

News Currents

In Brief

CMS Gives 75 Percent Rule The Go Ahead

GAO Study Tips The Balance

The Centers for Medicare & Medicaid Services (CMS) has announced it will begin enforcing a Medicare regulation—commonly known as the 75 percent rule—that ensures that patients are cared for in the proper setting.

CMS decided to apply the revised rule after it found that a congressionally mandated Government Accountability Office (GAO) study reaffirmed its position that expanded medical condition criteria for inpatient rehabilitation facilities (IRFs) were necessary.

The American Health Care Association (AHCA) has indicated its support for reimplementing of the 75 percent rule, maintaining that patients who don't require intensive rehabilitation can have services delivered by less expensive entities such as skilled nursing facilities (SNFs) or home health agencies. Implementation of the 75 percent rule would save \$370 million in Medicare payments, according to AHCA, which noted that Medicare pays \$820 per day to IRFs for rehabilitation services that can be delivered for \$320 per day by SNFs.

IRFs can qualify for the higher Medicare payment if they can prove that at least 75 percent of their Medicare patients required intensive rehabilitation during the prior year. GAO, however, found that only 6 percent of the IRFs in 2003 qualified for the higher Medicare payments. In

2003, Medicare paid an estimated \$5.7 billion for the care of more than 500,000 patients in IRFs.

Up until now, opponents of the revised 75 percent rule—originally issued in May 2004—have been successful in delaying its implementation. Congress inserted a provision in the Consolidated Appropriations Act of 2005 that required CMS to suspend implementation of the revised rule until 60 days after the completion of the



McClellan

GAO study. The act also required CMS to determine if its rule contradicted GAO's findings. CMS found its rule was consistent with the study.

"CMS is committed to ensuring that Medicare beneficiaries receive the care they need in the most appropriate setting, and we are supporting a full range of care settings based on patient needs," says CMS Administrator Mark McClellan. "The criteria we adopted in 2004 for the first time takes into account not just the patient's diagnosis, but, in knee or hip joint replacement cases, also considers other patient characteristics such as advanced age and obesity."

The rule contains a four-year transition period that requires the percentage of patients with a qualifying condition to increase gradually from 50 percent to 75 percent. The revised rule expanded those medical criteria to include patients with stroke, spinal cord injury, congenital deformity,

amputation, major multiple trauma, fractures of the femur, brain injury, neurological disorders, burns, and three types of arthritis.

Responding to GAO's recommendation to add functional status to the patient criteria, CMS says it intends to conduct further research. The agency noted that its medical necessity review has the potential to offer improved methods for classifying IRF patients, and it may use the research to further define subgroups of patients. But CMS is concerned that this could result in more stringent criteria than those set out in the May 7 rule. Thus, CMS says, it prefers the gradual implementation of the threshold.

—Lisa Gelhaus

Vermont Sets Medicaid Precedent

Waiver Program Elevates Status Of Community Care

Vermonters eligible for skilled nursing facility (SNF) services under Medicaid may opt to receive services in their home or in community-based settings under a groundbreaking waiver program.

The Centers for Medicare & Medicaid Services (CMS) recently approved Vermont's Section 1115 waiver application, which establishes home- and community-based services (HCBS) as an entitlement equal to skilled nursing care, while reconfiguring SNF eligibility. The waiver also institutes a state-run patient-assessment program to control admission to SNFs and sets a budget for spending.

The waiver will cover 4,500 Medicaid recipients age 65 and over, as well as adults with physical disabilities. All of Vermont's current SNF patients are eligible, according to conditions of the waiver.

Under the waiver, Vermont has agreed to cap the number of beneficiaries and its Medicaid expenditure growth rate at 7.28 percent per year over the five-year duration.

CMS says Vermont's innovative waiver plan holds the promise of reducing Medicaid's "institutional bias that other states could follow" and incorporates the "money-follows-the-person" concept. CMS will be evaluating the results of this waiver program for future application in other states.

"We are using the approach that has been proven most effective in getting needed support services to more people with disabilities at the lowest cost by allowing the money to follow the beneficiary's own preferences," says CMS Administrator Mark McClellan.

"This program will provide important evidence on how to end the institutional bias in Medicaid and allow

people to live in the community when they prefer to do so—without increasing Medicaid costs."

Both the American Health Care Association (AHCA) and the Vermont Health Care Association (VHCA), however, have expressed concerns that the future impact of the waiver program could force some facility closures in the state, while ensuring that the sicker, frailer beneficiaries who do enter SNFs will require higher levels of services at a higher cost.

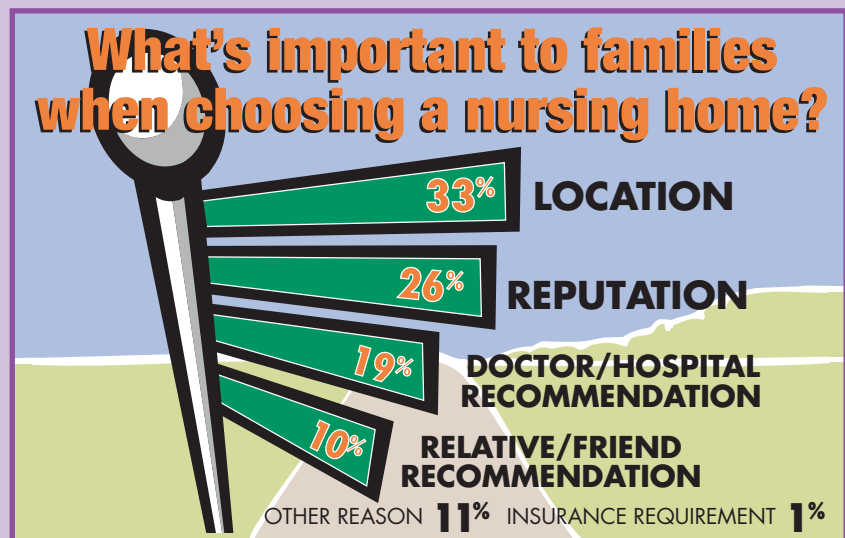
"Even with the dramatic limit to growth, there appears to be an expectation that everyone's needs would be met and that money will be saved because home-based care services are supposedly less expensive," says Janice Zalen, AHCA's senior director of special programs.

AHCA supports allowing beneficiaries to choose their own care settings, Zalen says, as long as the setting is medically appropriate. "We're concerned that those people who would normally be eligible for SNF care will be left out if the state runs out of money," she says.

AHCA and VHCA estimate that some 2,100 Medicaid patients currently in SNFs would be eligible for HCBS under the Vermont waiver. The state will employ a new assessment program to classify long term care beneficiaries into three groups, depending on their level of need. Individuals being assessed as belonging to the "highest needs group" would be given the choice of entering a SNF or receiving HCBS.

The remaining categories of beneficiaries—the "high needs" and "moderate needs" groups—will benefit from earlier and more cost-effective services, according to Vermont's waiver application. The theory is that services such

By The Numbers



Source: Family satisfaction surveys conducted in 2004 in 26 states by My InnerView Inc.™ (www.myinnerview.com)

as a weekly visit from a paid homemaker or a case manager will ultimately stabilize a patient's condition, thereby resulting in postponing admission to a higher level of care, according to the Vermont proposal submitted to CMS on Oct. 1, 2003.

Vermont anticipates cost savings because state officials believe that most future beneficiaries will choose to remain at home, thereby saving the state money on SNF-provided care. Vermont's Commissioner of Aging

Patrick Flood told the Barre *Times Argus* that home care costs \$28,000 per patient year, while SNF care would cost \$54,000. Currently, 1,200 people receive Medicaid-covered care and, under the waiver, the 100 people on a waiting list would get assistance. Vermont's Department of Aging and Disabilities will oversee the development of care plans and expenditures for individuals, according to the waiver plan, a concept conceived as a managed care component of the program.

In addition, the waiver states that Vermont will launch a public information campaign about long term care resources and programs. State officials will educate individuals and families about the state's community-based options.

The state also promised to encourage personal responsibility for long term care costs by developing incentives to encourage individuals to purchase long term care insurance.

—Lisa Gelhaus