October 19, 2023

SUBMITTED ELECTRONICALLY

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Chair
Medicare Payment Advisory Commission

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Executive Director
Medicare Payment Advisory Commission

Re: AMRPA Response to October 2023 Public Meeting Session on IRF & SNF Payment Reform Models

On behalf of the American Medical Rehabilitation Providers Association (AMRPA) and our 700+ inpatient rehabilitation hospital members, we write to express our significant concerns with the alternative payment options for inpatient rehabilitation facilities (IRFs) and skilled nursing facilities (SNFs) discussed during the Medicare Payment Advisory Commission (MedPAC) October 2023 public meeting. Perhaps even more concerning than the payment proposals themselves, we were alarmed at much of the underlying discussion and mischaracterization of IRF coverage requirements and the patient populations served by our providers, as well as the lack of acknowledgment of the physician-led process through which patients are deemed appropriate for inpatient rehabilitation. As a result of these oversights, we believe MedPAC's analysis fails to capture the inherent complexity (seen through case-mix index, functional deficits, comorbidities, and other factors) shared across all patients admitted to inpatient rehabilitation. We have outlined below our perspective on the points raised during the October 2023 session, and we plan to further engage with the Commission to address each of these critical issues. We also respectfully request that our comments be shared with both the Commissioners and staff to ensure that any future IRF payment-related recommendations are based on accurate interpretations of Medicare regulations and appropriate understandings of the patients in need of the unique services provided by our member hospitals.

Consistent with our extensive past correspondence with MedPAC, AMRPA fiercely opposes payment models that would base patient placement decisions on short-term costs rather than clinical needs and longer-term outcomes. The two proposals discussed during the October session – creating a site-neutral payment rate for patients who do not count towards the 60% rule threshold or uniformly lowering IRF payments to make them more aligned with the SNF benefit – are consistent with these types of models. We are particularly concerned that the incomplete and, at times, inaccurate data presented to the Commissioners may have distorted the impact such proposals would have on care delivery and patient access. Our primary areas of concern with these proposals and the October discussion surrounding their implementation are as follows:

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(1) Mischaracterization of the IRF "60% rule" as a tool for determining the types of patients who qualify for IRF services, the limited (or lack of) acknowledgment of the role of the rehabilitation physician in an IRF admission, and what appears to be a fundamental misunderstanding of the types of patients who benefit from inpatient rehabilitation;
(2) Limited discussion of outcomes-related data that demonstrate the clear differences between the IRF and SNF benefit (i.e., discharge to community and readmissions), which are far more salient than some of the measures that received primary consideration during the October meeting;
(3) Reliance on the qualitative data from a discharge planning survey that only included 12 discharge planners – despite the fact there are nearly 3,200 acute care hospitals in the Inpatient Prospective Payment System (IPPS), more than 1,100 IRFs paid under the IRF Prospective Payment System (IRF PPS), over 15,000 skilled nursing facilities (SNF) paid under the SNF PPS, and many market-specific factors that impact discharge planners' placement decisions;
(4) Numerous assertions that Medicare Advantage (MA) admission rates may be instructive for MedPAC's work when, in fact, MA plans continue to face intense scrutiny for their overly restrictive IRF coverage practices and inappropriate denials;[1] and
(5) Major concerns surrounding the current staffing adequacy within SNFs and long-term care facilities – including those raised by MedPAC itself during the October meeting – and the fact that these issues create an even greater risk for adverse outcomes if patients are inappropriately diverted from the IRF to SNF setting.

Our detailed comments on each of these issues follow:

I. MedPAC's Proposed Payment Reforms Reflect Mischaracterizations of the 60% Rule & Misperceptions of the IRF Patient Population

One of AMRPA's most significant concerns with the October discussion centered on how the intent and function of the 60% Rule were presented to the Commissioners. As we assume MedPAC is aware, the 60% rule is purely used to determine, in the aggregate, whether a freestanding rehabilitation hospital or unit can maintain its designation and payment under the IRF PPS. Developed approximately 40 years ago, the current rule requires that at least 60% of all patients admitted to an IRF for treatment must have a diagnosis of one or more of 13 specified conditions[2] listed in 42 C.F.R. § 412.29(b)(2) (which include conditions such as stroke, spinal cord injury, and brain injury) as a way of distinguishing IRFs from acute care hospitals paid under the IPPS. The other 40% (or less) of an IRF's patients may have different underlying

[1] *See, e.g.*, Department of Health and Human Services (HHS) Office of Inspector General (OIG), Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care (April 2022). (https://oig.hhs.gov/oei/reports/oei-09-18-00260.pdf). This report found that MA plans denied nearly 15% of prior authorization requests that in fact met Medicare coverage rules, and that IRF services were cited as a service especially vulnerable to such inappropriate denials.

[2] The full list of 13 conditions are: stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, fracture of the hip, brain injury, burns, active polyarthritis, systemic vasculitis with joint involvement, specified neurologic conditions, severe or advanced osteoarthritis, knee or hip replacement (if bilateral, body mass index >50, or age 85).

diagnoses and conditions, but nonetheless face the identical and extensive coverage requirements to gain admission to an IRF – such as a sufficient level of acuity and the documented expectation that the patient both requires and can actively participate in the intensive rehabilitation therapy program unique to the IRF. Examples of these complex patient populations include oncology, organ transplant, and cardiac patients, among numerous others. The IRF coverage criteria are detailed in a separate section of the regulations, 42 C.F.R. § 412.622. The 60% rule has **never been used to determine whether individual patients qualify for admission to an IRF, as this would run in direct conflict to the physician-led, patient-centric (rather than condition-based) process that has always been used for IRF admissions**.

Compared to other post-acute care settings, inpatient rehabilitation arguably represents the most regulated Medicare benefit and requires the most intensive physician involvement in an admission determination. The stringency of an IRF admission is perhaps most clearly demonstrated by the language of the common pre-admission screen (PAS) or PAS-related tools.[3] As seen by these admission requirements, there is no condition- or diagnosis-based requirement for IRF admissions. Instead, patients who are accepted by rehabilitation physicians for IRF care – regardless of whether they have one of the 13 conditions that count toward a hospital's 60% threshold – are deemed acute enough to require intensive, interdisciplinary treatment, in an inpatient hospital setting, with a need for significant medical management and oversight for their underlying and co-existing conditions. If a patient does not meet the full slate of coverage criteria in the clinical judgment of the rehabilitation physician, they will not be approved for an IRF admission – which happens with respect to patients who count toward the 60% rule threshold and those who do not.

In fact, our members consistently report that a high percentage of patients referred to IRFs are determined by the IRF clinical team to not meet these very stringent criteria. For example, based on information sourced from eRehabData®,[4] IRFs selectively admitted just under 40% of all patients referred to their hospitals or units after conducting the pre-admission screen, regardless of whether their primary condition was one that would count toward the 60% threshold. When referrals to IRFs are made, the rehabilitation physician and the clinical team conduct the comprehensive PAS and may turn away patients for various reasons, including not meeting the medical necessity requirements for the Medicare IRF benefit, not having a severe enough functional deficit to necessitate an intensive IRF stay, or not having significant enough potential for improvement after treatment. This further emphasizes that IRF admission decisions are based on the patient's individual circumstances and clinical needs under the IRF coverage regulations, without relying on whether their condition meets the 60% rule or not.

[3] Please see the Pre-Admission Screening requirements in the Medicare Benefits Policy Manual, Chapter 1 Section 110.1.1. An example of a pre-admission screening tool used by eRehabData® subscribers is found in Appendix I.

[4] eRehabData® is AMRPA's outcomes and policy modeling system. In addition to assisting inpatient rehabilitation hospitals and units in their compliance with CMS' regulations under the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) and IRF Quality Reporting Program (IRF QRP), based on the IRF Patient Assessment Instrument (IRF-PAI), eRehabData® and AMRPA partner together to analyze trends in the IRF field and assess the implications of current and proposed policies.

Despite the history and intent of the 60% rule, broad assertions were made during the October session that patients with conditions that fall outside of those covered by the rule are considered "non-qualifying" for inpatient rehabilitation. This is a grave and alarming misunderstanding of the 60% rule and the IRF patient population. The populations of patients that do not count toward the 60% rule (but do qualify for IRF admission) are highly complex and include underlying conditions such as organ transplantation, oncology, and pulmonology (among others). In fact, in the years since the initial conditions were first identified for the purposes of the 60% rule, advances in medicine and technology have made rehabilitation all the more critical for the full functional recovery of a broader patient population (this explains, for example, the increasing focus in oncology-related rehabilitation in recent years). Any assertion that these patients do not need or cannot benefit from the more intensive IRF benefit fails to account for highly complex and diverse IRF patient population, as well as the changes in care delivery since the 60% rule was first implemented.

For these reasons, AMRPA asserts that MedPAC must not only correct its description of the 60% rule and description of those patients who do not count toward the threshold, but must cease using the term "non-qualifying" when referring to these patients. While we assume this term is being used to clarify that these patients do not "qualify" towards IRFs' compliance with the 60% rule, the term was used in both the presentation and discussion to insinuate that these patients should not "qualify" as IRF patients at all. The latter notion has been refuted by the thousands of patients who do *not* count toward the 60% rule who nonetheless have been deemed (through IRFs' stringent review practices, the heightened review by Medicare audit contractors, and external entities such as the Office of Inspector General) as precisely the types of patients who need and benefit from IRF care. Quite simply, the rule would have been termed the "100% rule" had it ever been intended to distinguish those patients who do and do not qualify for an IRF admission. AMRPA has long respected MedPAC's efforts to provide data-driven, unbiased payment recommendations to Congress, and we therefore have serious concerns with the use of terminology that appears biased toward the policy recommendations offered by the staff.

Lastly, AMRPA seeks clarity from MedPAC regarding its assertion that CMS itself has "stated that [non-60% compliance-counting] conditions could be treated in a lower-cost setting." AMRPA has not identified any such written assertions or guidance from CMS, nor have we encountered any such statements from CMS during our numerous meetings regarding IRF coverage and payment rules in recent years. In fact, AMRPA is actively working with the CMS Center for Program Integrity (CPI) to address instances where Medicare contractors are rationalizing denials on the fact that the beneficiaries' underlying conditions did not count toward the 60% rule threshold, despite the fact that these types of denials violate the Medicare program rules. The CPI team's strong concern with this kind of contractor behavior firmly refutes the notion that CMS would support the 60% rule as a factor in the determination of medical necessity for an IRF stay.

In sum, AMRPA believes immediate and comprehensive corrections are required in future MedPAC discussions regarding the 60% rule. The October discussion not only mischaracterized the rule itself, but also failed to take into account the complexity of patients who do not count towards the rule's threshold but qualify for IRF services based on their specific functional deficits and need for a multi-disciplinary intensive therapy program uniquely

furnished by IRFs (among other factors). ***The whole premise on which MedPAC's current site neutral payment analysis rests is, therefore, fundamentally flawed and needs to be completely rethought and re-communicated to Commissioners if MedPAC intends to proceed further with this line of inquiry.*** We also have serious concerns with terminology used in the discussion and insinuations that CMS has supported MedPAC's interpretation of the 60% rule, despite the fact that AMRPA has never encountered such a position from CMS. We urge MedPAC to fully address these concerns if and when it proceeds with this line of analysis.

II. MedPAC Must Consider More Nuanced Claims Data & Outcomes-Focused Measures When Assessing Differences Across IRF and SNF Patients

AMRPA strenuously opposes several of the analytical findings presented at the end of October 2023 presentation. These findings - which are used to support either an identical payment rate for "non-qualifying" IRF patients and "comparable" SNF patients or a lower IRF payment rate – are not based on the most relevant clinical and outcome measures, and represent a serious misunderstanding of the IRF patient population. Some examples from MedPAC presentation, along with AMRPA's refutations, include the following:

- **MedPAC Finding:** "IRF patients [that do not count toward the 60% rule threshold] are either similar or have fewer impairments" compared to SNF patients.
- **AMRPA Refutation:** MedPAC bases this conclusion on only three metrics, two of which relate to incontinence (bladder and bowel incontinence). MedPAC's analysis overlooks the fact that IRF providers have reported challenges with the sensitivity and resulting patient severity of the incontinence measures following the transition from the FIM to Section GG/H reporting instruments. Previously, the FIM Instrument measured bladder and bowel management, taking into account not only the frequency of accidents, but also the patient's need for assistance in managing bladder and bowel events. The FIM Instrument included a seven-day assessment period (four days prior to admission and three days after admission) for frequency of accidents, capturing a patient's need for bowel and bladder management in advance of admission to the IRF. The level of assistance was part of the 3-day admission assessment period, but importantly, this included consideration for device use or other assistance from IRF clinicians to manage bladder and bowel events. Under current reporting requirements, only incontinent episodes that occur during the first three days of the stay are used to identify bladder and bowel impairment, and any need for assistance provided by the clinicians is ignored. This data therefore underrepresents those IRF patients who have bladder or bowel impairments and require incontinence-related assistance throughout their stay.

  Furthermore, MedPAC staff indicated that "IRF patients with non-qualifying stays also had lower rates of comorbidities," but did not provide any analysis of comorbidities or the methodology for making this determination in the publicly available materials. The IRF payment system recognizes the high number of IRF patients who require intensive therapy and physician oversight not only for their primary condition, but for numerous medical deficits and complex comorbidities. For this reason, IRF providers receive a higher payment depending on the "tiering" of certain comorbidities that carry a higher cost when accompanying the primary diagnosis. Tier 1 includes patients who require

medical services for tracheostomies or dialysis, which can only be addressed by physician-led, hospital-level, interdisciplinary care provided in an IRF. Patients in Tier 2 are often diagnosed with dysphagia (a swallowing difficulty). While MedPAC assessed swallowing difficulty across IRF and SNF patients, its analysis was based on patient assessment data (i.e., alternative nutrition approaches identified at admission, such as patients with an IV or feeding tube). This effectively captures the services rendered to patients with swallowing difficulty, rather than the true impairment. AMRPA believes that the dysphagia diagnosis ICD-10 code is a more accurate and effective way to identify patients with true swallowing difficulty, or at the very least, that MedPAC should capture this data as part of its assessment to better ensure an accurate comparison across IRF and SNF patients in this area. Finally, patients with Tier 3 comorbidities are typically those requiring assistance with the management of diabetes in addition to their primary diagnosis, which similarly requires physician-led, hospital-level, interdisciplinary care provided in an IRF.

We encourage MedPAC staff and Commissioners to consider these points and refine its analysis as necessary to ensure its comorbidities-focused analyses accurately capture the IRF population.

- **MedPAC Finding: "**IRF patients with nonqualifying stays and comparable SNF patients had similar functional status."
- **AMRPA Refutation:** In reviewing MedPAC's publicly available materials, AMRPA notes that MedPAC only examined nine items when assessing the motor scores across IRFs and SNFs – which represents less than half the number of motor-related items reported by IRFs on the IRF-PAI. This raises questions as to what factors were examined and whether other more relevant measures were excluded from MedPAC's analysis. We urge MedPAC to be much more transparent with respect to the data being used to compare functional status and explain why such a limited dataset was used.

  We also question the use of the Brief Interview for Mental Status (BIMS) as a proxy for cognitive status. Beginning October 1, 2022, CMS expanded the collection of Standardized Patient Assessment Data Elements (SPADEs) to capture additional measurement of a patient's cognitive and mental health, including Signs and Symptoms of Delirium (from CAM©), and Patient Mood Interview (PHQ-2 to 9) (from Pfizer Inc.©). Cognitive specialists supported the inclusion of this information, noting that the BIMS was not sensitive enough to capture cognitive impairments that required additional therapeutic interventions as part of the IRF stay. Furthermore, the range of values presented by MedPAC staff appears to exclude instances where the BIMS Score would be a 99, indicating an instance where the patients were unable to complete the interview due to nonsensical responses or not responding at all. This occurs in IRF data and appears to be underrepresented in the information provided, calling into question any comparison of impairment between the IRF and SNF data.

- **MedPAC Finding:** "Non-qualifying patients typically do not require the intensive rehabilitation that is unique to IRFs."

- **AMRPA Finding:** It is entirely unclear how MedPAC arrived at this conclusion. As we discuss in Section I, the decision to admit a patient to an IRF is based on a patient-specific screening overseen by a rehabilitation physician, taking into account factors ranging from the patient's medical history to the home environment they may be able to return to post-injury or illness. Just as certain patients who count toward the 60% rule threshold may be deemed inappropriate for an IRF stay (for example, a traumatic brain injury patient who cannot yet endure an intensive therapy program or a mild stroke patient who does not need an intensive, coordinated therapy program), there are corresponding "non-qualifying" patients who are optimally treated at an IRF. The appropriateness of these IRF placements reflect the complexity of their underlying condition(s), comorbidities, and medical/functional deficits, and numerous other factors identified in their pre-admission screen.

  Further, in noting that IRF and SNF patients receive a similar number of total therapy minutes (1,355 in an IRF versus 1,258 in a SNF) over the course of their stays, MedPAC fails to consider the much more stringent and patient-tailored therapy programs offered in an IRF. Patients in an IRF receive their therapy in less than half the time that SNF patients do (an average stay of 12 days versus 25 days), representing a significantly more intensive and multi-disciplinary therapy program compared to what is offered in the SNF setting. This critical difference in therapy delivery drives significant differences in outcomes, which were not discussed as part of MedPAC's analysis. In reviewing publicly available outcomes-related data on the CMS Care Compare website, IRF patients enjoy a 67% return to community rate versus 52% for short-stay SNF patients. IRF patients are also at lower risk for falls with major injury (0.2% vs 1.6%) and new or worsening pressure ulcers/injuries (1.1% vs. 2.8%) when compared to SNF short-stay outcomes. IRFs also perform better in comparison to SNF on Medication Reconciliation, with 97.7% of patients receiving a full drug regimen and follow-up completed versus only 91.6% of SNF Short Stay patients.

  Lastly, we note that patient satisfaction data - as collected by eRehabData®[5] - further shows that the "nonqualifying" patients have an over 95% satisfaction rate with their IRF care. This high rate is presumably influenced by the shorter stays and enhanced functional recovery. Several Commissioners requested that these types of outcomes-focused data to be incorporated into future discussions, and we urge MedPAC to address these analytical gaps if it proceeds with this line of work.

These findings are just select examples of the quantitative and qualitative data presented at the October meeting that must be corrected or revised moving forward.

III. MedPAC's Qualitative Findings Regarding IRF/SNF Admission Decisions Must Be Populated with More Representative Data and Shared with Stakeholders

During the October meeting discussion, MedPAC staff and Commissioners repeatedly

[5] eRehabData® implemented its' Patient Satisfaction system in 2005 to meet the needs of a rehabilitation hospital-specific patient satisfaction reporting tool. Since its implementation, eRehabData® has collected patient satisfaction assessment data on over 350,000 inpatient rehabilitation patients.

referred to a survey of discharge planners that was used to provide additional context on how patients are deemed appropriate for IRFs versus SNFs. AMRPA has several concerns with the survey itself, as well as the fact that it was not shared with stakeholders prior to the discussion.

Based on what we learned during the October public discussion, MedPAC aimed to learn more about the internal and external factors that determine IRF and SNF placement decisions through interviews with hospital discharge planners. While AMRPA supports these types of efforts to learn more about the nuanced PAC placement process, we question why other key stakeholders – such as rehabilitation physicians – were not part of these discussions. Of greatest concern was a staff comment indicating that only 12 discharge planners were interviewed as part of this qualitative data collection effort. Given that there are nearly 3,200 acute care hospitals and the post-acute care sector represents more than 1,100 IRFs and 15,000 SNFs across the nation, we have serious questions about whether 12 discharge planners can speak meaningfully to the diverse factors that impact PAC placement decisions across the nation (e.g., provider accessibility, condition-specific expertise of certain providers in select markets). We urge MedPAC to significantly build out this survey with additional discharge planners as well as other key stakeholders involved in the PAC placement process.

Furthermore, and consistent with points raised by numerous Commissioners, the impact of restrictive coverage policies used by Medicare Advantage (MA) and commercial payers must be properly considered by the Commission when considering the survey findings. AMRPA amplified these issues through its 2021 survey on the significant delays[6] and administrative burdens tied to IRF coverage issues in the MA program (this survey is discussed in greater detail in Section IV). The AMRPA survey was likely an impetus behind recent CMS rulemaking that, effective Calendar Year 2024, will limit MA plans' ability to use guidelines that conflict with Medicare coverage criteria, as well as employ unqualified reviewers (i.e., those without training and experience in inpatient rehabilitation) to review the medical necessity of an IRF admission. Even after these rules take full effect on January 1, 2024, however, discharge planners will continue to be inevitably impacted by payer behavior and the likelihood that patients referred to the IRF setting will be challenged by payers due to cost-related incentives. If MedPAC continues to rely on any type of discharge planning survey in future sessions on this topic, we believe it is imperative that the external pressures on discharge planners be addressed both in the survey itself and in related discussions.

IV. Medicare Advantage Admission Practices Are Under Serious Scrutiny & Cannot Serve as a Model for Traditional Medicare PAC Placement

During the October session, there were several assertions by staff and Commissioners that the MA program could be instructive in identifying appropriate IRF and SNF utilization. Several Commissioners offered an opposing view and noted that cost-driven (rather than clinically based) determinations rendered by MA plans presented serious access issues for both IRFs and SNFs. Consistent with our past engagement with MedPAC, AMRPA believes that qualitative and quantitative data strongly support the latter perspectives.

[6] AMRPA Report; Access to Inpatient Rehabilitation for Medicare Advantage Beneficiaries: An Examination of Prior Authorization Practices (March 2022); available here: https://amrpa.org/Portals/0/AMRPA%20PASurveyReport_Final.pdf.

AMRPA has previously shared both anecdotal and quantitative data with MedPAC showing the serious and improper restrictions on IRF access in the MA program. As just one example, our AMRPA member survey (representing over 12,100 IRF prior authorization requests to MA plans in August 2021) found that 53% of all initial requests for an IRF admission were denied, resulting in nearly 6,500 patients being diverted to less-intensive settings of care during just one month of data collection. The high rate of denial was very consistent across providers, with 87% of all hospitals having at least 30% of their requests denied during the month.

As we emphasize in our commentary above, each of these denials represents the overruling of a practicing rehabilitation physician treating a severely and acutely ill or injured patient, who refers that patient based on the physician's holistic assessment of their rehabilitation needs. Furthermore, the survey affirmed that MA beneficiaries spend an astounding number of unnecessary days in the acute care hospital waiting for prior authorization determinations, with a 2.5+ day average wait time for all determinations. Even among patients for whom MA plans approved their initial request for IRF admission, the survey found that the impacted patients spent 14,000 days in the aggregate spent waiting for a determination during a single month. These unnecessary delays result in additional acute care hospitalization expenses while restricting acute care hospitals from filling their beds with other patients with pressing care needs. While some staff and Commissioners insinuated that MA plans may be employing appropriate "checks" on inappropriate IRF admissions, the AMRPA survey instead shows that plans are using prior authorization as a delay tactic with the goal of diverting patients to lower-cost, less intensive settings of care that are inappropriate for many patients.

Recent federal oversight reports and regulatory action affirm and amplify AMRPA's findings.[7] In 2018, the Office of Inspector General (OIG) found that MA plans were misusing and even abusing prior authorization for their financial benefit. Specifically, the report found that MA plans overturned 75% of their own denials, demonstrating the inaccuracy of all MA beneficiary placement and service decisions. Even more recently, the OIG found that IRF services were among the "most prominent" of the service types that MA plans denied despite meeting Medicare coverage rules.[8] These findings show the immediate need to address IRF coverage in the MA program and fully counter any notion that MA plan behavior can offer meaningful and reliable guidance with respect to traditional Medicare PAC coverage policy, including with respect to IRF/SNF payment model proposals.

V. Staffing Adequacy Issues in the SNF Setting Must Be Addressed in MedPAC's Analysis

Finally, while AMRPA believes that any policy proposals that would effectively divert

[7] *See, e.g.*, Department of Health and Human Services (HHS) Office of Inspector General (OIG), Medicare Advantage Appeal Outcomes and Findings Raise Concerns About Service and Payment Denials (September 2018) (https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf).

[8] Department of Health and Human Services (HHS) Office of Inspector General (OIG), Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care (April 2022). (https://oig.hhs.gov/oei/reports/oei-09-18-00260.pdf).

certain patients from the IRF to SNF setting will result in serious adverse outcomes for patients, we note these negative impacts would be further exacerbated given the current staffing challenges impacting SNF providers. Recent analysis from the Kaiser Family Foundation found that employment levels in SNFs are more than 11% below pre-pandemic levels,[9] with wide variations across the country. In recognition of the severity of staffing shortages within SNFs and nursing homes and the impact on care delivery, CMS recently launched a "multi-faceted approach aimed at determining the minimum level and type of staffing needed to enable safe and quality care in nursing homes."[10] This effort culminated in a recent proposed rule that would create new minimum requirements for nurse staffing levels in SNFs. The same Kaiser analysis projects that less than 20% of all facilities would meet the new requirements, while the vast majority (more than 80% of providers) would need to hire additional staff.

Current staffing rates and the policy efforts aimed at addressing these shortages starkly highlight the workforce challenges facing the SNF sector. We note that numerous Commissioners touched on these points during a separate session in the October meeting, with several raising alarm about staffing levels, turnover rates, and the corresponding impact of quality of care. AMRPA recognizes the complexity of these matters and supports MedPAC's efforts to develop potential solutions that could help both SNF providers and the patients they serve. At the same time, staffing gaps among key positions (such as registered nurses) raise even more questions as to why MedPAC would support a policy that would essentially force SNFs to assume the care of more acute and complex patients.

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In sum, the proposals discussed during the October meeting would institute a barrier to IRF coverage for all patients who fall outside an IRF's 60% rule calculation, creating immediate and egregious access issues for many patients in need of medical rehabilitation. As discussed extensively in this letter, we believe these proposals are based on inaccurate and incomplete assessments of key IRF coverage and classification rules, admission practices, and the nuances of the IRF patient population. We also urge the staff and Commissioners to consider how the support for its proposals may be impacted by the incorporation of additional measures and analytical limitations identified by AMRPA. Finally, we note the proposals and underlying discussion fail to reflect advances in medicine and technology that have made intensive, hospital-based rehabilitation an integral part of the recovery for an increasingly broad range of patients – which in turn demonstrates the ongoing need for patient-centered and physician-led admission decision-making currently captured in the IRF admission process.

We encourage MedPAC to meet with our team to further discuss these critical issues involving the Commission's post-acute care work in the coming weeks. In the meantime, if you have any questions related to our concerns or recommendations, please contact Kate Beller, AMRPA Executive Vice President for Policy Development and Government Relations, at

[9] Kaiser Family Foundation; What Share of Nursing Facilities Might Meet Proposed New Requirements for Nursing Staff Hours? (Sept. 18, 2023); https://www.kff.org/medicaid/issue-brief/what-share-of-nursing-facilities-might-meet-proposed-new-requirements-for-nursing-staff-hours/.

[10] CMS Press Release (Aug. 2022); https://www.cms.gov/blog/centers-medicare-medicaid-services-staffing-study-inform-minimum-staffing-requirements-nursing-homes.

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Sincerely,

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