

## **CMS Rehabilitation Policy: Expediency vs. Rationality**

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There is little doubt as to the pressure from Washington to control health care costs through the Centers for Medicare and Medicaid Services (CMS). Inpatient rehabilitation facilities (IRFs) have been targets of this mission through legislation known as the 75% Rule (the Rule). Published originally in 1983, its purpose was to define eligibility for IRF payment reimbursement by mandating that 75 percent of admissions have one of ten diagnoses. Upon revisiting the Rule in the late 90s, CMS concluded that it was applied inconsistently among IRFs, suggesting the need for clearer criteria to avoid what it deemed to be abuse of the guidelines. CMS expanded the list of diagnoses to thirteen and mandated strict adherence to avoid overpayment for unneeded services (see Figure 1). This article explores two recent briefs, from CMS and from the American Hospital Association (AHA), that demonstrate the perspectives of stakeholders regarding the Rule and its effects on the field of rehabilitation.

A quote by Peter Drucker may aid in approaching the difference in outlook of CMS and AHA. Drucker writes, “Efficiency is doing things right; effectiveness is doing the right things.” CMS is attempting to be “efficient” in this matter by juggling admission criteria in the updated Rule to save money quickly. In an interesting shift from previous communications, the CMS news brief, *Inpatient Rehabilitation Facility PPS*, addresses Wall Street directly. Understandably, the financial community is monitoring events closely to ensure that changes in the Rule do not turn the rehabilitation industry topsy-turvy. In an effort to quell any dissatisfaction, CMS emphasizes the financial strength of IRFs, citing as an example their profit margins that range near 15 percent, and their compound annual growth rates that border on five percent.<sup>1</sup> In addition, it identifies the heterogeneity of IRF distribution and patient populations requiring their services, calling into question the need for so many facilities. Skilled Nursing Facilities (SNF) and home health agencies (HHC), it argues, can act as suitable alternatives. Finally, CMS demonstrates how “inappropriate” admissions decreased in the years 2003-2005 when it enforced the Rule more strictly, with a compensatory increase in “suitable” admissions assumed to require a greater level of care. In essence, CMS wields data to convince Wall Street that changing IRF behavior would lead only to positive results.

AHA’s position, as stated in its brief, *The Current Reality of the 75% Rule*, is that the CMS argument fails to acknowledge the “effectiveness” of IRFs. Using Moran Company data, the AHA asserts that application of the Rule has resulted in denial of IRF admission to over 40,000 patients, well above the CMS estimate.<sup>2,3</sup> This number will likely increase to over 64,000 in year two, and continue to mount thereafter. Additional anticipated effects of the Rule include a reduction of staff in 45% of IRFs, a decrease in total beds at

38% of IRFs, and complete closure for 14% of IRFs.<sup>2,4</sup> Studies have already shown that care will be compromised in an environment where patients are admitted based strictly on diagnosis, without consideration for functional ability.<sup>5,6</sup> The AHA report also reveals that only seven percent of post-acute care dollars go to IRFs, while HHC and SNFs receive 11.3 and 13.2 percent, respectively. Furthermore, only four percent of all acute care hospital discharges are admitted to IRFs. The AHA questions whether significant financial savings will result from changes related to the revised Rule. It projects that enforcement of the Rule will hamper patient access to required services, threaten proper patient care, and eliminate multiple jobs, causing economic disruption.

After revision, CMS initiated the Rule as the 50% Rule, to be later increased to the planned 75%. Legislation to extend implementation at 50% for two additional years was spearheaded by Senators Specter and Santorum, and Representative LoBiondo, among others. Their bills also proposed the creation of a Rehabilitation Advisory Council to develop admission criteria consistent with the focus of IRFs on improving function.

The result of this effort, after Conference Committee action on these bills, was a one year continuation of the requirement that 60% of the IRF admissions be patients with one of the designated diagnoses, after which there will be a stepwise return to 75%. The legislation did not call for an advisory committee.

The American Medical Rehabilitation Providers Association (AMRPA) is tracking admissions to IRFs to document reductions in access. Studies are ongoing to determine if care is hampered when patients requiring inpatient care are instead triaged to alternative

facilities. It also is tracking savings to CMS. Although CMS projected that the Rule will have modest impacts on IRFs, early data distributed by the AMRPA show that both access and economics far exceed the CMS projections. Neither stakeholder, the CMS nor the AHA, has sufficient evidence to support their respective preferred models of service delivery. Providers with strong views on the effectiveness of their services need to develop supportive evidence that includes reviewing the use of alternative models.

### **Table One**

Original 10 diagnoses: Stroke, Spinal Cord Injury, Congenital Deformity, Amputation, Multiple Trauma, Femur Fracture, Brain Injury, Neurological Disorders, Burns, and Polyarthritis\*.

\*This was subdivided into three categories with very specific definitions regarding joint disease in the new classification.

### **References**

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