American Hospital Association®

Reject Proposals to Equalize Payments for Inpatient Rehabilitation Hospitals and Units and Skilled Nursing Facilities for Certain Services

AHA View

Some in Congress are discussing the possibility of equalizing the rates paid to inpatient rehabilitation facilities (IRFs) and skilled nursing facilities (SNFs) for Medicare patients with selected conditions in order to reduce costs to the program. This misguided proposal would limit access to care for Medicare beneficiaries who have medical needs that can be met only in IRFs. Medicare cannot require IRFs to provide this hospital-level care but pay them SNF rates.

Background

IRFs provide unique clinical value for patients who require hospital-level care and intensive rehabilitation after an illness, injury or surgery. They have faced significant scrutiny from Congress and the Centers for Medicare & Medicaid Services (CMS) in recent years that has led to the application of strict criteria for the types of patients IRFs may treat, multiple payment cuts and other policy restrictions. Collectively, these policy changes have reshaped the population treated in IRFs by dramatically reducing the overall volume and steadily increasing the medical complexity of IRF patients.

The AHA has expressed serious concerns with a Medicare Payment Advisory Commission (MedPAC) proposal to reduce IRF payments to SNF levels for patients with selected conditions. The MedPAC approach lacks a structure to identify and differentiate the types of patients who need IRF rather than SNF care due to their clinical condition. To proceed with this approach would put at risk the Medicare beneficiaries who need IRF services.

IRFs provide a unique clinical setting for patients who need inpatient rehabilitation services. The chart below outlines the fundamental differences between IRFs' hospital-level care and SNF care:

IRFs vs. SNFs

Required by Medicare	IRFs	SNFs
Close medical supervision by a physician with specialized training	Yes	No
24-hour rehabilitation nursing	Yes	No
Multidisciplinary team approach	Yes	No
3 hours of intensive therapy; 5 days per week	Yes	No
Patients must require hospital-level care	Yes	No
Physician approval of preadmission screen and admission	Yes	No
Medical care and therapy provided by a physician-led multidisciplinary medical team including specialty trained registered nurses	Yes	No
Discharge rate to community	70%	33%
2013 Medicare fee-for-service spending	$6.8 billion	$26.6 billion

Data source: Medicare Payment Advisory Commission.

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Key Facts

- **IRFs Fill a Distinct Role.** IRFs treat a highly targeted group of patients who need both hospital-level treatment and intensive therapy. Relatively few Medicare beneficiaries meet these stringent criteria. The hallmark of IRF care is the combination of hospital-level care provided by a physician-led medical team, plus three hours of rehabilitation per day – a clinical focus not provided in any other setting.

- **IRFs Provide Better Quality.** Not only do IRFs provide a distinct service, they produce strong outcomes. MedPAC reported that, in 2013 (the latest year for which data are available), IRFs had a far higher rate of discharging patients to the community than SNFs (IRFs: 70 percent; SNFs: 33 percent). IRFs also had a far better record on avoidable rehospitalizations. MedPAC reported that, in 2013, 2.5 percent of patients were readmitted during an IRF stay, while 11.1 percent of SNF patients were readmitted during their stay.

- **IRFs Serve a Targeted Population.** IRF patients must meet very detailed admission criteria, which are among the most specific criteria required by Medicare. Through a series of policy decisions that substantially tightened these criteria, Congress and CMS have significantly decreased the number of Medicare patients treated in IRFs, with 122,000 fewer IRF patients discharged in 2013 compared to their peak in 2004. IRF admissions are expected to decrease further in fall 2015 when CMS reduces the condition codes that can qualify under the "60% Rule."

- **The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 Will Bring Systemic Change to All Post-acute Settings, Including IRFs.** The IMPACT Act requires all post-acute settings, including IRFs, to conduct standardized patient assessments and report consistent quality and resource use measures. These data will inform future post-acute payment reform efforts over the next three years, beginning in 2016. The law also will yield a model for a post-acute payment system that pays for all post-acute services based on patient characteristics.