

## THE WALTER J. ZEITER LECTURE

# Medicare Funding for Inpatient Rehabilitation: How Did We Get to This Point and What Do We Do Now?

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This edited transcript of the 2004 Zeiter Lecture is intended to underscore the current plight of inpatient rehabilitation facilities (IRFs) and the attempt to deliver services to patients while coping with the limitations of the federal "75% rule." The history of federal funding for inpatient rehabilitation is traced from the first attempt to nationalize health insurance in 1916 to the funding status at the time of the lecture in October 2004. Important events along the way are highlighted, including the signing of the Medicare Act in 1965, permitting those on Social Security disability income to be eligible for Medicare after being disabled for 24 months (1972); onset of the hospital inpatient prospective payment system and IRF exemption in 1982; advent of the original 75% rule in 1983; impact of the Balanced Budget Act of 1997; and negative impact of the final 75% rule of 2004. The critical need for members of the American Academy of Physical Medicine and Rehabilitation and their patients to be involved in eliminating or changing the 75% rule is stressed in a "call to action."

**Key Words:** Inpatients; Prospective payment system; Rehabilitation.

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**T**HIS LECTURE IS INTENDED to be a call to action by the membership. There is no greater issue facing physiatrists and the entire rehabilitation community than the current limitations of the "75% rule." The following case provided by Frank Bonner, MD, of Vineland, NJ, illustrates our current quandary: "The patient was a 75-year-old woman in the acute care hospital directly next to our rehabilitation hospital. She was having severe back pain. Prior to admission, she had been living independently at home. Because of chronic obstructive pulmonary disease, she had been taking steroids for many years. She was now experiencing one of the consequences of that—severe osteoporosis. Her back pain and immobilization were secondary to acute vertebral compression fractures. She was referred to us for admission to our rehabilitation hospital. But because of our 'numbers' at that time, and because she did not fit within the current list of 13 recognized diagnostic categories, it wasn't possible for us to take her that week."

This patient obviously had functional deficits and needed to be admitted for inpatient rehabilitation. But because her diagnosis was not one of those that counts toward the 75% rule, the center could not accommodate her. The irony is that the patient might

have been admitted a week later if the 75% rule numbers at the rehabilitation center permitted. This confuses our referring physicians and the discharge planners because patients with the same diagnoses and functional problems might be eligible for admission 1 week and not the next. Dr. Bonner related how this made him feel: "Well, it makes me feel rather like a powerless pawn in the system. The medical decision-making as to the placement of a patient who's in the need of rehab care has been preempted by irrational rules."

This is a common scenario in rehabilitation facilities around the United States. To help us understand how we got to this point and what we can do about it, the following is a brief summary of the history of government funding for inpatient rehabilitation.

## THE EARLY HISTORY OF GOVERNMENT INVOLVEMENT IN HEALTH CARE FINANCING

The history begins in 1916, when the American Medical Association first asked Congress to enact some form of national health insurance. America at that time was mainly agricultural, and doctors wanted to be paid in cash, rather than in chickens. The trade unions, however, were against it. The unions wanted health insurance to be a benefit that they could "win" for their members from employers. Congress was also against it because both parties felt it sounded too much like socialism. They also worried about having to raise taxes to pay for it. Franklin D. Roosevelt wanted it, but did not push for it because he knew it was not a political possibility. There was not really any discussion of national health insurance until Harry Truman brought it up again in 1945 after World War II.

In 1945, President Truman wrote a letter to Congress and asked for national health insurance, probably something like the British were doing at the same time. Congress, however, was still against it because it was too expensive and it was too much like socialism or communism. There was also a concern that the government would not be very good at running a national health system. Some feared that going to the doctor might be like a visit to the local bureau of motor vehicles. Truman's desire to have national health insurance never really had a chance at passage.

## MEDICARE AND MEDICAID SIGNED INTO LAW IN 1965

Not much happened in federal funding for health care until 1965. By this time, there were a lot of different insurance companies, like Blue Cross and Blue Shield and others, and doctors were now firmly against national health insurance. This was especially true for any kind that featured a single-payer system.

Medicare began on July 30, 1965. Lyndon B. Johnson traveled to Independence, MO, to sign the bill in the presence of Harry and Bess Truman. Medicaid began on the same day because the bill that Johnson signed was not only for Medicare but also for Medicaid. Harry Truman became the first enrollee in Medicare and got Medicare card number 1. His wife Bess got Medicare card number 2. Medicare had Parts A and B, just as it does now. Part A was for hospitalization, and part B was for physician services. The Medicare Part B premium was set at \$3 per month. There was also supposed to be a Part C for prescription drugs, but this did not pass in the final bill.

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Most physicians supported the passage of the Medicare and Medicaid bills, if for no other reason than that they now had a chance to be paid for taking care of the poor and the elderly—the 2 groups most likely not to have health insurance at that time. Private health insurance companies did not really want to insure the elderly because of their relatively high consumption of health care resources. They knew that even among the noninstitutionalized “healthy” elderly, 47% have arthritis, 41% hypertension, 30% heart disease, 29% hearing problems, 23% mental disorders, and 10% have diabetes. The private health insurance that was available at that time was often too expensive for most seniors and could be cancelled or not renewed if they had serious health problems.

### MEDICARE CHANGES IN 1972

The next major chapter in Medicare funding of health care occurred in 1972, when people under the age of 65 could receive Medicare after being disabled for 24 months. One of the biggest problems that faced many of our patients at that time was loss of their health insurance after meeting the criteria for Social Security disability. Because they were no longer working, they could not get insurance from their employers. Private insurance companies either would not sell them insurance at any price or charged a rate for it that these patients could not afford. They were not yet old enough to get Medicare. They often came to us for care with either Medicaid or no insurance at all. It was a boon to these patients and to our field that they could now get on Medicare and pay for their medical services. The same bill also allowed patients on active renal dialysis to be covered by Medicare.

### PROSPECTIVE PAYMENT AND ITS IMPACT ON INPATIENT REHABILITATION IN 1982

The year 1982 is the year that many feel the sun really rose on the field of rehabilitation, with the advent of the new Medicare prospective payment system (PPS) for inpatient care. The old cost-reimbursement charge-basis system for hospital care was replaced by a PPS based on diagnosis-related groups (DRGs). A critical factor for us was that rehabilitation hospitals and units, psychiatry units, and burn units were exempt from PPS and remained in the old cost-reimbursement system.

Because there was no definitive limit on what the exempt inpatient hospitals could charge in a cost-reimbursement system, we came under a new “TEFRA limit” for inpatient rehabilitation. This was part of the Tax Equity and Fiscal Responsibility Act (TEFRA), which also had many other provisions in it. The TEFRA limit was the most that Medicare could be charged for an inpatient stay at an inpatient rehabilitation facility (IRF). Each IRF was given a different TEFRA limit based on its payment history in 1982. If an IRF submitted a bill to Medicare that was under its TEFRA limit, Medicare gave that IRF a bonus payment as sort of an incentive not to spend the entire TEFRA limit.

Richard Verville, JD, long-time counsel to the American Academy of Physical Medicine and Rehabilitation (AAPM&R) has stated the reason why IRFs were exempt from prospective payment: “Congress made it clear at that time that the new DRG-based PPS was only for relatively short hospital stays, and that it didn’t have any application to longer hospital stays such as those in IRFs.”

The exemption from PPS also started a boom in new IRFs. Mr. Verville stated the reason for this: “What it produced was a situation in which there was a payment system for IRFs and a separate payment was available in addition to the PPS payment to the acute care hospital. So hospitals now had 2 potential payments, one for acute care and one for rehab. This was a real inducement for hospital systems to develop inpatient rehabilitation units, and

Medicare recognized these units just as they had free-standing rehabilitation hospitals.”

### THE 75% RULE IN 1983

On September 1, 1983, IRFs got a new rule that would have a major impact on the nature of inpatient rehabilitation—the “75% rule.”<sup>1</sup> This was an interim final rule from the Health Care Financing Administration (HCFA). It appeared in the *Federal Register*, and it came to be known as 48 FR 39752. It listed 8 diagnoses and stated that 75% of our patients had to have those diagnoses. These diagnoses included stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, fracture of the femur (hip fracture), brain injury, and polyarthritis. Medicare said that these 8 diagnoses came partly from a document called Sample Screening Criteria for Review of Admissions to Comprehensive Medical Rehabilitation Hospitals/Units. This document was generated by the Committee on Rehabilitation Criteria for the Professional Standards Review Organization of AAPM&R and American Congress of Rehabilitation Medicine. Medicare officials also consulted with the Joint Commission of Hospitals (now the Joint Commission on Accreditation of Healthcare Organizations), the Commission on the Accreditation of Rehabilitation Facilities, and the American Hospital Association (AHA).

Leon Reinstein, MD, former president of the Academy, stated how the 8 diagnoses came into being: “Well, unfortunately, at that time we weren’t really into evidence-based medicine. As chair of the committee, I basically walked up to a blackboard with a piece of chalk and asked the committee members to help me list the typical patients they were seeing in their rehab centers. And that’s how we came up with those 8 diagnoses.”

Dr. Reinstein also explained additional criteria developed by his committee that have stood the test of time: “One was that the patient had to be medically stable sufficient to tolerate 3 hours per day of physical and/or occupational therapy. The second was that the patient had to have a reasonable expectation of significant functional improvement in a reasonable period of time. Those 2 criteria have stood the test of time fairly well. The big controversy, of course, has been over the 8 diagnoses.”

### POST-PPS GROWTH IN INDEPENDENT REHABILITATION FACILITIES

When IRFs were exempted from the PPS, the field of inpatient rehabilitation for adults took off like a rocket. Acute hospitals began sending their patients to IRFs quicker and sicker. It was relatively easy at that time to convince just about any hospital with empty beds to start a rehabilitation unit. In the decade that followed the PPS exemption, the number of rehabilitation beds in both units and centers doubled. This growth also caused a boom in physical medicine and rehabilitation residency programs, mainly because physiatrists were in demand to be the medical directors of all the new IRFs. Ted Cole,<sup>2</sup> in his Zeiter Lecture of 1992, referred to the decade after the introduction of PPS as the “golden era of rehabilitation.”

### THE 10 DIAGNOSES RULE IN 1984

The first 75% rule we got from HCFA was an interim rule. We got the final rule<sup>3</sup> on January 3, 1984. Medicare had been asked to lower the 75% rule to 60%. The feeling at that time was that we could live with the 8 diagnoses if the rule was relaxed to 60%. HCFA stuck to the 75% rule, but did give us 2 new diagnoses—neurologic disorders and burns. That is how we got the 10 diagnoses that we have been living with since 1984.

Although we had some intense discussions with HCFA about Medicare payment for psychiatric services and other issues in the late 1980s and early 1990s, there were not any

major changes in Medicare funding for IRFs. The 75% rule with the 10 diagnoses continued unchanged.

### THE IMPACT OF THE BALANCED BUDGET AMENDMENT OF 1997

By the early 1990s, the HCFA began showing increasing concern about the rising cost of postacute care (PACs). From 1985 to 1995, the Medicare payments for rehabilitation rose 20% per year, to over \$430 million. There were even higher increases in other areas of PAC: home health care payments increased 24% per year to \$17 billion; skilled nursing facility (SNF) Part A payments increased 33% per year to over \$12 billion; and long-term acute care (LTAC) hospital payments increased 28% per year to \$120 million. IRFs were also complaining because of the unlevel playing field for TEFRA limits for IRF payments. HCFA had created a system that held IRFs in operation before 1982 to a TEFRA limit based on their historical experience in costs. New hospitals and units were able to determine their own TEFRA limits because the TEFRA limit for new IRFs was based mainly on the average cost per patient in the first year of operation. Some of the older IRFs were stuck with TEFRA limits as low as \$6000 per case, whereas some newer IRFs had limits as high as \$40,000.

While HCFA pondered these problems, it came out with another final rule<sup>4</sup> on September 1, 1994. In this rule, HCFA acknowledged that the field had asked again for an update of the diagnoses list that would allow more diagnoses. We wanted oncology, pulmonary, cardiac, and chronic pain cases to be included in the list of diagnoses that counted for the 75% rule. HCFA agreed to think about it. On November 1, 1994, HCFA came out with another final rule, which basically said that HCFA had thought about it, and the answer was still no.

In 1997, Congress enacted a Balanced Budget Amendment (BBA), which attempted to resolve some of the problems in PAC, including runaway growth. In inpatient rehabilitation, the BBA was intended to reduce costs, level the TEFRA playing field, and eliminate the cost-reimbursement payment system. Congress basically ordered HCFA, now called the Centers for Medicare and Medicaid Services (CMS), to put all PAC components under the PPS. CMS began this process by implementing a PPS for nursing homes. It then moved to home care and then to IRFs. The new PPS system for IRFs actually took effect on January 1, 2002.

The reason IRFs had a cost-reimbursement system for so long was that the DRG-PPS model of payment really did not work in acute inpatient rehabilitation. For example, a patient with a relatively mild stroke might require only minimum IRF services and a short length of stay (LOS), whereas a patient having a severe stroke might require a much longer LOS and many more treatment resources. Investigators were trying to work out a PPS system that would work for inpatient rehabilitation. In a personal communication (2004), Carl Granger, MD, related the following to me: "In the background and in anticipation of some form of rehabilitation PPS, Dr. [Margaret] Stineman had been working with the Uniform Data System for Medical Rehabilitation in developing the forerunner of the rehabilitation PPS through creation of the FIM-FRGs [functional related groups]. This was foreseen as the solution to the problem of classifying medical rehabilitation patients for payment, as well as for other quality and care-efficiency studies." He went on to note that Stineman and colleagues had published their landmark paper<sup>5</sup> "A case-mix classification system for medical rehabilitation" in *Medical Care* in 1994.

Dr. Granger also related in personal communication (2004) that: "In the final rule issued in August 2001, the FIM instrument was embedded in the IRF-PAI [inpatient rehabilitation facility-patient assessment instrument] with implementation scheduled for January 1, 2002." He related Stineman's description of "... how

the FIM-FRGs [which were based on LOS] were validated and then converted to a system of classification based on cost developed by Grace Carter at RAND." When CMS decided to embed the FIM-FRG in the IRF-PAI instead of the Minimum Data Set (MDS) for PAC, it saved IRFs considerable time and staffing costs. (It is estimated to take 120 minutes for staff to fill out the 300 item MDS-PAC as compared with about 23 minutes for the FIM).

The BBA caused CMS to replace the old TEFRA limit with a new national rate of payment for inpatient rehabilitation services. There were still 2 issues on which CMS and IRFs disagreed, however. One was the use of the MDS-PAC instead of the FIM, which was mentioned previously. The other issue was whether the PPS should be a per diem system or a per discharge system. It is clear that there are many more government officials at CMS who come from nursing home backgrounds than from IRF backgrounds. This could be why CMS wanted to use the MDS-PAC and the per diem payment system because both are used in nursing homes. However, CMS ultimately agreed to use the FIM and to go with a per discharge payment system in IRFs.

### CONCERNS ABOUT NONCOMPLIANCE WITH THE 75% RULE

About the time the new PPS for IRFs was implemented in January 2002, CMS became concerned that many IRFs might not actually be adhering to the 75% rule. This prompted CMS to do a study, which found that its own fiscal intermediaries were being inconsistent in determining whether IRFs were meeting the 75% rule. CMS learned that some IRFs were not being checked at all. CMS examined its own records of the bills that IRFs turned in to them and calculated that only 13.3% of IRFs actually met the 75% rule. CMS clearly wanted to enforce the 75% rule but was reluctant to demand that all IRFs immediately come into compliance, fearing that some IRFs would be forced to close.

What CMS decided to do was temporarily suspend the 75% rule until it could determine what to do about the problem (the suspension occurred on June 7, 2002). IRFs applauded this move and sought to make the suspension permanent. A lot of lobbying occurred not only from AAPM&R but also from many other rehabilitation-related organizations. AAPM&R presidents during this time were Thomas Strax, MD, and Daniel Dumitru, MD, PhD, and the effort to change the rule continued. AAPM&R was convinced that the concept of using a short list of diagnoses to define the nature of an IRF was simply out of date, especially because the list of diagnoses has been fixed since the early 1980s. The list of 10 diagnoses simply ignored practice changes over a 20-year period, especially in the area of total joint replacement (TJR). "Dear Colleague" letters signed by 75 senators and similar letters signed by 230 Congressmen were sent to Secretary Tommy Thompson and to CMS administrator Richard Scully. These letters basically asked that the suspension be continued until further study could be done by an agency outside of CMS. The letters from the House of Representatives suggested that the outside agency be the Congressional Budget Office, but the letters from the Senate suggested that the agency be the Institute of Medicine (IOM).

On May 16, 2003,<sup>6</sup> we got our answer from CMS, but it was not the one we wanted. In a proposed rule, CMS stated that it would begin enforcing the 75% rule again on October 1, 2003. The rule further stated that there would be no change in the 10 diagnoses and that IRFs should have adequate time to come into compliance. A coalition of rehabilitation organizations, including AAPM&R, submitted strong letters of opposition to this proposed rule. CMS seemed to be paying attention to this and, on September 9, 2003, released another proposed rule in which it expressed a willingness to change the polyarthritis diagnosis into 3 new

**Table 1: IRFs (N=333) Indicate Whether They Can Meet the 75% Rule**

| Year | Rule Phase-In (%) | % of Responders |
|------|-------------------|-----------------|
| 1    | 50                | 78              |
| 2    | 60                | 53              |
| 3    | 65                | 35              |
| 4    | 75                | 21              |

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diagnosis definitions (which would expand the diagnosis list to 12). CMS also suggested that the 75% rule requirement be dropped to 65%. The rehabilitation coalition continued its work to eliminate the 75% rule and to expand its list of diagnoses.

### IMPACT OF THE CMS FINAL RULE OF MAY 5, 2004

On May 5, 2004, CMS came out with its final rule<sup>7</sup> on this subject. In this 44-page document, CMS recanted its offer to permanently lower the 75% rule to 65% and substituted a plan that simply phased in getting back to the 75% rule by July 1, 2007.

The phase-in scheme required IRFs to meet a 50% rule by July 1, 2004; 60% by July 1, 2005; 65% by July 1, 2006; and 75% by July 1, 2007. The 3 new diagnoses that were formed out of the old polyarthritis diagnosis seemed to restrict further the ability of IRFs to admit patients with TJRs. The first of these diagnoses was active, polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies. The second was systemic vasculidities with joint inflammation. The third diagnosis was severe or advanced osteoarthritis involving 3 or more major (weight-bearing) joints with joint deformity and substantial loss of range of motion, atrophy, significant functional impairment of ambulation, and activities of daily living. CMS later changed this requirement of 3 joints to 2 joints. However, these diagnoses would only count toward the 75% rule if the patient had gained no improvement after appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission (IRFs have to be able to show documentation of this). They also stated that the replaced joint no longer counted as an affected joint.

The final rule of May 2004 also rejected our request that new diagnoses be added. The rule specifically rejected the diagnoses of single joint replacement, debility, pulmonary rehabilitation, cardiac rehabilitation, other multiorgan failure that impairs mobility, cancer rehabilitation, and pain. CMS further stated that certain types of TJR patients would count toward the 75% rule. These patients had to have bilateral hip or knee replacements, be morbidly obese (body mass index,  $\geq 50\text{kg/m}^2$ ), or be "frail" as defined by being over 85 years of age. CMS considered these exceptions to be another diagnosis and now claims that there are a total of 13 diagnoses.

Obviously one of our greatest arguments with CMS is over patients with TJR. In the Medicare-eligible age group, these patients range from the relatively young and healthy who can have a single joint replaced and be adequately cared for after discharge with home care or outpatient therapy to those having multiple comorbidities who need inpatient rehabilitation to safely return them to the community. CMS appears to want those patients admitted to subacute nursing homes and to other programs rather than to IRFs. A personal contact of mine from inside the Washington beltway related to me that the people inside CMS feared that, if they dropped the 75% rule and liberalized the rules on

TJRs, everyone now in a nursing home would be eligible for admission to an IRF. Clearly, this fear is unfounded, and appropriate criteria for admission to an IRF do not require that a medical diagnosis be involved. Wouldn't it be strange if the emergency departments had a limited list of diagnoses for admission to the acute hospital?

For those of you not doing inpatient rehabilitation right now, I hope Bonner's dilemma, expressed earlier, is now more clear to you. Currently, we are under the 50% rule, and IRFs around the United States are tracking their compliance literally on a daily basis. Lately, when I try to admit a patient with debility or with a single joint replacement, I might get a response from our admitting office like this: "Sorry, we are at 48% compliance this week, so we aren't taking patients with those diagnoses until our numbers improve." A couple of weeks later when the percentage has improved to 52%, then patients like the 2 I mentioned with debility and single TJR could be admitted.

After this final rule came out, the Rehabilitation Section of the AHA and the American Medical Rehabilitation Providers Association (AMRPA) sent out a survey to IRFs. One question on the survey asked if the IRF could meet the phased in 75% rule. The results of the 333 IRFs who responded to the survey are listed in table 1. Note that only 21% reported that they could meet the 75% rule. Another question on the survey asked IRFs about the types of patients who were the most likely to be denied care. The results are seen in table 2, wherein it is clear that joint replacement patients would be the hardest hit. The survey also asked how the IRFs intended to cope with the 75% rule. Table 3 shows the methods these 333 IRFs plan to use, with 14% stating an intention to close the rehab beds.

Essentially, all of our congressional efforts in regard to the 75% rule have failed. Another "Dear Colleague" letter was sent from the House of Representatives and the Senate to Secretary Thompson, in which we again asked for a suspension of the 75% rule until an independent study of its impact could be done. CMS essentially ignored this letter. CMS also failed to respond to similar directives placed in the Medicare Prescription Drug Act, as well as in the Consolidated Appropriations Act of 2003. Their actions taken together basically amount to this: "We like the 75% rule and we're not changing it."

### THE PROBLEM OF LOCAL COVERAGE DETERMINATIONS

Another problem facing IRFs and physiatrists is that of local coverage determinations (LCDs). The 75% rule battle that we are fighting is about defining the minimum requirements of an IRF from a licensing standpoint. LCDs are aimed not at defining an IRF but determining whether a specific patient meets the criteria

**Table 2: Which Patients Are the Most Likely to Be Refused Services**

| Service Patient Likely to Be Denied Under IRF | Percent |
|-----------------------------------------------|---------|
| Joint replacement                             | 84      |
| Cardiac therapy                               | 71      |
| Pulmonary therapy                             | 71      |
| Other                                         | 47      |
| Transplant                                    | 27      |
| Stroke                                        | 4       |

From: Impact of Inpatient Rehabilitation 75% Rule on Access to Care. Source: AHA/AMRPA IRF survey (333 respondents), June 2004. Reprinted with permission of the American Medical Rehabilitation Providers Association.

**Table 3: How IRFs (N=333) Will Cope**

| Strategy to Meet 75% Rule   | Percent |
|-----------------------------|---------|
| Reduce staff                | 45      |
| Reduce no. of beds          | 38      |
| Cutting back services       | 30      |
| Converting to SNF beds      | 17      |
| Converting to acute care    | 14      |
| Closing rehab unit/hospital | 14      |
| Other                       | 23      |

From: Impact of Inpatient Rehabilitation 75% Rule on Access to Care. Source: AHA/AMRPA IRF survey (333 respondents), June 2004. Reprinted with permission of the American Medical Rehabilitation Providers Association.

for admission. Bruce Gans, MD, current Academy president, described an LCD as follows:

"There are 11 fiscal intermediaries (FIs) around the United States, and these are the folks who are supposed to administer the Medicare program in various regions. They can, but are not required, to develop LCDs dealing with any specific benefit covered by Medicare, including payment for inpatient rehabilitation. LCDs can be written so narrowly that few patients meet the criteria for admission to an IRF. For example, Administar is an FI that has created an LCD that is actually quite consistent with the belief systems and practices within the field. It's not perfect, but it does follow a lot of the standard practices and principles that we have all used over the years. On the other hand, an FI known as Riverbend is led by a medical director who has a different world view about rehabilitation, one foreign to our own. The Riverbend LCD appears to start with the assumption that almost no one on the planet really belongs in an IRF. Unfortunately, several other FIs around the country are following the Riverbend model. We have to fight this battle on the local front, FI by FI. Many here in the audience have been involved in their states in this battle, and have been encouraging that LCDs contain rational rules. All of us have argued against irresponsible rules that would deny patients access to services that we all know are medically necessary."

When asked what the worst case scenario was regarding LCDs, Dr. Gans stated: "There's an additional benefit determination option available to the Medicare program called a National Coverage Determination (NCD). It is possible for CMS to put into place a single national rule, rather than allowing each FI to make up its own LCD. This would be for us a very high stakes gamble with a single roll of the dice. If the NCD turned out well (similar to the Administar model, for example), it would solve our LCD problems with the FIs. However, if it turned out to look like the Riverbend LCD, it would have a major negative impact on the entire field of rehabilitation."

### THE IMPACT OF THE RISING HEALTH CARE COSTS ON FUNDING FOR INPATIENT REHABILITATION

Why is CMS playing hardball with a rigid 75% rule and some unfriendly LCDs? Some of the reasons are the cost of Medicare keeps rising, more Medicare enrollees are coming soon, and the majority of the employees at CMS dealing with rehabilitation are from a nursing home background. Perhaps many of the CMS employees cannot see the real difference between the level of care provided by an IRF as compared with an SNF.

Health care is getting more expensive. In 1997, we were already spending about \$4000 a year per person for health care, which is twice what Germany and Canada spend and 3 times what the United Kingdom spends. The percentage that Americans spend on

health care of all types is now almost 15% of our gross domestic product. Medicare is also getting more expensive. Medicare spending has doubled in the last decade, going from approximately \$100 billion in 1990 to \$200 billion in 2000.

Curiously, despite these increasing health care costs, Americans actually get fewer days of hospitalization than the citizens of other industrialized nations. One of the reasons for this is that administrative costs of medical care in the United States keep going up every year.

An additional and major problem facing Medicare is the coming of the baby boomers. These people were born between 1946 and 1964 and were the children of soldiers who returned from World War II with a pent-up need to have a marriage and a family. The boomers are the largest demographic group in our country, over 78 million strong. They have flattened everything in their path. They overran the grade schools, the high schools, the colleges, and the job market, and now they are going to overrun hospitals, nursing homes, and rehabilitation centers. CMS knows the boomers will start retiring soon, and they are trying to figure out how to pay their Social Security and to fund their Medicare.

We are getting older as a country, a phenomenon called the graying of America. For example, the number of people in the United States age 65 and over has gone from 10 million in 1950 to 40 million in 2000 and will grow to an estimated 80 million by 2050. Politicians have been quiet about this issue because one of the fastest ways to lose any election is to say that you're going to make changes in Social Security and/or Medicare. Alan Greenspan recently suggested to the Congress that we do not have the money to pay for boomer retirees and that the politicians need to do something about it.<sup>8</sup>

The catch-22 in all this for IRFs is that the new final rule of May 2004 might well require us to reduce our capacity for inpatient rehabilitation at a time when the first wave of baby boomers will be coming at us in only 6 years. Why would our nation want to reduce our IRF capacity just when we need to start building it?

### WHAT DO WE REALLY WANT?

What do we do now? What do we really want? We want and need a RATIONAL set of criteria to distinguish us from acute care hospitals. We do not want IRFs to be defined by diagnoses, even by 13 diagnoses. The patients in our rehabilitation hospitals and units have functional problems, and the therapy aspects of our hospital level of care are delivered intensively for a minimum 3 hours a day. Care in an IRF is delivered by a coordinated interdisciplinary team. There is an interdisciplinary team approach that is led by a rehabilitation physician. IRFs have 24-hour rehabilitative nursing care. IRFs can prove that what they do works because we can show by FIM scores and other measures that we can produce functional improvement in our patients. We want IRFs to be defined on the basis of these characteristics rather than by an out-of-date set of diagnoses.

### AMENDMENTS TO SUSPEND THE 75% RULE

Amendments to suspend the 75% rule until an outside agency does a study of how IRFs should be defined are going through both houses of Congress at the time of this lecture. The House version is attached to their fiscal year (FY) 2005 appropriations bill and is being championed by Nita Lowey (D-NY), Frank LoBiondo (R-NJ), and Zach Wamp (R-TN). This amendment would stop the enforcement of the 75% rule until we have a study by the General Accounting Office (GAO). The Senate version is attached to their 2005 appropriations bill and is being championed by a number of senators including Arlen Specter (R-PA). The

Senate bill also calls for a moratorium on the 75% rule until an independent study is done but asks that the independent study be done by IOM. I hope we can get these bills put together and signed into law during the lame duck session of Congress that will happen after the 2004 election.

We really need to get this amendment passed. When the members of AAPM&R need something badly, we always turn to the Health Policy and Legislation Committee (HPL). This group began as the Ad Hoc Committee on Legislation in 1975 and became known as HPL in 1989. The chairs of HPL have been some of the most important names in our field, including Edward Lowman, MD, Leonard Bender, MD, Justus Lehmann, MD, Richard Materson, MD, Bruce Gans, and John Ditunno, MD. The new HPL chair is Kurt Hoppe, MD, of the Mayo Clinic. Kurt will be leading our effort to define IRFs using rational criteria rather than an out-of-date list of diagnoses.

### CONCLUSIONS

Here are some tidbits of advice I would like to share with you. One of them is that I would encourage all of you to develop a PAC continuum back in your communities. If your institution has a PAC continuum (including such components as inpatient, outpatient, home care, subacute, LTAC, and day hospital for rehabilitation services), you are in the best possible position to match a patient's rehabilitation needs with the available reimbursement stream. One of the new roles for the physiatrist in acute rehabilitation is to serve as a "travel agent" in this 21st century PAC continuum. Having an adequate PAC continuum also helps insulate both you and your patients from the changing tides of Medicare funding.

I also think it would be very useful to inform your patients and your local medical consumer groups about this problem because it could restrict their access to rehabilitation services. The patients most likely to be discriminated against for inpatient rehabilitation access include those with arthritis, pulmonary disease, cardiac problems, and pain. I know some of you are reluctant to talk to such groups or to legislators because you fear that you are not completely up to date on what is going on in Washington. The instant cure for that is to call the AAPM&R office. The outstanding staff there can bring you up to date very quickly. If you are going to talk to a local consumer group or to a legislator, they can give you the talking points you need to help us win this battle. The Academy has its finger on the pulse of this and other important political issues. We also have other groups in a coalition of rehabilitation associations who are also very much interested in the 75% rule. These include our allies in AMRPA and in the Rehabilitation Division of the AHA. Their websites contain much helpful up-to-date information.

Another bit of advice is that you keep your political options open. It is essential that we work both sides of the political aisle. If someone comes up to you and says: "I don't like that guy Ted Kennedy. What do you think?" My response would be to ask: "On what issue?" If someone says to you: "I don't like that guy Tom DeLay. What do you think?" My response again would be: "On what issue?" Regardless of your political affiliation, you cannot possibly agree with any legislator on every issue. You might be in disagreement on some issues and in full agreement on others. If you label legislators who are not in your party as bad guys and refuse to work them, you will be penalizing yourself. We need to follow the mature attitude toward legislators exhibited by Frank Bonner. He is a personal friend of Bill Clinton but that does not keep him from working with Representative LoBiondo, the Republican congressman in his district. With Frank's encouragement, LoBiondo has become one of our staunchest supporters on Capitol Hill. That is called working both sides of the aisle. If you

want us to win this battle to help our patients get what they need, we are all going to have to work both sides of the aisle and be good at doing it.

This lecture is a call to action! All of us need to find out who our congressmen and senators are and invite them to our rehabilitation centers and units. Make sure they understand what you do. Make sure your patients relay to them how important inpatient rehabilitation services are in their lives. If we all work together, we can reverse this 75% rule situation that is limiting access to inpatient rehabilitation. We can win this—not only for ourselves, but also for our patients. **We must win this!**

### Postscript

On December 8, 2004, President Bush signed the FY 2005 omnibus spending bill (Public Law No. 108-447), which includes a provision on the 75% rule. The new law's provision on the 75% rule prohibits the secretary of the Department of Health and Human Services (DHHS) from reclassifying any inpatient rehabilitation facility as an inpatient acute care hospital, until the secretary responds to a pending GAO report. Following the release of the GAO report, the DHHS secretary has up to 60 days to determine that either the 75% rule, as created in the May 2004 final rule, is consistent with the GAO findings or the secretary may issue an interim final rule that revises the 75% rule so that it is consistent with the GAO report.

The GAO study, authorized under the Medicare Modernization Act of 2003, asked the GAO to assess whether the current 75% rule is clinically appropriate and, if not, to recommend whether additional conditions should be added to the current 13 rehabilitation categories. The report may be issued to Congress in early 2005.

In November 2004, members of the national 75% rule coalition, including AAPM&R, met with GAO staff to discuss the study and again reiterated our position that GAO should form an outside panel of physicians, clinicians, and practitioners from the medical rehabilitation field to assist with providing crucial information and data necessary for a credible study.

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### References

- Centers for Medicare and Medicaid Services. Medicare Program; prospective payments for Medicare inpatient hospital services. 48 Federal Register 39752 (1983).
- Cole T. The 25th Walter J. Zeiter Lecture. The greening of physiatry in the golden era of rehabilitation. *Arch Phys Med Rehabil* 1993;74:231-7.
- Centers for Medicare and Medicaid Services. Medicare Program; prospective payment for Medicare inpatient hospital services. 49 Federal Register 234 (1984).
- Centers for Medicare and Medicaid Services. Medicare program; changes to hospital inpatient prospective payment systems and fiscal year 1995 rates. 57 Federal Register 45330 (1994).
- Stineman M, Escarce J, Goin J, et al. A case-mix classification system for medical rehabilitation. *Med Care* 1994;32:366-78.
- Centers for Medicare and Medicaid Services. Medicare program; changes to the inpatient rehabilitation facility prospective payment system and fiscal year 2004 rates. 68 Federal Register 26786 (2003).
- Centers for Medicare and Medicaid Services. Final rule: Medicare program; changes to the criteria for being classified as an inpatient rehabilitation facility. 69 Federal Register 25752 (2004).
- Crutsinger M. Greenspan urges retiree benefit cuts. *Associated Press* 2004 Aug 28.