VIA ELECTRONIC MAIL

February 19, 2016

The Honorable Fred Upton
Chairman, House Energy & Commerce Committee
Rayburn House Office Building, # 2183
Independence and S. Capitol St., S.W.
Washington, DC 20515

The Honorable Joseph Pitts
Chairman, Subcommittee on Health
Cannon House Office Building, #420
1st and Independence Ave., S.E.
Washington, DC 20515

RE: CPR'S RESPONSE TO SOLICITATION OF STAKEHOLDER INPUT ON SITE-NEUTRAL PAYMENT PROPOSALS

Dear Chairman Upton and Chairman Pitts:

We write with respect to the House Committee on Energy & Commerce's February 5, 2016 letter which focuses on site-neutral payments under the Medicare program. We note that the letter primarily addresses site-neutral payments in the outpatient setting. Our response does not address this issue but focuses on site-neutral payment proposals between skilled nursing facilities (SNFs) and inpatient rehabilitation hospitals and units, commonly referred to as "IRFs."

The Coalition to Preserve Rehabilitation,[1] a coalition of disability and rehabilitation organizations led by a consumer-directed steering committee, has serious concerns about site-neutral payment between SNFs and IRFs. We believe that such proposals raise alarming concerns for Medicare beneficiaries that could have long-term implications on their ability to access the appropriate level of rehabilitative care in the right setting and at the right time post-injury or illness.

Payment Reform Requires Serious Deliberation

All Medicare post-acute care (PAC) reforms that Congress considers should, first and foremost, preserve access to quality rehabilitation services provided at the appropriate level of intensity, in the right setting, and at the right time to meet the individual needs of Medicare beneficiaries. This is, of course, much easier said than done. Meeting this challenge, while making Medicare post-acute care payment policy more efficient, requires serious deliberation. Uniform and current data need to be collected across a variety of PAC settings with a major emphasis on appropriate quality standards and

[1] The Coalition to Preserve Rehabilitation (CPR) is a coalition of national consumer, clinician, and membership organizations that advocate for policies to ensure access to rehabilitative care so that individuals with injuries, illnesses, disabilities and chronic conditions may regain and/or maintain their maximum level of health and independent function.

risk adjustment to protect patients against underservice. The IMPACT Act,[2] enacted in October 2014, now serves as the foundation for this uniform data collection activity. *We request Congress give the Centers for Medicare and Medicaid Services (CMS) sufficient time to collect and analyze data under the IMPACT Act's provisions before prematurely legislating significant post-acute care reforms.*

SNFs and IRFs are Not Equivalent

To date, site neutral payment proposals in the PAC setting (i.e., between SNFs and IRFs) have been fundamentally different from site neutral payment proposals in the outpatient or other settings. In those settings, the services at issue are described as "site neutral" because the services are highly similar regardless of the setting in which they are provided. But PAC site neutrality compares rehabilitation services in two settings that are fundamentally different. Rehabilitation provided in SNF and IRF settings are simply not equivalent. Proponents of site-neutral payments assert they are appropriate because these two settings of care allegedly treat similar patients and achieve equal outcomes regardless of setting. To the contrary, the expertise, staffing, equipment and medical care in SNFs and IRFs are drastically different. The level of medical and therapeutic care available in IRFs is far more intense, complex, and multi-disciplinary.

Furthermore, IRFs are required to provide patients with close medical supervision by a physician with specialized training in rehabilitation, a multidisciplinary, coordinated approach to rehabilitation that includes 24-hour rehabilitation nursing, an intensive therapy program—widely regarded as three or more hours of skilled therapy per day—and licensure and accreditation for hospital level rehabilitation care. SNFs, on the other hand, do not require any of these staffing levels or care coordination.[3] To treat both of these settings as essentially the same will endanger some of the most physically and medically vulnerable Medicare beneficiaries.

Outcomes Between IRFs and SNFs Differ Dramatically

According to a July 2014 report by Dobson | DaVanzo, Medicare data over a two-year period demonstrated that when patients are matched on demographic and clinical characteristics, rehabilitation provided in inpatient rehabilitation hospitals leads to lower mortality, fewer readmissions and emergency room visits, and more days at home—not in a PAC institutional setting—than rehabilitation provided in SNFs for the same condition. In terms of mortality, the starkest difference between the two settings involved patients with stroke, traumatic brain injury, and amputations.

This study demonstrates that care provided in IRFs and SNFs is not the same and that outcomes are, in fact, significantly different as a result of the specific type of services provided in these two different settings. The study also demonstrates the enduring effects of timely, intensive and coordinated rehabilitation provided in an IRF and how these services improve not only the length of beneficiaries' lives, but the quality of their lives as well.[4]

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[2] *Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014*, http://www.gpo.gov/fdsys/pkg/BILLS-113hr4994enr/pdf/BILLS-113hr4994enr.pdf, pages 1, 4-7.

[3] See American Medical Rehabilitation Providers Association, https://www.amrpa.org/newsroom/AMRPA-infographic.png.

[4] See Dobson Davanzo, *Assessment of Patient Outcomes of Rehabilitative Care Provided in Inpatient Rehabilitation Facilities (IRFs) and After Discharge*, July 2014, https://www.amrpa.org/newsroom/Dobson%20DaVanzo%20Final%20Report%20-%20Patient%20Outcomes%20of%20IRF%20v%20%20SNF%20-%207%2010%2014%20redated.pdf. See also study highlights for amputation, traumatic brain injury, stroke, and other patients at American Medical Rehabilitation Providers Association at http://www.amrpa.org/Public/Study_Rehab_Hospitals_Yield_Better_Outcomes.aspx.

Site-Neutral Payment Creates Financial Disincentives for IRFs to Accept Certain Patients
CPR opposes any SNF/IRF site-neutral proposal as it is little more than an outright financial disincentive for inpatient rehabilitation hospitals and units to accept certain Medicare patients. Site-neutral payments between SNFs and IRFs would use Medicare payment policy to essentially bar the door to the rehabilitation hospital based solely on patients' diagnoses, not based on their individual medical and functional needs. Such a financial disincentive may well drive IRFs to avoid admitting such patients, depriving these beneficiaries of access to the IRF level of coordinated, intensive rehabilitative care. Conversely, site-neutral payments would benefit SNFs financially.[5]

Site-Neutral Payment Based on Diagnosis May Violate CMS Regulations and Federal Case Law
A site-neutral payment system based on diagnosis would essentially ignore the established, comprehensive, regulatory framework that was developed to determine whether a patient is eligible for care in an IRF. This set of Medicare regulations and manual instructions places a premium on an individual assessment of each patient's rehabilitative and medical needs, physician judgment, and extensive documentation to demonstrate coverage and medical necessity. As acknowledged by the commissioners of the Medicare Payment Advisory Commission (MedPAC) in their meeting on November 7, 2014, SNF/IRF site-neutral payment for certain conditions may cause a categorical shift of those patients to SNFs, based solely on primary diagnosis.

This dynamic could easily be described as the use of an impermissible "rule of thumb" for determining coverage. Medicare coverage for inpatient hospital rehabilitation must be determined on an individual basis.[6] The Medicare program has been very clear that "rules of thumb" are not permissible bases upon which to make a determination of medical necessity and coverage of care.[7] In fact, the Secretary of Health and Human Services explicitly agreed that "denials of admissions, services, and/or Medicare coverage based upon numerical utilization screens, diagnostic screens, *diagnosis*, specific treatment norms, the 'three hour rule,' or other 'rules of thumb' are not appropriate."[8]

Instead, medical review determinations are to be "based on reviews of individual medical records by qualified clinicians, not on the basis of diagnosis alone."[9] The denial of care for patients with the effected condition codes will not be carried out by Medicare contractors, but if the Medicare program makes it financially infeasible for IRFs to admit such patients, the impact will be the same. Patients may be denied care to which they are otherwise entitled based on regulatory coverage criteria that focuses on a single factor; diagnosis.

Cost-Effectiveness of Rehabilitation in Various Settings
Proponents of site-neutral payments argue that it costs more for Medicare to treat similar patients in IRFs than in SNFs. In fact, because SNFs are reimbursed on a per diem payment system and lengths of stay appear to be significantly greater than in IRFs for these patients, there is a real question as to the cost-effectiveness of treating these patients in SNFs. In addition, in its report to Congress, MedPAC did not measure the cost-effectiveness of timely, coordinated and intensive inpatient hospital

[5] See InsideHealthPolicy, *MedPAC Eyes Making 17 Conditions Site-Neutral At IRFs, SNFs; Beneficiaries Upset*, November 2014, https://healthpolicynewsstand.com/newsstand-login?n=79354&destination=node/79354. Subscription-only publication.
[6] Medicare Benefit Policy Manual, CMS. Pub. 100-2, ch. 1, § 110.
[7] *Hooper v. Sullivan*, 1989 WL 107497 (D. Conn.).
[8] *Id.* (emphasis added).
[9] 73 Fed. Reg. 46,370, 46,388 (August 8, 2008).

rehabilitation over the long term, including the impact that a lack of these services may have on Medicaid expenditures on long-term nursing home stays.

From a health care sector perspective, MedPAC's June 2014 Databook illustrates that from 2001 to 2011, home health care and SNF expenditures have contributed more to Medicare post-acute care spending than IRF spending. In 2012, Medicare post-acute care expenditures totaled only $6.7 billion for IRFs, as compared to $18.3 billion for home health agencies and $28.4 billion for SNFs.[10] Site-neutral legislation would likely drive patients into less intensive, less appropriate rehabilitation settings, rather than the setting that best meets their rehabilitation needs.

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The disability and rehabilitation community understands the magnitude of the problem that our nation faces in attempting to contain federal health care spending. However, achieving federal savings through what we believe to be short-sighted post-acute care reforms that do not adequately take into account long-term cost-effectiveness, maximal patient outcomes, and the future capacity of our rehabilitation system, is not the path to success.

We look forward to working with you to strengthen the Medicare program while preserving access to rehabilitation services in all settings for all Medicare beneficiaries. *We also reiterate our request that Congress wait until data across PAC settings authorized under the IMPACT Act*[11] *can be collected and analyzed before recommending significant post-acute care reforms.*

For more information, please contact the CPR Steering Committee members listed below. Thank you for considering our views.

[10] See Medicare Payment Advisory Commission, *A Data Book: Health Care Spending and the Medicare Program*, June 2014, http://www.medpac.gov/documents/publications/jun14databookentirereport.pdf?sfvrsn=1, page 112.
[11] *Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014*, http://www.gpo.gov/fdsys/pkg/BILLS-113hr4994enr/pdf/BILLS-113hr4994enr.pdf, pages 1, 4-7.

Sincerely,

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Endorsing Organizations

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CC: James "JP" Paluskiewicz
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