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Dear Dr. Gage and CMS Colleagues:

IRFReporttoCongress@cms.hhs.gov
bgage@rti.org

Re: Medicare Classification Criteria for
Inpatient Rehabilitation Facilities

The Center for Medicare Advocacy (the Center) is a nonprofit, nonpartisan organization that works to advance fair access to Medicare and necessary health care. The Center has focused on access to appropriate rehabilitation services for more than 20 years. We have worked with hundreds of Medicare beneficiaries to ensure that they, and others who do not have advocates, are able to get high quality rehabilitation from the health care providers that are best able to meet their individual needs. It is clear from our decades of experience representing Medicare beneficiaries that, as they focus on Medicare classification criteria for inpatient rehabilitation facilities (IRFs), the Centers for Medicare & Medicaid Services (CMS) and Congress must ensure that IRFs remain a meaningful and available option for people with Medicare.

The Center submits the following comments on Medicare classification criteria for IRFs. We first address the three issues identified for the report to Congress and then provide additional background material on why skilled nursing facilities (SNFs) are generally not an appropriate alternative to IRFs.

1. Whether Medicare beneficiaries have access to medically necessary rehabilitation services and any potential effect of the "75% rule" on their access to appropriate care.

There is no question that IRFs and IRF beds have been lost, not only with the 75% rule, but also with the 60% rule now in effect. Both John Rigg of the California Hospital Association and Sam Martell of UDSMR described specific losses of IRFs when they spoke at the February 2, 2009 Town Hall meeting. Dr. Martell reported that at least 86 IRFs in 30 states have closed since 2006.

A primary concern for the Center is ensuring that Medicare beneficiaries have access to a full range of high quality treatment options that are most appropriate for them. The loss of IRFs and IRF beds nationwide means that fewer beneficiaries have this post-acute option even theoretically available. The loss of facilities and beds needs to be halted and, if possible, reversed.

2. Whether alternative criteria or refinements to the 75% rule could be used to determine IRF classification, including patients' functional status, diagnosis, comorbidities, or other attributes.

The Center strongly endorses the comments of numerous witnesses at the Town Hall meeting, including Dr. Bruce Gans (American Medical Rehabilitation Providers Association) and Dr. Leon Reinstein (past president, Academy of Physical Rehabilitation), calling for disaggregating the definition of IRFs from the determination of the appropriateness of the admission of any particular Medicare beneficiary to an IRF. The Center agrees with Dr. Gans's articulation of the issue. Health care providers should be defined by the services they provide and the purposes for which they are organized. Using the definition of a facility to determine the coverage of a particular person is not medically appropriate. It also violates the Medicare law to deny coverage on the basis of a particular diagnosis, treatment norm, or other "rule of thumb." Rather, an individual assessment is required of each beneficiary's healthcare needs and eligibility for Medicare coverage. (*See Fox v. Thompson*, CA No. 3:78 CV 541 (SRU) (D. Conn. 2002; *Fox v. Bowen*, 656 F. Supp. 1236 (D. Conn. 1987); *Hooper v. Sullivan*, CA No. H-80-99 (PCD) (D. Conn. July 24, 1989) and related CMS policy and regulations.

The 75% rule (and now the 60% rule) was developed when the prospective payment system for acute hospital care was first implemented, in order to identify IRFs that would be exempt from the new payment system for acute care hospitals. This definition of IRFs, created for purposes of reimbursement policy, should not be used to determine Medicare beneficiaries' eligibility for post-acute care and services.

3. Whether IRF care is appropriate for certain other types of conditions which are commonly treated in IRFs, but are outside of the 13 conditions specified in the 75% rule. Are there differences in patient outcomes and costs when these cases are treated in different settings?

Although the Center supports deleting the 75% rule in its entirety as a better public policy than simply adding conditions to the list of 13, we would (reluctantly and if better policy alternatives were not implemented) support updating the list of conditions that may be covered in IRFs. As Dr. Reinstein clearly confirmed at the Town Hall meeting, the group that initially developed the criteria for IRFs in 1983 addressed facility definition and patient characteristics. As an "afterthought," group members identified 10 common diagnoses reflecting beneficiaries who received rehabilitation care. The group was not asked about percentages and never developed the 75% rule (or 60% rule). Plainly, the change in health care since 1983 justifies adding conditions to the list of 13.

The last question – about differences in patient outcomes and costs in different settings – is critical. While beneficiaries should receive care in settings that are appropriate (and available) to meet their needs, various settings can be reasonable replacements for each other only if the beneficiaries and their outcomes are comparable. If beneficiaries have different outcomes in different settings, then the settings are not substitutes for each other. Evidence supports the finding that IRFs and SNFs are not comparable in their provision of rehabilitation services.

In addition, the Center strongly encourages CMS and RTI to consider **total** beneficiary costs when comparing IRFs with other post-acute settings. Total costs must include, at a minimum, Medicare costs in hospitals and Medicaid costs in nursing facilities. Costs are not "saved" when they are simply shifted from one Medicare service to another or from Medicare to other payers.

Patient outcomes

Studies have indicated that patients in IRFs have better outcomes than those who receive rehabilitation in skilled nursing facilities (SNFs).

A 2005 study by the Medicare Payment Advisory Commission (MedPAC) found

- IRF patients discharged at 14+ days had higher functional status scores than SNF patients with a 14-day or longer stay;
- 76% of IRF patients were walking independently at discharge at 14+ days after admission, compared with 31% of SNF residents at 14 days; and
- 79% of IRF patients were transferring independently at discharge at 14+ days after admission, compared with 30% of SNF residents at 14 days.[1]

A widely-quoted study of Medicare beneficiaries with hip fractures who showed the greatest potential to reduce disability also reported better outcomes for IRF patients than for SNF residents. Comparing two similar groups of beneficiaries, it found that those who

[1] Medicare Payment Advisory Commission, *Report to the Congress; Issues in a Modernized Medicare Program*, 108 (June 2005), http://www.medpac.gov/publications/congressional_reports/June05_Entire_report.pdf.

went to IRFs had much shorter lengths of stay (12.8 days, compared to 36.2 days for SNF residents) and better functional outcomes 12 weeks after discharge from the hospital than those who received rehabilitation in SNFs.[2] In addition,

- 81.1% of IRF patients returned home, compared to 45.5% of SNF residents; and

- Only 8.1% of IRF patients were discharged to nursing homes, compared to 36.4% of SNF residents. Another 4.6% of SNF residents went to other "non-home settings."[3]

A later report reviewing the same patients' status at 24 weeks confirmed the initial findings. IRF patients continued to have better outcomes at 24 weeks than SNF residents. "IRF patients displayed a faster rate of initial recovery and more rapid discharge to home."[4]

Total costs of care must be considered

While the *per day* costs of IRFs are considerably higher than those of SNFs, the significantly shorter lengths of stay in IRFs serve to reduce the *per episode* costs of care.[5] Moreover, since IRF patients are more likely to go home than to remain in an institutional setting, the potential savings from less costly SNFs are substantially reduced, if not entirely eliminated, when SNFs are used instead of IRFs.

Additional concerns about skilled nursing facilities (SNFs)

For many Medicare beneficiaries, SNFs are not an appropriate placement for rehabilitation. The rehabilitation and nursing services provided by SNFs are not adequate in quantity or quality.

CMS itself has identified concerns about the quality and outcomes of rehabilitation in SNFs.

In a 2006 report, CMS called into question the quality, quantity, and outcomes of therapy services provided by SNFs.[6] CMS reported

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[2] Michael C. Munin, "Effect of rehabilitation site on functional recovery after hip fracture," *Archives of Physical Medicine and Rehabilitation*, Vol. 86: 367-372 (March 2005), http://www.archives-pmr.org/article/PIIS0003999304012493/abstract.

[3] *Id.*

[4] Michael C. Munin, "Influence of Rehabilitation Site on Hip Fracture Recovery in Community-Dwelling Subjects at 6-Month Follow-Up," *Archives of Physical Medicine and Rehabilitation*, Vol. 87: 1004-1006 (July 2006).

[5] Michael C. Munin, "Effect of rehabilitation site on functional recovery after hip fracture," *Archives of Physical Medicine and Rehabilitation*, Vol. 86: 367-372 (March 2005), http://www.archives-pmr.org/article/PIIS0003999304012493/abstract; Statement of Felice Loverso, American Medical Rehabilitation Providers Association, submitted for the record to the House Ways and Means Committee, Subcommittee on Health, Hearing on Post Acute Care (June 16, 2005), http://waysandmeans.house.gov/hearings.asp?formmode=view&id=3967.

[6] CMS, *Report to Congress on Patient Classification under Medicare's Prospective Payment System (PPS) for Skilled Nursing Facilities (SNFs)* (Sep. 19, 2006),

- The minimum data set (MDS) assessments for SNF residents include services delivered in the hospital prior to the SNF admission (Report 13). As a result, "certain high intensity/high cost services reported on the MDS and used in the current SNF PPS are unreliable indicators of actual service use during the SNF stay itself."[7]

- With respect to "the relationship between function and therapy received in the SNF . . . patients with moderate functional impairment received more therapy than patients with either substantial impairment or minimal impairment."[8]

- The 2001 addition by Congress of a 20% payment "increase to three of the 14 rehabilitation groups . . . created a strong incentive to match the level of therapy to the three groups with the highest payment."[9]

- "The RUG-III therapy payments have been criticized as functioning more like a fee schedule than as a PPS."[10]

- "Since RUG-III essentially pays for therapy as ordered, and because adding therapy to the mix of other skilled services generally increases payment, the PPS creates strong incentives to assign residents to the rehabilitation category."[11]

- "Using data from 1999 and 2001 (a period when certain therapy categories were more profitable than others), the researchers found that the amount of therapy provided was clustered just above the break points for each of the most profitable RUG-III therapy groups. In other words, what was intended to be the low end of a range had become the therapy standard."[12]

- SNFs do not prepare discharge assessments, making it "impossible to identify and evaluate the outcomes of therapy furnished to beneficiaries."[13]

- The Medicare Payment Advisory Commission similarly reported in March 2007 that it lacked adequate data to evaluate whether various post-acute settings provide "comparable quality of care and if their patients achieved similar outcomes."[14]

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http://www.cms.hhs.gov/SNFPPS/Downloads/RC_2006_PC-PPSSNF.pdf. The report is based on a study by the Urban Institute, *Final Report to CMS: Options for Improving Medicare Payments for SNFs* (March 2007), http://www.cms.hhs.gov/SNFPPS/Downloads/snf_report_final_03-01-07-2.pdf.

[7] *Id.* 28.

[8] *Id.* 16.

[9] *Id.* 32.

[10] *Id.* 22.

[11] *Id.* 30.

[12] *Id.*

[13] *Id.* 31.

[14] *See also* MedPAC, *Report to Congress: Medicare Payment Policy* 154, 157 (March 2007) ("patients [in SNFs] are not assessed at admission and discharge, so measuring improvement is not possible"), http://www.medpac.gov/publications/congressional_reports/Mar07_EntireReport.pdf.

These serious concerns about the quality of therapy services in SNFs, and especially the lack of any assessment data that prevent any evaluation of the outcomes of SNFs' therapy services, should make CMS and Congress reluctant to identify SNFs as an appropriate substitute for IRFs.

More recently, in 2008, CMS proposed to recalibrate the RUGs-III categories. In 2005, CMS added nine RUGs categories to the original 44 to account for residents requiring both extensive medical care and rehabilitation services. CMS intended that the reclassification would be budget-neutral. However, SNFs classified many more residents into the highest RUGs categories than CMS had projected.[15]

Despite reporting that SNFs had been overpaid $780 million, CMS did not make the change it proposed and did not recalibrate the rates. It yielded to what it acknowledged was the pressure of the nursing home industry and said that it would take "additional time" to evaluate the proposed recalibration.[16]

The Government Accountability Office (GAO) has made similar findings to those made by CMS. A 2002 GAO study reported that, two years after implementation of PPS for SNFs, residents assigned by SNFs to medium and high rehabilitation groups received less therapy than before PPS and half did not receive the minimum number of minutes that were needed to be classified into those rehabilitation groups.[17] SNFs told the GAO that the high and medium rehabilitation groups had "more favorable payments, relative to their costs, than other categories."[18] The GAO concluded:

> Our work indicates that SNFs have responded to PPS in two ways that may have affected how payments compare to SNF costs. SNFs have (1) changed their patient assessment practices and (2) reduced the amount of therapy services provided to Medicare beneficiaries. The first change can increase Medicare's payments and the second can reduce a SNF's costs.[19]

In addition, SNFs may not have sufficient nursing staff to meet the needs of residents requiring rehabilitation. The GAO found that SNFs did not increase their nurse staffing after the new highly profitable[20] Medicare reimbursement system was implemented, even when Congress added money to Medicare rates specifically for nursing services.[21]

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[15] 73 Federal Register 25,918, at 25,923 (May 7, 2008), http://frwebgate3.access.gpo.gov/cgi-bin/PDFgate.cgi?WAISdocID=86307320059+0+2+0&WAISaction=retrieve.
[16] 73 Federal Register 46,416, at 46,421-424 (Aug. 8, 2008), http://frwebgate5.access.gpo.gov/cgi-bin/PDFgate.cgi?WAISdocID=862217302431+0+2+0&WAISaction=retrieve.
[17] Government Accountability Office, *Skilled Nursing Facilities; Providers Have Responded to Medicare Payment System by Changing Practices*, GAO-02-841, 3 (Aug. 2002), http://www.gao.gov/new.items/d02841.pdf.
[18] *Id.* 12.
[19] *Id.* 16.
[20] The GAO found that freestanding SNFs "generally received Medicare payments that exceeded their costs, often by considerable amounts." GAO, *Skilled Nursing Facilities: Medicare Payments Exceed Costs for Most but Not All Facilities* 20, GAO-03-183 (Dec. 2002), http://www.gao.gov/new.items/d03183.pdf.
[21] GAO, *Skilled Nursing Facilities: Available Data Show Average Nursing Staff Time Changed Little after Medicare Payment Increase*, GAO-03-176 (Nov. 2002), http://www.gao.gov/new.items/d03176.pdf.

The profitability of Medicare payments led the nursing home industry to eagerly anticipate implementation of the 75% rule. The cover story of the November 2006 issue of the American Health Care Association's *Provider* magazine reported that the nursing home industry was "modernizing and refurbishing aging facilities" and repositioning services "to attract higher Medicare reimbursement and more private payers."[22] *McKnight's Long-Term Care News & Assisted Living* reported the changes that SNFs were making: "Renovations may include building more private or semi-private rooms, incorporating residential features, or building rehab gyms for short-stay residents to take advantage of Medicare's lucrative reimbursements."[23] Neither publication reported increased numbers of nursing or rehabilitation staff.

Prior efforts to divert beneficiaries to lower-cost post-acute settings have led to poor outcomes for beneficiaries and loss of better, alternative settings.

CMS and Congress should also learn from past experiences. Nursing homes have been identified before as a low-cost post-acute setting providing comparable care to higher-cost settings. But the outcomes of care for beneficiaries have declined, costs have risen, and alternative post-acute settings have been closed.[24]

The prospective payment system for acute care hospitals assumed that patients could get comparable rehabilitation services in nursing facilities. Research on the treatment of beneficiaries with hip fractures found enormous changes in care settings and costs following the implementation of PPS. One study found that before PPS, patients received rehabilitation in the hospital and generally went home, either directly from the hospital or following a short stay in a SNF. After PPS, hospital lengths of stay declined from 22 days to 13 days and the percentage of residents discharged to SNFs increased from 38% to 60%. The expectation was that patients could get the same rehabilitation services in SNFs that they had received in acute care hospitals, but at lower cost. This did not prove true. After PPS, the researchers found that, for various reasons, "rehabilitation therapy within the nursing homes was less effective than inpatient therapy before PPS." The outcomes for patients with hip fracture were worse following PPS. Instead of getting therapy and returning home, patients were more likely to be in the nursing home a full year after their hip fracture; a 200% increase in the rate of nursing home residence was reported by the

[22] Meg LaPorte, "Providers Upgrade Buildings, Expand Services; Companies target post-acute rehab, short-stay, and higher acuity patients," *Provider* (Nov. 2006), http://www.providermagazine.com/pdf/cover-11-2006.pdf.

[23] Liza Berger, "Finance feature: Climate change," *McKnight's Long-Term Care News & Assisted Living* (Feb. 7, 2007), http://www.mcknightsonline.com/content/index.php?id=24&tx_ttnews[swords]=Liza%20Berger&tx_ttnews[tt_news]=3583&tx_ttnews[backPid]=25&cHash=ea5cb2b07b.

[24] *See* Testimony of Toby S. Edelman before Subcommittee on Health, House Committee on Ways and Means, "Hearing on Post-Acute Care" (June 16, 2005), http://waysandmeans.house.gov/hearings.asp?formmode=view&id=2796.

study after PPS was implemented.[25] The researchers called this finding "alarming" and their most important finding. Services were not the same in the different settings.

Not only were care outcomes worse for beneficiaries with hip fractures following PPS, but expected cost savings also failed to materialize as costs moved elsewhere. After PPS, people with hip fractures spent less time in the hospital, but these patients then became Medicare patients in SNFs and then, frequently, as the researchers found, long-term residents of nursing homes. Medicare payments to SNFs increased in the years following implementation of PPS for hospitals.[26] And patients who would have gone home from the hospital now found themselves living in nursing facilities on a long-term basis, generally, as Medicaid beneficiaries. Savings in Medicare acute care hospital costs were accompanied by increases in Medicare and Medicaid post-acute costs. Costs shifted from one setting to another, with worse care outcomes for beneficiaries.

In a second example, Medicare PPS reduced the payment differential between free-standing and hospital-based SNFs, on the assumption that facilities should get the same level of reimbursement for providing the same level of care. The assumption was not correct. Hospital-based SNFs appear to be different from free-standing SNFs, providing a more intensive level care to a sicker cohort of residents. They had and have, even today, significantly higher staffing levels than free-standing SNFs. (CMS in fact reports staffing data separately for hospital-based and free-standing SNFs on its website *Nursing Home Compare*[27] because the staffing levels are so different in the two types of SNFs.) And like IRFs, hospital-based SNFs had higher *per day* costs, but lower lengths of stay than free-standing SNFs.

The results of PPS for SNFs have been negative profit margins of 36% for hospital-based SNFs, the closure of many hospital-based SNFs, and 11% *positive* profit margins for free-standing SNFs.[28] The site-neutral reimbursement for the two types of SNFs has effectively eliminated the hospital-based SNF option for many beneficiaries.

CMS and Congress should not make the same mistake again by using the 75% rule, or 60% rule, or any similar provision, which will result in the elimination of the IRF option for many Medicare beneficiaries.

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[25] John F. Fitzgerald, M.D., et al, "The Care of Elderly Patients with Hip Fracture," *New England Journal of Medicine* 319(21):1392-1397 (Nov. 24, 1988).

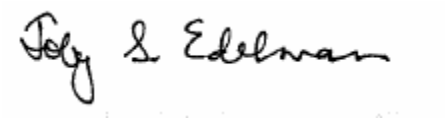
[26] MedPAC reported that Medicare spending in SNFs increased from $3.6 billion in 1992 to $13.5 billion in 2003. MedPAC, *A Data Book; Healthcare Spending and the Medicare Program* 142, Chart 9-2 (June 2004). Other factors also contributed to the growth in SNF care during this period, including new SNF coverage guidelines issued in 1988, enactment of the Medicare Catastrophic Coverage Act of 1988 (which revised rules for SNF coverage), and Medicare's use of cost-based reimbursement prior to 1998. "A Review of Issues in the Development and Implementation of the Skilled Nursing Facility Prospective Payment System" 2 (May 2004).

[27] http://www.medicare.gov/NHCompare/Include/DataSection/Questions/SearchCriteria.asp?version=default&browser=IE%7C7%7CWinXP&language=English&defaultstatus=0&pagelist=Home&CookiesEnabledStatus=True.

[28] *Report to Congress on Patient Classification under Medicare's Prospective Payment System (PPS) for Skilled Nursing Facilities (SNFs)*, page 33 (Sep. 19, 2006), http://www.cms.hhs.gov/SNFPPS/Downloads/RC_2006_PC-PPSSNF.pdf.

Thank you for the opportunity to submit comments.

Sincerely,



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