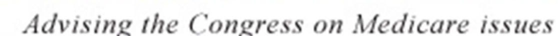

Site-neutral payments for select conditions treated in inpatient rehabilitation facilities and skilled nursing facilities

Carol Carter and Sara Sadownik

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Road map

- Background on how inpatient rehabilitation facilities (IRF) and skilled nursing facilities (SNF) differ
- Criteria used to select conditions
- Compare beneficiary characteristics and outcomes
- Estimate impacts on payments to IRFs
- Waive certain IRF program requirements

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Examples of how IRFs and SNFs differ

- Licensure
- Medicare requirements for IRFs
  - Physician oversight
  - Nursing availability 24 hours per day
  - Multidisciplinary team approach
  - Minimum 3 hours therapy per day
- Separate PPSs
  - SNFs paid per day
  - IRFs paid per discharge. Add-on payments for teaching, low income share, and high cost outliers

Selection of 3 conditions

Factors

- IRF volume and spending
- Condition frequently treated in SNFs
- Conditions selected by other studies that compared cost and outcomes in SNFs and IRFs

Conditions selected

- Stroke
- Major joint replacement
- Hip and femur procedures (including hip fracture)

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IRF payments are generally, but not always, higher than SNF payments in 2011

DRG	Description	SNF payment per stay	IRF payment per stay	Ratio of IRF to SNF
65	Stroke with CC	$15,873	$20,864	1.3
470	Major joint replacement without MCC	9,843	13,821	1.4
481	Hip & femur procedures with CC	17,646	17,406	1.0

Source: Analysis of IRF and SNF MedPAR 2011 data conducted by the Urban Institute for MedPAC. Data are preliminary and subject to change.

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For select conditions, characteristics of beneficiaries admitted to IRFs and SNFs in the same market are similar

	Risk Score (HCC)	Age	% dual eligible	% minority	% female
Stroke with CC					
SNF	1.8	81	28%	21%	65%
IRF	1.5	76	22	22	55
Major joint replacement without MCC					
SNF	1.3	76	15	11	74
IRF	1.4	77	15	11	72
Hip & femur procedures with CC					
SNF	1.7	83	21	8	79
IRF	1.7	80	17	8	74

Source: Analysis of 2011 denominator file, 2011 HCC risk scores, 2011 MedPAR 2011 conducted by the Urban Institute for MedPAC. Data are preliminary and subject to change.

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Overlap of the distributions of beneficiaries admitted to IRFs and SNFs: risk scores and age

- Benchmark: 80% of SNF patients are within the 10th and 90th percentiles
- 72% to 82% of IRF beneficiaries' risk scores were within 10th and 90th percentiles of the SNF distribution, depending on the condition
- 78% to 81% of IRF beneficiaries' ages were within 10th and 90th percentiles of the SNF distribution, depending on the condition

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Source: Analysis of MedPAR and HCC data by the Urban Institute for MedPAC. Data are preliminary and subject to change.

Overlap of the distributions of beneficiaries admitted to IRFs and SNFs: predicted ancillary costs

- Predicted ancillary costs per stay are indicators of patient care needs
- Benchmark: 80% of SNF patients' predicted costs are within the 10th and 90th percentiles
- Share of IRF predicted costs within 10th and 90th percentiles of the SNF distributions:

	Stroke	Major joint replacement	Hip & femur procedures
Nontherapy ancillary	79%	79%	73%
Therapy	73	80	53

Source: Predicted costs based on SNF alternative PPS model developed by the Urban Institute for MedPAC. Data are preliminary and subject to change.

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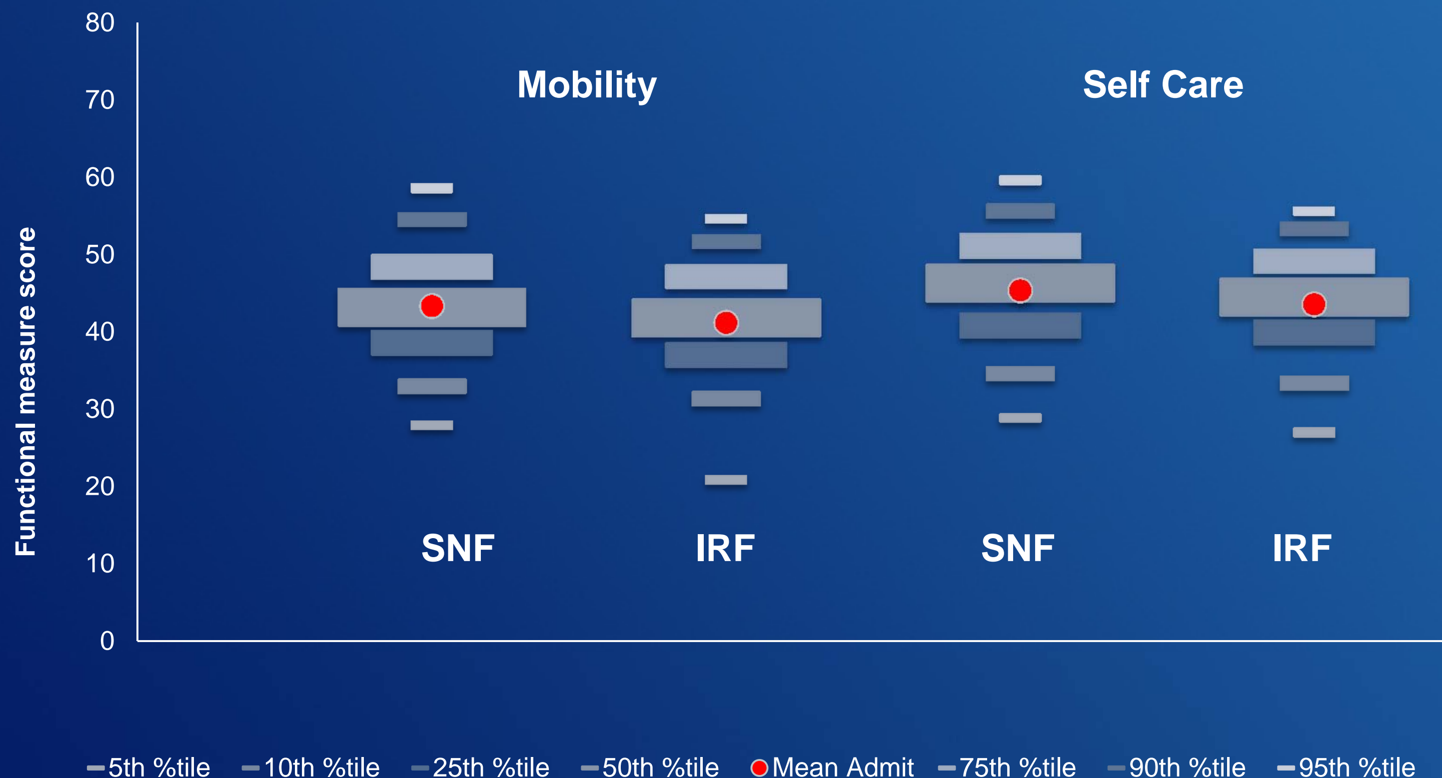
For select conditions, prevalence of comorbidities of beneficiaries admitted to SNFs and IRFs are generally similar

Comorbidity (HCC)	Stroke w/ CC		Major joint replacement w/o MCC		Hip & femur procedures w/CC	
	SNF	IRF	SNF	IRF	SNF	IRF
COPD	18%	15%	13%	15%	19%	19%
Congestive heart failure	26	20	13	15	22	20
Diabetes without complication	18	19	16	17	14	16
Heart arrhythmias	29	22	15	17	23	21
Polyneuropathy	10	9	8	10	9	10
Renal failure	19	15	11	12	17	15
Stroke (during previous year)	17	13	3	5	7	6
Vascular disease	25	18	16	18	24	20

Source: Analysis of 2011 HCC risk scores conducted by the Urban Institute for MedPAC.
Data are preliminary and subject to change.

CMS PAC demonstration found patients admitted to participating IRFs and SNFs had similar functional status at admission



Source: B. Gage, et al. 2011. Post-acute payment reform demonstration: Final Report. 2011.

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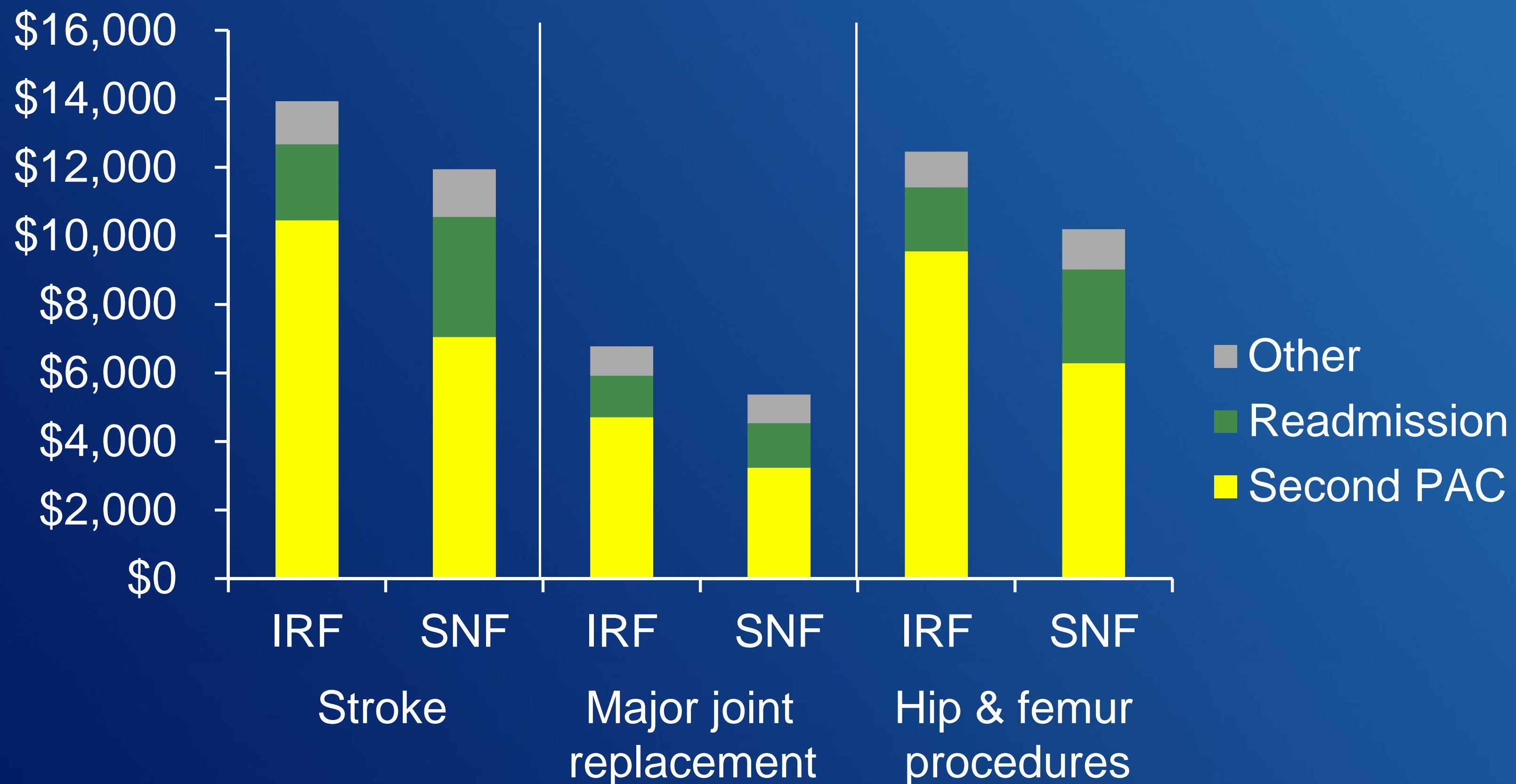
Outcomes: Readmission rates

- Unadjusted readmission rates: rates were higher in SNFs compared with IRFs
- Risk adjusted: CMS PAC demonstration
  - No significant differences in rates between IRFs and SNFs for musculoskeletal or nervous system (e.g., stroke) conditions

Outcomes: Changes in functional status

- PAC-PRD results allows for risk-adjusted, comparable measures
- Mobility: no significant differences between IRFs and SNFs for musculoskeletal or nervous system (e.g., stroke) conditions
- Self care: No significant differences for musculoskeletal conditions; larger improvement for patients admitted to IRFs for nervous system conditions

Spending during 30 days after discharge from IRF or SNF was higher for IRF patients



Source: MedPAC analysis of 2011 MedPAR data. Data are preliminary and subject to change.

Methods to estimate payment impacts

- Compared IRF base payments (2014) with two SNF payment scenarios for the cases:
  - Current SNF PPS
  - Alternative SNF PPS design
- Converted SNF payments per day to payments per discharge, based on average SNF length of stay by condition
- No change to IRF add-on payments:
  - Indirect medical education, share of low-income patients, and high-cost outliers

Impacts on per discharge IRF payments in 2014

	Payment rate per IRF discharge (2014)			Impact to per discharge payment	
	IRF	SNF current policy	SNF alternative design	SNF current policy	SNF alternative design
Stroke with CC (DRG 65)	$22,389	$17,440	$17,057	-22%	-24%
Major joint replacement w/o MCC (DRG 470)	$14,650	$11,218	$12,013	-23%	-18%
Hip & femur procedures with CC (DRG 481)	$18,775	$19,788	$19,975	5%	6%

- Impacts were fairly consistent across the broader DRGs for the conditions

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Source: Analysis based on 2011 MedPAR and IRF-PAI conducted by the Urban Institute for MedPAC. Data are preliminary and subject to change.

Aggregate payment impacts vary by span of cases included

- Site-neutral payments for conditions with the 3 DRGs would lower Medicare payments by ~$300M or 4 percent of Medicare IRF spending
  - DRGs 65, 470, 481 represent 25% of IRF cases
- Using the broader set of 8 DRGs examined would lower Medicare payments by ~$415M or 5 percent of IRF spending
  - The 8 DRGs represent 34% of IRF cases
- Total impacts smaller with SNF alternative model

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Data are preliminary and subject to change.

Total payment impacts similar by provider type

- Payment impacts similar (-4%) for non-profit, for-profit, hospital-based, and freestanding IRFs
  - Payments decreased 4% for urban IRFs versus 5% for rural IRFs
- Aggregate base payments decreased slightly more for non-profit and hospital-based IRFs, due to higher shares of patients with the conditions
- Non-profit and hospital-based IRFs receive more add-on payments, lessening total financial impact

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Data are preliminary and subject to change.

Waiving IRF regulatory requirements

- Consideration of whether to waive IRF regulations for site-neutral cases:
  - Regulations include provision of 3 hours of therapy a day, frequency of physician supervision, changes to 60 percent compliance threshold
- Waving regulations could create a level playing field by enabling IRFs to vary care according to patient severity

Next steps for advancing PAC reform

- Refine which conditions could qualify for site-neutral payments
- Identify key factors that predict admission to IRFs versus SNFs

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Issues for discussion

- Selecting cases for site-neutral payments
  - Which conditions?
  - Exemptions?
- Should some IRF requirements be waived to create a more level playing field?