American Hospital Association

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Glenn M. Hackbarth, J.D.
64275 Hunnell Road
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Dear Mr. Hackbarth:

On behalf of the American Hospital Association's (AHA) nearly 5,000 member hospitals, health systems and other health care organizations, including approximately 1,200 inpatient rehabilitation facilities (IRFs) and 850 hospital-based skilled nursing facilities (SNFs), I write to respond to the Medicare Payment Advisory Commission's (MedPAC) March 6 presentation on site-neutral payment for IRFs and SNFs. During this presentation, MedPAC discussed potential "site-neutral payment" approaches to reduce IRF rates to "SNF-like" levels for patients discharged from a general acute care hospital with one of three conditions (stroke, major joint replacement, hip and femur fracture) who are clinically similar and commonly receive post-acute services in both IRFs and SNFs.

Paying for care in the IRF and SNF settings in a truly site-neutral manner is extremely complex and may be difficult to achieve. Nonetheless, the AHA supports the cautious exploration of a site-neutral payment policy that applies exclusively to patients who are clinically similar and can safely be treated in either setting. However, as outlined below, we are concerned that MedPAC has not targeted appropriate patients and urge the commission to refine its approach. As also outlined below, it is imperative that for services subject to IRF-SNF site-neutral payments, IRFs should face a level playing field with respect to regulatory requirements; that is, for services subject to site-neutral payments, the Medicare regulations requiring IRFs to provide hospital-level care must be removed.

SITE-NEUTRAL POLICY MUST TARGET CLINICALLY SIMILAR PATIENTS

When designing an IRF-SNF site-neutral payment policy, it is critical to ensure that the policy targets clinically similar patients. As discussed by MedPAC commissioners, achieving such an apples-to-apples comparison can be difficult due to the incompatible IRF and SNF patient classification systems. However, we have several suggestions that we believe would help ensure that MedPAC's policy targets clinically similar patients.

First, when comparing the mix of patients treated in more than one post-acute setting, MedPAC should use the most recent data available to ensure that any resulting policy recommendations reflect current post-acute referral and utilization patterns. The mix of IRF and SNF patients continues to shift due to changes in payment and coverage policies, yet MedPAC data charts from the March presentation used 2011 data rather than the most recent data available. Furthermore, both the presentation and the subsequent discussion cited the Centers for Medicare & Medicaid Services' (CMS) 2011 final report to Congress on the post-acute care payment reform demonstration, which is largely based on data collected from 2008 through 2010. We encourage MedPAC to update its analyses using 2012 data, and again with 2013 data when they become available this fall.

In addition, the AHA urges MedPAC to further refine its analysis to avoid solely relying on the prior acute care hospital discharge diagnosis to find similar IRF and SNF patients. The March presentation compared IRF and SNF data based on patients' discharge diagnosis from the prior stay in a general acute care hospital. However, relying solely on discharge diagnosis to classify patients for the purpose of comparing clinical characteristics has widely recognized limitations because a patient's prior hospital diagnosis is often unrelated to the patient's post-acute diagnosis, which addresses a different recuperative stage in the episode of care. For example, MedPAC estimated that 25 percent of IRF cases have one of the three targeted conditions based on IRF claims data, but these conditions represent only 0.8 percent of IRF patients when grouped by the discharge diagnosis from their prior hospital stay. Furthermore, diagnosis alone – whether a diagnosis from the prior hospital stay or a post-acute discharge – does not reflect functional status, which is critical to post-acute placement decisions. For example, an alternative approach that makes an apples-to-apples-comparison across post-acute settings is the Uniform Data System for Medical Rehabilitation (UDSMR)[1] two-year stroke study that compares IRF and SNF outcomes. To identify comparable stroke patients, the study selects similar patients based on their prior hospital diagnosis *paired with* data from a functional assessment by the discharging hospital that includes physical and cognitive items, and SNF and IRF outcomes data. The compilation of these data elements is needed to achieve a meaningful apples-to-apples comparison of similar IRF and SNF patients.

We also urge MedPAC to incorporate robust risk adjustment into any discussion of IRF-SNF site-neutral payment policy. Comprehensive risk adjustment will be the critical element of a site-neutral payment policy. For example, the March presentation of 30-day readmission rates for IRFs and SNFs for the three targeted conditions should have been risk adjusted.

In addition, as discussed by MedPAC commissioners, we encourage further comparative research on IRF and SNF readmission rates using multiple episode lengths, including 60- and 90-day episodes, to ensure that the longer SNF average

[1] UDSMR is an independent repository of IRF patient assessment data and rehabilitation outcomes.

lengths of stay are captured. Per MedPAC[2], one-third of SNF stays exceed 30 days in length. Readmissions patterns for this material portion of SNF stays are not included in MedPAC's 30-day readmissions data, which can be corrected by adding readmissions analyses for longer episodes.

SITE-NEUTRAL PAYMENTS SHOULD NOT APPLY TO 60% RULE COMPLIANT CASES

We urge MedPAC to apply IRF-SNF site-neutral payment policy development efforts only to conditions that fall outside of the "60% Rule" and that are also frequently treated in SNFs, such as lower-acuity joint replacement cases.[3] MedPAC should not consider IRF-SNF site-neutral payment policies in isolation from the IRF 60% Rule. Rather, MedPAC should factor in the intent of the 60% Rule when selecting cases to consider for site-neutral treatment. Through the 60% Rule, Congress and CMS have directed IRFs to concentrate their services on 13 clinical conditions. As such, it would be incongruous to reimburse cases with 60% Rule qualifying conditions – such as stroke cases – with SNF-level payments.

MedPAC estimated that industry-wide, in 2013, 60.8 percent[4] of IRF prospective payment system cases had a qualifying condition. Yet, compliance with the 60% Rule – a facility requirement that each IRF must meet to maintain the IRF payment classification – will become more difficult in 2014. Specifically, in October 2014, new CMS guidance will take effect that reduces by 20 percent the number of ICD-9-CM codes that qualify toward 60% Rule compliance. Applying CMS's narrower set of qualifying codes to UDSMR's fiscal year 2013 IRF patient assessment data[5] indicates that IRF facility compliance with the 60% Rule presumptive test[6] would drop by 15 to 20 percent (prior to accounting for behavior change by the field). **The uncertainty about the ramifications of the narrower set of 60% Rule qualifying codes and the concurrent transition to ICD-10 codes, provide further reasons why MedPAC should not add more complexity by proposing to co-mingle the site-neutral payment policy concept with the 60% Rule.**

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[2] MedPAC's March 2012 report to Congress, (page. 197).

[3] Only joint replacement cases meeting the following criteria are compliant with the 60% Rule: Patients with a knee or hip-joint replacement, or both, during an acute care hospitalization immediately preceding the inpatient rehabilitation stay that also meet one or more of the following specific criteria: 1) The patient underwent bilateral knee or bilateral hip joint replacement surgery during the acute care hospital admission immediately preceding the IRF admission; 2) The patient is extremely obese with a Body Mass Index of at least 50 at the time of admission to the IRF; or 3) The patient is age 85 or older at the time of admission to the IRF. Joint replacement cases may also comply with the 60% Rule if the patient has a qualifying comorbidity.

[4] MedPAC's March 2014 report to Congress (p. 249) estimates IRF 60% Rule case compliance based on January 2013 to July 2013 data from eRehabData.

[5] The UDSMR database contains IRF patient assessment instrument data for greater than 800 IRFs.

[6] IRFs that fail to meet the 60% Rule presumptive test must them demonstrate 60% Rule compliance through a chart audit of a random sample of medical records.

STROKE POPULATION IS UNSUITABLE FOR SITE-NEUTRAL PAYMENT

As suggested during the MedPAC commissioners' discussion, the AHA urges MedPAC to eliminate stroke patients from any IRF-SNF site-neutral payment policy at this time. IRFs provide hospital-level care led by physicians, while SNFs provide a less-intensive set of recuperative services that is, on a day-to-day basis, typically provided by nurses, therapists and lower-level aides. The stroke populations treated in both settings are illustrative of the differences between each setting's level of clinical service and each setting's patient mix. MedPAC's March presentation provided several data points demonstrating the higher acuity levels of the stroke patients treated in IRFs, including a higher overall hierarchical condition category risk score, greater ancillary costs and greater prevalence of comorbidities. These gaps between IRF and SNF stroke patients were notably wider than for the other two targeted conditions (joint replacement and hip/femur fractures).

IRF REGULATORY RELIEF MUST APPLY TO SITE-NEUTRAL CASES

The AHA agrees with MedPAC that a level regulatory playing field is an essential component of any future site-neutral payment policy for IRF and SNF cases. Current Medicare statute and regulations require IRFs to provide hospital-level care, and, therefore, they must be paid hospital-level rates. If in the future, IRF and SNF rates for targeted conditions are made on a site-neutral basis, then the service and regulatory expectations for the site-neutral cases treated in IRFs should be lowered. Likewise, such requirements for SNFs should be raised as needed to achieve apples-to-apples parity for site-neutral cases. Regulatory relief for IRF cases receiving site-neutral payment should include: elimination of the three-hour rule, elimination of the 60% Rule, and elimination of other requirements related to providing hospital-level care, such as maintaining physician and nursing levels on par with hospitals.

We appreciate your consideration of these concerns. IRF-SNF site-neutral payment warrants further exploration by MedPAC, but it should proceed with great caution given the challenge of identifying truly similar patients in both settings. If you have any questions, please feel free to contact me or Rochelle Archuleta, senior associate director of policy, at (202) 626-2320 or rarchuleta@aha.org.

Sincerely,

/s/

Linda E. Fishman
Senior Vice President, Public Policy Analysis and Development

Cc: Mark Miller, Ph.D.
MedPAC Commissioners