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Interviews with Acute Care Hospital Discharge Planners about Inpatient Rehabilitation Facility and Skilled Nursing Facility Placement

A report by L & M Policy Research for the Medicare Payment Advisory Commission

The views expressed in this report are those of the authors. No endorsement by MedPAC is intended or should be inferred.

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Interviews with Acute Care Hospital Discharge Planners about Inpatient Rehabilitation Facility and Skilled Nursing Facility Placement
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AUTHORS

This report was authored by staff from L&M Policy Research (L&M). This collaborative effort included Julia Doherty, Heather McPheron, Amanda Dranch, Madelyn McDonald, and Margaret Johnson.

EXECUTIVE SUMMARY

The Medicare Payment Advisory Commission (MedPAC) engaged L&M Policy Research, LLC (L&M) to deepen its understanding of how and why discharge planners choose one setting over another for Medicare beneficiaries who need inpatient rehabilitation therapy after an acute care hospital (ACH) stay. These patients are generally transferred to either an inpatient rehabilitation facility (IRF) or a skilled nursing facility (SNF) after an ACH discharge planner makes one or more referrals.

This report summarizes the empirical research and synthesis of interviews L&M conducted with discharge planners and executives responsible for care management at 12 ACHs. During these interviews, the L&M team explored the variety of factors that ACH staff considered when referring Medicare beneficiaries to either IRFs or SNFs. The interviews yielded insights into ACH discharge planners' perspectives on the capabilities of each setting and their services. The team gathered information about how ACHs factor market conditions, assessments of the level of care needed by patients, and patient characteristics into placement decisions for patients who need intensive rehabilitation therapy after their hospital stay.[1]

Methodology

The L&M team worked with MedPAC staff to identify an initial list of 12 ACHs and 24 alternate ACHs in geographically varied markets across the country.[2] The team sought diversity in both ACH characteristics and market characteristics, including ACHs that were community hospitals, teaching hospitals, part of a health system, and those that operated in urban and rural geographies. The small but purposive sample was weighted toward nonprofit facilities and included ACHs that directly owned IRFs and/or SNFs as well as those that did not.

The team conducted 12 one-hour interviews with 23 individuals representing 12 ACHs between June 2023 and August 2023. Interviews typically included at least one case management or discharge planning supervisor who was either a licensed social worker or a registered nurse actively engaged in the discharge planning process. Four interviews included staff representing the target ACH and other ACHs within the same health system. The team used a semi-structured discussion guide (see the Appendix for the full discussion guide). Two senior staff led the interviews while a research assistant took notes organized according to the topics in the discussion guide. MedPAC staff attended interviews when possible. Interviews were conducted via Zoom and recorded for notetaking purposes with permission from the participants. Following each interview, the team discussed facility attributes and key findings about the patient population, discharge planning practices, and market in which the ACH operated. The team analyzed the interview notes by topic. This approach allowed for comparison and synthesis of findings across ACHs. Through this process and the ensuing team discussions, the team identified key themes as well as similarities and differences across the interviews.

[1] For the purposes of this report, intensive therapy generally refers to three or more hours of daily inpatient rehabilitation therapy at least five days per week.

[2] The sample excluded critical access hospitals which are not paid under the inpatient (acute care hospital) prospective payment system.

Summary of Key Findings

Interviews bore out multiple factors that impacted placement of patients needing intensive inpatient rehabilitation after an ACH stay. Meaningful patterns that emerged from the interviews included:

- Medicare fee-for-service (FFS) patients with a Medicare IRF qualifying diagnosis who could and were willing to withstand intensive therapy were readily referred to IRFs if there was one nearby, and often admitted.

- In contrast, Medicare Advantage (MA) patients, even if they had a qualifying condition, were far less likely to be placed in an IRF. ACHs attributed this pattern to many MA plans restricting or denying most IRF-level care regardless of whether patients had qualifying conditions.

Other key findings from the interviews include:

- **A constellation of factors and perspectives influenced patient placement.** Internal factors included the average census at the discharging ACHs, care team perspectives and practices, ACH referral processes, and patient condition and functional capacity. External factors included the availability of IRF and SNF beds in the market. Also influencing patient placement were patient and caregiver preferences, potential to be discharged to home post-rehabilitation, Medicare coverage type, and the distance and travel time between a patient's residence and nearby post-acute care facilities. Perspectives on this group of factors and how much weight was placed on each varied among clinicians and discharge planners within the same ACH, patients and their caregivers, and the facilities to which they were referred.

- **The degree of formality of the process for determining level of care and associated discharge options varied among ACHs.** All ACHs reported that therapy teams were primarily responsible for evaluating patients' functional capacity and making the post-discharge level of care recommendation. Several ACHs reported that the final decisions related to referrals were made by a multidisciplinary team, and only two ACHs mentioned using a standardized assessment tool as part of the process to determine the post-ACH level of care that patients need.

- **Level of care needed could fall in the "grey area" between an IRF and a SNF.** ACHs noted that some patients could benefit from more intensive therapy than is available at SNFs, but they may not need or be able to tolerate three hours of daily therapy in an IRF. Typically, for these patients, ACH therapy teams recommended "IRF or SNF care," leaving the outcome to patient choice and/or facility acceptance.

- **ACHs did not perceive IRF care and SNF care in their markets as interchangeable.** While some ACHs indicated that there was at least one SNF in their market that could care for some medically complex patients (e.g., those with tracheostomies), none of the ACHs reported that SNFs could provide intensive therapy that ACHs considered comparable to that provided in an IRF.

- **ACHs suggested that the list of 13 diagnoses was too restrictive since other patients could benefit from intensive therapy beyond those with qualifying diagnoses.** Interviewees provided examples of patients with conditions such as chronic obstructive pulmonary disease, congestive heart failure, post-COVID acute respiratory failure, and general debility who could benefit from intensive therapy. ACHs reported that the extent to which IRFs admitted patients with diagnoses other than those on the list of 13 varied.

- **All ACH interviewees indicated that patients meeting Medicare IRF qualifying criteria were easier to place and said that IRFs' admission decisions for patients not meeting qualifying criteria were opaque.** The majority of ACHs said that at least one IRF in their area was strict about only accepting patients with a Medicare qualifying diagnosis. Two of the ACHs with an on-site IRF unit reported that the unit could fill its beds with patients meeting qualifying conditions and was thus generally unwilling to accept patients with non-qualifying conditions.

- **Nearly universally, ACHs posited that patients with MA coverage were difficult to place in IRFs.** Interviewees cited delays in processing prior authorization requests as burdensome both to hospitals and to patients. ACHs reported that many MA plans denied IRF admissions even after the ACHs appealed the initial denial.

- **Most ACHs reported that many patients and caregivers considered driving time more important than any other factor when choosing placement options.** As a result, patients who were accepted to and would benefit from IRF care sometimes opted instead to go to a nearby SNF or even to go directly home following an ACH stay.

- **Patients without a safe IRF discharge plan or those with behavioral health diagnoses were more difficult to place in an IRF than in a SNF.** These patients could be challenging to place even if they were otherwise suitable for IRF-level care.

- **During the public health emergency, few ACHs reported that area IRFs expanded their admission criteria to accept patients who would not otherwise qualify.** ACHs also reported that SNF placements were easier during the same period due to the CMS waiver of the SNF three-day prior hospitalization requirement.

Conclusion

While ACHs reported that patient diagnoses were always considered in determining if an IRF referral was warranted or likely to be accepted, diagnoses were only one of many factors under consideration as discharge planners decided whether to send patients to IRFs or SNFs after an ACH stay. The combination and weights of each factor discharge planners considered, as well as the considerations of the potential IRFs and SNFs to which they may be referred, varied for each patient and their caregivers.

Most ACHs' discharge planning approaches required some degree of subjective consideration of the many variables in play by therapists, clinicians, discharge planners, potential receiving facilities, and the patient and their caregivers. Only two ACHs provided examples of more formal processes and tools used to support making referral decisions. For the limited number of

ACHs in this study, like patient diagnoses, neither geographic location nor the accessibility of an IRF alone could explain the differences in how ACH discharge planners decided to send patients to IRF or SNF care.

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BACKGROUND

Discharge planning for Medicare beneficiaries who require intensive inpatient rehabilitation following an acute care hospital (ACH) stay is shaped by a variety of factors. Ultimately, these factors impact whether a patient ends up receiving care in an inpatient rehabilitation facility (IRF) or a skilled nursing facility (SNF). Research shows that there are instances in which health outcomes are similar for patients with the same condition treated in either an IRF or SNF, making it unclear when higher cost IRF care is necessary or appropriate.[3,4,5,6]

Before patients are discharged from an ACH, clinical teams make level of care determinations for patients who need intensive rehabilitative care—which can include physical, occupational, or speech-language therapy—after a hospital stay. Clinical teams also consider market characteristics such as bed availability across settings, and patient characteristics including diagnoses and willingness to participate in intensive therapy as well as insurance coverage, among other elements, as they decide whether to refer patients to IRFs or SNFs.

Typical IRF and SNF services differ because of Medicare conditions of participation, coverage requirements, and payment policies. IRFs are either freestanding rehabilitation hospitals or rehabilitation units within ACHs (referred to as an IRF unit) that provide intensive services to patients following treatment in an ACH.[7,8] In addition to meeting the conditions of participation for ACHs, IRFs must offer care that is supervised by a rehabilitation physician, provide more medical coverage on site, and have more nursing resources available than SNFs. Further, IRFs are required to meet a compliance threshold of having no less than 60 percent of their patients admitted with a primary diagnosis or comorbidity of at least one of the 13 "qualifying" conditions specified by the Centers for Medicare & Medicaid Services (CMS).[9,10] The 13 IRF

[3] Cogan, A. M., Weaver, J. A., McHarg, M., Leland, N. E., Davidson, L., & Mallinson, T. (2020). Association of length of stay, recovery rate, and therapy time per day with functional outcomes after hip fracture surgery. *JAMA Network Open*, *3*(1), e1919672. https://doi.org/10.1001/jamanetworkopen.2019.19672

[4] Cogan, A. M., Weaver, J. A., Ganz, D. A., Davidson, L., Cole, K. R., & Mallinson, T. (2021). Association of therapy time per day with functional outcomes and rate of recovery in older adults after elective joint replacement surgery. *Archives of Physical Medicine and Rehabilitation, 102*(5), 881–887. https://doi.org/10.1016/j.apmr.2020.10.123

[5] Padgett, D. E., Christ, A. B., Joseph, A. D., Lee, Y.-Y., Haas, S. B., & Lyman, S. (2018). Discharge to inpatient rehab does not result in improved functional outcomes following primary total knee arthroplasty. *The Journal of Arthroplasty, 33*(6), 1663–1667. https://doi.org/10.1016/j.arth.2017.12.033

[6] Medicare Payment Advisory Commission. (2014). *June 2014 report to the Congress: Medicare and the health care delivery system.* https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/chapter-6-site-neutral-payments-for-select-conditions-treated-in-inpatient-rehabilitation-facilities.pdf

[7] Medicare Payment Advisory Commission. (2023). *March 2023 report to the Congress: Medicare payment policy.* https://www.medpac.gov/wp-content/uploads/2023/03/Ch9_Mar23_MedPAC_Report_To_Congress_SEC.pdf

[8] Centers for Medicare & Medicaid Services. (2021). *Inpatient rehabilitation facilities.* Retrieved September 5, 2023, from https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/inpatientrehab#:~:text=IRFs%20are%20free%20standing%20rehabilitation,intense%20rehabilitation%20services%20per%20day

[9] Centers for Medicare & Medicaid Services. (2023). *Inpatient rehabilitation facility PPS.* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS

[10] Classification criteria for payment under the inpatient rehabilitation facility prospective payment system, 42 C.F.R. § 412.29. (2023). https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-B/section-412.29

qualifying conditions (primary diagnoses or comorbidities) are stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, fracture of femur (hip fracture), brain injury, types of neurological disorders, burns, certain types of arthritis (systemic vasculitis with joint inflammation or severe or advanced osteoarthritis), and bilateral knee or hip joint replacement.[11] The compliance threshold (commonly referred to as the 60 percent rule) and the requirement that patients generally receive three hours a day of therapy five days a week (or at least 15 hours of therapy per week) in multiple therapy disciplines distinguish IRFs from SNFs, although both facility types admit patients with certain conditions, such as stroke and other neurological conditions.[12,13]

Medicare beneficiaries receive inpatient rehabilitation services more frequently from SNFs than IRFs in part because there are many more SNFs nationwide.[7] SNFs primarily provide care to patients requiring medical or nursing care, or rehabilitation services due to injury, illness, or disability.[14] Many SNFs are also certified as nursing homes, which furnish long-term care that is not covered by Medicare.[15] The mix of services provided in a SNF differ from those available in an IRF and typically involve fewer nursing resources and significantly fewer minutes of rehabilitative therapy per week. Clinical supervision may be provided by, or under the supervision of, technical staff such as registered nurses or licensed practical nurses. While SNFs often care for less medically complex patients than do IRFs, the absence of IRFs in some areas of the country implies that beneficiaries in those areas may receive some similar services in SNFs.

MedPAC engaged L&M to deepen its understanding of how ACH discharge planners decide to send Medicare beneficiaries to either SNFs or IRFs after an ACH stay. To examine how and why one setting is selected rather than the other, the L&M team gained perspectives from ACH staff who regularly work with Medicare beneficiaries in need of intensive inpatient rehabilitation therapy after an ACH stay. The team interviewed discharge planners and executives responsible for care management at 12 ACHs across the country to explore the variety of factors that lead to placement in either an IRF or a SNF. The interviews were designed to help inform the Commission's understanding of the difference in the capabilities of each setting from the ACH discharge planner's perspective and identify instances when receiving care in one setting over another may be optimal.[16]

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[11] Unilateral knee or hip joint replacement may be counted toward the 60 percent rule if the patient is over 85 years old or obese.
[12] Basis of payment. 42 C.F.R. § 412.622. (2023). https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-P/section-412.622#p-412.622(a)(3)(ii)
[13] Wissoker & Garrett. (2023). *Updated simulation of a propective payment system for post-acute care.* Medicare Payment Advisory Commission. https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_PAC_PPS_Updated_Simulation_MedPAC_CONTRACTOR_SEC.pdf
[14] Centers for Medicare & Medicaid Services. (2000). *Medicare Skilled Nursing Facility Manual, Transmittal 367.* https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R367snf.pdf.
[15] Medicare Payment Advisory Commission. (2023). *March 2023 report to the Congress: Medicare payment policy.* https://www.medpac.gov/wp- content/uploads/2023/03/Ch7_Mar23_MedPAC_Report_To_Congress_SEC.pdf
[16] While the team heard about a variety of challenges that ACH discharge planners encounter when trying to place patients in SNFs, this report focuses on those findings specific to placing patients who could benefit from intensive rehabilitation therapy.

METHODOLOGY

Identification of Interview Candidates

The L&M team worked with MedPAC staff to identify an initial list of 12 primary acute care hospitals (ACHs) and 24 alternate ACHs in geographically varied markets across the country (the list excluded critical access hospitals). In recruiting hospitals to participate, the team aimed for diversity in both ACH and market characteristics. ACHs in the sample frame included those with different ownership types (for profit, nonprofit, government-owned), affiliations (part of a health system, academic/teaching hospital), sizes (number of beds), direct ownership of IRF and/or SNF, and if so, type (freestanding, hospital-based), and volume of annual ACH discharges to IRFs and SNFs.[17]

When selecting ACHs to recruit, the team also considered characteristics of the markets in which the ACHs operate. In addition to census region and division, the team considered rurality and proximity to metropolitan areas (as defined by the census), and the number of IRFs and SNFs operating in each ACH's Hospital Service Area and Hospital Referral Region. The team selected ACHs in both metropolitan centers and those outside of cities to ensure that geographic areas with both abundant and few IRFs nearby were included. Once candidate ACHs were identified, the team reviewed ACH websites to corroborate or update information about each facility from a MedPAC-provided dataset.

Recruitment

The team developed a letter from MedPAC to send to potential interview candidates and encourage their participation. The letter stated that the goal of the study was to improve the accuracy and fairness of the IRF Prospective Payment System (PPS) and emphasized that the information gathered would not be attributed to individuals or the participating ACHs in MedPAC reports.

The team began recruitment after identifying the primary and alternate candidates in each target market area. The team contacted the directors of care management and/or discharge planning managers, and if it helped, the executive offices at the candidate ACHs to recruit participants. Ultimately, the team replaced three candidate hospitals from the primary candidate list and three candidate hospitals from the alternate list because, after repeated follow up, the individuals were either unresponsive or they indicated that they were unable to or not authorized to participate. Among the six candidate hospitals that were replaced, two were for profit facilities and one was a county-owned hospital.

Interviews

This purposive sample of 12 ACHs is comprised of nonprofit facilities, which reflects the predominant type of ownership of ACHs in the country.[18] The ACHs interviewed included urban and rural facilities with IRF units on-site, hospitals in markets with no IRFs within a reasonable

[17] Using a datafile provided by MedPAC, we excluded from consideration any ACH that discharged fewer than 20 patients to IRFs in 2021, the most recent year of data available from PA154.
[18] American Hospital Association. (2023). *Fast Facts on U.S. Hospitals, 2023*. https://www.aha.org/system/files/media/file/2023/05/Fast-Facts-on-US-Hospitals-2023.pdf

driving time, and at the other end of the continuum, one ACH operating in a metropolitan area with over 12 IRFs available. Characteristics of the ACHs that participated in the study are provided below (Table 1).

Table 1. Characteristics of ACHs in the Study

ACH Number	Hospital Type	Teaching Status***	Area	Urbanicity /Rurality	Bed Size Range	ACH or System Owns IRF
1	Community Hospital	Non-teaching	Midwest	Urban/Rural**	100–199	No
2	Community Hospital	Other Teaching	Midwest	Rural	200–299	Yes
3	Community Hospital	Non-teaching	West	Rural	40–99	No
4	Community Hospital	Other Teaching	East Coast	Urban/Rural**	40–99	Yes
5	Tertiary Care Center	Other Teaching	South	Rural	500–999	Yes
6	Tertiary Care Center	Major teaching	East Coast	Urban	400–499	No
7	Community Hospital	Non-teaching	West	Urban/Rural**	100–199	Yes
8	Tertiary Care Center	Major teaching	East Coast	Urban	500–999	Yes
9	Tertiary Care Center	Non-teaching	West	Urban	500–999	No
10	Community Hospital	Non-teaching	West	Urban	200–299	Yes*
11	Tertiary Care Center	Other Teaching	South	Urban	300–399	Yes*
12	Community Hospital	Other Teaching	Midwest	Urban	100–199	Yes

NOTES: All data shown were provided by interviewees unless noted otherwise.
** IRFs owned by these ACHs or their health systems were reportedly seldom used by patients at the ACH interviewed due to distance or geographic factors that prolonged driving time.*
*** All but three interviewees reported urbanicity/rurality that matched that of the U.S. Census Bureau Statistical Area (CBSA) indicator. The CBSA indicator is shown first followed by information provided by the interviewee(s).*
**** Derived from a MedPAC-provided dataset that included variables from Medicare Cost Report 2021, among other sources.*

The team conducted one-hour interviews with 23 individuals across the 12 ACHs between June 2023 and August 2023. Interviews typically included at least one case management or discharge planning supervisor who was either a licensed social worker or a registered nurse actively engaged in the discharge planning process. Four interviews included staff representing the target ACH and other ACHs in the target ACH's health system. In these discussions, at least one executive could speak to how other ACHs within the system refer patients to IRFs and SNFs. All interviews were conducted with executives and/or managers of discharge planning with 10 to 30 years of experience in nursing, social work, discharge planning, and/or care management.

The team used a semi-structured discussion guide to conduct the interviews (see the Appendix for the full discussion guide). Two senior staff led the interviews while a research assistant took

notes organized according to the topics in the discussion guide. MedPAC staff attended interviews when possible. Interviews were conducted via Zoom and recorded for notetaking purposes with permission from the participants. The team sent discussion guide and interview notes to MedPAC for review and approval and met with MedPAC regularly to discuss the findings. Shortly after each interview or set of interviews, the team debriefed and discussed facility attributes and key findings about the patient population, discharge planning practices, and market in which the ACH operated. Subsequently, the team analyzed the full sets of transcript-like interview notes. Using a spreadsheet, the team organized interview notes by topic, allowing for synthesis of findings across ACHs. Through this process and the ensuing team discussions, the team identified key themes as well as similarities and differences across the interviews.

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FINDINGS

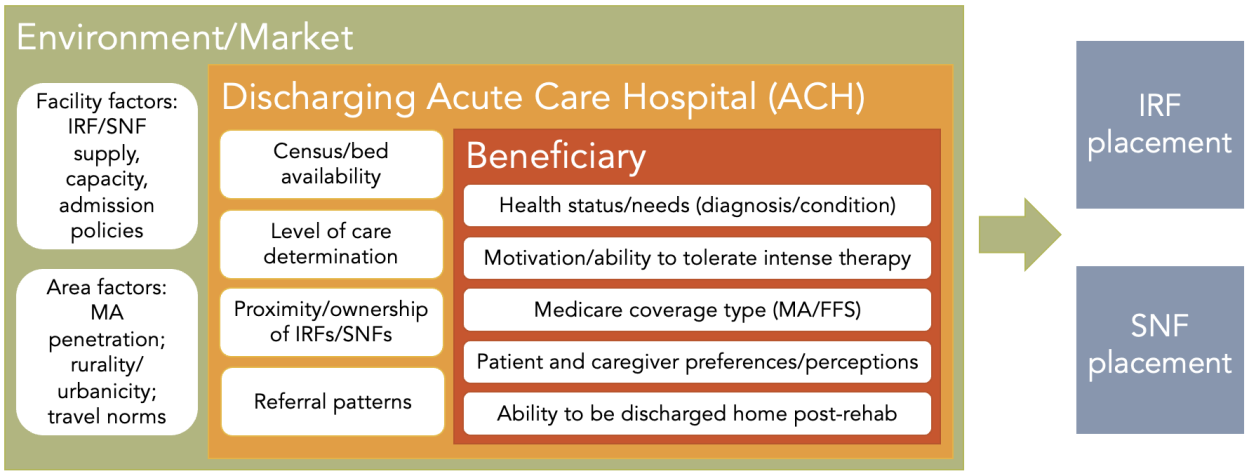
Hospital discharge planners in geographically varied markets across the country provided insights into the key factors that influence their referral decisions—these factors are shown below in Figure 1. As part of each interview, the team asked the ACHs about the IRFs and SNFs in their market area and how ACH staff referred and facilitated placements for patients who need intensive therapy following ACH discharge (often interpreted as being able to tolerate and participate in three or more hours of daily inpatient rehabilitation therapy at least five days per week).

The interviews bore out multiple factors that impacted placement of patients needing intensive inpatient rehabilitation therapy after an ACH stay. This constellation of factors included:

- ***Environmental factors*** such as the availability of IRF and SNF beds in the market; IRF and SNF facility admissions policies, treatment capabilities, and capacity constraints,
- ***ACH factors*** such as daily census/bed availability at the discharging ACH; ACH discharge and referral processes; clinical, therapy, and discharge planning team perspectives and practices, and,
- ***Beneficiary factors*** such as the patients' diagnoses, their functional capabilities and medical needs; their potential to be discharged to home post-rehabilitation; their Medicare coverage (Medicare Advantage (MA) or fee-for-service (FFS); the distance and travel time between a patient's residence and nearby post-acute care (PAC) facilities; and, ultimately, the patient and caregiver preferences for discharge.

Many of these individual factors were weighted differently by an ACH, different clinicians, and discharge planners within the same ACH, by patients and their caregivers, and by the facilities to which they were being referred.

Figure 1. Factors Influencing Referral Decisions for Patients Who Need Intensive Therapy



This section describes the team's findings related to the factors that impacted referrals as described by the ACH interviewees.

Market factors that impact referrals include proximity, referral relationships, and capacity

The team asked discharge planning staff at each ACH to describe their market in terms of referral options for patients who need inpatient rehabilitation therapy. Interviewees reported varying levels of ease/difficulty with which to discharge their patients due to several factors.

Proximity and convenience impacted where ACHs referred patients. ACHs reported that patients and caregivers often had strong preferences based on factors such as travel time and other traffic considerations. While all the interviewees said there were at least some SNFs nearby, ACHs' proximity to IRFs varied. Eight of the ACHs had one or more IRFs within six miles of their campus, and all 12 ACHs had at least one IRF unit or facility within 30 miles.

None of the ACHs reported having formal referral relationships with IRFs besides those the ACH or its health system owned. Even those ACHs with an IRF unit at the hospital reported referring some patients to other IRFs, in addition to accepting external referrals to their on-site units. None of the ACHs report currently having formal referral relationships with SNFs, although one mentioned that they discontinued a formal relationship with a SNF due to issues with quality assurance. Some described having informal relationships or being in regular communication with one or more SNFs.

Additionally, three ACHs noted that at least one IRF in their market had limited capacity. They described instances when, even if a patient was accepted by an IRF, the patient would be unable to transfer unless the ACH held the patient until the IRF bed became available. Only one ACH reported a willingness to hold patients for this reason; interviewees at this ACH asserted that they did not want to prevent a patient from going to an IRF, even if it meant delaying the ACH discharge.

> *"If they are accepted [to an IRF] and it's Monday and [the IRF] tells us they won't have a bed until Wednesday, then [the patient] moves Wednesday. We don't independently downgrade them [to a SNF]."*

One ACH reported a 200 percent increase in their hospital's discharges to IRFs in the past several years. When asked why, the ACH explained that their market had multiple IRFs nearby and an additional IRF recently opened. This ACH also experienced an influx of IRF liaisons visiting the hospital, sometimes uninvited, and giving patients a "high-pressure sales pitch." They articulated how liaisons convinced patients that IRF care was the best option and emphasized that at IRFs, patients have a private room in a newer facility with other amenities. The interviewees said that, as a result, patients expected to be discharged to the IRF they preferred (most often mirroring the IRF that the liaison represented) and were unreceptive to other referral options discharge planners raised. Further, the ACH said some IRF liaisons advised patients to dispute their discharge until the IRF of their choice had a bed available, which was challenging for the ACH when census was high.

ACHs' approaches to level of care assessments varied

The degree of formality of the process for determining level of care and associated discharge options varied among ACHs. All ACHs reported that physical, occupational, and speech-language therapy staff were primarily responsible for evaluating patients' functional capacity and therapy needs and making the post-discharge level of care recommendation. In some instances, multidisciplinary teams, of which the therapists are a part, made level of care decisions. These teams included physicians, other clinical staff, and discharge planners who were typically nurses or social workers. Discharge planners at a few ACHs, however, considered their main role to be facilitating referrals based on recommendations made by therapists rather than being part of a larger team determining level of care recommendations.

Only two ACHs stated that their staff use a standardized assessment tool as part of the process to determine the level of care patients need post ACH discharge. One ACH developed its own level of care assessment tool, a chart with specific criteria that matched to a particular discharge destination. Multidisciplinary staff used the tool as a guideline for care team discussions and to support placement recommendations. Therapists at the other ACH used the Activity Measure for Post-Acute Care (AM-PAC) assessment tool, which measures aspects such as difficulty, assistance, and limitations in activities of daily living and applied cognitive functions, and assists staff in predicting acute care hospital discharge destinations.[19] This ACH stated that any patient with an AM-PAC score of at least 15 and a therapy recommendation that the patient would benefit from therapy five to seven times per week should be considered by the multidisciplinary team for a potential IRF referral.[20]

All ACHs mentioned that the patient's ability to tolerate an intensive level of therapy was a key consideration when determining whether to make an IRF referral. Most ACHs also took diagnoses into account when making IRF referrals, although one third of ACHs placed greater emphasis on patients' ability to tolerate and willingness to participate in intensive therapy than on diagnoses.

Level of care needed could fall in the "grey area" between an IRF and a SNF

Some patients could benefit from more intensive therapy than is available at SNFs, but they may not be able to tolerate three hours of daily therapy in an IRF. A third of the ACHs emphasized that the amount of therapy a patient can tolerate and benefit from could change over the course of an inpatient ACH stay, with level of care recommendations changing accordingly. One ACH noted that some area IRFs were flexible about accepting these "grey area" patients. For example, interviewees said the IRF recognized that some therapy could be delivered bedside rather than in the designated therapy area, such as working on personal grooming, until the patient's stamina increased. Another ACH mentioned sending some stroke patients to a SNF first, and then moving them to an IRF when their tolerance for therapy increased. Typically, for

[19] American Physical Therapy Association. 2017. *Activity Measure for Post-Acute Care (AM-PAC) – '6 Clicks' Inpatient Short Forms.* Retrieved September 5, 2023, from https://www.apta.org/patient-care/evidence-based-practice-resources/test-measures/activity-measure-for-post-acute-care-am-pac--6-clicks-inpatient-short-forms

[20] The interviewee reported that AM-PAC scores range from 1 (complete impairment) to 24 (no impairment), with scores 15 or higher suggesting a patient could potentially benefit from three hours of therapy at least five days a week.

patients in this grey area, ACH therapy teams recommended "IRF or SNF care," leaving the outcome to patient choice and/or facility acceptance.

> *"If they [therapists] feel like the patient definitely needs five days a week therapy but aren't quite sure if it should be rehab [IRF] or SNF, their recommendation will be five days per week therapy...And we may try [to make referrals to] both rehab and SNF."*

ACHs did not perceive IRF care and SNF care in their markets as interchangeable

All ACHs spoke of IRFs providing a significantly higher level of care than SNFs, both in terms of providing more hours of daily therapy and treating more medically complex patients. While some ACHs indicated there was at least one SNF in their market that could care for medically complex patients (e.g., those with tracheostomies, ventilators, or wound care needs), only two ACHs said there was a SNF in their area that could provide more than the standard amount of therapy expected at a SNF. These two reported that while one nearby SNF could provide more therapy than most SNFs, they could not provide the intensive level offered by area IRFs. While all ACHs believed that IRFs provide a higher level of care including more intensive therapy, five mentioned they do not know how much therapy patients discharged to a SNF are able to receive after the ACH stay. One other ACH specifically reported SNFs typically provide about 45 minutes to 90 minutes of therapy a day.

Many ACHs considered Medicare's list of IRF qualifying conditions to be too restrictive

A third of interviewees suggested that qualifying conditions should not be limited to 13 diagnoses and that IRF care should be available to any patient that could benefit from intensive therapy. Many ACHs provided examples of a patients who could have benefited from intensive therapy but did not meet IRF qualifying criteria. Two mentioned patients that would benefit from intensive therapy but did not have complex medical needs.

> *"In my opinion, if [a patient] could benefit from that amount of therapy and it would improve their outcome, that really should be what matters more than if they fit in that 13 diagnoses list."*

> *"I had a 95-year-old woman in here the other day that drove and mowed her lawn. She fell and broke her leg, and I could not put her into an acute rehab environment because she did not have enough medical need. And [in an IRF] she would have gotten better that much faster and would have had more intense services."*

Several other ACHs also described patients whose recovery would have benefitted from intensive therapy but did not have a Medicare qualifying diagnosis. Interviewees indicated that these patients had conditions such as COPD, CHF, post-COVID acute respiratory failure, and general debility.

We have had patients that may not have the support systems, just really needed that extra therapy and more of that [intensity] … A lot of them, you have to be like a double knee or severe automobile accident [to qualify for IRF admission].”

For patients without a qualifying condition, IRF admitting patterns were inconsistent

All ACH interviewees knew that IRFs considered Medicare qualifying condition when screening admissions and indicated that patients with these diagnoses were easier to place in an IRF. Many discharge planners noted that while their therapy or interdisciplinary teams made an initial recommendation about the level of care a patient may benefit from, admission screening teams at the IRFs ultimately determined whether a given patient would be admitted. Yet, ACHs reported that patients with neurological disorders such as stroke, medically complex conditions, multi-trauma, multiple sclerosis, traumatic brain injury, and certain orthopedic conditions were more likely to be admitted by IRFs than patients with other conditions. Only a few ACHs specifically mentioned the compliance threshold IRFs must meet, or the “60 percent rule” by name. For patients without a qualifying condition, some ACHs mentioned that predicting whether an IRF may accept them was challenging, as IRFs’ decision processes for patients without a qualifying condition were opaque.

Nine ACHs said that at least one IRF in their area was strict about only accepting patients with a Medicare qualifying diagnosis. By contrast, the other three ACHs reported that area IRFs did not restrict admissions to patients with a Medicare qualifying condition and were primarily concerned with other factors, such as having evidence that referred patients required some level of intensive therapy.

“It’s not necessarily the diagnosis, but it’s the recommendations that have been made by the therapy department. If a patient is a stroke patient and they have some definite need for inpatient rehab of course they would want to take them…I have not seen where [the on-site IRF is] picky and choosy regarding the diagnosis… [R]egardless of the diagnosis, therapy [has to] have to have documentation that supports that level of care.”

Two of the three ACHs with an on-site IRF unit reported that the unit could fill its beds with patients meeting qualifying conditions. The two on-site IRFs that could fill their beds with these patients were also less likely to accept internal referrals than freestanding IRFs in the area, unless the patients being referred met all Medicare IRF qualifying criteria.

Many Medicare Advantage plans frequently deny IRF admissions

Nearly universally, ACHs posited that patients with MA coverage were especially difficult to discharge to IRFs. Interviewees estimated that MA plans’ prior authorization process for IRF care routinely takes several days to a week. Few hospitals were able or willing to allow patients to occupy ACH beds for extended periods while awaiting MA plan responses. Even the instances in which a patient with MA coverage received authorization to transfer to an IRF, interviewees

cited delays in processing prior authorization requests as burdensome both to the hospital and to the patient.

> *"… We're a small facility, the community we serve is [remote]; it's a huge area. We can't keep people here that don't need this level of care. We can't just keep waiting and waiting for prior [authorizations]. So, we're discharging to a less than optimal place because they can't stay here."*

All ACHs that regularly referred patients to IRFs reported that, even after submitting extensive documentation and appeals, MA plans frequently denied IRF admissions.[21] ACHs asserted that MA plans often restricted access to intensive rehabilitation care for patients who would have otherwise qualified if they had Medicare FFS coverage. Interviewees reported that while some MA plans limited admissions, others rarely or never authorized IRF admissions. One interviewee reported that MA plans told the ACH that IRF care is "not part of the benefit." Two other ACHs maintained that IRF denials were more likely if discharge planners requested prior authorization for both IRF and SNF, prompting them to refrain from making concurrent referrals to improve the chances of an IRF placement.

> *"We've also found that sometimes submitting for [authorizations] at multiple levels of care, the insurance will approve the lowest level because it's the cheapest. If we're trying to get an [authorization] for a certain level, it doesn't do us a whole lot of good to do multiple levels at the same time."*

Numerous ACHs described the consequences of prolonged prior authorization processes on patient recovery and ACH census. Some ACHs mentioned that the dynamic nature of patients' functional capabilities could render them ineligible for IRF by the time the MA plan considered the authorization request. Another point interviewees made was that MA prior authorization delays resulted in some patients missing the crucial timeframe wherein intensive therapy would have yielded the highest prospect of recovery. Additionally, four ACHs said that high census made it untenable to keep patients in beds after they no longer required acute care.

Most interviewees expressed that submitting appeals to MA plans was a futile effort as the process rarely resulted in overturned decisions. Seven ACHs were willing to submit appeals despite MA plans' onerous peer-to-peer review requirements. Peer-to-peer requirements dictated short turnaround times to respond to plans and yet added days to discharge planning. One ACH indicated that the MA authorization and appeal process could take several weeks. Two other ACHs reported an unwillingness to appeal IRF coverage denials. One ACH said that upon the initial IRF denial, their team immediately pivots to sourcing a SNF placement since appealing MA denials simply delayed discharges and winning an appeal was rare.

[21] Only one of the ACHs interviewed rarely referred patients to IRFs. The one IRF referral this interviewee could recall did not have MA coverage.

ACHs considered patient preferences for facilities and convenience/proximity

Most ACHs reported that many patients and caregivers considered driving time more important than any other factor when choosing placement options after an ACH stay. Interviewees explained that many patients were reluctant to be discharged to IRFs that required their caregivers to contend with mileage, significant traffic, or traverse geographic barriers such as rivers or city centers. As a result, patients who were accepted to and would benefit from IRF care sometimes opted instead to go to a nearby SNF or even to go directly home.

> *[Driving time or distance overrides everything, even being in a nursing home] "It really does, and we try to talk to the family about what the resources that are available [at IRFs versus SNFs] and how they differ. They really don't care. They want to be some place where they're close to their family member."*

Most ACHs reported that they referred to IRFs when it was the patient's preferred setting even if the ACH thought the IRF referral would likely be denied. Nearly half of the ACHs stated that their patients considered IRF care to be superior and preferable to SNF care. They reported multiple reasons for patients preferring IRFs, including that IRFs were typically newer facilities, were more likely to have private rooms, and did not have the stigma associated with nursing homes.

IRF placement was challenging for patients without safe discharge plans and those with behavioral health issues

Multiple ACHs emphasized that patients who lacked a safe IRF discharge plan were more difficult to place in an IRF than in a SNF, even if the patients were otherwise suitable. As part of the admission screening, IRFs routinely inquired about patients' caregiver support and whether they would have a suitable place to stay upon discharge from the IRF. Many ACHs indicated that unhoused patients were particularly challenging to place in any facility and three ACHs specifically mentioned that IRFs were unlikely to accept referrals for unhoused individuals.

In addition, four of the ACHs shared that it was particularly difficult to place patients with behavioral health conditions in PAC facilities. Patients with behavioral health or substance use disorders were repeatedly mentioned as being challenging to place in IRFs post discharge, and sometimes in SNFs as well. One of those ACHs indicated that they referred patients with psychiatric needs to an IRF further away than others since it specialized in working with patients who present with behavioral health challenges. Another ACH indicated that they observed IRFs in their market "cherry-picking," with some IRFs rejecting admissions of patients with behavioral health or addiction issues, those on long-term antibiotics, and patients in need of wound care.

Most ACHs reported that area IRFs did not expand admission criteria during the public health emergency

During the COVID public health emergency (PHE), CMS made some exceptions to Medicare's facility requirements for both IRFs and SNFs to help facilities manage patient flow. **Despite the**

flexibilities, only two ACHs reported that during the PHE some area IRFs expanded their admission criteria to accept patients who would not have qualified for IRF care pre-PHE. In addition, the ACH with an on-site IRF unit said *"[The IRF unit] did not feel the pressure of checking every box during the pandemic. We didn't have to meet the 60 percent rule."*

On the other hand, most ACHs noted that discharging patients to SNFs during the PHE was much easier due to CMS' temporary waiver of the SNF 3-day rule.[22] An interviewee emphasized the value of the waiver in getting patients the care they needed. Many others noted discharge planning was more efficient and it was far easier to place patients in the appropriate level of care—IRF or SNF—during the PHE.

> *"The waiver was great... In fact, I think we should function the way we were functioning during the emergency phase because things were functioning much more efficiently... there weren't those barriers to getting patients transitioned to the appropriate level of care."*

Some ACHs described referring patients to IRFs who could have more appropriately received care at a SNF if not for the SNF 3-day rule. Two ACHs said they refer patients like this for IRF level care because a SNF stay would not be covered by Medicare and it would be unsafe to send them home. Another ACH indicated its staff had been on a "road show" to clarify for system physicians that they can no longer refer certain types of patients—such as those recovering from outpatient procedures—to SNFs now that the PHE has ended.

> *" A pelvic fracture that does not require surgical intervention does not meet an inpatient level of care in an acute care environment. But this patient can't walk, and patients aren't capable, in a lot of cases, of going home, or the family can't manage their care. Our option then becomes referring to an [IRF] acute rehab environment, hoping that they can meet those requirements..."*

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[22] During the COVID-19 public health emergency (PHE), CMS used statutory flexibility under Section 1812(f) of the Social Security Act to temporarily waive the requirement for a three-day prior hospitalization for Medicare coverage of a SNF stay until May 11, 2023.

CONCLUSION

While patient diagnosis was a key factor always considered in referral decisions since it impacted whether the admission met an IRF's compliance threshold, diagnosis was only one of many considerations. As discussed, many other factors impacted whether an ACH referred a patient for intensive therapy in an IRF or to a SNF. Although all the ACHs interviewed reported a defined set of factors to determine if a patient should be referred to an IRF, there was little agreement across ACHs about the relative importance of each factor that went into determining if an IRF referral was warranted or was likely to be accepted, except that a patient should be able to tolerate at least three hours of therapy a day.

Most discharge planning approaches described require some degree of subjective consideration by therapists, clinicians, discharge planners, potential receiving facilities, and the patient and their caregivers. Only two ACHs provided examples of more formal processes and tools used to support making referral decisions. In the limited sample of ACHs interviewed as part of this study, the combination and weights of each factor varied *for each patient* regardless of their geographic location or the accessibility of an IRF. Table 2 presents the array of factors that ACHs considered when discharging a patient to an IRF or SNF.

Table 2. Factors Considered in Discharge Planning for IRFs or SNFs

Factors	Considerations
Market conditions	• ACH bed availability/census • Presence of on-site IRF or SNF • Number of IRFs, capacity and admission patterns (e.g., selectivity, how close an IRF is to the compliance threshold) • Number of SNFs, capacity and admission patterns (e.g., selectivity)
ACH level of care assessment approach	• Use of standardized tools • Therapy team's assessment of patient's ability to tolerate intensive therapy
Patient characteristics	• Willingness to participate in intensive therapy • Diagnosis (e.g., Medicare qualifying condition) • Medical complexity • Potential to be discharged home post-rehabilitation • Medicare coverage (FFS or MA) • Convenience and proximity/drive time to facilities • Perceptions of area facilities

Yet, the team identified a meaningful pattern: Medicare FFS patients with at least one Medicare IRF qualifying condition who could and were willing to withstand intensive therapy were readily referred to IRFs if there was one nearby, and often admitted. In contrast, MA patients, even if they had a qualifying condition, were unlikely to be placed in an IRF. ACHs attributed this pattern to many MA plans restricting or denying most IRF-level care regardless of whether patients had qualifying conditions. No other meaningful patterns that lead to a patient's placement in an IRF rather than a SNF were discernable.

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APPENDIX

Interview Discussion Guide

Background

- Please describe the post-acute care (PAC) market and the levels of care available at PAC inpatient facilities in your region. We are especially interested in hearing about SNFs that can care for patients who qualify for IRF-level care.

PAC Market Context

- Does your organization own an IRF or a SNF?
- Please tell us about your relationships with SNFs and IRFs in your market.
    - Do you have longstanding relationships with specific SNFs or IRFs in the area?
    - Are they the same facilities to which you send patients to who could benefit from 3 hours or more of daily inpatient rehabilitation therapy?
    - Are you part of a network of providers, a Medicare ACO or bundled payment arrangement that affects your PAC referral patterns?
        - What effects that has on where you place patients who would benefit from 3 hours or more of daily inpatient rehabilitation therapy?
- How many IRFs are in your area?
    - How many of these facilities do you discharge patients to? Are there certain IRFs that admit most of your (IRF-bound) patients?
    - If the IRFs in your area are full or will not accept a patient, do you refer the patient to an area SNF or do you find an IRF or SNF outside of the area?
- To what extent are SNFs in your area willing and able to admit Medicare patients who:
    - (1) qualify for Medicare IRF-level care or
    - (2) need at least 3 hours of daily inpatient rehabilitation therapy?
- Can you describe any overlaps in the type of care provided between SNFs and IRFs in your market?
    - What, if any, characteristics make some of the SNFs in your market similar to IRFs (e.g., services offered, staffing ratios, interdisciplinary medical team, physician on premises)?

- Do IRF or SNF representatives or clinical liaisons visit your staff or the discharge planning office?

As we continue our discussion, please keep in mind we are interested in Medicare patients being discharged to SNFs and/or IRFs who came to the hospital from the community. We are less interested in patients who were already residents in a nursing home when they were admitted to your hospital.

Discharge Planning: Factors Affecting SNF-IRF Placement Decisions

Identifying Facility Options

- Can you briefly describe your process at a high level, starting with how you determine that a patient requires 3 or more hours of daily inpatient rehabilitation therapy post-discharge or meets Medicare IRF-qualifying criteria?
    - When you're working on discharge planning with a patient who will require inpatient rehab, who is the lead decision maker within the patient's care team?
    - After the determination is made that a patient needs 3 hours of daily inpatient therapy, what are the usual steps that you take?
        - Is there a clinical decision tree or patient screening process that helps guide your next steps in identifying potential placement options?
            - Do you consider whether the patient has an IRF-qualifying or non-qualifying condition?
        - Are there other patient factors (demographics, proximity to IRF or SNF) that affect which facilities you offer as options to these patients?
        - What information do the admitting facilities typically require about these patients and at what points do they require it?
- What clinical or other characteristics make it easier or harder for you to decide what type of facility to recommend for such patients?
    - Do certain patient characteristics or care needs dominate these placement decisions?

Placement Considerations

- What kinds of patients do you most often refer to IRFs?
    - Types of diagnoses/conditions
    - Payer
    - Level of care required.

- Are certain types of patients more difficult to place in IRFs? (i.e., Are patients with Medicare non-qualifying IRF conditions (e.g., cardiac, cancer, transplant, on dialysis) harder to place in IRFs than those with Medicare IRF-qualifying conditions?)

- Within a given condition (e.g., joint replacement, stroke patients), are some types of patients more likely to be placed in a SNF versus an IRF? For example, a stroke patient with or without paralysis?

Hospitals That Own IRFs or SNFs

- *Own IRF(s):* What types of patients do you send to your IRF? Does your IRF accept Medicare patients with non-qualifying conditions? What types of patients do you refer to another IRF, if ever, and why? Under what circumstances would you send a patient who would benefit from 3 or more hours of inpatient rehabilitation therapy to a SNF (instead of an IRF), and why?

- *Own SNF(s):* Does your SNF care for patients who could benefit from 3 or more hours of daily inpatient rehabilitation therapy? Do you ever refer such patients to another SNF, and why? Does your SNF care for any Medicare patients that have IRF-qualifying conditions? What types of patients do you refer to an IRF, and why?

- *Own IRF(s) and SNF(s):* For a patient who could go to an IRF or a SNF, how do you decide which facility type to send them to, since you have both?

Other Factors

Impact of PHE

- When the PHE waivers were in place, was it easier or harder to place patients in need of 3 hours of daily inpatient rehabilitation therapy*?*

    - Thinking back to the IRF placements since the pandemic started, roughly what percent would you say would meet current IRF qualifying criteria?

MA vs. FFS Placement Experience

We have been talking about Medicare FFS patients, but we would also like to briefly touch on your experience placing patients with Medicare Advantage coverage.

- Are MA patients any more difficult to place than patients with traditional Medicare coverage?

    - How long does it typically take to get an MA plan to review and approve discharge referrals to an IRF or SNF?

    - Is it easier to get approval for one type of facility over another (SNF vs. IRF)?

- If transfer is authorized, is the approval for a specific length of stay?
- What is your opinion on whether the number of days plans authorize is generally reasonable?

- If the plan does not approve a referral to an IRF, what do you do?
  - What are the most common reasons MA plans deny transfer to an IRF?

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