



CMA Weekly Alert – March 8, 2007

MAINTAINING QUALITY REHABILITATION OPTIONS FOR MEDICARE BENEFICIARIES

INTRODUCTION

The Medicare program pays for rehabilitation services, including physical, speech and occupational therapies, in different settings. Various kinds of rehabilitation can be provided at home through the Medicare home health benefit, in an out-patient therapy facility, in a skilled nursing facility (SNF), in a comprehensive outpatient rehabilitation facility (CORF), in an inpatient rehabilitation facility (IRF), or in a long-term care hospital (LTCH). A patient's condition and medical needs should dictate the setting in which rehabilitation services are provided. The type and amount of care a person receives varies by setting. This Alert discusses two post-acute rehabilitation options – IRFs and SNFs.

A federal standard being phased in – the so-called “75% Rule” – would make it more difficult for a hospital to qualify as an IRF, with the result that more beneficiaries would lose access to this care and, instead, would likely enter SNFs for rehabilitation. Care in these settings is not the same. A bi-partisan group of Senators has introduced legislation, S. 543,¹ to stop the 75% Rule phase-in. The question for beneficiaries is, where should they receive post-hospital rehabilitation care?

THE CURRENT RULE AND THE IMPENDING CHANGE

Medicare defines inpatient rehabilitation facilities, in part, by the percentage of their patients who require care for one or more of 13 specified conditions. In addition, Medicare coverage is available for rehabilitation in an IRF for beneficiaries in need of close medical supervision by a physician with specialized training or experience in rehabilitation; 24-hour rehabilitation nursing; and a multi-disciplinary team approach and coordinated care.²

Federal regulations published in 2004 began a three-year phase-in of the requirement that to qualify as an IRF, 75% of the IRF's patients must have one or more of 13 specified conditions and otherwise require intensive rehabilitation services.³ At present, IRFs are defined as facilities in which 60% of patients have one of the 13 conditions and otherwise require intensive rehabilitation services; beginning July 1, 2007, the percentage moves to 75% of patients. Recently proposed legislation, S. 543, rejects implementation of the 75% rule, continues use of the current 60% compliance threshold, and explicitly requires CMS “to use and apply the criteria established in HCFA Ruling 85-2.”

The seemingly technical issue of whether IRFs should meet a 60% threshold or a 75% threshold pits one group of health care providers against another. Inpatient rehabilitation facilities favor continuation of the current 60% rule, contending that patients do not receive comparable care in other settings;⁴ skilled nursing facilities (SNFs) argue that they can provide the same care to beneficiaries at lower cost.⁵

What is true? Where should Medicare beneficiaries get post-hospital rehabilitation care? While the answer depends on the specific needs of individual beneficiaries and the types of facilities available in their communities, there is evidence that IRFs may serve different patients than SNFs, that SNFs may not provide sufficient rehabilitation and nursing services, that IRF patients have better outcomes than those who receive rehabilitation in SNFs, and that overall costs may actually be similar in the two settings.

IRFS AND SNFS MAY SERVE DIFFERENT POPULATIONS

While there is overlap in the Medicare beneficiaries who receive care in IRFs and SNFs, the facilities may serve different populations. A study commissioned by the Medicare Payment Advisory Commission (MedPAC) found that, “Compared with IRF patients, SNF patients [with hip or knee replacements] are significantly older, have more comorbidities [such as delirium, congestive heart failure, and dementia] and complications [including postoperative pulmonary compromise, cellulitis or decubitus ulcer, mechanical complications due to device or implant, and iatrogenic complications] and are more likely to be eligible for both Medicare and Medicaid.”⁶

To the extent that IRFs and SNFs provide care and services to different types of beneficiaries, both categories of providers need to be available to serve the full range of beneficiaries needing post-acute inpatient rehabilitation care.

SNFS MAY NOT PROVIDE SUFFICIENT REHABILITATION AND NURSING SERVICES

In general, IRF patients must require physician supervision and intense, coordinated, multi-disciplinary care.⁷ Residents in SNFs qualify for Medicare coverage of their stay if they receive therapy services five days per week.⁸ The medical oversight, intensity, and coordination of care in a SNF is usually less than that in an IRF.

A 2002 Government Accountability Office (GAO) study reported that, two years after implementation of a Medicare prospective payment system (PPS) for SNFs, residents assigned by SNFs to medium and high rehabilitation groups received less therapy than before PPS and half did not receive the minimum number of minutes that were needed to be classified into those rehabilitation groups.⁹ SNFs told the GAO that the high and medium rehabilitation groups had “more favorable payments, relative to their costs, than other categories.”¹⁰ The GAO concluded:

Our work indicates that SNFs have responded to PPS in two ways that may have affected how payments compare to SNF costs. SNFs have (1) changed their patient assessment practices and (2) reduced the amount of therapy services provided to Medicare beneficiaries. The first change can increase Medicare’s payments and the second can reduce a SNF’s costs.¹¹

In addition, SNFs may not have sufficient nursing staff to meet the needs of residents requiring rehabilitation. The GAO found that SNFs did not increase their nurse staffing after the new highly profitable¹² Medicare reimbursement system was implemented, even when Congress added money to Medicare rates specifically for nursing services.¹³

IRF PATIENTS HAVE BETTER OUTCOMES THAN SNF RESIDENTS

The MedPAC study found that

- IRF patients discharged at 14+ days had higher functional status scores than SNF patients with a 14-day or longer stay;
- 76% of IRF patients were walking independently at discharge at 14+ days after admission, compared with 31% of SNF residents at 14 days; and
- 79% of IRF patients were transferring independently at discharge at 14+ days after admission, compared with 30% of SNF residents at 14 days.¹⁴

A widely-quoted study of Medicare beneficiaries with hip fractures who showed the greatest potential to reduce disability also reported better outcomes for IRF patients than for SNF residents. Comparing two similar groups of beneficiaries, it found that those who went to IRFs had shorter lengths of stay (12.8 days, compared to 36.2

days for SNF residents) and better functional outcomes 12 weeks after discharge from the hospital than those who received rehabilitation services in SNFs.¹⁵ In addition,

- 81.1% of IRF patients returned home, compared to 45.5% of SNF residents; and
- Only 8.1% of IRF patients were discharged to nursing homes, compared to 36.4% of SNF residents. Another 4.6% of SNF residents went to other “non-home settings.”¹⁶

A later report reviewing the same patients’ status at 24 weeks confirmed the initial findings. IRF patients had better outcomes than SNF residents. “IRF patients displayed a faster rate of initial recovery and more rapid discharge to home.”¹⁷

OVERALL COSTS MAY BE SIMILAR IN THE TWO SETTINGS

While the *per day* costs of IRFs are considerably higher than those of SNFs, the significantly shorter lengths of stay in IRFs may serve to reduce the *per episode* costs of care.¹⁸ Moreover, since IRF patients are more likely to go home than to remain in an institutional setting, “any potential cost saving from the less expensive SNF settings may be mitigated.”¹⁹

CONCLUSION

There are several reasons to believe that implementation of the 75% rule may be poor public policy.

First, anticipation of full implementation of the 75% rule has already led IRFs to serve fewer Medicare beneficiaries.²⁰ Decreased access of beneficiaries to IRF care will intensify if the 75% rule is fully implemented.

Second, research indicates that outcomes for some beneficiaries may be better in IRFs than in SNFs.

Finally, while the cost differences between IRFs and SNFs have not been fully analyzed, the reduced lengths of stay in IRFs and reduced institutionalization following an IRF stay, compared with a SNF stay, suggest that Medicare reimbursement may not be saved by diverting beneficiaries from IRFs to SNFs.

Medicare beneficiaries have an interest in maintaining a full spectrum of the highest quality, appropriate health care providers. Enactment of S. 543 would help assure the availability of Inpatient Rehabilitation Facility care for Medicare beneficiaries in need of this important multi-disciplinary rehabilitation.

For more information on this topic, please contact attorney Toby Edelman (tedelman@medicareadvocacy.org) in the Center for Medicare Advocacy’s Washington, DC office at (202) 216-0028.

¹ The Preserving Patient Access to Inpatient Rehabilitation Act was co-sponsored by Senators Nelson (D, NE), Bunning (R, KY), Stabenow (D, MI), Snowe (R, ME), Kerry (D, MA), Collins (R, ME), Reed (D, RI), Clinton (D, NY), and Menendez (D, NJ).

² *Hooper v Harris* 1985 WL 56560 (D. Conn 1985), *Hooper v Sullivan*, CCH Medicare-Medicaid Guide, ¶37,985 (D. Conn 1989); HCFA Ruling 85-2, 50 Federal Register 31,040 (July 31, 1985), corrected at 50 Federal Register 32,643 (August 13, 1985).

³ 42 C.F.R. §412.23(b)(2) (2004). The final rules and history of the 75% rule are discussed at 69 Fed. Reg. 25,752, at 25,753-755 (May 7, 2004, effective July 1, 2004). The 75% rule was originally established in 1983, but was suspended by the Centers for Medicare & Medicaid Services in 2002 after it found inconsistent use of the criteria by fiscal intermediaries. Government Accountability Office, *Medicare: More Specific Criteria Needed to Classify Inpatient Rehabilitation Facilities* 8-10, GAO-05-366 (April 2005), <http://www.gao.gov/new.items/d05366.pdf>.

⁴ Statement of Felice Loverso, American Medical Rehabilitation Providers Association, House Ways and Means Committee, Subcommittee on Health, Hearing on Post Acute Care (June 16, 2005), <http://waysandmeans.house.gov/hearings.asp?formmode=view&id=3967>.

⁵ AHCA, “AHCA: Preserving Medicare ‘75% Rule’ Provides U.S. Seniors Highest Quality Care in Most Cost-Efficient Manner; Congress Urged to Preserve Key Pro-Senior, Pro-Taxpayer Measure” (News Release, Feb. 14, 2007), <http://www.ahca.org/news/nr070214.htm>.

⁶ Medicare Payment Advisory Commission, *Report to the Congress; Issues in a Modernized Medicare Program*, 108 (June 2005), http://www.medpac.gov/publications/congressional_reports/June05_Entire_report.pdf; see also Michael C. Munin, “Effect of rehabilitation site on functional recovery after hip fracture,” *Archives of Physical Medicine and Rehabilitation*, Vol. 86: 367-372 (March 2005). An abstract of the article is available at <http://www.archives-pmr.org/article/PIIS0003999304012493/abstract>.

⁷ *Hooper v Harris* 1985 WL 56560 (D. Conn 1985), *Hooper v Sullivan*, CCH Medicare-Medicaid Guide, ¶37,985 (D. Conn 1989); Medicare Benefit Policy Manual, CMS Pub. 100-02, Chapter 1, §110.4.3, <http://www.cms.hhs.gov/manuals/Downloads/bp102c01.pdf>; HCFA Ruling 85-2, 50 Federal Register 31,040 (July 31, 1985), corrected 50 Federal Register 32,643 (Aug. 13, 1985).

⁸ 42 C.F.R. §409.34(a)(2).

⁹ Government Accountability Office, *Skilled Nursing Facilities; Providers Have Responded to Medicare Payment System by Changing Practices*, GAO-02-841, 3 (Aug. 2002), <http://www.gao.gov/new.items/d02841.pdf>.

¹⁰ *Id.* 12.

¹¹ *Id.* 16.

¹² The GAO found that freestanding SNFs “generally received Medicare payments that exceeded their costs, often by considerable amounts.” GAO, *Skilled Nursing Facilities: Medicare Payments Exceed Costs for Most but Not All Facilities* 20, GAO-03-183 (Dec. 2002), <http://www.gao.gov/new.items/d03183.pdf>. The profitability of Medicare payments has led the nursing home industry to eagerly anticipate implementation of the 75% rule. The cover story of the November 2006 issue of the American Health Care Association’s *Provider* magazine reports that the nursing home industry is “modernizing and refurbishing aging facilities” and repositioning services “to attract higher Medicare reimbursement and more private payers.” Meg LaPorte, “Providers Upgrade Buildings, Expand Services; Companies target post-acute rehab, short-stay, and higher acuity patients,” *Provider* (Nov. 2006), <http://www.providermagazine.com/pdf/cover-11-2006.pdf>. See also Liza Berger, “Finance feature: Climate change,” *McKnight’s Long-Term Care News & Assisted Living* (Feb. 7, 2007) (“Renovations may include building more private or semi-private rooms, incorporating residential features, or building rehab gyms for short-stay residents to take advantage of Medicare’s lucrative reimbursements.”), [http://www.mcknightsonline.com/content/index.php?id=24&tx_ttnews\[swords\]=Liza%20Berger&tx_ttnews\[tt_news\]=3583&tx_tnews\[backPid\]=25&cHash=ea5cb2b07b](http://www.mcknightsonline.com/content/index.php?id=24&tx_ttnews[swords]=Liza%20Berger&tx_ttnews[tt_news]=3583&tx_tnews[backPid]=25&cHash=ea5cb2b07b).

¹³ GAO, *Skilled Nursing Facilities: Available Data Show Average Nursing Staff Time Changed Little after Medicare Payment Increase*, GAO-03-176 (Nov. 2002), <http://www.gao.gov/new.items/d03176.pdf>.

¹⁴ Medicare Payment Advisory Commission, *Report to the Congress; Issues in a Modernized Medicare Program*, 108 (June 2005), http://www.medpac.gov/publications/congressional_reports/June05_Entire_report.pdf.

¹⁵ Michael C. Munin, “Effect of rehabilitation site on functional recovery after hip fracture,” *Archives of Physical Medicine and Rehabilitation*, Vol. 86: 367-372 (March 2005), <http://www.archives-pmr.org/article/PIIS0003999304012493/abstract>

¹⁶ *Id.*

¹⁷ Michael C. Munin, “Influence of Rehabilitation Site on Hip Fracture Recovery in Community-Dwelling Subjects at 6-Month Follow-Up,” *Archives of Physical Medicine and Rehabilitation*, Vol. 87: 1004-1006 (July 2006).

¹⁸ Michael C. Munin, “Effect of rehabilitation site on functional recovery after hip fracture,” *Archives of Physical Medicine and Rehabilitation*, Vol. 86: 367-372 (March 2005), <http://www.archives-pmr.org/article/PIIS0003999304012493/abstract>; Statement of Felice Loverso, American Medical Rehabilitation Providers Association, submitted for the record to the House Ways and Means Committee, Subcommittee on Health, Hearing on Post Acute Care (June 16, 2005), <http://waysandmeans.house.gov/hearings.asp?formmode=view&id=3967>.

¹⁹ Michael C. Munin, “Effect of rehabilitation site on functional recovery after hip fracture,” *Archives of Physical Medicine and Rehabilitation*, Vol. 86: 367-372 (March 2005), <http://www.archives-pmr.org/article/PIIS0003999304012493/abstract>.

²⁰ Statement of Felice Loverso, American Medical Rehabilitation Providers Association, submitted for the record to the House Ways and Means Committee, Subcommittee on Health, Hearing on Post Acute Care (June 16, 2005), <http://waysandmeans.house.gov/hearings.asp?formmode=view&id=3967> (contending that approximately 20,000 Medicare beneficiaries had been denied admission to IRFs since July 1, 2004 and predicting that one of three patients would be turned away in the fourth year of the 75% rule). Senator Nelson suggested in 2007 that as many as 88,000 Medicare beneficiaries may have been denied access to IRF. Congressional Record, page S1850 (Feb. 12, 2007), <http://frwebgate3.access.gpo.gov/cgi-bin/waisgate.cgi?WAIIdocID=86690319867+3+0+0&WAIAction=retrieve>.