Advising the Congress on Medicare issues

Site-neutral payments for select conditions treated in inpatient rehabilitation facilities and skilled nursing facilities

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MEDPAC

Overview

- Previous findings reported in June
- Follow-up analyses of stroke cases
- Analysis of new conditions
- Guidance sought on design of a site-neutral policy
  - Conditions to include
  - Consideration of stroke

Medicare's requirements for IRFs and SNF differ

	SNF	IRF
MD oversight	Seen by MD day 14; then every 30 days	At least 3 times a week
RN coverage	8 hours a day	24 hours a day
Therapy provided	Varies; ¾ of days get at least 2.4 hours per day	"Intensive" Often interpreted as 3 hours per day
PPS	Day-based No add-on payments	Discharge-based Add-on payments

- IRFs must meet compliance threshold

Criteria considered to evaluate conditions for site-neutral payment

- Consistent with approach taken in Commission's other site-neutral work
  - Frequently treated in lower-cost setting
  - Similar risk profiles
  - Similar outcomes

Site-neutral policy for IRFs and SNFs

- For qualifying conditions, IRF base rate would be the average SNF payment per discharge
- All add-on payments to IRFs would remain at current levels
- For qualifying conditions, IRFs would get relief from certain regulations regarding how care is furnished

Previous findings (June 2014): Joint replacement and hip and femur procedures

- Majority of patients treated in SNFs
- IRF and SNF patients have similar risk profiles
- IRF outcomes compared with SNF:
  - Comparable risk-adjusted readmissions and change in mobility
  - More improvement in self care
  - Lower unadjusted mortality rates (differences would narrow with risk adjustment)
  - Higher spending during 30 days after discharge from IRF

Conclusion: possible starting point for site-neutral policy

Previous findings (June 2014): Stroke

- Majority of stroke patients treated in IRFs
- IRF patients are younger, have lower risk scores, and lower prevalence of comorbidities
- IRF outcomes compared with SNF:
  - Comparable risk-adjusted readmissions and change in mobility
  - More improvement in self care
  - Lower unadjusted mortality rates (differences would narrow with risk adjustment)
  - Higher spending during 30 days after discharge from IRF

Conclusion: Patients more variable; more analysis needed

Follow-up analyses of stroke cases

- Interviewed 12 practitioners in markets with IRFs and SNFs about placement decisions
- Reached out to medical society for physical medicine and rehabilitation physicians
- Additional data analysis of themes we heard
  - Severity of illness of patients
  - Severity of the stroke
  - IRF occupancy

Interviews about where stroke patients are referred

- Patient severity
  - No agreement on where severely ill patients are placed
  - No agreement on whether certain comorbidities or the need for special services dictate the choice of setting
  - Mild stroke patients may be discharged home
  - IRF use may vary by capabilities of SNFs in market
- Severity of the stroke
  - Prognosis and ability to participate in therapy key to site selection
- Use of IRF and IRF occupancy

Theme 1: Patient severity

- Some medical complexities mentioned as IRF-appropriate are infrequent in both settings
- Other medical complexities were more likely to be treated in SNFs, though some differences were small
- Site selection differed by severity as coded by hospital (APR-DRG)
  - SNFs treat the majority (56%) of the most severely ill
  - IRFs treat the majority (56%) of the least severely ill

Data are preliminary and subject to change.

Theme 2: Severity of the stroke

- No direct measure of the severity of the stroke
- Looked at 2 proxy measures
- Proxy measure: Patients with paralysis
  - Patients with paralysis were more likely to use IRFs
  - Patients with paralysis that is harder to recover from (dominant side paralysis) were less likely to go to IRFs compared with patients with less severe strokes (non-dominant side paralysis)
- Proxy measure: Functional status of patients admitted to SNFs in markets with and without IRFs
  - In markets with IRFs, SNFs patients have lower functional status compared to SNF patients in markets without IRFs

Theme 3: IRF bed availability

- Markets:
  - High IRF occupancy rates: SNFs are used less (38% of strokes went to SNFs)
  - Low IRF occupancy rates: SNFs are used more (52% of strokes went to SNFs)
  - IRF use may differ by prevailing practice patterns and individual market dynamics

Stroke conclusions

- A site-neutral policy could include a subset of stroke patients
  - Most severely ill (who generally can not tolerate intensive therapy)
  - Least severely ill (who generally do not need the intensity of an IRF)
- CMS needs to narrow the definition of stroke cases counting towards IRF compliance and modify the threshold

New conditions to consider for a site-neutral policy

- 17 conditions examined
- All met first criterion--majority of cases treated in SNFs
- Mix of orthopedic, pulmonary, cardiac, and infections
- Comprise 10% of IRF cases and spending
- Total IRF payments (including add-on payments) are 64% higher than SNF rates
- IRF base rates are 49% higher than SNF rates

Data are preliminary and subject to change.

Risk profiles for the 17 conditions

- Risk scores were similar (SNF slightly higher)
- SNF patients are older
- Most comorbidities were more common in SNF users or comparable between the two settings
  - Exceptions: Obesity, polyneuropathy
- From CMS's PAC demonstration: considerable overlap in the functional status at admission between IRF and SNF users

Outcomes

- MedPAC analysis of the 17 conditions
  - Observed mortality rates were higher in SNFs in part because their patients are older and sicker
  - 30-day spending higher in IRFs
- CMS's PAC demonstration (all conditions, not just the 17)
  - Risk-adjusted readmission rates and changes in mobility were similar
  - Risk-adjusted changes in self care were higher in IRFs

Method to estimate payment impacts

- Converted 2012 SNF payments per day to payments per discharge by summing daily payments for each condition
- Estimated IRF base payments using SNF payments per discharge for select conditions
- Maintained IRF add-on payments at current levels:
  - No changes to payments for indirect medical education, share of low-income patients, and high-cost outliers

Effect of IRF site-neutral policy on Medicare spending

- For 17 new conditions: –$309 million
- For orthopedic conditions: –$188 million
  (June 2014)

- Combined: –$497 million
- Impact on total IRF spending: –7.1%

Assumes no behavioral change

Data are preliminary and subject to change.

Implementing a site-neutral policy for IRFs

- Refine case-mix groups (CMGs) and weights to reflect costs of non-site neutral cases
- Waive certain coverage criteria, including:
  - Provision of 3 hours of therapy a day
  - Face-to-face physician visits 3 times/week
- Revise the 60 percent rule requirements

Behavioral impacts of site-neutral payment for IRFs

Depend on:

- Will IRFs change their costs?
  - Reduce the intensity of services furnished to site-neutral cases

  →Note: Some site-neutral cases may still be profitable for some IRFs
- Will IRFs change their mix of cases?
  - Shift volume towards cases paid under IRF PPS
  - Likely will depend on market characteristics

Issues for discussion

- Conditions to include in site-neutral policy
- Consideration of stroke