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Preserving Patient Access to Inpatient Rehabilitation Hospitals Act of 2005

 In 1970, the “HCFA-10” was established to designate 10 rehab diagnoses that would qualify a facility as an inpatient rehabilitation hospital. In 1984, the “HCFA-10” was incorporated in a “75 Percent Rule” which proposed that 75 percent of a rehabilitation hospital’s patients must fall within one of these 10 diagnostic categories in order to qualify your site under Centers for Medicare and Medicaid Services (CMS) as an inpatient rehab hospital and receive reimbursement as such. Some of the major diagnoses that fall

under the criteria are strokes, spinal cord injuries, brain injuries, neurological disorders, major trauma, fractures, and poly arthritis. The 75 percent threshold excluded cardiac and pulmonary patients which are frequently in need of rehabilitative services and so these conditions fell into the other "25 percent non-HCFA" threshold which limited their access to care.

In September of 2003, CMS proposed to restructure one of the "HCFA-10" rehab diagnoses called poly arthritis in a cost-containment measure which has impacted the rehab industry dramatically. Under the "NEW 75 Percent Rule" (no longer called the HCFA-10, but the CMS-13) which went into effect in July, 2004, any arthritis patients impaired in any single hip or knee joint who receives surgical intervention and are under the age of 85 or have a BMI of 50 or less, are no longer considered part of the 75 percent threshold. These cases encompassed a large percentage of the rehab business for rehabilitation hospitals throughout the nation. Now they would fall under the other 25 percent threshold along with cardiac and pulmonary patients.

CMS requested that the "New 75 Percent Rule" be implemented over a period of three years with incremental thresholds each year of 50, 60, 70, per cent, respectively, with the 75 percent threshold for compliance under the CMS-13 being met within the fourth year. The research conducted by the Government Accountability Office (GAO) in April, 2005, to study the impact of the reclassification of the rule clearly indicated that further research was needed in order to refine the rule because of a lack of uniform standards in admitting criteria in the industry for patient admissions. CMS enforced the rule without giving consideration to further investigation to define which types of patients might be better served in a rehab setting. Instead all patients regardless of their potential for improvement in their functional status, or regardless of their appropriate placement based on medical necessity are clumped into one diagnostic criterion. As a result this has led to a tremendous decrease in volume for rehab hospitals throughout the nation during the first year of

trying to meet the 50 percent compliance threshold for the CMS-13. It has also limited access to approximately 40,000 Medicare beneficiaries from receiving needed inpatient rehabilitative care which was estimated, according to CMS, to only be an impact of 1,100 cases per year.

The impact of this "75 Percent Rule" has not only limited patient access to care, but it has also required rehab hospitals throughout the nation to close down beds and layoff employees. Florida alone has suffered 24.6 percent decrease in rehabilitation cases from second quarter of 2004 to second quarter of 2005, and as compliance thresholds increase, it will even be more difficult to admit patients which could possibly force many rehab hospitals throughout the nation to close down. What will this mean for those cases that do fall under the criteria of rehabilitative care, but are not sufficient enough in numbers for us to meet the "75 Percent Rule"; they will end up being subjugated to substandard treatment.

Currently there is a bill that is before Congress called the "Preserving Patient Access to Inpatient Rehabilitation Hospitals Act of 2005". If this bill is passed it will keep the compliance thresholds at 50 percent for the next three years till further studies can be conducted and the impact of the "75 Percent Rule" can be better defined with regards to patient outcomes and cost-containment.

CMS has the right to look at cost-containment to save Medicare dollars, but what should not happen is that patients are clumped into diagnostic labels that neither reflects their potential for improvement or their medical necessities. What CMS must realize is that a policy that encourages that patients be treated in an appropriate setting according to medical necessity and functional status is fair, but to limit access to a patient because of a diagnosis is unfair.

Each day, as I sit through my admissions meeting, I find that we must turn away patients not necessarily because they don't meet the criteria for an inpatient rehabilitative stay, but because they don't qualify under their diagnosis. These individuals should have the right to have accessibility to the

healthcare they need in order to overcome their disabilities, and in some of these cases a higher intensity of rehab services is what is required.

At the current time because of the 50 percent compliance, we have had to close 25 percent of our rehab beds due to an 11 percent loss of admissions from last year, and this has led to a 12 percent reduction in staff through layoffs. As the compliance threshold increases, it will be more difficult to admit patients, which means that the "Rule" as it currently stands will force our hospital to scale back even further, and possibly even be eliminated.

HealthSouth as a company is aggressively lobbying for this bill to be passed through the Senate and the House of Representatives. So far we have been able, at our hospital, to generate many letters from our local community physicians, patients, families, and employees for submission to our Florida Representatives in the House and in the Senate so that they will co-sponsor the bill. Our hope is to generate enough support for this bill so that a moratorium at 50 percent will be maintained for the next three years until further studies are conducted and the "Rule" can be redefined based on patient's needs and functional outcomes.

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