Overview of Rehabilitation Legislative Issues and Rehabilitation Nursing

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WHAT IS THE ROLE OF REHABILITATION NURSING WITHIN THE REGULATORY ENVIRONMENT?

- The history of legislation and the role of rehabilitation nursing
- The regulatory environment in which we live
- The economics of healthcare
“Rehab” began long ago…….

From ancient to modern times, humans have adapted & coped with disability

- from Hippocrates in 400-300 BC,
- to 1854 when Florence Nightingale organized professional nursing and
- to now, with ongoing advances in science that increase potential for survival & physical restoration

Rehab is an important and essential part of the process
1854: Florence Nightingale organized professional nursing in England

Late 19th Century: Advances in science increase potential for survival & physical restoration

1889: 1st US schools for crippled children established

1919: Identified need for licensure & definition of specialty of rehabilitation

1935 Social Security Acts established permanent authorization for vocational rehab & series of federally-funded programs (i.e. Unemployment Compensation, Child Welfare Services)

World War II: Dr Howard Rusk demonstrated positive impact of rehab on veterans hospitalized since WWI; established 1st rehab services in US civilian hospital in 1947

1943 Vocational Rehab Act: Made funds available for education & training of disabled

1951: Alice Morrissey wrote 1st textbook: Rehabilitation Nursing

“Each sick person regarded not as patient with disease but as person with future”

1962 Medicare legislation stimulated increased demand for rehabilitation services
Timeline of Rehab

- **1965:** Workman’s Compensation and Rehabilitation Law: placed emphasis on workplace

- **1966:** Commission on Accreditation of Acute Rehabilitation Facilities (CARF): established as consultative accrediting process

- **1973:** Rehabilitation Act of 1973 increased public awareness of needs of disabled; prohibits discrimination on basis of disability in programs run by federal agencies; promoted eliminating physical barriers.

- **1974:** ARN established

- **1976 ARN:** recognized as specialty organization & published standards

- **1975 The Education for All Handicapped Children Act:** required states to provide educational services free of cost to any school aged child

- **1984 CRRN credential established**
Americans with Disability Act (ADA): 1990

○ **1990 Americans with Disability Act (Landmark Legislation)**

○ Comprehensive civil rights legislation that prohibits discrimination and guarantees that people with disabilities have the same opportunities as everyone else to participate in the mainstream of American life -- to enjoy employment opportunities, to purchase goods and services, and to participate in State and local government programs and services.

○ Modeled after the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color, religion, sex, or national origin – and Section 504 of the Rehabilitation Act of 1973

○ Is an "equal opportunity" law for people with disabilities.

○ To be protected by the ADA, one must have a disability, which is defined by the ADA as a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment. The ADA does not specifically name all of the impairments that are covered.

http://www.ada.gov/ada_intro.htm
The Patient Protection and Affordable Care Act: 2010

- Requires every American to have Health Insurance Coverage or pay a penalty
- Ends Pre-Existing Condition Exclusions for Children: Health plans can no longer limit or deny benefits to children under 19 due to a pre-existing condition.
- Keeps Young Adults Covered: If you are under 26, you may be eligible to be covered under your parent’s health plan.
- Ends Arbitrary Withdrawals of Insurance Coverage: Insurers can no longer cancel your coverage just because you made an honest mistake.
- Guarantees Your Right to Appeal: You now have the right to ask that your plan reconsider its denial of payment.
- Costs
  - Ends Lifetime Limits on Coverage: Lifetime limits on most benefits are banned for all new health insurance plans.
  - Reviews Premium Increases: Insurance companies must now publicly justify any unreasonable rate hikes.
  - Helps You Get the Most from Your Premium Dollars: Your premium dollars must be spent primarily on health care – not administrative costs.
- Care
  - Covers Preventive Care at No Cost to You: You may be eligible for recommended preventive health services. No copayment.
  - Protects Your Choice of Doctors: Choose the primary care doctor you want from your plan’s network.
  - Removes Insurance Company Barriers to Emergency Services: You can seek emergency care at a hospital outside of your health plan’s network.

http://www.hhs.gov/healthcare/rights/
**REGULATIONS THAT GOVERN ACUTE REHABILITATION TODAY**

-- Acute Rehabilitation Units/Hospitals are licensed
  - 75%/60% rule
  - 3 hour rule
  - 24-7 Specialized Rehab Nursing

-- Patient must meet “medical necessity” criteria (can’t be treated at lower level of care)

-- Prospective Payment System (PPS) (Medicare)
  -- Predetermined payment rate regardless of cost for care for specific patient
The 75%/60% Rule in a Nutshell

Established in 1983 to differentiate inpatient rehab facilities (IRF) from acute hospitals

Rule requires certain percentage of IRF patients fall in 13 categories:

- 1. Spinal Cord Injury
- 2. Neurological Conditions
- 3. Polyarthritis/Rheumatoid Arthritis
- 4. Amputation
- 5. Stroke
- 6. Brain Injury
- 7. Fractured Hip
- 8. Multiple Trauma
- 9. Burns
- 10. Multiple Fractures
- 11. Congenital Deformities
- 12. Total Joint Replacement with at least one of 3 conditions:
  - Bilateral knee or bilateral hip joint replacement at the same time
  - Obese patients with a BMI of at least 50
  - Total joint replacement patients who are at least 85 years of age
- 13. Other diagnoses with one of the previous diagnoses as a co-morbidity that complicates the rehabilitation process substantially
**Post Acute Care Funding from Medicare—PPS**

- Began in 2002 in response to Balanced Budget Act of 1997; payment system uses IRF-PAI (Inpatient Rehabilitation Facility Patient Assessment Instrument)

- Functional Independence Measure (FIM) is part of this instrument

- Centers for Medicare and Medicaid Services (CMS) require IRF-PAI

- Acute rehabilitation is one venue of post acute care with special method of funding
  - SNF = Minimum Data Set (MDS)
  - Home Care = Outcome and Assessment Information Set (OASIS)
IMPORTANCE OF FIM

- Scoring MUST be accurate
  - LOWEST score is recorded (aka Greatest burden of care)

- Documentation in daily notes MUST reflect the scores that are written

- The scores drive payment for CMS
  - Compliance issue!
  - Evaluation over 3 calendar day window on admission and discharge, including the day of admission and the day of discharge
  - Critical competency
Case Mix Group (CMG): LOS based on this

- FIM
- Impairment Group Code (IGC)
  - Ex: Stroke, BI
- ICD-10 (Admitting Diagnosis)
- Comorbidies
FIM

- 18 items—13= motor, 5= cognitive
- Score of 1-7 indicating amount of assistance needed:
  - 7= independent
  - 6= modified independent
  - 5= supervision or set up
  - 4= minimal assistance (contact guard)
  - 3= moderate assistance
  - 2= maximal assistance
  - 1= total assistance
The Economics of Health Care

Funding continues to have a significant impact on access and utilization of services.

- Medicare: A federally funded program for US citizens over the age of 65 or those with end stage renal disease or who have been disabled for 2 years
Part A

Part A: Hospital Insurance that covers:

- Inpatient
  - acute care
  - including rehab
  - skilled nursing
  - home health
  - hospice care

No monthly premium but responsible for a deductible and coinsurance of extended stays
Part B

Part B: Supplementary Medical Insurance program, that covers:

- Physician
- Outpatient services
- Home health
- Preventative services
- Medical equipment
- Supplies

Financed by Supplementary Medical Insurance Trust Fund by federal taxes and monthly premiums from beneficiaries
Part C

Part C: Private Plans

- Plans include preferred provider organizations (PPOs), provider-sponsored organizations, private fee-for-service plans, high-deductible plans linked to medical savings accounts and special needs program for people who are dually eligible for Medicare and Medicaid.
- Provides hospital and physician coverage and often includes prescription drug coverage (alternate to Parts A, B and D)
- NOT separately financed from Parts A, B and D
- Medicare Advantage enrollees generally pay the monthly Part B premium and often pay an additional premium directly to their plan
Part D: Prescription Plan

- Outpatient prescription coverage offered through private companies
- Coverage varies depending on the plan costs
- Financed through taxes, beneficiary premiums, state payments for people with both Medicare and Medicaid coverage
SUPPLEMENTAL “GAP” COVERAGE

Medicare beneficiaries in the original plan may buy private Medicare supplemental insurance to cover the costs not covered:

- Deductibles
- Coinsurance
- Vision
- Dental
CAPPED MEDICARE PART B PAYMENTS

- Rehab therapy for post acute delivery has an annual financial cap
- Combined outpatient PT and speech therapy share the same cap
- OT also has an annual cap
- Treatment MUST be medically necessary
- % of the Medicare-approved amount is the client’s responsibility
- Medicare-certified beds in a skilled nursing facility have the same cap amounts
**Medicare Set-Asides (MSA)**

- Regulated by CMS
- A fund to protect Medicare’s interests in workers’ compensation case settlements and in personal injury cases for people on Medicare or expected to enroll in Medicare within 30 months of settlement.
- The MSA allocates a portion of the settlement for future medical expenses related to the injury that would otherwise be funded by Medicare.
MEDICAID

- Health insurance program for certain individuals and families with low income and resources
- Began with enactment of Title XIX of the SS Act of 1965 to provide medical assistance to people and families receiving cash assistance (welfare)
- Expanded to cover health and long-term care services for specific categories of low-income people and to expand in 2014 to include the majority of people younger than 65 years with income up to 133% of the poverty level
MEDICAID CONTINUED

- Managed by each state through a state agency with oversight from CMS
- Financed by a federal-state partnership in which the federal government matches state Medicaid spending
- Covered services may vary by state
- Eligibility
  - Qualify if they meet the financial criteria and belong to one of the groups that are “categorically” eligible for the program
  - American citizens and certain lawfully residing immigrants
  - Mandatory groups include:
    - Limited-income families with children who meet certain eligibility requirements
    - Most adults and people with disabilities who receive Supplemental Security Income
    - Children under 6 & pregnant women whose family is at or below 133% of poverty level
    - Children ages 6-18 living below 100% of the federal poverty level
MEDICAID ELIGIBILITY CONTINUED

Under the Patient Protection and Affordable Care Act of 2010:

- Most people younger than 65 with income below a national “floor” will be eligible for Medicaid
  - Limited to American citizens and
  - Certain lawfully residing immigrants
MEDICAID ELIGIBILITY CONTINUED

- States have the option to provide coverage for other “categorically needy” groups:
  - Pregnant women, children and parents with income exceeding mandatory thresholds
  - Older adults and people who are disabled earning up to 100% of the federal poverty level
  - Working disabled people earning up to 250% of the federal poverty level
  - People residing in nursing facilities with income below 300% of the SSI standard
  - People who would be eligible if institutionalized but are receiving care under home and community based service waivers
  - “Medically needy” people who cannot meet the financial criteria but have high medical expenses related to their income and who belong to one of the categorically eligible groups
STATE CHILDREN’S HEALTH INSURANCE PLAN

- Health insurance plan for children in families with incomes too high to qualify for Medicaid but too low to afford private health insurance
  - Jointly financed by state and federal government
    - States are given broad flexibility in tailoring program to meet their own circumstances
  - States can create or expand their own separate insurance programs, expand Medicaid or combine both
  - State have the opportunity to set eligibility criteria for age, income, resources and residency within broad federal guidelines
WORKERS’ COMPENSATION

- Government-sponsored and employee-financed systems for compensating employees who incur an injury or illness in connection with their employment

- Benefits provided include
  - Medical care
  - Disability payments
  - Rehabilitation services
  - Vocational Rehab
  - Survivor benefits
  - Funeral expenses
WORKERS’ COMPENSATION COVERAGE

- Provides both medical care related to the compensable injury and income benefits through the following sources:
  - Private commercial insurance companies
  - Self-insurance
    - (corporations that are able to carry the risk)
  - State funds
  - State’s secondary injury fund
PRIVATE HEALTH INSURANCE

- Employers and other organizations may purchase private health insurance on behalf of a group or individual.
  - Purchasing groups often negotiate coverage so benefits vary by group
  - Members contribute to the insurance premium
- Individuals may purchase private health insurance and pay the full premium
- Under the Affordable Care Act, health insurance is now required
**Types of Health Insurance and Service Plans**

- **Indemnity Plans** provide comprehensive coverage for medical and hospital services
  - The employer or subscriber pays a premium and the subscriber agrees to pay any required deductible, copayments and amounts over the usual and customary rate for specific services
  - The subscriber may receive services from physicians, hospitals or other qualified providers of choice for services that are medically necessary and meet accepted standards of medical practice
Types of health insurance and service plans

- Managed care plans provide an identified set of medical or hospital care services for a fixed, predetermined premium
  - MCO may restrict choice of providers and control subscriber access
  - Subscribers choose or are assigned to a PCP who is employed or under contract with the MCO. The PCP acts as a gatekeeper
ACOs

- **Accountable Care Organizations (ACOs)** are groups of doctors, hospitals, and other healthcare providers, who come together voluntarily to give coordinated high quality care to their Medicare patients.

- The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

- When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, it will **share in the savings** it achieves for the Medicare program.

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/aco
BUNDLING

- A single, "bundled" payment covers services delivered by two or more providers during a single episode of care or over a specific period of time.

- For example, if a patient has cardiac bypass surgery, rather than making one payment to the hospital, a second payment to the surgeon and a third payment to the anesthesiologist, the payer would combine these payments for the specific episode of care (i.e., cardiac bypass surgery).

PROS AND CONS OF ACOS AND BUNDLING

Pros:
- Hospitals take greater ownership for expenses and are incentivized to deliver cost effective care
- Potential for better communication exists between providers in the same ACO
- Bundled payment saves Medicare dollars

Cons:
- Hospitals may overly scrutinize care beyond standard level of care for a given diagnosis
- Providers outside of the ACO may not receive referrals as they previously have
- Profit margins decrease for hospitals
- Hospitals that participate in bundling are responsible for provider expenses outside of their organization
ROLE RESPONSIBILITIES OF REHAB NURSES

1. Provider of Care
   -- Caregiver
   -- Client Advocate
   -- Client Educator
   -- Counselor
   -- Nurse Practitioner
   -- Expert Witness
   -- Researcher
ROLE RESPONSIBILITIES OF REHAB NURSES

2. Designer, Manager and Coordinator of Care Skills
   -- Communication
   -- Collaboration
   -- Negotiation
   -- Delegation
   -- Coordination
   -- Evaluation of Interdisciplinary Work
   -- Team Leaders and Members
ROLE RESPONSIBILITIES OF REHAB NURSES

3. Member of a Profession
   -- Lifelong Learning
   -- Identify with Profession’s Values
   -- Incorporate Professionalism into Practice
   -- Client Advocacy
   -- Shape Public Policy
   -- Educate Public in Disease & Trauma Prevention
ROLE OF REHABILITATION NURSING IN HISTORICAL DEVELOPMENT OF LEGISLATION

- Advocacy
- Intermediary between legislators and reality of disability
- Organizational power of the ARN
- Credentials for the specialty
- Partnering with other advocacy groups to protect rights of disabled to care
From the Patient’s Perspective

- Advocacy is critical to moving both legislative and regulatory processes
- Rehabilitation is a very small part of the healthcare pie
- The philosophical goals are
  - Back to work/school
  - Reduced lifetime costs
  - Functional recovery is good for the patient and good for society
- Rehab nurses are a trusted and valued voice in the ongoing dialogue to do what is best for our patients
Which piece of legislation is believed to be the most far-reaching civil rights law ever enacted?

A) Rehabilitation Act of 1973

B) Surface Transportation Act

C) Americans with Disabilities Act

D) Individuals with Disabilities Education Act
The Americans with Disabilities Act is a landmark piece of legislation providing all Americans with disabilities equal opportunity and access in employment and services to that offered to the general public. The Rehabilitation Act of 1973 and subsequent amendments impacted both social and health-related areas of life. The Surface Transportation Act provided tax incentives for the removal of barriers and the Individuals with Disabilities Education Act established education as a right for all children 5 to 17 years.
Medicare Part A covers which of the following?

1. Inpatient hospital services
2. Skilled nursing facilities
3. Physician fees
4. Hospice care

a. 1 & 4
b. 1, 2 & 4
c. All of the above
B. Medicare Part A covers inpatient hospital care, skilled nursing facilities, home health and hospice care. Physician fees are covered under Medicare Part B.
WHAT FIM SCORE IS GIVEN IF A PATIENT WITH A TOTAL HIP REPLACEMENT IS ABLE TO TRANSFER ONTO A RAISED TOILET USING HER WALKER?

A. 5
B. 4
C. 6
D. 7
C. FIM score 6 is modified independent.
Which person under the age of 65, is eligible for Medicare Part A coverage without collecting Social Security disability benefits for 2 years?

A. Those with chronic renal disease requiring dialysis or transplant
B. A person injured on the job who has only worked 1 year
C.Infants with disability born to mothers receiving Medicaid
D. Those who have served in the military
A. Those with chronic renal disease requiring dialysis or transplant.
“A well-informed, articulate, passionate rehabilitation nurse can be a valued resource to elected officials and their staff, can raise issues of importance, and can help craft and implement necessary solutions”