services. In both cases, the consumer will receive fewer hours of therapy than they would in inpatient rehabilitation. Lower service levels correspond to longer timeframes for recovery.[3,4]

Longer stays in acute care will cause increased competition for acute care beds and increased costs borne by acute care hospitals. Patients will again receive fewer hours of physical, occupational, speech and other therapies than are provided in inpatient rehabilitation.

In September 2003, CMS proposed a revision that would lower the threshold of "qualifying" diagnoses to 65% for three years. Despite the lower threshold, the proposed revision offers little improvement because it narrows the definition of polyarthritis to include only three rare types. After three years, the threshold would revert to 75%.

Magee Rehabilitation Hospital has spearheaded a number of events and initiatives designed to inform elected representatives and the public about the rule. Supported by Thomas Jefferson University and Thomas Jefferson University Hospital, these have included educating leaders on Capitol Hill and participating in a widely publicized rally on Independence Mall in Philadelphia. Consumers and the rehabilitation industry are asking CMS to "Stop, Study and Modernize" the 75% Rule. Senators Arlen Specter (R-PA) and Rick Santorum (R-PA) have indicated that a reasonable solution will be found, but the decision now lies in the hands of Tommy Thompson, Secretary of Health and Human Services.

To date, CMS has not made a decision regarding the 75% Rule. The proposed $213 million savings for Medicare may be quite costly for consumers and for the healthcare community.

References

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