



Legacy Health

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November 4, 2019

Matt Gilman, MPPA
Pam Krecklow
Certificate of Need Program
Health Care Regulation and Quality Improvement Program
800 NE Oregon Street, Suite 465
Portland, OR 97232

Dear Mr. Gilman and Ms. Krecklow:

We are submitting our public comments on Certificate of Need (“CON”) applications submitted by Encompass Health Rehabilitation Hospital of Oregon, LLC (“Encompass”) and Post Acute Medical – PAM Squared at Portland, LLC (“PAM”). Oregon’s CON law and related regulations have been developed with the purpose to ensure that health services are adequately distributed around the state without unnecessary duplication of services or excessive costs to patients. The two applications for inpatient rehabilitation facility (“IRF”) projects, both in Washington County, OR, do not meet the burden of proof for justifying the need for a 50 bed IRF, which each applicant proposes.

Legacy Health owns and/or operates six hospitals, 27 primary care locations throughout the Portland Metro area and 90 specialty clinic locations that span from Southwest Washington to the Willamette Valley. Legacy’s hospitals include Legacy Emanuel Medical Center, a tertiary/quaternary hospital with a Level 1 trauma designation. Randall Children’s Hospital is also part of Legacy Emanuel.

Most relevant to this CN application is Legacy Good Samaritan (“Good Sam”). Good Sam was founded in 1875 on exactly the same land that it operates on today in Northwest Portland. In addition to being one of the region’s most advanced medical centers and a magnet for specialty services, it operates the Legacy Rehabilitation Institute of Oregon (“RIO”), an inpatient rehabilitation facility offering the highest level of care available.

In its 36 beds, RIO provides 24/7 rehabilitation nursing care, a team of board-certified physiatrists (rehabilitation doctors), certified rehabilitation registered nurses and certified stroke therapists, physical, occupational, recreational and speech therapists and neuro-psychology services for emotional support. The Program also includes state-of-the art equipment including the Zero-G gait and balance training system and an internationally recognized Horticulture Therapy program.

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RIO is accredited by the Commission on the Accreditation of Rehabilitation Facilities, and treats a comprehensive array of diagnoses.

Both applicants noted meeting with Legacy and that Legacy rejected the opportunity to collaborate with them in the creation of a new freestanding IRF. In fact, we declined involvement in either of the proposed applications only after considerable due diligence and determining the need in this service area fails any analysis of need for additional rehab beds.

The CN Process

The CN process is governed by a number of rules adopted by the Oregon Health Authority (“OHA”) under ORS 442.315(2), found at Oregon Administrative Rules (“OAR”) 333, Divisions 545 through 670. The burden of proof for justifying need and the viability of the proposal rests with the applicants. In order for a CN to be granted, OHA must find that the applicants satisfied all the criteria in OAR 333-580-0040 to 333-580-0060. The criteria incorporate the applicable service-specific methodologies and standards in OAR 333, Divisions 590 (Demonstration of Need for Acute Inpatient Beds and Facilities); and the applicable service-specific methodologies and standards in Division 645 (Demonstration of Need for Rehabilitation Services).

In order to approve the applications and issue CONs, the applicants must demonstrate the criteria and standards referenced in OAR 333-580-0030(1) are met. Criteria will be considered to have been met if the applicant can demonstrate that the questions posed in the criteria can be answered in the affirmative. OAR 333 590-0050 provides a 14-step methodology to determine if need for additional acute beds exists, and if it does how the beds should be allocated.

In the two current applications each proposing a new acute rehabilitation hospital, each hospital referenced 333-590-0030, but did not follow the prescribed methodology. Even absent a precise application of 333-590-0030, one of the applicants, Encompass, reached the conclusion that numeric need for additional beds does not exist (page 14-15 of their application).

The Service Area Population Does Not Need Either Proposed Project

This criterion requires the applicant to use particular indicators and specific standards and methodologies to determine the appropriate service area and to determine whether there is a need for both general acute care beds and IRF beds within the service area. The applicants have not met their burden with regard to the bed-need within the proposed service area. The current and historical rates of hospitalization do not support a conclusion of need for additional supply. The availability, accessibility, quality and levels of utilization of the existing IRF services address the medical needs of the applicable patient groups.

Both applicants state that 333-645-0030 anticipates seven acute rehabilitation beds per 100,000 population; in fact, the rule states that total need for inpatient rehabilitation services is such that inpatient facilities *shall not exceed seven beds in* 100,000 general population. Moreover, OAR 333-645-0030 also requires that an applicant demonstrate consistency with historical use patterns for rehabilitation services. It does allow adjustments if the applicant submits information that demonstrates, among other factors *the availability, accessibility, quality, and levels of utilization*

of existing inpatient services addressing the needs of those groups. While each applicant made general statements comparing lower use rates in Oregon to other states, absolutely no data was given to suggest that availability, accessibility; quality and occupancy are barriers to care.

According to a March 2018 AHA Fact Sheet: IRFs have faced significant scrutiny from Congress and the Centers for Medicare & Medicaid Services (“CMS”) in recent years, which has led to multiple interventions, including strict criteria for IRF patients, multiple payment cuts and other policy restrictions. Collectively, these interventions have reshaped the population treated in IRFs by dramatically reducing the overall volume and steadily increasing the medical complexity of IRF patients. The volume of IRF discharges has dropped significantly from 2004 through 2013 – 122,000 fewer cases per year.¹

A new rehabilitation unit must demonstrate that it will be able to achieve and maintain a minimal annual occupancy rate of 75 percent of unit capacity within three years of certificate of need approval. The RIO unit at Good Sam operates at 64% average annual occupancy. Data included in the Encompass application (table restated below), shows that neither of the two existing providers operate their acute rehabilitation units at 85%, simply because demand does not exist to do so. The record should reflect that not one of the letters of support nor those testifying in support of one or both of the applications provided data nor otherwise suggested any impact on patient outcomes as a result of the current acute rehabilitation bed supply. Rather, the letters generally hypothesized that “a freestanding inpatient rehab hospital will potentially provide better outcomes.

Table 1

Tri-County Hospital Rehabilitation Beds, Patient Days and Occupancy, 2016-2017

Hospital	Legacy Samaritan Center	Good Medical	Providence Portland Medical Center	Tri-County Total	Portland
Service Area County	Tri-County		Tri-County	Tri-County	
2017 Population (CPRC)				1,811,860	
Beds (2016/2017)*	36		18	54	
Discharges*	640		402	1,042	
Length of Stay*			9	10	
Patient Days*	8,385		4,999	13,384	
Average Daily Census	23		14	37	
Occupancy*	64%		76%	68%	

Source: Encompass Table 1, Attachment B, January 2019 Completeness Response

While each applicant has projected patient days that suggest they will achieve 75% capacity within three years of opening (but, inconsistent with rule, not within three years of CN approval), these estimates are unreliable. The unreliability is due to fundamental underlying assumptions errors—and especially those that employ an artificial standard requiring 7 IRF beds per 100,000 and

¹ See Fact Sheet: Inpatient Rehabilitation Facilities (IRFs) at <https://www.aha.org/factsheet/2018-03-19-fact-sheet-inpatient-rehabilitation-facilities-irfs>

reliance on Oregon, despite its decades of commitment to lower use of high cost facilities, to begin “looking like” the rest of the nation vis-à-vis acute rehabilitation utilization.

The Proposed Projects Will Not Result in an Improvement in Patients’ Reasonable Access to Services

Both applicants have overstated current and future demand and they have failed to perform any analysis of idle licensed beds and shelved space at these three existing IRF providers. As previously outlined here, total need for IRF services is such that inpatient facilities *shall not exceed seven beds in 100,000 general population*. This standard is set as a maximum standard, or population based cap because merely demonstrating that the cap has not been exceeded in a service area is not sufficient to meet the applicable standard.

OAR 333-645-0030 also requires that an applicant demonstrate consistency with historical use patterns for rehabilitation services. It does allow adjustments if the applicant submits information that demonstrates, among other factors *the availability, accessibility, quality, and levels of utilization of existing inpatient services addressing the needs of those groups*. While each applicant made general statements comparing lower use rates in Oregon to other states, absolutely no data was given to suggest that availability, accessibility; quality and occupancy are barriers to care.

Notably, OAR includes a provision mandating expansion of existing rehabilitation units be given priority over creation of new rehabilitation units for comparable services, unless it can be demonstrated that the applicant is offering the least costly service. Rehabilitation units must have an annualized occupancy rate of at least 85 percent prior to expansion of any bed capacities, and expansion should be such that the unit can maintain a minimal occupancy rate of 75 percent on unit capacity, within 1-1/2 years of CON approval.

Our experience operating RIO and another small 12 bed IRF at Randall conclusively demonstrates that patients within the applicants’ proposed service area currently have reasonable access to IRF services. In fact, our experience illustrates the existence of excess access to IRF beds; we consistently have capacity to serve over 10 additional patients at RIO, and several more at Randall. RIO is licensed to operate 36 of the 140 IRF beds in Oregon. RIO’s Case Mix Index (Acuity) is 1.44, and compared to the Region (1.37) and Nation (1.38), RIO’s is the highest in Acuity. A higher Case Mix Index suggests RIO handles a higher acuity patient mix than average. Despite RIO’s high acuity, RIO’s average length of stay is 13.6 days, for our Region it is 14.6 days and the National figure is 13.9. On average RIO’s daily census is 25 patients a day – 11 below our licensed capacity.²

Over the past decade, RIO’s average daily census has remained relatively unchanged, however the length of stay (LOS) a decade ago was on average 23 days compared to LOS stay of 13.6 today. This means the patient population is growing, however as technology and treatment has continued to improve and more patients are referred to Inpatient Rehab, they require less inpatient Rehab days and no additional inpatient beds are currently needed with our excess capacity able to meet projected demand into the foreseeable future.

² Randall operates at an average of roughly six daily patients per day.

OAR 333-645-0020 established, “Given the diversity of services possible, rehabilitation units should provide the least restrictive and most cost-effective setting possible to meet patient needs. Applicants shall demonstrate that their proposed services are the least costly of any reasonable alternatives.” RIO has the highest acuity of patients compared to the region and nation with the best discharge rate to the community (89.5%), compared to the Region (83.5%) and Nation (78.5%) as reported by the Uniform Data System for Inpatient Rehabilitation Facilities (UDSPRO). RIO’s Overall Likelihood of recommending facility, patients prepared to function at home, prepared to function in the community and overall care ratings rank higher than Top Box score according to the Hospital Consumer Assessment of Healthcare Providers and Systems, patient satisfaction survey required by CMS, Centers for Medicare and Medicaid Services.

RIO serves Legacy’s seven hospitals, Kaiser, OHSU (with a Level 1 trauma designation), and Tuality. In addition, RIO receives high acuity referrals from other rehab centers in Oregon and Vancouver, WA, along with out of state referrals. Both applicants included the Kaiser population as those lacking adequate access; however, Legacy has an exclusive contract with Kaiser. The applicants did not provide documentation to suggest that Kaiser will choose to send patients to their proposed facilities. This error is significant because Kaiser’s market share ranges from 15 to 24 percent. Both also included the VA population in their calculations of need, even though the VA operates inpatient acute rehabilitation beds in Vancouver.

Given the abundance of Inpatient Rehab beds, if additional Inpatient Rehab beds were added to the community, this would jeopardize the long-term viability of RIO and create a negative impact on patients in the proposed service area. In addition, there is no other facility with the capability to rehabilitate the high acuity patients, keeping those patients in hospital beds for a longer period. RIO is the most comprehensive Inpatient Rehabilitation Center in Oregon and Southwest Washington.

Regulatory Defects of the Encompass Application

Consistent with OAR 333-590-0040, the CON Program has a long and consistent history of requiring applicants to demonstrate numeric need for acute care beds before specialty beds can be added. Encompass proposes a three (3) County service area, which includes three existing providers of IRF beds and services.

Encompass, after stating that the methodology is flawed, itself concurs that there is no need for acute care beds under the existing bed need methodology and related data showing overall use rates that are declining. In terms of the bed need methodology, it has been prescribed in rule for decades and no applicant, including Encompass, has petitioned OHA for any rule amendment to address alleged defects in the data when it is not helpful to applicants with demonstration of need.

Encompass included the Kaiser population, even though Legacy has an exclusive contract with Kaiser. Encompass provided no documentation to suggest that Kaiser will send patients to its facility. This error is significant as Kaiser’s market share ranges from 15% to 24%. Additionally, Encompass included the VA population in its calculation of need, even though VA operates inpatient acute rehab beds in Vancouver.

Encompass asserts that the lack of IRF services places a financial strain and resource burden on patients and their families that requires the Oregon Department of Human Services (“DHS”) to intervene with the provision of services funded through Medicaid, increasing obligations of our state’s general fund. Approving the Encompass application is more likely to cause an increase in avoidable nursing home care costs. As previously noted, RIO currently has an average daily availability of 11 beds, resulting from excess supply in the service area. Roughly, half of our daily patients have their services paid by traditional Medicare. Our review of the Encompass application does not indicate that they will be willing to serve the Medicaid population, nor does Encompass name any commercial or Medicare insurance payors as supporters of this application. It is reasonable to conclude that Encompass will be limited to serving patients in the traditional Medicare program, also called fee-for-service (“FFS”).

By choosing to limit their scope to FFS, permitting either application will cause segmenting of an already scarce patient population. This will impair RIO by pushing its case mix into imbalance, increasing its proportional share of Medicaid and Medicare Advantage. RIO is an essential community provider to patients of the Oregon Health Plan in this service area. The dual hardship of introducing one or two IRFs into our over-supplied service area, coupled with their focus on FFS patients places our entire program in potential financial jeopardy. Given the faulty underlying assumptions, the project’s conformance to applicable financial feasibility criteria cannot be confirmed due to overstatement of potential patient days per OAR 333-580-0060.

Encompass has encountered some regulatory enforcement penalties casting doubt on its ability to reasonably assure that care will be that care will be provided in accord with applicable Federal and State laws as required by OAR 333-580-0040 and 333-580-0050. In June 2019, Encompass entered into a settlement agreement with the Department of Justice for a settlement payment of \$48 million following a seven-year investigation.

Regulatory Defects of the PAM Application

Consistent with OAR 333-590-0040, the CON Program has a long and consistent history of requiring applicants to demonstrate numeric need for acute care beds before specialty beds can be added. PAM proposed a seven (7) County service area that already includes three providers of acute rehabilitation. In its application, PAM cited historical data for the existing inpatient rehabilitation facilities as the rationale for its selected geography. No data was provided to support this assumption. At the same time that it selected its seven County service area, it noted in its application that the Department limited Ascend in its specialty hospital CN decision to a single zip code service area.

PAM did not use the required population data (Center for Population Research and Census) as outlined in OAR 333-590-0050. PAM provided no data to suggest that residents of the seven Counties are not able to timely access the care they need.

The patient days and subsequent use rates provided by PAM included in Table 4 of the methodology (Section B, p. 18) are in error. The patient days in Table 4 are lower than the discharge data in Table 3. The use rates in Table 4 cannot be calculated with the population data

in Table 1 and the patient day data in Table 4 and are significantly overstated. In addition, if the correct use rates were applied, there is no need for additional acute care beds. Given the faulty underlying assumptions, the project's conformance to applicable financial feasibility criteria cannot be confirmed due to overstatement of potential patient days per OAR 333-580-0060.

On page, 54, the PAM application offers very little with respect to serving Oregon's Medicaid population or provision of charity care. PAM projects Medicaid service at 2% of its planned patient capacity, despite also suggesting that it plans to form a partnership with Care Oregon and its 175,000 Medicaid clients in the service area. PAM assumes no charity care. In fiscal year 2019, the combined percentage of patients covered by Medicaid and/or benefiting from charity care served by RIO totaled 47.85%. Like Encompass, PAM intends to focus its services on serving a high percentage of Medicare FFS patients.

PAM's assertion that it will be superior on rates, access and patient satisfaction is incorrect. RIO is superior on all metrics and currently has sufficient capacity to serve more patients and meet patient need. RIO has previously expanded to accommodate patient need in the service area. RIO has capacity and access to sufficient financial resources to implement additional expansions should it become apparent that patient need supports an increase in supply.

PAM's recent history creates some doubt of its ability to meet OAR standards related to its history of demonstrated noncompliance with all applicable federal and state rules given its August of 2018 execution of a corporate integrity agreement ("CIA") with the US Office of Inspector General ("OIG") for the US Department of Health and Human Services.³ OIG imposed the terms of the CIA resulting from a settlement where PAM agreed to pay the federal government, Texas, and Louisiana a total of \$13,168,000 to settle allegations that they violated the False Claims Act, and the Texas and Louisiana false claims statutes, by knowingly submitting claims to the Medicare and Medicaid programs that resulted from violations of the Anti-Kickback Statute and the Physician Self-Referral Law.

Oregon's Uniquely Efficient Health Care Delivery System

Both applicants rely heavily on the documented dual observations that Oregon ranks 50th out of 50 states in Medicare FFS referrals to IRF service and 50th in hospital beds per 1,000 people. The applicants employ this data in an effort to demonstrate a deficit of patient access to IRF services and to justify approval of their projects. These cherry-picked points of data fail to demonstrate that there is a lack of alternatives to the high cost new services proposed by the applicants. In fact, the opposite is true; any close observer of public policy governing health care services in Oregon over the past several generations knows that Oregon has conscientiously promoted inpatient alternatives and patients have used them to positive effect to their personal health while improving aggregate efficiency of our system.

Oregon embarked on health care transformation nearly 20 years prior to the Affordable Care Act ("ACA"). In the early 1990s, Oregon moved its 240,000 Medicaid recipients into the newly formed Oregon Health Plan. Under this plan, Oregon contracted with managed care organizations

³ To review the CIA, see: https://oig.hhs.gov/fraud/cia/agreements/Post_Acute_Medical_LLC_et_al_08132018.pdf

to provide care for members. It was also able to expand enrollment and control costs using a prioritized list of covered services.

In 2012, Oregon's next substantial proposed Medicaid waiver was approved, with the state receiving nearly \$2 billion in federal funding to be an early adopter of transformation, and in accepting the funds, it committed to improving health care access and quality – and reduce health care spending – by focusing on prevention and primary care. The state and its Medicaid administrator, OHA, committed to accomplishing the triple aim of better health, better quality and lower costs by forming coordinated care organizations (“CCOs”). They were a new type of health plan charged with coordinating the physical, behavioral and oral health needs of people on the Oregon Health Plan. The CCOs were contractually obligated to make improvements in care while operating within a fixed global budget, which could grow, by no more than 3.4 percent per year, which was two percentage points below the projected growth rate in federal health care spending. It is important to note that while the initial efforts were related to the Medicaid program, the transformation has ultimately affected care delivery and utilization for all residents, regardless of payer.

According to Oregon's five-year report card, during the period of 2012-2017, the State's Medicaid reforms have saved taxpayers an estimated \$2.2 billion. An independent analysis of Oregon's 2012-2017 Medicaid waiver shows that Oregon has spent less per Medicaid member than neighboring Washington has, and that it has reduced emergency room visits and “low value” care.

Both applicants suggest that Oregon's acute rehabilitation use rate somehow precludes accessibility and quality care, but as data shows, the Western US in general, and Oregon in particular enjoy lower use rates for many services:

1. A Kaiser Family Foundation (KFF) report entitled “State Health Facts” identifies community hospital beds in each of the 50 states ranks beds per 1,000 population. The US average is 2.5 beds per 1,000. The high is 4.8 beds per 1,000 and the low is 1.7 beds per 1,000. Two states—Washington and Oregon—are tied at 1.7 beds, or more than 30% below the average.⁴
2. The same KFF report includes community hospital emergency room visits per 1,000 population. The US average is 445 visits per 1,000. The high is 698 visits per 1,000. Here, and at 378 visits per 1,000, Oregon ranks 43rd.⁵

In addition, the same KFF report provides data on average total nursing hours in certified nursing facilities by State. The report shows that in 2017 the US average was 4.0 nursing hours per patient day (PPD). The high was 5.2 PPD. Oregon tied for second highest at 4.8, and the lowest was 3.6. This reinforces that Oregon's Skilled Nursing Facilities are equipped to manage higher acuity patients. This demonstrates that Oregon's system is efficient in delivering services to the right patients, at the right time, using the right level of services.

⁴ See <https://www.kff.org/other/state-indicator/emergency-room-visits-by-ownership/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

⁵ *Id.*

Finally, Oregon has high Medicare Advantage penetration. Medicare Advantage is a managed care product that often use a network of specific providers and requires enrollees to secure prior authorization services. Many plans may cover care outside of the network, but it requires the enrollee to pay more out of pocket. A KFF report on 2018 Medicare Advantage Enrollees as a Percent of Total Medicare Population shows that the US average is 34%. The highest State penetration is 56%. Oregon is third highest at 43%. The low is 1%.⁶ The service area proposed by the applicants has Medicare Advantage enrollment rates of roughly 60%.

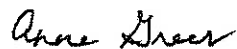
Conclusion

The CON applications of PAM and Encompass will not have an appropriate relationship with its service area, will result in an unnecessary duplication of services and will have a negative financial impact on other providers, failing the required standard under OAR 333-580-0050(3). If OHA approves either application, RIO and Randall will suffer significant negative financial impact with resulting harm to Oregon's patients receiving Medicaid or charity care.

The applicants failed to accurately address any negative impact the proposal will have on those presently offering or reimbursing for similar or alternative services. As noted previously, the applicants have not met their burden of establishing that the proposed IRFs will result in an improvement in patients' reasonable access to services. There are IRF beds available in the service area and concerted efforts underway to vigorously assess prospective patients to assure that they are appropriate for IRF services or receive lower cost and more effective alternatives to IRF services designed to prevent the need for hospitalization and to shorten lengths of stay.

Both proposed facilities would add unneeded beds resulting in an unnecessary duplication of services. We urge OHA to deny approval of the CON applications CN #679 and CN #680, each proposing a 50-bed IRF in Washington County.

Sincerely,



Anne T. Greer
Interim Vice President, Legal Services

⁶ See <https://www.kff.org/medicare/state-indicator/enrollees-as-a-of-total-medicare-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Overall%22,%22sort%22:%22desc%22%7D>

November 4, 2019

By Email matt.s.gilman@state.or.us and Hand Delivery

Matthew S. Gilman, Program Manager
Oregon Health Authority
Oregon State Public Health Division
800 N.E. Oregon Street, Suite 465
Portland, OR 9723

Dear Mr. Gilman:

Thank you for the opportunity for Post Acute Medical (“PAM”) to submit further written testimony in order to respond to statements made at the OHA hearing on October 14, 2019, on PAM’s application for a certificate of need. PAM’s responses are organized in the order that the witnesses’ testimony was provided, and is tied to the time each bit of testimony was provided. PAM has also provided attachments with this document to go along with the responses.

We hope this provides clarity and addresses the outrageous misrepresentations generated by the comments offered at our hearing, and we invite you to ask if you have any remaining uncertainties concerning the need for PAM’s hospital or about how the services will benefit the State of Oregon.

Respectfully yours,



Kristen Smith
EVP and President of Clinical Innovation and Business Intelligence

**Post Acute Medical Response to Oral Comments Made at Open Hearing Certificate of Need
Application #680**

PAM Rehabilitation Hospital of Portland

Tigard, Oregon

October 14, 2019

PAM Rehabilitation Hospital of Portland will be licensed as an acute care hospital. To maintain this distinction, throughout this response, the term Inpatient Rehabilitation Hospital (“IRH”) refers to both the proposed project and the nature of services it will offer.

Dr. Kathryn Kolonic: CMO of Marquis Companies

Marquis Comment – Marquis’ facilities “provide therapy services every day.” Its average is “2-plus hours, 6 or 7 days a week.” (Recording 00:25:57-0026:03).

PAM’s Response – For therapy services, PAM’s minimum is 3 hours per day, which is greater than those provided at Marquis facilities, and Marquis’ testimony suggests that Marquis provides more therapy than most SNFs provide. In addition, for patients to qualify for treatment in a rehabilitation hospital, they must require at least two therapy disciplines (PT, OT, SLP, and/or Prosthetics/Orthotics), demonstrating not only a complex medical patient but one that has complex therapy needs and requires intense therapy services.

A key concept to keep in mind is that PAM’s Rehabilitation Hospitals are a hospital level of care, rather than a skilled nursing level of care, which means that, like other IRHs, PAM provides more than rehabilitation/therapy services. PAM has 24/7 physician and nursing coverage, respiratory therapy, and in-house pharmacy to meet the medical needs of the patients in our hospitals, services that SNFs including Marquis do not provide.

Marquis Comment – “We offer our therapy patients significant provider resources including seven to nine physical therapists, occupational therapists, speech therapists, and assistants in each building daily.” (Recording 00:26:26-00:26:33).

PAM’s Response – PAM’s 50-bed rehabilitation hospitals are staffed with 24 therapists (comprised of physical, occupational, and speech therapy), compared to the 7-9 therapy staff at a Marquis facility.

Marquis Comment – Outcomes at Marquis are better than the SNF national averages with a discharge to community rate of 65% compared to national SNF average of 49% and a re-admission rate of 17% with a within facility rate of 12% compared to a state average of 21.4% and national average of 22.24%. “We also measure functional improvement in all our patients

that receive rehab services.” Marquis’ facilities “show an average of 34.16 gain.” (Recording 00:27:38-27:57).

PAM’s Response – This demonstrates the significant difference between a SNF and an IRH. PAM’s quality data shows a higher percentage discharge home, a lower percentage of persons readmitted to a general acute hospital before discharge, and a lower 30-day readmission rate after discharge. The functional gain reported by Dr. Kolonic is on a different functional scale than that which CMS required inpatient rehabilitation hospitals to use. These data therefore do not reflect a comparison between SNFs and IRHs, because the two scales measure different items and have different numeric values. While we commend what Marquis says about its performance in comparison to other SNFs, it is clear from national data that quality and outcomes in these areas are significantly better in an inpatient rehabilitation hospital versus a skilled nursing facility.

Marquis Comment – “We currently employ three physicians and eleven nurse practitioners and physician assistants in our facilities on a daily basis.” (Recording 00:28:24-00:28:27).

PAM’s Response – Three physicians and eleven NPs/PAs over 10 facilities and 705 beds is significantly less medical coverage than what PAM provides in one hospital. At PAM, each hospital (with an average size of 40 beds) has a Physical Medicine and Rehabilitation physician and an Internal Medicine physician that sees each patient daily. In addition to that minimum expectation, we have medical staffs credentialed for our rehabilitation hospitals that average 128 physicians per hospital across a variety of specialties, such as orthopedic, neurology, pulmonology, and neuro-psychiatry, to provide necessary medical care to our patients during their rehabilitation stay.

Marquis Comment – “[T]he types of patients that were discussed earlier, this feels exactly like the kinds of patients that I see in our facilities every day in terms of diagnoses and the level of illness.” (Recording 00:28:42-00:28:51).

PAM’s Response – Regardless of where patients go when discharged from a critical care hospital, the types of patients requiring post-acute care are going to be similar from a diagnostic perspective. It is their residual deficits, impairments, and medical co-morbidities that determine whether they should go to an IRH, to a SNF, or home. For example, a stroke patient with zero co-morbidities and no residual deficits that admits to a hospital within a short enough timeframe to receive tissue plasminogen activator (“tPA”) and breakdown of the blood clot may not need any inpatient post-acute care. However, a similar stroke patient that did not timely receive tPA and that has uncontrolled diabetes, a left hemi-paresis, peripheral vascular disease, high blood pressure, and/or functional deficits requiring a minimum of two therapies, is best treated in acute inpatient rehabilitation. The third example, appropriate for recovery in a skilled nursing facility, is a stroke patient that is medically stable, but has functional deficits and is not safe to return home. All three examples include the diagnosis of “stroke” but present very differently and therefore require different services/level of care.

Questions by OHA for Marquis:

Question: What are your criteria for acceptance or non-acceptance?

Dr. Kolonic's Response: It depends on what we have going on in the building and the acuity of the patient's need.

Question: So, you don't have standard criteria?

Dr. Kolonic's Response: No, I think it's just mostly on an individual basis.

(Recording 00:29:59-00:30:04; Recording 00:30:33-00:30:35).

PAM's Response – Unlike Marquis and other SNFs, which do not operate under any defined acceptance criteria, PAM adheres to Medicare criteria for acute inpatient rehabilitation hospitals. These are set forth in the Medicare Benefit Policy Manual which define patients who:

- Need Close Medical Supervision
- Need 24/7 nursing
- Have therapy needs requiring a minimum of two therapies (PT, OT, SLP, and/or Prosthetics/Orthotics) and one of which has to be PT or OT
- Have the ability to tolerate a minimum of three hours of therapy, five days a week
- Demonstrate the ability to make practical and significant improvement
- Have the goal to discharge home

Our clinical navigators conduct a pre-admission screening assessment on every referral to our inpatient rehabilitation hospitals. The assessment is very detailed clinically and outlines the patient's medical conditions, past medical history, functional abilities and deficits, and justification criteria supporting the above bullet points that is reviewed and approved, prior to admission, by a rehabilitation physician. This is a standard process for acceptance or non-acceptance into our rehabilitation hospitals. PAM hospitals admit patients on the basis of strict clinical criteria; not on a "case by case" basis depending on "what we have going on in the building."

The attached direct quotes from the Medicare Benefits Policy Manual Chapter 8 Coverage of Extended Care (SNF) Services. Please refer to Attachment 1 for full pages. This attachment shows that SNF level care is intended to continue care started in the hospital. It has a general focus, unlike the specific clinical protocol focus of an IRH:

- "A person who develops a complication that would require rehabilitation of more than 30 days is not covered for SNF, unless the person is readmitted to the hospital for at least 3 days. (20.2.2)

- “In determining the type of case that this exception¹ is designed to address, it is necessary to recognize the intent of the extended care benefit. The extended care benefit covers relatively short-term care when a patient requires skilled nursing or skilled rehabilitation services as a continuation of treatment begun in the hospital. The requirement that covered extended care services be provided in a SNF within 30 days after hospital discharge is one of the means of assuring that the SNF care is related to the prior hospital care.” (20.2.2.1)
- Care in a SNF is covered if all of the following four factors are met:
 - “The patient requires skilled nursing services or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel (see §§30.2 - 30.4); are ordered by a physician and the services are rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services”;
 - “The patient requires these skilled services on a daily basis” (see §30.6); and
 - “As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF.” (See §30.7.)
 - “The services delivered are reasonable and necessary for the treatment of a patient’s illness or injury, i.e., are consistent with the nature and severity of the individual’s illness or injury, the individual’s particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity.” (30)

“If a beneficiary who has been in a covered Part A stay requires readmission to a hospital, and subsequently returns directly to the SNF for continuing care, there is a presumption that he or she meets the level of care criteria upon readmission to the SNF when correctly assigned one of the case-mix classifiers that CMS designates for this purpose as representing the required level of care. A new Medicare 5-day assessment is required and the presumption of coverage lasts through the assessment reference date of that assessment, which must occur no later than the eighth day of the stay.” (30.1)

¹ Reference to 20.2.2 Medical Appropriateness Exception for admissions occurring at a time other than immediately upon hospital discharge. Attachment 1

Legacy (RIO)

Legacy's Comment – “We also serve the same types of patients that PAM serves, but we also serve ventilator patients as well as burn patients.” (Recording 00:33:01-00:33:18).

PAM's Response – PAM's slide describing the types of patients seen in its rehabilitation hospitals was not an all-inclusive set of diagnoses served, but reflects the common types of patients PAM treats. PAM also accepts patients on a ventilator, burn patients, and others requiring and meeting the acute inpatient rehabilitation criteria, which are not based on diagnosis alone.

Legacy's Comment – “Consistent with Oregon Administrative Rule 333 Division 590 Section 0040, the program has a long and consistent history of requiring applicants to demonstrate a numeric need for acute care beds before specialty beds can be added.” (Recording 00:33:56-00:34:14).

PAM's Response – OAR 333-590-0040 applies to demonstrating need for acute care beds in existing hospitals, not to demonstrating need for new hospitals, which is governed by OAR 333-590-0050.

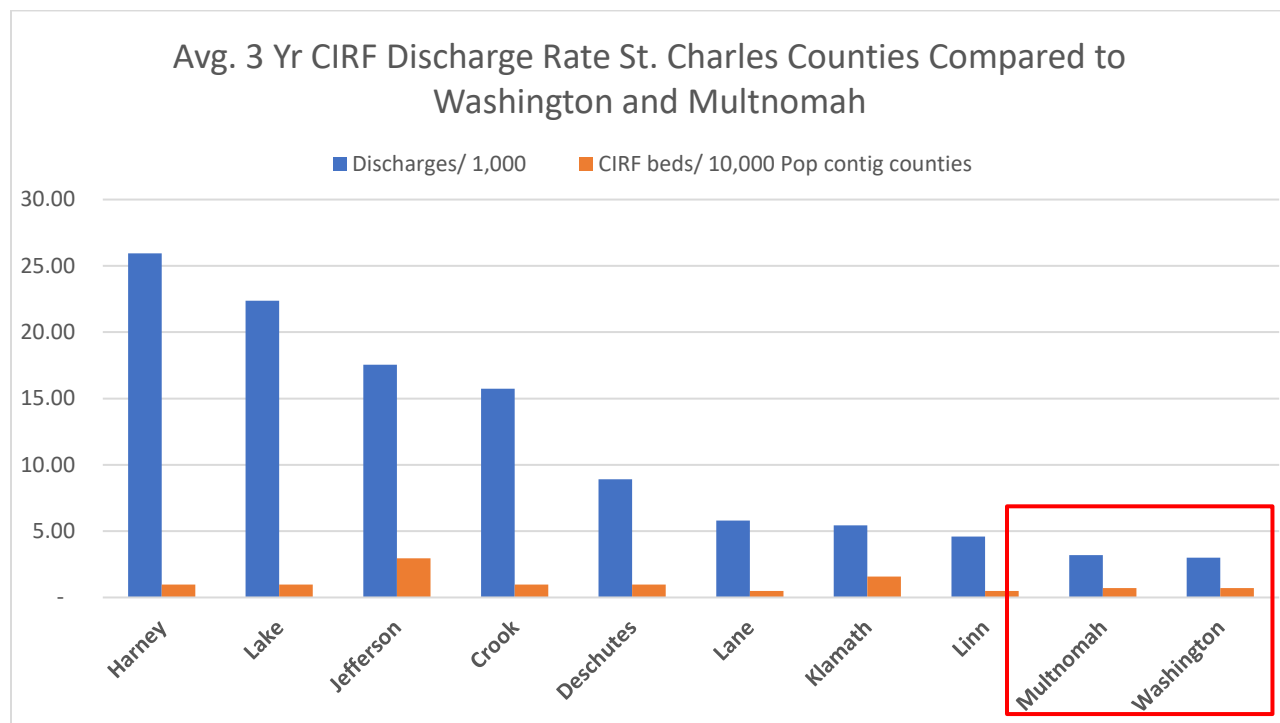
That having been said, we did the analysis of acute care beds – see application Section B. Table 14 on page 33 shows an acute care bed deficit during the first three project years. Regardless of the methodology used, the acute bed deficit exceeds the number of beds proposed for PAM Rehabilitation Hospital at Portland.

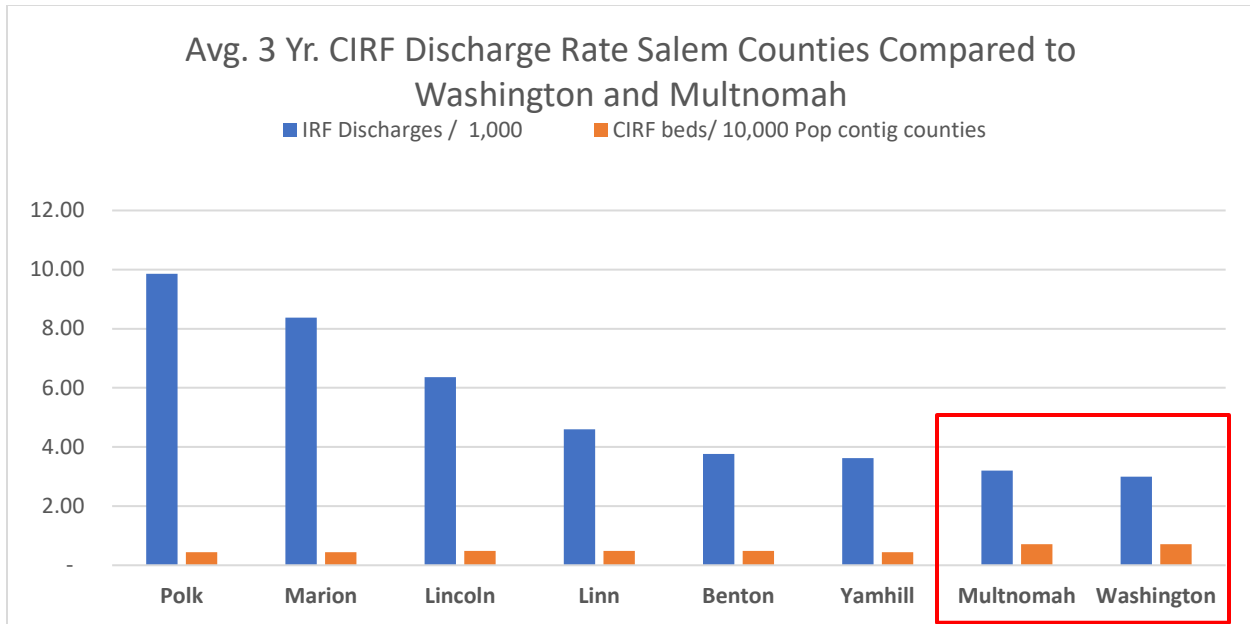
Legacy's Comment – “The current occupancy rate does not support the expansion of existing rehabilitation facilities at this time. The rule states a maximum of 7 beds per 100,000. Oregon has the lowest overall acute care beds per 1,000 residents, tied at 50th in the nation with Washington state at 1.7 per 1,000 population.” (Recording 00:34:56-00:35:20).

PAM's Response – Legacy's comment confuses the Oregon Comprehensive Inpatient Rehabilitation Facility (“CIRF”) standard for rehabilitation beds with Oregon's available acute care beds. It is true that OAR 333-645-0030 sets 7 beds in 100,000 general population as a standard, but it is not absolute and Oregon's number of acute care beds per 1,000 residents does not relate to that standard. The regulation specifically provides in subsection (1)(b) that adjustments to this standard can be made for a specialty rehabilitation services where the application demonstrates need, specifically noting that a unit specializing in strokes one of PAM's anticipated patient populations is an example of the kind of group to which those adjusted standards may be applied.

Being last in the nation in access to IRH treatment is hardly an attractive argument for preserving that situation. Oregon's health care market long has driven for efficiency through managed care, and much of that effort has been positive, such as the innovation of Coordinated Care Organizations. But efficiency for its own sake, without due consideration of patient needs and evolving medical outcomes evidence, can become de facto denial of the evidence-based care that Oregon public policy long has encouraged. In PAM's proposed service area, as the evidence shows, lack of specialized IRH beds effectively denies specialized rehabilitation care to all but a fraction of those who likely would benefit from it.

As illustrated in Attachment 2 and the following charts, some parts of Oregon have high IRH use rates. In fact, closer examination shows that the Salem Health and St. Charles Health IRHs have higher use rates and the communities around them have higher CIRF use rates. Data are from OHA all-payer hospital database. See Charts below. Both St. Charles Health and Salem Health have expanded their IRH facilities and moved programs into separate buildings on their campuses. Like PAM, St. Charles Health and Salem Health appear to realize the separate and distinct needs of the acute IRH patient. As illustrated below, though supply of beds is important to assure access, utilization data suggest that the IRH service program plays a critical role in patient and physician decision to admit to IRH care.





Data in Attachment 2 and Appendix F of the PAM application

Legacy’s Comment – “According to a March 2018 American Hospital Association fact sheet, inpatient rehabilitation facilities have faced significant scrutiny from Congress and CMS in recent years, which has led to multiple interventions including strict criteria for IRF patients, multiple payment cuts, and other policy restrictions. Collectively these interventions have reshaped the population treated by IRFs by dramatically reducing the overall volume and steadily increasing the medical complexity of IRF patients.” (Recording 00:35:38-00:36:09).

PAM’s Response – The fact sheet actually was published on February 23, 2015, in response to President Obama’s FY 16 budget proposals. In addition, Mr. Greenman failed to note the remaining information in the fact sheet, which was an advocacy effort supporting IRH level of care and demonstrating the importance of Acute Inpatient Rehabilitation versus Skilled Nursing Facilities. The complete article, which we commend to OHA’s consideration, can be found in online at <https://www.aha.org/system/files/2018-03/fs-rehab.pdf>.

Legacy’s Comment – “Collectively, Legacy Health serves 750 patients a day on average. Its average daily census at RIO is 25 patients, although it has 36 beds. This census has remained the same for a decade, but the Average Length of Stay has decreased at RIO from 23 days to a length of stay of 13.6.” (Recording 00:37:21-00:37:49).

PAM’s Response – Given the size of Legacy and the volumes in its health system, PAM suspects that there are patients in need of acute inpatient rehabilitation services that are not now getting access to the care they need, although PAM has of course no insight into how Legacy triages its patients. In eRehabData, a national provider database for acute inpatient rehabilitation hospitals, the average length of stay in 2009 (a decade ago) was 13.89. The 2019 average length of stay is 14.20. These data are not consistent with the occupancy deficits noted by RIO.

PAM has seen no decline in admissions or decline in the need for inpatient rehabilitation. PAM provides rehabilitation services that meet medical necessity criteria, versus admitting to the inpatient “60% rule” (a regulatory rule that was created in the 1980s to define an inpatient rehabilitation setting). When you operate a hospital in response to medical necessity, given the aging population and medical/rehabilitation needs that exist, the need for acute inpatient rehabilitation remains and will continue to grow with an aging population. The slight increase in length of stay observed from 2009 to 2019 is purely a reflection of acuity of patients served. Volume of patients in need of these services has and will continue to grow as the service area population grows and requires medical and rehabilitation services.

Legacy’s Comment – “The payers in our markets are not always willing to actually approve rehab services. So that’s the difference in our market than any other market is getting patients approved.” (Recording 00:38:22-00:38:34).

PAM’s Response – This market is no different from any other market in which PAM operates in terms of potential payor acceptance of cost-effective patient treatment. PAM satisfied itself that there is payor interest when it spoke to third party payers during the application process. PAM routinely faces payor challenges across a variety of markets where the need for Acute Inpatient Rehabilitation versus a less costly setting are in question.

PAM has a strong clinical navigator team and a protocol to advocate for patients in need of rehabilitation through a diligent appeals and peer review process, and its model of being a stand-alone IRH rather than being identified with a particular hospital system has promoted acceptance both with payors and with referrals. Our success rate in overturning third party payor denials to rehab is high and the outcomes help support our efforts, and ultimately PAM has been successful in gaining “buy in” from payors on acceptance to our programs.

Gwen Dayton representing the OHCA:

OHCA Comment – “OHCA members provide a high level of therapy services in these nursing facilities.” (Recording 00:43:14-00:43:17).

PAM’s Response – PAM provides a higher level of therapy services than does any Skilled Nursing Facility, combined with 24/7 physician, in-house pharmacy, and 24/7 nursing services with an average medical staff of 128 physicians for each hospital. We provide a *hospital* level of care, which cannot fairly be compared to skilled nursing facilities.

OHCA Comment – Oregon is “different.” (Recording 00:43:26).

PAM’s Response – We have heard this argument in many other states. States are different from each other only from a regulatory and licensure perspective. The needs of patients do not change from one state to another. If someone has a stroke in Oregon as compared to Nevada, the patient’s need for services will not vary by geography. The fact that Oregon does not provide IRH services at a level comparable with the remainder of the country results in individuals seeking such care outside of Oregon, as one witness’s testimony reflected, or seeking care in a non-specialized setting likely to produce less than desirable quality outcomes and ultimately a potentially lower quality of life. The whole point of IRH is to help patients recover to a level that allows them to return to home and as normal of a daily life as possible, and thus prevent what otherwise would be premature admissions to IRHs and SNFs.

PAM completely agrees with and supports the state's policy under 410.020. For example, ORS 410.020(1) states that Oregon must “coordinate the effective and efficient provision of community services to older citizens and citizens with disabilities so that the services will be readily available to the greatest number over the widest geographic area ...” Among the tools to provide “effective and efficient ... services” to Oregon’s citizens is to have the right level of care for each patient readily available in Oregon, making decisions like the one before OHA on PAM’s application in a patient-focused manner, not in a manner that gives undue weight to the concerns of existing providers of services that could most appropriately be complemented by that which PAM offers.

OHCA’s Comment – “Our nursing facilities tend to care for higher acuity residents than they do nationally. That is part of the reason we have much shorter stays. We are not like nursing facilities in other states and should not be viewed in the same way.” (Recording 00:43:47-00:44:17).”

PAM’s Response – Higher-acuity patients generate longer lengths of stay, not shorter, whether in an IRH or in a SNF, so OHCA’s comment on that topic does not reflect the reality of medical acuity. Comparing Oregon SNF data to other skilled nursing facilities’ data proves nothing relevant to this proceeding. When you compare SNF data, either from Marquis or other OHCA member facilities or SNF national data, to data from IRHs, acute inpatient rehabilitation hospital outcomes are better for patients.

OHCA’s Comment – In OHCA’s written testimony, there is “evidence that payments to inpatient rehabilitation facilities are far higher than they are for those services in nursing facilities.” (Recording 00:45:17-00:45:32).

PAM’s Response – Although the cost of care, on a per diem basis, can be higher in an inpatient rehabilitation hospital compared to a skilled nursing facility, that reflects the higher level of care, which generally results in shorter stays with better outcomes. IRHs generally compare favorably to SNFs on a cost per *episode* basis, which from the standpoint both of the patient and of society is a better measure than cost per diem.

Per page 70 of PAM's application, using 2016 Medicare rates:

- Medicare payment for an Ultra High Therapy patient in an SNF was \$932 per day
 - At an ALOS of 13 days the Medicare cost per admission would be \$12,116
 - At an ALOS of 23 days the Medicare cost per admission would be \$28,892
- Medicare payment for an orthopedic inpatient rehabilitation admission was \$10,810.

OHCA Comment – “As recently as 2019, Med PAC issued a report indicating that IRFs, inpatient rehab facilities, are paid too much, they are paid too highly, and those reimbursements in fact should be reduced. We also -- and this is a significant concern to all of us who represent providers. The Office of Inspector General in 2018 indicated that -- let me get this right -- 85 percent of all inpatient rehab facility payments that they audited were unnecessary and unreasonable. So, the payments are excessive for the same services that we provide -- or the similar services that we provide, and a vast majority of them were deemed to be unnecessary.” (Recording 00:45:32-46:13).

PAM's Response – This is not a fair characterization of the OIG's position, and ignores similar statements made by the OIG with respect to SNF payments. Ms. Dayton's references are highly misleading, casting aspersions upon an entire sector of health care that happens to compete in some respects with OHCA's members. Ms. Dayton's comments do not fairly characterize either the Medpac or OIG reports, and to understand what these statements mean requires a deeper dive than OHCA did in attempting to smear the entire IRH industry with one-line comments.

The Medpac report, as you may know, is an annual report to Congress with recommendations on health care paid for by Medicare. Contrary to the implication of Ms. Dayton's remarks, Medpac's report chapter on Inpatient Rehabilitation Facilities-- like other provider types -- is a technical analysis of payment rates and makes, as one would expect of body charged with stewardship of Medicare dollars, recommendations to modify payments. Medpac did recommend a 5 percent overall reduction in payment rates, but within a context *favorable to freestanding hospitals*, which is exactly what PAM proposes to build in Tigard:

“Growth in IRFs' costs historically have been low. From 2009 to 2015, the cumulative growth in cost per discharge was 8.4 percent, well below the 13.5 percent increase in the market basket for IRFs over the period. In 2016, per case cost growth (3.6 percent in aggregate) exceeded payment growth (2.9 percent in aggregate) for the first time since 2008. In 2017, however, per case payments again grew faster than costs (3.4 percent compared with 2.8 percent), resulting in an aggregate IRF margin of 13.8 percent. In 2018 to 2019, we anticipate costs in IRFs will grow faster than payments since updates in those years were constrained to 1.0 percent and 1.35 percent, respectively. For 2019, we project an aggregate Medicare margin of 11.6 percent.”

“This year, the Commission for the first time examined the financial performance of relatively efficient IRFs. Our analysis found that relatively efficient IRFs performed better on quality metrics and had costs 18 percent lower than other IRFs. Relatively efficient IRFs were on average larger and had higher occupancy rates, contributing to greater economies of scale and lower costs. Freestanding and for-profit facilities were more likely to be in the relatively efficient group.”

“On the basis of these factors, the Commission recommends a 5 percent reduction to the IRF payment rate for fiscal year 2020. In addition, the Commission reiterates its March 2016 recommendations that (1) the high-cost outlier pool be expanded to further redistribute payments in the IRF payment system and reduce the impact of misalignments between IRF payments and costs and (2) the Secretary conduct focused medical record review of IRFs that have unusual patterns of case mix and coding and conduct other research necessary to improve the accuracy of payments and protect program integrity and coding and conduct other research necessary to improve the accuracy of payments and protect program integrity.”

Source: Medpac Report to Congress: Medicare Payment Policy, March 2019, Chapter 10, p. 253. Provided to OHA as Attachment 3 to this comment letter (emphasis added).

In Chapter 8 of the same report, Medpac makes recommendations about Skilled Nursing Facility payments, as well as observations about the effects of SNF payment formula changes that took effect Oct. 1, 2019. Medpac observes that the level of SNF payments “remains too high” and recommends that SNF payment rates not be “updated,” i.e. increased, for FY2020. Medpac also makes important observations about changes in payments for complex patients, which also were noted in PAM’s comments on Oct. 14:

“The Commission recommends that the Secretary proceed with revising the SNF PPS and annually recalibrate the relative weights of the case-mix groups to keep payments aligned with the costs of care. The implementation of a revised SNF PPS will increase the equity of Medicare’s payments across different conditions and narrow the disparities in financial performance across SNFs. *The redesigned PPS is likely to alter the mix of cases treated in SNFs, providers’ cost structures, and the relative costs of different types of stays.* To keep costs and payments aligned across types of cases, CMS will need to regularly recalibrate the relative weights of the new case-mix groups.

“The level of [SNF] payments continue to be well above the cost to treat Medicare beneficiaries. Several factors indicate that the aggregate level of Medicare’s payments remains too high

“Considering these factors, the Commission recommends that the Congress eliminate the fiscal year 2020 update to the Medicare base rates. While the level of payments indicates a reduction to payments is needed to more closely align aggregate payments and costs, the SNF industry is likely to undergo considerable changes as it adjusts to the redesigned PPS.”

Source: Medpac Report to Congress: Medicare Payment Policy, Chapter 8, March 2019, p. 195. Provided to OHA as Attachment 4 to this comment letter (emphasis added).

Ms. Dayton’s characterization of the Office of Inspector General report of September 2018 similarly was misleading.

The focus of the OIG’s September 2018 report was on the documentation required to substantiate claims, part of its ongoing effort to improve Medicare payment systems, not on clinical criteria. Where the OIG found documentation deficiencies, its report says, “... we were *unable to determine* that IRF care for those 175 stays was reasonable and necessary.” *Not knowing* is very different from OHCA’s broad assertion that claims were “unnecessary and unreasonable.” Please Refer to Attachment 5 for a summary of this OIG report.

In this context, it is important to note that Medicare documentation requirements are stringent, and unintentional administrative errors can result in initial payment denials. For example, Medicare rules require physician documentation of clinical need within 24 hours of admission; if that documentation is done at 25 hours even though a patient assessment is done at seven hours, for example, payment may be denied. In the normal course of business, such process and clerical errors may occur; upon appeal, however, such denials often are overturned upon finding of clinical need.

The OIG included in its recommendations the need for better education of billing personnel at provider organizations, as well as a pilot project for pre-admission authorization of admissions, as most Medicare Advantage plans require.

It also is important to note that the 2018 OIG report examined Medicare Part A fee-for-service payments, which the OIG notes during the audit period were not subject to pre-admission review. PAM views pre-admission assessment by medical personnel as essential to ensure that patients admitted to its facilities truly need inpatient, medically supervised rehabilitative care. PAM tracks all referrals, including those that are not accepted to our rehabilitation hospitals. From 10/1/18-9/30/19, 15 percent of the patients referred to our rehabilitation hospital did not meet criteria for acceptance into our program. This demonstrates our diligence in assessing and applying criteria for acceptance into our programs. In addition, when patients do not meet criteria, they are often referred to a skilled nursing facility.

PAM’s processes – consistent with the recommendations made by the OIG -- include mandatory pre-admission clinical qualification review, *regardless of payment source*. In addition, PAM’s policies and procedures call for *post-admission* clinical review of patient need

to remain in its hospitals, and when patients are found ready for discharge they are discharged to their homes or the next appropriate point of care – all in close coordination with the patients’ physicians.

Furthermore, IRHs are not, as Ms. Dayton’s comments imply, under special CMS scrutiny compared to other elements of the health care delivery system. In February of 2019, the CMS OIG released a report on SNF admissions, “CMS Improperly Paid Millions of Dollars for Skilled Nursing Facility Services When the Medicare Three-Day Inpatient Hospital Stay Requirement Was Not Met.” Please Refer to Attachment 5. The focus of this OIG report, like its report on IRH admissions, was on documentation: “We attribute the improper payments to the absence of a coordinated notification mechanism among the hospitals, beneficiaries, and SNFs to ensure compliance with the 3-day rule. We noted that hospitals did not always provide correct inpatient stay information to SNFs, and SNFs knowingly or unknowingly reported erroneous hospital stay information on their Medicare claims to meet the 3-day rule.” Unfortunately, CMS rejected the OIG’s process improvement “recommendations related to a coordinated notification mechanism among hospitals, beneficiaries, and SNFs. Without a coordinated notification mechanism, CMS will continue to make improper payments when the 3-day rule is not met.”

PAM does not allege that Oregon SNFs systematically admit patients who have not met the three-day requirement. However, it is worth noting that PAM’s admissions and discharge processes involve extensive coordination with referring general acute care hospitals, our patients’ physicians, and their families, precisely to ensure that patients get the right level of care in the right venue and in a timely manner.

PAM ensures that all of CMS’s documentation requirements are met and that the patient meets medical necessity through PAM’s required pre-admission screening assessment, review of the assessment and compliance of the required staff, sign/date/time, and physician approval prior to admission. PAM has dedicated individuals in each of its rehabilitation hospitals who track adherence to the timelines and specified requirements throughout the patient stay. This not only meets the outlined requirements in the Medicare Beneficiary Policy Manual, but it demonstrates PAM’s commitment to ensuring patients meet criteria, from pre-admission assessment through discharge.

OHCA Comment – “So, the payments are excessive for the same services that we provide---or the similar services that we provide.” (Recording 00:46:01-00:46:09).

PAM’s Response – No, the payments to IRHs do not reflect the same or similar services provided by SNFs. IRHs provide a *hospital* level of care, a different product than nursing and therapy services.

OHCA Comment – “We’re also concerned that the entry of these facilities into this marketplace, given that many of these services are already provided, will be highly disruptive.” (Recording 00:46:22-00:46:32).

PAM's Response – PAM entered a very similar market in Dover, Delaware, earlier this year. Delaware is a CON state and was similar to Portland, Oregon, in rankings on the low utilization of IRH beds. PAM opened a 34-bed rehabilitation hospital in February of this year, which was full within a month and has had a waiting list since. In addition, a skilled nursing facility opened in the area around the same time. PAM has never come into a market and precipitated the closure of any skilled nursing facility. PAM works collaboratively with SNFs to coordinate patient care across the continuum, focusing on the patient.

OHCA Comment – “We note that in the PAM application they indicate that they are going to accept approximately 2% Medicaid.” (Recording 00:46:32-00:46:36).

PAM Response – That is not an accurate statement characterization of what PAM said in its application, which is that PAM anticipates admitting 2% Medicaid patients and 3-5% Medicaid Managed Care patients, since the Managed Care penetration is higher in the state of Oregon. To the extent this one-liner comment intended to suggest that PAM has a policy or practice of declining Medicaid admissions, to the detriment of SNFs, the comment is erroneous and misleading. When patients are dual eligible -- have both Medicare and Medicaid coverage -- Medicare by federal law is the primary payer and Medicaid is the secondary payer. Hence, the patient is recorded as a Medicare patient.

PAM's patient population is typically discharged from a critical care hospital before Medicaid kicks in from the “spend-down” phenomenon. In a skilled nursing facility, the patient often exhausts Medicare benefits, and eventually Medicaid becomes the primary payer and they transition to long-term care. Given the large population over age 65 in an IRH, the percentage reflects as a large percentage Medicare coverage of the inpatient stay versus what happens when a similar patient is in a skilled nursing facility.

OHCA Comment – “[W]e also, I would say, have some concern that just because of the lack of support in the community for an inpatient rehab facility, the payer mix, the contracts with Medicare Advantage payers--you know, we may well just see a lack of success.” (Recording 00:47:33-00:47:55).

PAM's Response – PAM does not have “lack of support in the community.” In fact, there were more community supporters in the hearing audience than opposers. The payer mix, like we've predicted, is analogous to that in PAM's rehabilitation operations in other markets. PAM wouldn't be putting forth this effort if it didn't believe strongly that it will prove to be successful for the patients in need of acute inpatient rehabilitation services in Oregon.

OHCA's Comment – In the Indiana Business Journal there was an article that states PAM “just closed down two long-term care hospitals in Corpus Christi. And they have an application for an inpatient rehab facility in an Indiana community that's being viewed with some concern.” (Recording 00:47:58-00:48:19).

PAM's Response – Whether intentional or not, these are additional one-line misrepresentations of the facts. With respect to Corpus Christi, PAM closed one hospital in that city, not two. The closing of this hospital was not for lack of need for beds; it was closed to combine its services into a brand new post-acute hospital opened there to offer a combination of acute inpatient rehabilitation and long-term acute care hospital beds to better serve patient needs in the Corpus Christi community. With respect to Indiana, PAM has no idea what OHCA is trying to communicate about someone's "concern," but there is no application pending from PAM. Indiana does not issue certificates of need for inpatient rehabilitation hospitals, but recently did institute a certificate of need process for skilled nursing facilities (again emphasizing that these are separate markets).

OHCA's Comment – "[W]e do provide heavy and significant therapy services. So, nursing facilities must be counted when you're assessing whether there is the need for these services in this service area." (Recording 00:48:28-00:48:41).

PAM's Response – Again, PAM is applying not to build a SNF, but to provide a different service level – a free-standing acute care rehabilitation hospital to serve a need that is currently unmet in this service area and that cannot be met by SNFs.

Under OAR 333-590-0010(1), "acute inpatient care" is specifically defined to exclude "skilled nursing facility, intermediate care facility, long-term care or supportive routine case for chronic disease or disability, convalescent care, or rest cures." Under OAR 333-590-0010(3), "acute inpatient bed capacity" means "any space which could be made readily available for use as an acute inpatient bed." OAR 333-590-0050 defines the methodology for determining need for general "acute inpatient beds," which therefore excludes SNF beds in that calculation. OAR 333-645-0030(4) provides that bed need calculation is to be consistent, where applicable, with the methods and principles established in OAR 333-590-0030 through 333-590-0060, obviously including OAR 333-0590-0050. Thus, when OHA calculates bed need for CIRFs, SNF beds are to be excluded by the express terms of the applicable regulations, contrary to OHCA's position.

Dr. Lawlor, Legacy:

Lawler Comment – "Shortly after I left my training at Stanford, the inpatient unit at Stanford closed, and that was really because there were an excess number of beds in the region." (Recording 00:50:32-00:50:44).

PAM Response – Dr. Lawler left California and became licensed in Oregon in approximately 1997. See Oregon Medical Board license verification report attached as Attachment 6.

She furthermore seems to have no direct operational knowledge of the Stanford situation. PAM understands that Stanford around that time *replaced* its IRH with beds at another location, making room to expand its general acute care hospital. While PAM has not been able to locate contemporaneous documentation of these events, today the Santa Clara Valley Medical Center's inpatient rehabilitation facility, located in nearby San Jose, is affiliated with the

Stanford University School of Medicine.² In addition, Stanford operates a small IRH on its own campus.

But what happened in the 1990s Bay Area market hardly is relevant to the application before the Oregon Health Authority. OHA's task is to determine whether PAM's application meets a current or foreseeable bed need in Oregon in and through the 2020s.

OHA Questions:

OHA Question – Matt Gilman asked all to describe deployment of innovative equipment.

PAM Response – PAM'S additional information in follow-up to this question- Since 2017, each of our new hospitals includes the following base package of state-of-the-art rehabilitation technology:

- LiteGait- A body weight support treadmill system that is designed to off-load all or a percentage of weight through the limbs to begin ambulation. This device works over a treadmill or on-ground to assist patients with walking.
- Monitored Rehab (MR) Cube- a rehab training tool that can be used stand-alone or interfaced to any piece of rehab equipment to assess and improve neuromuscular development. This is a full-body device used by physical or occupational therapists.
- Vital Stimulation- Neuromuscular electrical stimulation for individuals with swallowing deficits (speech therapy).
- Korebalance system- Uses the latest in virtual and interactive technology for balance assessment and training
- Lower Extremity Bioness- Neuromuscular electrical stimulation to assist with foot drop and re-educate and improve muscle function for ambulation
- InMotion Arm- Upper extremity robotic device for improving arm and hand function
- Exoskeleton- Lower extremity robotic device

When we build a new hospital, PAM assesses and modifies our core list, including additional equipment based on local market needs. In addition, we continually assess our older hospitals and upgrade with the above equipment, based on the patient population and market needs.

² Ten Reasons to Choose SCVMC, Rehabilitation (2019). Santa Clara Valley Medical Center. Retrieved from <https://www.scvmc.org/health-care-services/Rehabilitation/Pages/10-Reasons-to-Choose-SCVMC.aspx>

OHA Question – Ms. Kilmurray (Legacy RIO) says: "[Stroke patients] get well. They don't actually need rehab." (Recording 01:03:32-01:03:35).

PAM Response – It is correct that not all stroke patients need or benefit from inpatient rehabilitation. But for those who do, IRH-level services make a tangible difference in a patient's recovery, jump-starting what can be a very long road back to pre-stroke level of function, or as close to that as a patient can get. For those who need it, it is the difference between premature admission to an IRH or staying at home, and it greatly reduces caregiver burden, a hidden cost of major illnesses. The ASA guidelines in 2016 support early rehabilitation in and acute inpatient hospital is key to patient recovery following stroke.³

³ Guidelines for Adult Stroke Rehabilitation. (2016). American Heart Association/ American Stroke Association. Retrieved from <https://www.ahajournals.org/doi/pdf/10.1161/STR.000000000000098>



PAM Rehabilitation Hospital of Portland

Attachments for Response to Public Meeting Comments

11/04/19

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Attachment 1

In determining the 30-day transfer period, the day of discharge from the hospital is not counted in the 30 days. For example, a patient discharged from a hospital on August 1 and admitted to a SNF on August 31 was admitted within 30 days. The 30-day period begins on the day following actual discharge from the hospital and continues until the individual is admitted to a participating SNF, and requires and receives a covered level of care. Thus, an individual who is admitted to a SNF within 30 days after discharge from a hospital, but does not require a covered level of care until more than 30 days after such discharge, does not meet the 30-day requirement. (See §20.2.2 below for an exception under which such services may be covered.) Conversely, as long as a covered level of care is needed and initiated in the SNF within the specified timeframe, the timely transfer requirement is considered to be met even if actual **Medicare payment** does not commence until later (for example, in a situation where another payment source that is primary to Medicare has assumed financial responsibility for the initial portion of the SNF stay).

If an individual whose SNF stay was covered upon admission is thereafter determined not to require a covered level of care for a period of more than 30 days, payment could not be resumed for any extended care services he or she may subsequently require, even though he or she has remained in the facility, until the occurrence of a new qualifying hospital stay. In the absence of a new qualifying hospital stay, such services could not be deemed to be “post-hospital” extended care services. (For exception, see §20.2.2 below.)

20.2.2 - Medical Appropriateness Exception (Rev. 1, 10-01-03)

A3-3131.3.B, SNF-212.3.B

An elapsed period of more than 30 days is permitted for SNF admissions where the patient’s condition makes it medically inappropriate to begin an active course of treatment in a SNF immediately after hospital discharge, and it is medically predictable at the time of the hospital discharge that he or she will require covered care within a predeterminable time period. The fact that a patient enters a SNF immediately upon discharge from a hospital, for either covered or noncovered care, does not necessarily negate coverage at a later date, assuming the subsequent covered care was medically predictable.

20.2.2.1 - Medical Needs Are Predictable (Rev. 1, 10-01-03)

A3-3131.3.B.1, SNF-212.3.B.1

In determining the type of case that this exception is designed to address, it is necessary to recognize the intent of the extended care benefit. The extended care benefit covers relatively short-term care when a patient requires skilled nursing or skilled rehabilitation services as a continuation of treatment begun in the hospital. The requirement that covered extended care services be provided in a SNF within 30 days after hospital

discharge is one of the means of assuring that the SNF care is related to the prior hospital care.

This exception to the 30-day requirement recognizes that for certain conditions, SNF care can serve as a necessary and proper continuation of treatment initiated during the hospital stay, although it would be inappropriate from a medical standpoint to begin such treatment within 30 days after hospital discharge. Since the exception is intended to apply only where the SNF care constitutes a continuation of care provided in the hospital, it is applicable only where, under accepted medical practice, the established pattern of treatment for a particular condition indicates that a covered level of SNF care will be required within a predeterminable time frame. Accordingly, to qualify for this exception it must be medically predictable at the time of hospital discharge that a covered level of SNF care will be required within a predictable period of time for the treatment of a condition for which hospital care was received and the patient must begin receiving such care within that time frame.

An example of the type of care for which this provision was designed is care for a person with a hip fracture. Under the established pattern of treatment of hip fractures it is known that skilled therapy services will be required subsequent to hospital care, and that they can normally begin within four to six weeks after hospital discharge, when weight bearing can be tolerated. Under the exception to the 30-day rule, the admission of a patient with a hip fracture to a SNF within 4 to 6 weeks after hospital discharge for skilled care, which as a practical matter can only be provided on an inpatient basis by a SNF, would be considered a timely admission.

20.2.2.2 - Medical Needs Are Not Predictable (Rev. 1, 10-01-03)

A3-3131.3.B.2, SNF-212.3.B.2

When a patient's medical needs and the course of treatment are not predictable at the time of hospital discharge because the exact pattern of care required and the time frame in which it will be required is dependent on the developing nature of the patient's condition, an admission to a SNF more than 30 days after discharge from the hospital is not justified under this exception to the 30-day rule. For example, in some situations the prognosis for a patient diagnosed as having cancer is such that it can reasonably be expected that additional care will be required at some time in the future. However, at the time of discharge from the hospital it is difficult to predict the actual services that will be required, or the time frame in which the care will be needed. Similarly, it is not known in what setting any future necessary services will be required; i.e., whether the patient will require the life-supporting services found only in the hospital setting, the type of care covered in a SNF, the intermittent type of care which can be provided by a home health agency, or custodial care which may be provided either in a nursing home or the patient's place of residence. In some instances such patients may require care immediately and continuously; others may not require any skilled care for much longer periods, perhaps measured in years. Therefore, since in such cases it is not medically predictable at the

The SNF may not charge the beneficiary or family members for any services that, in the absence of a payment sanction, would have been covered under the SNF PPS.

However, the beneficiary is entitled to reimbursement for those services excluded from the SNF PPS rate. Services excluded from consolidated billing such as outpatient hospital emergency care and related ambulance service should be billed by the provider/supplier actually furnishing services, and not by the SNF.

20.3.1.6 - Impact on Spell of Illness (Rev. 1, 10-01-03)

The SNF days during the sanction period will be used to track breaks in the spell of illness. A beneficiary's care in an SNF met the skilled level of care standards if a Medicare SNF claim for the services provided in the SNF was denied on grounds other than that the services were not at a skilled level of care. If the patient is receiving a skilled level of care the benefit period cannot end.

30 - Skilled Nursing Facility Level of Care - General (Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14) A3-3132, SNF-214

Care in a SNF is covered if all of the following four factors are met:

- The patient requires skilled nursing services or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel (see §§30.2 - 30.4); are ordered by a physician and the services are rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services;
- The patient requires these skilled services on a daily basis (see §30.6); and
- As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF. (See §30.7.)
- The services delivered are reasonable and necessary for the treatment of a patient's illness or injury, i.e., are consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity.

If any one of these four factors is not met, a stay in a SNF, even though it might include the delivery of some skilled services, is not covered. For example, payment for a SNF level of care could not be made if a patient needs an intermittent rather than daily skilled service.

In reviewing claims for SNF services to determine whether the level of care requirements are met, the A/B MAC (A) first considers whether a patient needs skilled care. If a need for a skilled service does not exist, then the “daily” and “practical matter” requirements are not addressed. See section 30.2.2.1 for a discussion of the role of appropriate documentation in facilitating accurate coverage determinations for claims involving skilled care. Additional material on documentation appears in the various clinical scenarios that are presented throughout these level of care guidelines.

Coverage of nursing care and/or therapy to perform a maintenance program does not turn on the presence or absence of an individual’s potential for improvement from the nursing care and/or therapy, but rather on the beneficiary’s need for skilled care.

Eligibility for SNF Medicare A coverage has not changed with the inception of PPS. However, the skilled criteria and the medical review process have changed slightly. For Medicare to render payment for skilled services provided to a beneficiary during a SNF Part A stay, the facility must complete an MDS.

EXAMPLE: Even though the irrigation of a suprapubic catheter may be a skilled nursing service, daily irrigation may not be “reasonable and necessary” for the treatment of a patient’s illness or injury.

30.1 – Administrative Level of Care Presumption

(Rev. 242, Issued: 03-16-18, Effective: 06-19-18; Implementation: 06-19-18)

Under the SNF PPS, beneficiaries who are admitted (or readmitted) directly to a SNF after a qualifying hospital stay are considered to meet the level of care requirements of 42 CFR 409.31 up to and including the assessment reference date (ARD) for the 5-day assessment prescribed in 42 CFR 413.343(b), when correctly assigned one of the case-mix classifiers that CMS designates for this purpose as representing the required level of care. The current set of case-mix classifier designations appears in the paragraph entitled “Case Mix Adjustment” on the SNF PPS web site, at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html>. If the beneficiary is not admitted (or readmitted) directly to a SNF after a qualifying hospital stay, the administrative level of care presumption does not apply.

For purposes of this presumption, the assessment reference date is defined in accordance with 42 CFR 483.315(d), and must occur no later than the eighth day of posthospital SNF care. Consequently, if the ARD for the 5-day assessment* prescribed in 42 CFR 413.343(b) is set on day 9, or later, the administrative level of care presumption does not apply. The coverage that arises from this presumption remains in effect for as long thereafter as it continues to be supported by the facts of the beneficiary’s condition and care needs. However, this administrative presumption does not apply to any of the subsequent assessments.

To be correctly assigned, the data coded on the Resident Assessment Instrument (RAI) must be accurate and meet the definitions described in the Long Term Care Facility RAI User's Manual. The beneficiary must receive services in the SNF that are reasonable and necessary. Services provided to the beneficiary during the hospital stay are reviewed to ensure proper coding of the most recent version of the RAI. The two examples illustrated below demonstrate a correct assignment and an incorrect assignment.

Incorrect Assignment: IV med provided in hospital coded on MDS, but IV was for a surgical procedure only – as a consequence, the MDS is not accurate and the presumption does not apply (see Chapter 3, Section P of the RAI).

Correct Assignment: Beneficiary is receiving oxygen therapy as well as rehab service. The respiratory therapy services are found reasonable and necessary; however, the rehab services are found not reasonable and necessary, resulting in a revised case-mix classification. Beneficiary was and is now correctly assigned – presumption applies.

A beneficiary who is not assigned one of the case-mix classifiers designated as representing the required level of care on the 5-day assessment prescribed in 42 CFR 413.343(b) is not automatically classified as meeting or not meeting the SNF level of care definition. Instead, the beneficiary must receive an individual level of care determination using existing administrative criteria and procedures.

*Includes Medicare Readmission/Return Assessment.

The following scenarios further clarify that a beneficiary's correct assignment of one of the case-mix classifiers that CMS designates for this purpose as representing the required level of care would serve to trigger the coverage presumption under the initial 5-day, Medicare-required assessment only when that assessment occurs directly following the beneficiary's hospital discharge.

1. Routine SNF Admission Directly From Qualifying Hospital Stay

If the beneficiary is admitted to the SNF immediately following a 3-day qualifying hospital stay, there is a presumption that he or she meets the Medicare level of care criteria when correctly assigned one of the case-mix classifiers that CMS designates for this purpose as representing the required level of care. The presumption lasts through the assessment reference date of the 5-day assessment, which must occur no later than the eighth day of the stay.

2. Admission to SNF does not immediately follow discharge from the qualifying hospital stay, but occurs within 30 days (as required under the "30 day transfer" rule)

If the beneficiary is discharged from the hospital to a setting other than the SNF, the presumption of coverage does not apply, even if the beneficiary's SNF admission occurs

within 30 days of discharge from the qualifying hospital stay. Accordingly, coverage would be determined based on a review of the medical evidence in the file.

3. SNF Resident is Re-Hospitalized and Then Returns Directly to the SNF

If a beneficiary who has been in a covered Part A stay requires readmission to a hospital, and subsequently returns directly to the SNF for continuing care, there is a presumption that he or she meets the level of care criteria upon readmission to the SNF when correctly assigned one of the case-mix classifiers that CMS designates for this purpose as representing the required level of care. A new Medicare 5-day assessment is required and the presumption of coverage lasts through the assessment reference date of that assessment, which must occur no later than the eighth day of the stay.

4. Routine SNF Admission Directly From Qualifying Hospital Stay, but Initial Portion of SNF Stay Covered by Another Insurer (Medicare as Secondary Payer)

When a beneficiary goes directly from a qualifying hospital stay to the SNF, but the initial portion of the SNF stay is covered by another insurer that is primary to Medicare, Medicare coverage would not start until coverage by the primary insurer ends. Accordingly, the Medicare required schedule of assessments is not required to begin until the first day of Medicare coverage. If a beneficiary met the level of care criteria for Medicare coverage during the first 8 days of the stay following a qualifying hospital stay, and the other insurer covered this part of the stay, there is no presumption. If Medicare becomes primary before the eighth day of the stay following a qualifying hospital stay, the presumption would apply through the assessment reference date on the 5-day assessment or, if earlier, the eighth day of the stay.

5. Readmission to SNF Within 30 Days After Discharge From Initial SNF Stay – No Intervening Hospitalization

As noted in scenario 1, if a beneficiary is initially admitted to the SNF directly from the hospital for a covered Part A stay, the presumption for that stay is applicable when the beneficiary is correctly assigned one of the case-mix classifiers that CMS designates for this purpose as representing the required level of care. However, if that beneficiary is discharged (NOT to an acute care facility) and then subsequently readmitted, there is no presumption applicable to the second SNF admission. (If the beneficiary is transferred to a hospital, and returns directly to the SNF, see scenario 3 above).

6. Initial, Non-Medicare SNF Stay Followed by Qualifying Hospitalization and Readmission to SNF for Medicare Stay

Dually eligible (Medicare/Medicaid) beneficiaries whose initial stay in the SNF is either Medicaid-covered or private pay, are eligible for the Medicare presumption of coverage when readmitted to the SNF following a qualifying hospitalization, when correctly assigned one of the case-mix classifiers that CMS designates for this purpose as representing the required level of care. (Of course, in order to qualify for Medicare coverage upon readmission, the beneficiary must be placed in the portion of the institution that is actually certified by Medicare as a SNF.)

No presumption of coverage applies when Medicare is the secondary payer for days 1 through 8 of the covered stay where Medicare becomes primary after day 8 due to a reversal or denial by the secondary insurer.

7. Transfer From One SNF to Another

There is no presumption of coverage in cases involving the transfer of a beneficiary from one SNF to another or from SNF-level care in a swing bed to a SNF. The presumption only applies to the SNF stay that immediately follows the qualifying hospital stay when the beneficiary is correctly assigned one of the case-mix classifiers that CMS designates for this purpose as representing the required level of care. Therefore, in cases involving transfer of a beneficiary from a swing-bed hospital to a SNF, the presumption only applies if the beneficiary was receiving acute care (rather than SNF-level care) immediately prior to discharge from the swing-bed hospital.

30.2 - Skilled Nursing and Skilled Rehabilitation Services (Rev. 1, 10-01-03)

A3-3132.1, SNF-214.1

30.2.1 - Skilled Services Defined (Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

Skilled nursing and/or skilled rehabilitation services are those services, furnished pursuant to physician orders, that:

- Require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech-language pathologists or audiologists; and
- Must be provided directly by or under the general supervision of these skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and to achieve the medically desired result.

NOTE: “General supervision” requires initial direction and periodic inspection of the actual activity. However, the supervisor need not always be physically present or on the premises when the assistant is performing services.

Skilled care may be necessary to improve a patient’s current condition, to maintain the patient’s current condition, or to prevent or slow further deterioration of the patient’s condition.

30.2.2 - Principles for Determining Whether a Service is Skilled (Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14) A3-3132.1.B, SNF-214.1.B

- If the inherent complexity of a service prescribed for a patient is such that it can be performed safely and/or effectively only by or under the general supervision of skilled nursing or skilled rehabilitation personnel, the service is a skilled service; e.g., the administration of intravenous feedings and intramuscular injections; the insertion of suprapubic catheters; and ultrasound, shortwave, and microwave therapy treatments.
- The A/B MAC (A) considers the nature of the service and the skills required for safe and effective delivery of that service in deciding whether a service is a skilled service. While a patient's particular medical condition is a valid factor in deciding if skilled services are needed, a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is not skilled.

EXAMPLE: When rehabilitation services are the primary services, the key issue is whether the skills of a therapist are needed. The deciding factor is not the patient's potential for recovery, but whether the services needed require the skills of a therapist or whether they can be provided by nonskilled personnel. (See §30.5.)

- A service that is ordinarily considered nonskilled could be considered a skilled service in cases in which, because of special medical complications, skilled nursing or skilled rehabilitation personnel are required to perform or supervise it or to observe the patient. In these cases, the complications and special services involved must be documented by physicians' orders and notes as well as nursing or therapy notes.

EXAMPLE:

Whirlpool baths do not ordinarily require the skills of a qualified physical therapist. However, the skills, knowledge, and judgment of a qualified physical therapist might be required where the patient's condition is complicated by circulatory deficiency, areas of desensitization, or open wounds. The documentation needs to support the severity of the circulatory condition that requires skilled care (see section 30.2.2.1).

- In determining whether services rendered in a SNF constitute covered care, it is necessary to determine whether individual services are skilled, and whether, in light of the patient's total condition, skilled management of the services provided is needed even though many or all of the specific services were unskilled.

EXAMPLE:

An 81-year-old woman who is aphasic and confused, suffers from hemiplegia, congestive heart failure, and atrial fibrillation, has suffered a cerebrovascular accident, is incontinent, has a Stage 1 decubitus ulcer, and is unable to communicate and make her needs known. Even though no specific service provided is skilled, the patient's condition requires daily skilled nursing involvement to manage a plan for the total care needed, to observe the patient's progress, and to evaluate the need for changes in the treatment plan.

As discussed in section 30.2.2.1 below, the medical condition of the patient must be described and documented to support the goals for the patient and the need for skilled nursing services.

- The importance of a particular service to an individual patient, or the frequency with which it must be performed, does not, by itself, make it a skilled service.

EXAMPLE:

A primary need of a nonambulatory patient may be frequent changes of position in order to avoid development of decubitus ulcers. However, since such changing of position does not ordinarily require skilled nursing or skilled rehabilitation personnel, it would not constitute a skilled service, even though such services are obviously necessary.

- The possibility of adverse effects from the improper performance of an otherwise unskilled service does not make it a skilled service unless there is documentation to support the need for skilled nursing or skilled rehabilitation personnel. Although the act of turning a patient normally is not a skilled service, for some patients the skills of a nurse may be necessary to assure proper body alignment in order to avoid contractures and deformities. In all such cases, the reasons why skilled nursing or skilled rehabilitation personnel are essential must be documented in the patient's record.

**30.2.2.1 – Documentation to Support Skilled Care Determinations
(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)**

Claims for skilled care coverage need to include sufficient documentation to enable a reviewer to determine whether—

- Skilled involvement is required in order for the services in question to be furnished safely and effectively; and
- The services themselves are, in fact, reasonable and necessary for the treatment of a patient's illness or injury, i.e., are consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice. The documentation must also show that the services are appropriate in terms of duration and quantity, and that the services promote the documented therapeutic goals.

Such determinations would be made from the perspective of the patient's condition when the services were ordered and what was, at that time, reasonably expected to be appropriate treatment for the illness or injury. Thus, when a service appears reasonable and necessary from that perspective, it would not then be appropriate to deny the service retrospectively merely because the goals of treatment have not yet been achieved. However, if it becomes apparent at some point that the goal set for the patient is no longer a reasonable one, then the treatment goal itself should be promptly and

appropriately modified to reflect this, and the patient should then be reassessed to determine whether the treatment goal as revised continues to require the provision of skilled services. By the same token, the **treatment goal itself** cannot be modified retrospectively, e.g., when it becomes apparent that the initial treatment goal of restoration is no longer a reasonable one, the provider cannot retroactively alter the initial goal of treatment from restoration to maintenance. Instead, it would make such a change on a prospective basis only.

Although the presence of appropriate documentation is not, in and of itself, an element of the definition of a “skilled” service, such documentation serves as the means by which a provider would be able to establish and an A/B MAC (A) would be able to confirm that skilled care is, in fact, needed and received in a given case.

It is expected that the documentation in the patient’s medical record will reflect the need for the skilled services provided. The patient’s medical record is also expected to provide important communication among all members of the care team regarding the development, course, and outcomes of the skilled observations, assessments, treatment, and training performed. Taken as a whole, then, the documentation in the patient’s medical record should illustrate the degree to which the patient is accomplishing the goals as outlined in the care plan. In this way, the documentation will serve to demonstrate why a skilled service is needed.

Thorough and timely documentation with respect to treatment goals can help clearly demonstrate a beneficiary’s need for skilled care in situations where such need might not otherwise be readily apparent, as when the treatment’s purpose changes (for example, from restoration to maintenance), as well as in establishing the efficacy of care that serves to prevent or slow decline—where, by definition, there would be no “improvement” to evaluate. For example, when skilled services are necessary to maintain the patient’s current condition, the documentation would need to substantiate that the services of skilled personnel are, in fact, required to achieve this goal. Similarly, establishing that a maintenance program’s services are reasonable and necessary would involve regularly documenting the degree to which the program’s treatment goals are being accomplished. In situations where the maintenance program is performed to maintain the patient’s current condition, such documentation would serve to demonstrate the program’s effectiveness in achieving this goal. When the maintenance program is intended to slow further deterioration of the patient’s condition, the efficacy of the services could be established by documenting that the natural progression of the patient’s medical or functional decline has been interrupted. Assessments of all goals must be performed in a frequent and regular manner so that the resulting documentation provides a sufficient basis for determining the appropriateness of coverage.

Therefore the patient’s medical record must document as appropriate:

- The history and physical exam pertinent to the patient’s care, (including the response or changes in behavior to previously administered skilled services);

- The skilled services provided;
- The patient’s response to the skilled services provided during the current visit;
- The plan for future care based on the rationale of prior results.
- A detailed rationale that explains the need for the skilled service in light of the patient’s overall medical condition and experiences;
- The complexity of the service to be performed;
- Any other pertinent characteristics of the beneficiary.

The documentation in the patient’s medical record must be accurate, and avoid vague or subjective descriptions of the patient’s care that would not be sufficient to indicate the need for skilled care. For example, the following terminology does not sufficiently describe the reaction of the patient to his/her skilled care:

- Patient tolerated treatment well
- Continue with POC
- Patient remains stable

Such phraseology does not provide a clear picture of the results of the treatment, nor the “next steps” that are planned. Objective measurements of physical outcomes of treatment should be provided and/or a clear description of the changed behaviors due to education programs should be recorded so that all concerned can follow the results of the provided services.

30.2.3 - Specific Examples of Some Skilled Nursing or Skilled Rehabilitation Services

**(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)
A3-3132.1.C, SNF-214.1.C**

The following sections describe specific examples of skilled nursing or skilled rehabilitation services.

30.2.3.1 - Management and Evaluation of a Patient Care Plan

**(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)
A3-3132.1.C.1, SNF-214.1.C.1**

The development, management, and evaluation of a patient care plan, based on the physician’s orders and supporting documentation, constitute skilled nursing services when, in terms of the patient’s physical or mental condition, these services require the involvement of skilled nursing personnel to meet the patient’s medical needs, promote recovery, and ensure medical safety. However, the planning and management of a

treatment plan that does not involve the furnishing of skilled services may not require skilled nursing personnel; e.g., a care plan for a patient with organic brain syndrome who requires only oral medication and a protective environment. The sum total of nonskilled services would only add up to the need for skilled management and evaluation when the condition of the beneficiary is such that there is an expectation that a change in condition is likely without that intervention.

The patient's clinical record may not always specifically identify "skilled planning and management activities" as such. Therefore, in this limited context, if the documentation of the patient's overall condition substantiates a finding that the patient's medical needs and safety can be addressed only if the total care, skilled or not, is planned and managed by skilled nursing personnel, it is appropriate to infer that skilled management is being provided, but only if the record as a whole clearly establishes that there was a likely potential for serious complications without skilled management, as illustrated in the following Examples.

EXAMPLE 1:

An aged patient with a history of diabetes mellitus and angina pectoris is recovering from an open reduction of the neck of the femur. He requires, among other services, careful skin care, appropriate oral medications, a diabetic diet, a therapeutic exercise program to preserve muscle tone and body condition, and observation to notice signs of deterioration in his condition or complications resulting from his restricted (but increasing) mobility. Although any of the required services could be performed by a properly instructed person, that person would not have the capability to understand the relationship among the services and their effect on each other. Since the nature of the patient's condition, his age and his immobility create a high potential for serious complications, such an understanding is essential to assure the patient's recovery and safety. The management of this plan of care requires skilled nursing personnel until such time as skilled care is no longer required in coordinating the patient's treatment regimen, even though the individual services involved are supportive in nature and do not require skilled nursing personnel. The documentation in the medical record as a whole is essential for this determination and must illustrate the complexity of the unskilled services that are a necessary part of the medical treatment and which require the involvement of skilled nursing personnel to promote the stabilization of the patient's medical condition and safety.

EXAMPLE 2:

An aged patient is recovering from pneumonia, is lethargic, is disoriented, has residual chest congestion, is confined to bed as a result of his debilitated condition, and requires restraints at times. To decrease the chest congestion, the physician has prescribed frequent changes in position, coughing, and deep breathing. While the residual chest congestion alone would not represent a high risk factor, the patient's immobility and confusion represent complicating factors which, when coupled with the chest congestion, could create high probability of a relapse. In this situation, skilled overseeing of the

nonskilled services would be reasonable and necessary, pending the elimination of the chest congestion, to assure the patient's medical safety. The documentation in the medical record as a whole is essential for this determination and must illustrate the complexity of the unskilled services that are a necessary part of the medical treatment and which require the involvement of skilled nursing personnel to promote the patient's recovery and medical safety in view of the patient's overall condition.

30.2.3.2 - Observation and Assessment of Patient's Condition
(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)
A3-3132.1.C.2, SNF-214.1.C.2

Observation and assessment are skilled services when the likelihood of change in a patient's condition requires skilled nursing or skilled rehabilitation personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures, until the patient's condition is essentially stabilized.

EXAMPLE 1:

A patient with arteriosclerotic heart disease with congestive heart failure requires close observation by skilled nursing personnel for signs of decompensation, abnormal fluid balance, or adverse effects resulting from prescribed medication. Skilled observation is needed to determine whether the digitalis dosage should be reviewed or whether other therapeutic measures should be considered, until the patient's treatment regimen is essentially stabilized. The medical documentation must describe the skilled services that require the involvement of nursing personnel to promote the stabilization of the patient's medical condition and safety.

EXAMPLE 2:

A patient has undergone peripheral vascular disease treatment including revascularization procedures (bypass) with open or necrotic areas of skin on the involved extremity. Skilled observation and monitoring of the vascular supply of the legs is required. The medical documentation must describe the skilled services that require the involvement of nursing personnel to promote the patient's recovery and medical safety in view of the patient's overall condition.

EXAMPLE 3:

A patient has undergone hip surgery and has been transferred to a SNF. Skilled observation and monitoring of the patient for possible adverse reaction to the operative procedure, development of phlebitis, or skin breakdown, is both reasonable and necessary. The medical documentation must describe the skilled services that require the involvement of nursing personnel to promote the patient's recovery and medical safety in view of the patient's overall condition.

EXAMPLE 4:

A patient has been hospitalized following a heart attack, and following treatment but before mobilization, is transferred to the SNF. Because it is unknown whether exertion will exacerbate the heart disease, skilled observation is reasonable and necessary as mobilization is initiated, until the patient's treatment regimen is essentially stabilized. The medical documentation must describe the skilled services that require the involvement of nursing personnel to promote the stabilization of the patient's medical condition and safety.

EXAMPLE 5:

A frail 85-year-old man was hospitalized for pneumonia. The infection was resolved, but the patient, who had previously maintained adequate nutrition, will not eat or eats poorly. The patient is transferred to a SNF for monitoring of fluid and nutrient intake, assessment of the need for tube feeding and forced feeding if required. Observation and monitoring by skilled nursing personnel of the patient's oral intake is required to prevent dehydration. The medical documentation must describe the skilled services that require the involvement of nursing personnel to promote the patient's recovery and medical safety in view of the patient's overall condition.

EXAMPLE 6:

A patient with congestive heart failure may require continuous close observation to detect signs of decompensation, abnormal fluid balance, or adverse effects resulting from prescribed medication(s) that serve as indicators for adjusting therapeutic measures. The medical documentation must describe the skilled services that require the involvement of nursing personnel to promote the patient's recovery and medical safety in view of the patient's overall condition, to maintain the patient's current condition, or to prevent or slow further deterioration in the patient's condition.

If a patient was admitted for skilled observation but did not develop a further acute episode or complication, the skilled observation services still are covered so long as there was a reasonable probability for such a complication or further acute episode.

“Reasonable probability” means that a potential complication or further acute episode was a likely possibility.

Information from the patient's medical record must document that there is a reasonable potential for a future complication or acute episode sufficient to justify the need for continued skilled observation and assessment.

Such signs and symptoms as abnormal/fluctuating vital signs, weight changes, edema, symptoms of drug toxicity, abnormal/fluctuating lab values, and respiratory changes on auscultation may justify skilled observation and assessment. Where these signs and symptoms are such that there is a reasonable potential that skilled observation and assessment by a licensed nurse will result in changes to the treatment of the patient, then the services are reasonable and necessary. However, observation and assessment by a

nurse is not reasonable and necessary to the treatment of the illness or injury where these characteristics are part of a longstanding pattern of the patient's waxing and waning condition which by themselves do not require skilled services and there is no attempt to change the treatment to resolve them.

Skilled observation and assessment may also be required for patients whose primary condition and needs are psychiatric in nature or for patients who, in addition to their physical problems, have a secondary psychiatric diagnosis. These patients may exhibit acute psychological symptoms such as depression, anxiety or agitation, which require skilled observation and assessment such as observing for indications of suicidal or hostile behavior. However, these conditions often require considerably more specialized, sophisticated nursing techniques and physician attention than is available in most participating SNFs. (SNFs that are primarily engaged in treating psychiatric disorders are precluded by law from participating in Medicare.) Therefore, these cases must be carefully documented.

30.2.3.3 - Teaching and Training Activities

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

A3-3132.1.C.3, SNF-214.1.C.3

Teaching and training activities, which require skilled nursing or skilled rehabilitation personnel to teach a patient how to manage their treatment regimen, would constitute skilled services. Some examples are:

- Teaching self-administration of injectable medications or a complex range of medications;
- Teaching a newly diagnosed diabetic to administer insulin injections, to prepare and follow a diabetic diet, and to observe foot-care precautions;
- Teaching self-administration of medical gases to a patient;
- Gait training and teaching of prosthesis care for a patient who has had a recent leg amputation;
- Teaching patients how to care for a recent colostomy or ileostomy;
- Teaching patients how to perform self-catheterization and self-administration of gastrostomy feedings;
- Teaching patients how to care for and maintain central venous lines, such as Hickman catheters;
- Teaching patients the use and care of braces, splints and orthotics, and any associated skin care; and

- Teaching patients the proper care of any specialized dressings or skin treatments.

The documentation must thoroughly describe all efforts that have been made to educate the patient/caregiver, and their responses to the training. The medical record should also describe the reason for the failure of any educational attempts, if applicable.

EXAMPLE:

A newly diagnosed diabetic patient is seen in order to learn to self-administer insulin injections, to prepare and follow a diabetic diet, and to observe foot-care precautions. Even though the patient voices understanding of the nutritional principles of his diabetic diet, he expresses dissatisfaction with his food choices and refuses to comply with the education he is receiving. This refusal continues, notwithstanding efforts to counsel the patient on the potentially adverse consequences of the refusal and to suggest alternative dietary choices that could help to avoid or alleviate those consequences. The patient's response to the recommended treatment plan as well as to all educational attempts is documented in the medical record.

30.2.4 - Questionable Situations
(Rev. 1, 10-01-03)

A3-3132.1.D, SNF-214.1.D

There must be specific evidence that daily skilled nursing or skilled rehabilitation services are required and received if:

- The primary service needed is oral medication; or
- The patient is capable of independent ambulation, dressing, feeding, and hygiene.

30.3 - Direct Skilled Nursing Services to Patients
(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)
A3-3132.2, SNF-214.2

Nursing services are considered skilled when they are so inherently complex that they can be safely and effectively performed only by, or under the supervision of, a registered nurse or, when provided by regulation, a licensed practical (vocational) nurse. (See 42CFR §409.32) If all other requirements for coverage under the SNF benefit are met, skilled nursing services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a registered nurse or, when provided by regulation, a licensed practical (vocational) nurse are necessary. Skilled nursing services would be covered where such skilled nursing services are necessary to maintain the patient's current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively provided, and all other requirements for coverage under the SNF benefit are met. Coverage does not turn on the presence or absence of an individual's

potential for improvement from nursing care, but rather on the beneficiary's need for skilled care.

A condition that would not ordinarily require skilled nursing services may nevertheless require them under certain circumstances. In such instances, skilled nursing care is necessary only when (a) the particular patient's special medical complications require the skills of a registered nurse or, when provided by regulation, a licensed practical nurse to perform a type of service that would otherwise be considered non-skilled; or (b) the needed services are of such complexity that the skills of a registered nurse or, when provided by regulation, a licensed practical nurse are required to furnish the services.

A service is not considered a skilled nursing service merely because it is performed by or under the direct supervision of a nurse. If a service can be safely and effectively performed (or self-administered) by an unskilled person, the service cannot be regarded as a skilled nursing service although a nurse actually provides the service. Similarly, the unavailability of a competent person to provide a nonskilled service, regardless of the importance of the service to the patient, does not make it a skilled service when a nurse provides the service.

Some examples of direct skilled nursing services are:

- Intravenous or intramuscular injections and intravenous feeding;
- Enteral feeding that comprises at least 26 percent of daily calorie requirements and provides at least 501 milliliters of fluid per day;
- Naso-pharyngeal and tracheotomy aspiration;
- Insertion, sterile irrigation, and replacement of suprapubic catheters;
- Application of dressings involving prescription medications and aseptic techniques (see §30.5 for exception);
- Treatment of decubitus ulcers, of a severity rated at Stage 3 or worse, or a widespread skin disorder (see §30.5 for exception);
- Heat treatments which have been specifically ordered by a physician as part of active treatment and which require observation by skilled nursing personnel to evaluate the patient's progress adequately (see §30.5 for exception);
- Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, that are part of active treatment and require the presence of skilled nursing personnel; e.g., the institution and supervision of bowel and bladder training programs;

- Initial phases of a regimen involving administration of medical gases such as bronchodilator therapy; and
- Care of a colostomy during the early post-operative period in the presence of associated complications. The need for skilled nursing care during this period must be justified and documented in the patient's medical record.

30.4 - Direct Skilled Therapy Services to Patients

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

A3-3132.1.C, SNF-214.1.C

The following sections contain examples and guidelines concerning direct skilled therapy services to patients, including skilled physical therapy, occupational therapy, and speech/language pathology therapy.

Coverage for such skilled therapy services does not turn on the presence or absence of a beneficiary's potential for improvement from therapy services, but rather on the beneficiary's need for skilled care. Therapy services are considered skilled when they are so inherently complex that they can be safely and effectively performed only by, or under the supervision of, a qualified therapist. (See 42CFR §409.32) These skilled services may be necessary to improve the patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition.

If all other requirements for coverage under the SNF benefit are met, such skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist are necessary for the performance of the rehabilitation services.

30.4.1 – Skilled Physical Therapy

(Rev. 1, 10-01-03)

A3-3132.3A, SNF-214.3.A

30.4.1.1 - General

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

Skilled physical therapy services must meet all of the following conditions:

- The services must be directly and specifically related to an active written treatment plan that is based upon an initial evaluation performed by a qualified physical therapist after admission to the SNF and prior to the start of physical therapy services in the SNF that is approved by the physician after any needed consultation with the qualified physical therapist. In those cases where a beneficiary is discharged during the SNF stay and later readmitted, an initial evaluation must be performed upon readmission to the SNF, prior to the start of physical therapy services in the SNF;

- Routine care in connection with braces and similar devices;
- Use of heat as a palliative and comfort measure, such as whirlpool or steam pack;
- Routine administration of medical gases after a regimen of therapy has been established (i.e., administration of medical gases after the patient has been taught how to institute therapy);
- Assistance in dressing, eating, and going to the toilet;
- Periodic turning and positioning in bed; and
- General supervision of exercises, which have been taught to the patient and the performance of repetitious exercises that do not require skilled rehabilitation personnel for their performance. (This includes the actual carrying out of maintenance programs where the performances of repetitive exercises that may be required to maintain function do not necessitate a need for the involvement and services of skilled rehabilitation personnel. It also includes the carrying out of repetitive exercises to improve gait, maintain strength or endurance; passive exercises to maintain range of motion in paralyzed extremities which are not related to a specific loss of function; and assistive walking.) (See Medicare Benefit Policy Manual, Chapter 1, "Inpatient Hospital Services.")

30.6 - Daily Skilled Services Defined

(Rev. 249, Issued: 11-02-18, Effective: 12-04-18, Implementation: 12-04-18)

Skilled nursing services or skilled rehabilitation services (or a combination of these services) must be needed and provided on a "daily basis," i.e., on essentially a 7-days-a-week basis. A patient whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the "daily basis" requirement when they need and receive those services on at least 5 days a week. (If therapy services are provided less than 5 days a week, the "daily" requirement would not be met.)

This requirement should not be applied so strictly that it would not be met merely because there is an isolated break of a day or two during which no skilled rehabilitation services are furnished and discharge from the facility would not be practical.

EXAMPLE:

A patient who normally requires skilled rehabilitation services on a daily basis may exhibit extreme fatigue, which results in suspending therapy sessions for a day or two. Coverage may continue for these days since discharge in such a case would not be practical.

In instances when a patient requires a skilled restorative nursing program to positively affect his functional well-being, the expectation is that the program be rendered at least 6 days a week. (Note that when a patient's skilled status is based on a restorative program, medical evidence must be documented to justify the services. In most instances, it is expected that a skilled restorative program will be, at most, only a few weeks in duration.)

The daily basis requirement can be met by furnishing a single type of skilled service every day, or by furnishing various types of skilled services on different days of the week that collectively add up to "daily" skilled services. However, arbitrarily staggering the timing of various therapy modalities *through* the week, merely in order to have some type of therapy session occur each day, would not satisfy the SNF coverage requirement for skilled care to be needed on a "daily basis." To meet this requirement, the patient must actually **need** skilled rehabilitation services to be furnished on each of the days that the facility makes such services available.

It is not sufficient for the scheduling of therapy sessions to be arranged so that some therapy is **furnished** each day, unless the patient's medical needs indicate that daily therapy is required. For example, if physical therapy is furnished on 3 days each week and occupational therapy is furnished on 2 other days each week, the "daily basis" requirement would be satisfied only if there is a valid medical reason why both cannot be furnished on the same day. The basic issue here is not whether the services are needed, but **when** they are needed. Unless there is a legitimate medical need for scheduling a therapy session each day, the "daily basis" requirement for SNF coverage would not be met.

30.7 - Services Provided on an Inpatient Basis as a "Practical Matter" (Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14) A3-3132.6, SNF-214.6

In determining whether the daily skilled care needed by an individual can, as a "practical matter," only be provided in a SNF on an inpatient basis, the A/B MAC (A) considers the individual's physical condition and the availability and feasibility of using more economical alternative facilities or services.

As a "practical matter," daily skilled services can be provided only in a SNF if they are not available on an outpatient basis in the area in which the individual resides or transportation to the closest facility would be:

- An excessive physical hardship;
- Less economical; or
- Less efficient or effective than an inpatient institutional setting.

The availability of capable and willing family or the feasibility of obtaining other assistance for the patient at home should be considered. Even though needed daily skilled services might be available on an outpatient or home care basis, as a practical matter, the care can be furnished only in the SNF if home care would be ineffective because the patient would have insufficient assistance at home to reside there safely.

EXAMPLE: A patient undergoing skilled physical therapy can walk only with supervision but has a reasonable potential to learn to walk independently with further training. Further daily skilled therapy is available on an outpatient or home care basis, but the patient would be at risk for further injury from falling, because insufficient supervision and assistance could not be arranged for the patient in his home. In these circumstances, the physical therapy services as a practical matter can be provided effectively only in the inpatient setting.

30.7.1 - The Availability of Alternative Facilities or Services (Rev. 1, 10-01-03)

A3-3132.6.A, SNF-214.6.A

Alternative facilities or services may be available to a patient when health care providers such as home health agencies are utilized. These alternatives are not always available in all communities and even where they exist they may not be available when needed.

EXAMPLE: Where the residents of a rural community generally utilize the outpatient facilities of a hospital located some distance from the area, the hospital outpatient department constitutes an alternative source of care that is available to the community. Roads in winter, however, may be impassable for some periods of time and in special situations institutionalization might be needed.

In determining the availability of more economical care alternatives, the coverage or noncoverage of that alternative care is not a factor to be considered. Home health care for a patient who is not homebound, for example, may be an appropriate alternative in some cases. The fact that Medicare cannot cover such care is irrelevant.

The issue is feasibility and not whether coverage is provided in one setting and not provided in another. For instance, an individual in need of daily skilled physical therapy might be able to receive the services needed on a more economical basis from an independently practicing physical therapist. However, the fact that Medicare payment could not be made for the services because the \$500 expense limitation applicable to the services of an independent physical therapist had been exceeded or because the patient was not enrolled in Part B, would not be a basis for determining that, as a practical matter, the needed care could only be provided in a SNF.

In determining the availability of alternate facilities or services, whether the patient or another resource can pay for the alternate services is not a factor to be considered.

Attachment 2

Deschutes and Surrounding Counties Compared to Washington and Multnomah

CIRF Discharges/ 10Kpop	State	County	Average Total Discharges 2015-2017 LOW	Average Total Discharge Rates 2015-2017 LOW	Average Total Discharges 2015-2017 HIGH	Average Rate of Discharges 2015-2017 HIGH	CIRF Beds in County	CIRF beds/ 10,000 Pop contig counties
	Oregon	Harney	19.00	25.94	19.00	25.94	0	0.98
	Oregon	Lake	15.33	19.05	18.00	22.36	0	0.98
	Oregon	Jefferson	40.00	17.54	40.00	17.54	0	2.95
	Oregon	Crook	34.00	15.75	34.00	15.75	0	0.98
	Oregon	Deschutes	157.67	8.92	157.67	8.92	18	0.98
	Oregon	Lane	212.33	5.80	212.33	5.80	18	0.49
	Oregon	Klamath	36.67	5.44	36.67	5.44	0	1.57
	Oregon	Linn	56.33	4.60	56.33	4.60	0	0.49
	Oregon	Multnomah	252.67	3.20	252.67	3.20	57	0.71
	Oregon	Washington	174.67	2.99	174.67	2.99	0	0.71

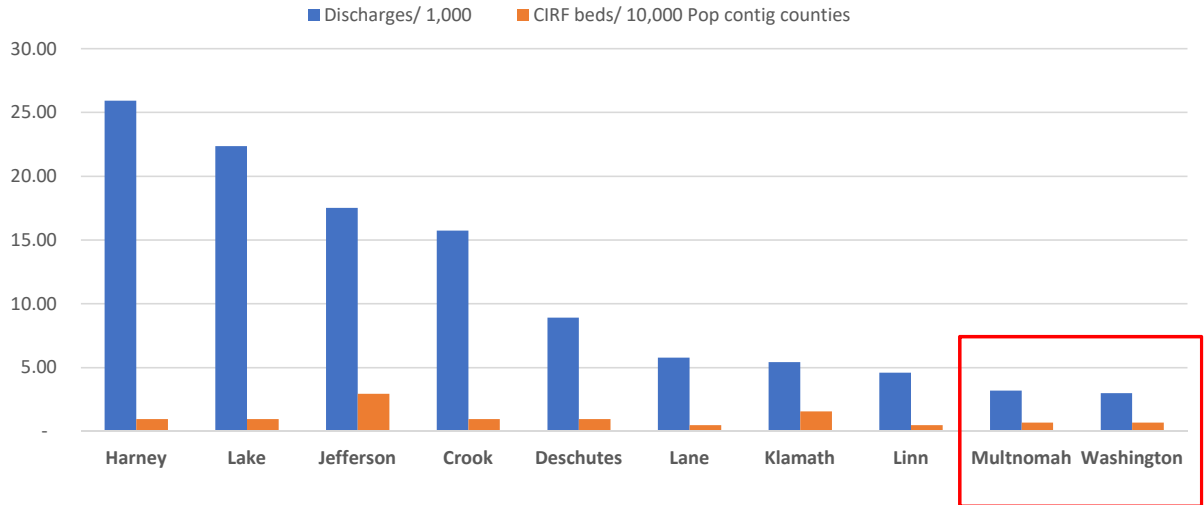
Source: OHA Hospital All Payer Database, Discharge Data

Polk and Surrounding Counties Compared to Washington and Multnomah

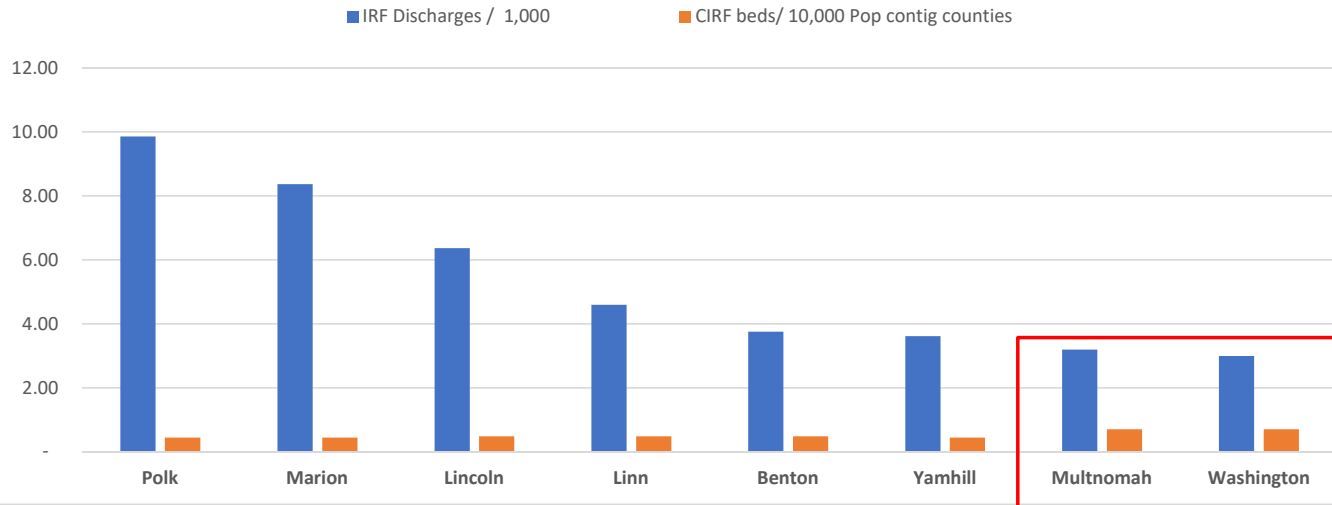
CIRF Discharges/ 10Kpop	State	County	Average Total Discharges 2015-2017 LOW	Average Total Discharge Rates 2015-2017 LOW	Average Total Discharges 2015-2017 HIGH	Average Rate of Discharges 2015-2017 HIGH	CIRF Beds in County	CIRF beds/ 10,000 Pop contig counties
	Oregon	Polk	78.67	9.86	78.67	9.86	0	0.44
	Oregon	Marion	280.00	8.38	280.00	8.38	15	0.44
	Oregon	Lincoln	30.33	6.37	30.33	6.37	0	0.49
	Oregon	Linn	56.33	4.60	56.33	4.60	0	0.49
	Oregon	Benton	34.33	3.76	34.33	3.76	0	0.49
	Oregon	Yamhill	38.00	3.62	38.00	3.62	0	0.44
	Oregon	Multnomah	252.67	3.20	252.67	3.20	57	0.71
	Oregon	Washington	174.67	2.99	174.67	2.99	0	0.71

Source: OHA Hospital All Payer Database, Discharge Data

Avg. 3 Yr CIRF Discharge Rate St. Charles Counties Compared to Washington and Multnomah



Avg. 3 Yr. CIRF Discharge Rate Salem Counties Compared to Washington and Multnomah



Attachment 3

CHAPTER

10

Inpatient rehabilitation facility services

R E C O M M E N D A T I O N

- 10** For 2020, the Congress should reduce the fiscal year 2019 Medicare base payment rate for inpatient rehabilitation facilities by 5 percent.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

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(Additionally, the Commission reiterates its March 2016 recommendations on the inpatient rehabilitation facility prospective payment system. See text box, p. 261.)

Inpatient rehabilitation facility services

Chapter summary

Inpatient rehabilitation facilities (IRFs) provide intensive rehabilitation services to patients after illness, injury, or surgery. Rehabilitation programs are supervised by rehabilitation physicians and include services such as physical and occupational therapy, rehabilitation nursing, speech–language pathology, and prosthetic and orthotic services. In 2017, Medicare spent \$7.9 billion on IRF care provided to fee-for-service (FFS) beneficiaries in about 1,180 IRFs nationwide. About 340,000 beneficiaries had around 380,000 IRF stays. On average, the Medicare FFS program accounted for 58 percent of IRF discharges.

Assessment of payment adequacy

Our indicators of Medicare payment adequacy for IRFs are positive.

Beneficiaries’ access to care—Our analysis of IRF supply and volume of services provided and of IRFs’ marginal profit under Medicare’s IRF prospective payment system suggest that access remains adequate.

- **Capacity and supply of providers**—After declining for several years, the number of IRFs increased in 2014 and continued to grow through 2016, reaching 1,188 facilities nationwide. In 2017, however, the number of IRFs declined slightly, to 1,178 facilities. Over time, the number of hospital-based and nonprofit IRFs has declined, while the number

In this chapter

- Are Medicare payments adequate in 2019?
- How should Medicare payments change in 2020?

of freestanding and for-profit IRFs has increased. In 2017, the average IRF occupancy rate remained at 65 percent, indicating that capacity is more than adequate to meet demand for IRF services.

- **Volume of services**—From 2016 to 2017, the number of Medicare FFS cases declined 2.7 percent, falling to about 380,000 cases after having experienced small annual growth every year since 2010.
- **Marginal profit**—The marginal profit, an indicator of whether IRFs with excess capacity have an incentive to treat more Medicare beneficiaries, was 19.4 percent for hospital-based IRFs and 38.8 percent for freestanding IRFs—a very positive indicator of patient access.

Quality of care—The Commission tracks three broad categories of IRF quality indicators: risk-adjusted facility-level change in patients' functional and cognitive status during the IRF stay, rates of discharge to the community and to skilled nursing facilities, and rates of readmission to an acute care hospital. Most measures were steady or improved between 2012 and 2017.

Providers' access to capital—The parent institutions of hospital-based IRFs continue to have good access to capital. The major freestanding IRF chain, which accounted for almost half of freestanding IRFs in 2017 and about a quarter of all Medicare IRF discharges, also has good access to capital. This assessment is reflected in the chain's continued expansion. We were not able to determine the ability of other freestanding facilities to raise capital. IRFs' access to capital in large part depends on their total (all-payer) profitability, and in 2017, total margins for freestanding IRFs were 10.4 percent. Data on all-payer profitability are not available for hospital-based units, but we can examine the all-payer margins of hospitals with IRF units, which, in 2017, had an aggregate all-payer margin across all lines of business of 7.0 percent.

Medicare payments and providers' costs—The aggregate Medicare margin for IRFs has grown steadily since 2009. In the three-year period between 2015 and 2017, the aggregate IRF Medicare margin remained above 13 percent and in 2017 stood at 13.8 percent. Also in 2017, Medicare margins in freestanding IRFs were 25.5 percent, down slightly from their peak in 2015 of 26.7 percent. In 2017, hospital-based IRF margins were comparatively low at 1.5 percent, but one-quarter of hospital-based IRFs had Medicare margins greater than 11 percent, indicating that many hospitals can manage their IRF units profitably. Lower margins in hospital-based IRFs were driven largely by higher unit costs. In addition, there are notable differences in hospital-based and freestanding IRFs' mix of cases, which may indicate differences in profitability across case types. Finally, while

not definitive, evidence indicates that IRFs' assessments of patients' motor and cognitive function are not reliably consistent across providers. To the extent that hospital-based IRFs routinely assess their patients as less disabled than do their freestanding counterparts, their payments—and margins—will be systematically lower.

Growth in IRFs' costs historically has been low. From 2009 to 2015, the cumulative growth in cost per discharge was 8.4 percent, well below the 13.5 percent increase in the market basket for IRFs over the period. In 2016, per case cost growth (3.6 percent in aggregate) exceeded payment growth (2.9 percent in aggregate) for the first time since 2008. In 2017, however, per case payments again grew faster than costs (3.4 percent compared with 2.8 percent), resulting in an aggregate IRF margin of 13.8 percent. In 2018 to 2019, we anticipate costs in IRFs will grow faster than payments since updates in those years were constrained to 1.0 percent and 1.35 percent, respectively. For 2019, we project an aggregate Medicare margin of 11.6 percent.

This year, the Commission for the first time examined the financial performance of relatively efficient IRFs. Our analysis found that relatively efficient IRFs performed better on quality metrics and had costs 18 percent lower than other IRFs. Relatively efficient IRFs were on average larger and had higher occupancy rates, contributing to greater economies of scale and lower costs. Freestanding and for-profit facilities were more likely to be in the relatively efficient group.

On the basis of these factors, the Commission recommends a 5 percent reduction to the IRF payment rate for fiscal year 2020. In addition, the Commission reiterates its March 2016 recommendations that (1) the high-cost outlier pool be expanded to further redistribute payments in the IRF payment system and reduce the impact of misalignments between IRF payments and costs and (2) the Secretary conduct focused medical record review of IRFs that have unusual patterns of case mix and coding and conduct other research necessary to improve the accuracy of payments and protect program integrity. ■

Background

After illness, injury, or surgery, some patients need intensive, inpatient rehabilitative care, including physical, occupational, and speech therapy. Such services can be provided in inpatient rehabilitation facilities (IRFs).¹ IRFs must be primarily focused on treating conditions that typically require intensive rehabilitation, among other requirements. IRFs can be freestanding facilities or specialized units within acute care hospitals. To qualify for a covered IRF stay, a beneficiary must be able to tolerate and benefit from intensive therapy and must have a condition that requires frequent and face-to-face supervision by a rehabilitation physician. Other patient admission criteria also apply. In 2017, Medicare spent \$7.9 billion on IRF care provided in about 1,180 IRFs nationwide. About 340,000 beneficiaries had almost 380,000 IRF stays. On average, Medicare fee-for-service (FFS) beneficiaries accounted for about 58 percent of IRF discharges.

Since January 2002, Medicare has paid IRFs under a per discharge prospective payment system (PPS).² Under the IRF PPS, Medicare patients are assigned to case-mix groups (CMGs) based on the patient's primary reason for inpatient rehabilitation, age, and level of motor and cognitive function. Within each of these CMGs, patients are further categorized into one of four tiers based on the presence of certain comorbidities that have been found to increase the cost of care. Each CMG tier has a designated weight that reflects the group's average relative costliness of cases compared with that of the average Medicare IRF case.³ The CMG weight is multiplied by a base payment rate and then adjusted to reflect geographic differences in the wages IRFs pay. The payment is further adjusted based on the IRF's share of low-income patients. Additional adjustments are made for IRFs that are teaching facilities and for IRFs located in rural areas. The IRF PPS also has outlier payments for patients who are extraordinarily costly. Starting in fiscal year 2020, CMS is changing the patient assessment instrument used to help classify patients for payment, shifting from IRF-specific measures of motor and cognitive function to measures that are standardized across post-acute care (PAC) settings. The changes to the assessment instruments will necessitate minor adjustments of the CMG definitions (see text box, pp. 256–257).

Medicare facility requirements for IRFs

To qualify as an IRF for Medicare payment, facilities must meet the Medicare conditions of participation for acute care hospitals. They must also:

- have a preadmission screening process to determine that each prospective patient is likely to benefit significantly from an intensive inpatient rehabilitation program;
- ensure that the patient receives close medical supervision and provide—through qualified personnel—rehabilitation nursing, physical therapy, occupational therapy, and, as needed, speech–language pathology and psychological (including neuropsychological) services, social services, and orthotic and prosthetic services;
- have a medical director of rehabilitation with training or experience in rehabilitation who provides services in the facility on a full-time basis for freestanding IRFs or at least 20 hours per week for hospital-based IRF units;
- use a coordinated interdisciplinary team led by a rehabilitation physician that includes a rehabilitation nurse, a social worker or case manager, and a licensed therapist from each therapy discipline involved in the patient's treatment;
- have a plan of treatment for each patient that is established, reviewed, and revised as needed by a physician in consultation with other professional personnel who provide services to the patient; and
- meet the compliance threshold, which requires that no less than 60 percent of patients admitted to an IRF have as a primary diagnosis or comorbidity at least 1 of 13 conditions specified by CMS.⁴ The intent of the compliance threshold is to distinguish IRFs from acute care hospitals. If an IRF does not meet the compliance threshold, Medicare pays for all its cases on the basis of the inpatient hospital PPS rather than the IRF PPS.

Medicare coverage criteria for beneficiaries

Medicare applies additional criteria that govern whether IRF services are covered for an individual Medicare beneficiary.⁵ For an IRF claim to be considered reasonable and necessary, the patient must be reasonably expected to meet the following requirements at admission:

Changes to the IRF assessment instrument and case-mix groups in fiscal year 2020

Under the inpatient rehabilitation facility (IRF) prospective payment system (PPS), for purposes of payment, patients are assigned to rehabilitation impairment categories (RICs) based on the principal diagnosis or primary reason for inpatient rehabilitation. Within each RIC, patients are sorted into case-mix groups (CMGs) based on the patient's level of motor and cognitive function at admission and then further categorized into one of four tiers based on the presence of specific comorbidities that have been found to increase the cost of care.

To determine the appropriate CMG, IRFs assess and score each patient's motor and cognitive function using the IRF–Patient Assessment Instrument (IRF–PAI). The IRF–PAI is based on a modified version of the Uniform Data System for Medical Rehabilitation patient assessment instrument, commonly referred to as the Functional Independence Measure™, or FIM™. The IRF–PAI's 18 FIM data elements and associated modifiers, along with the FIM measurement scale, are used to measure a patient's level of disability and the burden of care for a patient's caregivers. (All else equal, a greater level of disability generally results in a higher payment.)

The IRF–PAI also includes items that are standardized across post-acute care (PAC) settings and are used to collect information on a patient's motor and cognitive function for the IRF Quality Reporting Program (QRP). As shown in Table 10-1, the QRP items are very similar to the FIM elements and associated modifiers. Because the QRP elements overlap the FIM data elements, CMS believes that the collection of FIM elements and associated modifiers is no longer necessary and places undue burden on providers. Accordingly, in fiscal year 2020, CMS will remove the FIM elements and associated modifiers from the IRF–PAI and will rely on QRP items to assign cases to CMGs.

Because the QRP items are defined differently from the FIM elements and use a different scale of measurement, using QRP items for CMG assignment will require some revisions to the CMG classification system. However, CMS anticipates the similarity

between and overlap of the FIM and QRP items mean that CMS can replace FIM elements with QRP items without materially changing the case-mix classification system. All other aspects of the classification system will be unchanged, including the RIC structure, the assignment of comorbidity tiers, and the methodology for calculating the payment weights. The CMG classification system will continue to have 21 RICs (plus 2 for patients who have very short stays or who die in the IRF). However, the revisions will result in some consolidation of CMGs so that, instead of 92 CMGs, there will be 88. At the RIC level, the changes to the payment weights will be relatively small.

CMS plans to implement these revisions in a budget-neutral manner. CMS's initial analysis indicates that the change will redistribute payments across providers, resulting in increased aggregate payments for hospital-based and nonprofit IRFs as well as for smaller IRFs. This projected shift in payments suggests that assessments of patients' motor and cognitive function are not completely consistent across the two sets of data elements; that is, a patient's FIM function scores are not entirely predictive of the patient's QRP function scores.

One potential reason for these differences is that the FIM score is intended to reflect the patient's "lowest" level of function during the time of assessment, whereas the QRP score is intended to measure the patient's "usual" functional level during the period of assessment. In addition, functional status data are generally obtained by observation of the patient and are somewhat subjective. Moreover, the FIM scores are used to determine payment to IRFs, while the QRP scores have had no effect on payment to date. Because payment is materially affected by patients' FIM scores at admission—with higher payments associated with lower functional status—providers have a financial incentive when scoring the FIM elements to minimize patients' assessed levels of function at admission. No such incentive has existed for QRP scoring. However, that situation will change when CMS begins to use QRP scores to determine payment.

(continued next page)

Changes to the IRF assessment instrument and case-mix groups in fiscal year 2020 (cont.)

In a comment letter to the Secretary, the Commission supported replacing FIM items and modifiers with QRP items because doing so would relieve providers of having to report this information on functional status twice, using different definitions and measurement scales (Medicare Payment Advisory Commission 2018). Further, Section 1899(b)(3) of the Improving Medicare Post-Acute Care Transformation Act of 2014 requires the Secretary to replace existing setting-specific patient assessment data that duplicate or overlap the required

PAC-standardized data “as soon as practicable.” At the same time, moving toward an IRF classification system that adjusts payments using data elements that are standardized across all PAC settings is a necessary step toward a unified PAC PPS. The Commission noted, however, that once the QRP scores are used to determine payment, providers likely will respond quickly, devoting resources to improving the coding of the QRP functional measures, altering their QRP scoring practices, or both. ■

**TABLE
10-1**

Selected FIM™ elements and QRP counterparts on the IRF-PAI

	FIM	QRP
Self-care: Eating	<i>FIM item A</i> —The use of suitable utensils to bring food to the mouth, chewing and swallowing, once the meal is presented in the customary manner on a table or tray.	<i>GG130-A</i> —The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is placed before the patient.
Self-care: Bathing	<i>FIM item C</i> —Washing, rinsing, and drying the body from the neck down (excluding the back) in either a tub, shower, or sponge/bed bath.	<i>GG130-E</i> —The ability to bathe self in shower or tub, including washing, rinsing, and drying self.
Self-care: Dressing upper body	<i>FIM item D</i> —Dressing and undressing above the waist, as well as applying and removing a prosthesis or orthosis when applicable.	<i>GG130-F</i> —The ability to put on and remove shirt or pajama top; includes buttoning, if applicable.
Self-care: Toileting	<i>FIM item F</i> —Maintaining perineal hygiene and adjusting clothing before and after using a toilet, commode, bedpan, or urinal.	<i>GG130-C</i> —The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan, or urinal.
Transfers: Bed, chair, wheelchair	<i>FIM item I</i> —All aspects of transferring from bed to a chair, or wheelchair, or coming to a standing position, if walking is the typical mode of locomotion.	<i>GG170-D</i> —The ability to come to a standing position from sitting in a chair, or on the side of the bed. <i>GG170-E</i> —The ability to safely transfer to and from a bed to a chair (or wheelchair).
Transfers: Toilet	<i>FIM item J</i> —Includes safely getting on and off a standard toilet.	<i>GG170-F</i> —The ability to safely get on and off a toilet or commode.
Locomotion: Walk	<i>FIM item L</i> —Ability to/level of assistance needed to walk 150 feet.	<i>GG170-K</i> —Once standing, the ability to walk at least 150 feet in a corridor or similar space.

Note: FIM™ (Functional Independence Measure™), QRP (Quality Reporting Program), IRF-PAI (Inpatient Rehabilitation Facility–Patient Assessment Instrument).

Source: CMS, Inpatient Rehabilitation Facility–Patient Assessment Instrument, Version 1.5.

**TABLE
10-2**

The number and share of FFS IRF cases with neurological conditions and brain injury continued to grow, 2004-2017

Condition	Share of IRF Medicare FFS cases				Meets compliance threshold ^a	Percentage point change		
	2004	2008	2016	2017		2004-2008	2008-2016	2016-2017
Stroke	16.6%	20.4%	20.2%	20.5%	yes	3.8	-0.2	0.2
Other neurological conditions	5.2	8.0	13.6	15.0	yes	2.9	5.6	1.3
Fracture of the lower extremity	13.1	16.0	10.9	10.4	yes	3.0	-5.2	-0.4
Debility	6.2	9.1	10.6	10.6	no	2.9	1.5	0.0
Brain injury	3.9	7.0	9.9	10.7	yes	3.0	2.9	0.8
Other orthopedic conditions	5.2	6.1	8.2	7.9	no	0.9	2.1	-0.2
Cardiac conditions	5.3	4.6	6.0	5.5	no	-0.6	1.4	-0.3
Major joint replacement of lower extremity	24.1	13.1	5.4	4.4	^b	-11.0	-7.7	-1.1
Spinal cord injury	4.2	4.3	4.9	4.9	yes	0.1	0.6	0.0
All other	16.3	11.3	10.1	9.8	^c	-5.0	-1.1	-0.3

Note: FFS (fee-for-service), IRF (inpatient rehabilitation facility). "Other neurological conditions" includes multiple sclerosis, Parkinson's disease, polyneuropathy, and neuromuscular disorders. "Fracture of the lower extremity" includes hip, pelvis, and femur fractures. Patients with debility have generalized deconditioning not attributable to other conditions. "Other orthopedic conditions" excludes fractures of the hip, pelvis, and femur, and hip and knee replacements. "All other" includes conditions such as amputations, arthritis, and pain syndrome. All Medicare FFS IRF cases with valid patient assessment information were included in this analysis. Yearly figures presented in the table are rounded, but figures in the percentage point change columns were calculated using unrounded data.

^aThe compliance threshold requires that at least 60 percent of an IRF's patients have 1 of 13 specified diagnoses or have a comorbidity that could cause significant decline in functional ability such that the patient requires intensive rehabilitation. Some FFS cases with conditions that do not meet the compliance threshold could thus be counted toward the threshold if they had certain comorbidities.

^bCases admitted for rehabilitation after major joint replacement of the lower extremity count toward the compliance threshold if joint replacement was bilateral, if the patient had a body mass index of 50 or greater, or if the patient was age 85 or older.

^cConditions in the "all other" category that meet the compliance threshold include congenital deformity, lower-limb amputations, major multiple trauma, burns, and certain arthritis cases.

Source: MedPAC analysis of Inpatient Rehabilitation Facility-Patient Assessment Instrument data from CMS.

- The patient requires active and ongoing therapy in at least two modalities, one of which must be physical or occupational therapy.
- The patient can actively participate in and benefit from intensive therapy that most typically consists of three hours of therapy a day at least five days a week.
- The patient is sufficiently stable at the time of admission to actively participate in the intensive rehabilitation program.
- The patient requires supervision by a rehabilitation physician. This requirement is satisfied by face-to-face physician visits with a patient at least three days a week.

Patterns of use in IRFs

In 2004, CMS began to consistently enforce the IRF compliance threshold and enacted revisions to some of the qualifying conditions.⁶ The combination of renewed enforcement of the threshold and additional restrictions resulted—as intended—in a substantial decline in the volume of Medicare patients treated in IRFs. By 2008, the number of IRF discharges had fallen 26 percent, with the biggest declines seen in the number of medically complex (-73 percent), arthritis (-68 percent), and hip and knee replacement (-60 percent) cases. Average case-mix severity and cost per case increased as IRFs shifted their mix of cases to conditions that count toward the threshold, such as stroke, brain injury, and other neurological conditions (Table 10-2). IRF volume stabilized after 2008, but increases in certain neurological

**TABLE
10-3**

Mix of Medicare FFS IRF cases differed by provider type, selected conditions, 2017

Condition	Freestanding		Hospital based	
	For profit	Nonprofit	For profit	Nonprofit
Stroke	16%	26%	20%	26%
Other neurological conditions	21	8	13	10
Fracture of the lower extremity	9	8	13	11
Debility	11	8	12	10
Brain injury	10	12	11	11
Other orthopedic conditions	10	7	6	6

Note: FFS (fee-for-service), IRF (inpatient rehabilitation facility). "Other neurological conditions" includes multiple sclerosis, Parkinson's disease, polyneuropathy, and neuromuscular disorders. "Fracture of the lower extremity" includes hip, pelvis, and femur fractures. Patients with debility have generalized deconditioning not attributable to other conditions. "Other orthopedic conditions" excludes fractures of the hip, pelvis, and femur, and hip and knee replacements. All Medicare FFS IRF cases with valid patient assessment information were included in this analysis.

Source: MedPAC analysis of Inpatient Rehabilitation Facility–Patient Assessment Instrument data from CMS.

conditions—Parkinson’s disease and neuromuscular disorders—continued. Between 2008 and 2017, the number of IRF discharges with other neurological conditions almost doubled, climbing 99 percent, and the number of discharges with brain injuries (traumatic and nontraumatic combined) rose 63 percent, while the total number of Medicare IRF discharges increased 6 percent (data not shown). Notably, the number of cases with other orthopedic conditions, cardiac conditions, and debility also rose, though a sizable share of these cases do not count toward the compliance threshold.⁷ The number of hip and knee replacement cases going to IRFs continued their downward trajectory, declining an additional 55 percent from 2008 to 2016. IRFs also saw a large decline in cases for fractures of the lower extremity, falling 26 percent over the same period, even though they count toward the compliance threshold.

The distribution of case types differs by type of IRF (Table 10-3). For example, in 2017, only 16 percent of cases in freestanding for-profit IRFs were admitted for rehabilitation following a stroke, compared with 26 percent of cases in hospital-based nonprofit IRFs. Likewise, 21 percent of cases in freestanding for-profit IRFs were admitted with other neurological conditions, more than twice the share admitted to hospital-based nonprofit IRFs. Cases with other orthopedic conditions also made up a higher share of cases in freestanding for-profit facilities than in all other IRFs. By contrast, the

share of cases with brain injury or debility was similar across IRF types.

In 2017, 8.5 percent of IRF cases received high-cost outlier payments, although the share varied by case type. For example, high-cost outlier cases accounted for 12.6 percent of spinal cord injury cases, 10.7 percent of stroke cases, 6.3 percent of cases with other neurological conditions, and 5.2 percent of other orthopedic conditions. Outlier cases were also distributed unevenly among IRFs. High-cost outliers accounted for almost 15 percent of hospital-based IRF cases compared with 2.6 percent of freestanding IRF cases. On average, high-cost outliers had an average length of stay that was 7.3 days longer than non-outlier cases (19.4 days vs. 12.1 days). Outlier cases were also more likely to have comorbidities that increased case mix (65.6 percent of outlier cases vs. 55.1 percent for non-outlier cases).

High-margin IRFs have a different mix of cases

A previous Commission analysis of differences in the mix of cases across IRFs suggested that patient selection contributes to provider profitability (Medicare Payment Advisory Commission 2016). We found that IRFs with the highest margins in 2013 had a higher share of other neurological cases and a lower share of stroke cases.⁸ Further, we observed differences in the types of stroke

and other neurological conditions admitted to high-margin and low-margin IRFs. Stroke cases in the highest margin IRFs were two-and-a-half times more likely than those in the lowest margin IRFs to have no paralysis. Likewise, other neurological cases in the highest margin IRFs were almost three times more likely than those in the lowest margin IRFs to have a neuromuscular disorder (such as amyotrophic lateral sclerosis or muscular dystrophy) as opposed to neurological conditions like multiple sclerosis or Parkinson's disease.

As noted in our March 2016 report to the Congress, these findings suggest that, under the IRF PPS, some case types are more profitable than others. The Commission plans to assess variation in costs among the IRF CMGs and differences in relative profitability across CMGs in future analyses. It is necessary to identify and reduce variation in costs among CMGs and properly calibrate payments with costs for each group to avoid overpayments and reduce financial incentives for providers to admit certain types of cases and avoid others. In the short term, the Commission has recommended that the Secretary effect changes to reduce potential misalignments between IRF payments and costs by redistributing payments within the IRF PPS through the high-cost outlier pool (see text box on March 2016 recommendations). Expanding the outlier pool would increase outlier payments for the most costly cases, easing the financial burden for IRFs that have a relatively high share of these cases.

Data suggest patients not assessed uniformly across IRFs

A previous Commission analysis of acute care hospital claims data and data from the Inpatient Rehabilitation Facility–Patient Assessment Instrument (IRF–PAI), while not definitive, strongly suggests that IRFs differ in their assessment of patients' motor and cognitive function, raising more generalized concerns about patient assessment data (Medicare Payment Advisory Commission 2016).

Overall, when we compared patients in high-margin and low-margin IRFs, we found that patients in high-margin IRFs were less severely ill and resource intensive during the acute care hospitalization that preceded the IRF stay:

- Patients in high-margin IRFs had, on average, a lower case-mix index in the acute care hospital as well as a lower level of severity of illness and a shorter length of stay.

- Patients in high-margin IRFs were less likely to have been high-cost outliers in the acute care hospital or to have spent four or more days in the hospital intensive care or coronary care unit.

But once patients were admitted to and assessed by the IRF, the average patient profile changed, with patients treated in high-margin IRFs appearing to be more disabled than those in low-margin IRFs (as measured by motor impairment scores assigned by IRFs). This pattern persisted across case types.

As noted in our March 2016 report to the Congress, the consistent finding that high-margin IRFs have patients who are, on average, less severely ill in the acute care hospital but appear more functionally disabled upon assessment in the IRF suggests that assessment and scoring practices contribute to greater profitability in some IRFs, especially given the comparatively low level of costs and cost growth observed in high-margin facilities. If providers differ in their assessment and scoring of patients' motor and cognitive function, payments will not be properly aligned with the resource needs of patients. Some IRFs will receive payments that are too high relative to the costs incurred in treating their patients, while other IRFs will receive payments that are too low.

These findings led the Commission to recommend that CMS ensure payment accuracy and help improve program integrity by reviewing medical records and conducting other research as necessary (see text box on March 2016 recommendations). More recently, the Commission has begun to explore data integrity issues related to post-acute care (PAC) patient assessment data more broadly, and we expect to evaluate whether such data can continue to be used in Medicare's payment systems or quality incentive programs.

Are Medicare payments adequate in 2019?

To assess whether payments for fiscal year 2019 are adequate to cover the costs providers incur and how much providers' costs are expected to change in the coming year (2020), we examine several indicators of payment adequacy. Specifically, we assess beneficiaries' access to care by examining the capacity and supply of IRFs and changes over time in the volume of services provided, quality of care, providers' access to capital, and the relationship between Medicare payments and providers' costs.

The Commission reiterates its March 2016 recommendations on the IRF prospective payment system

Recommendation 9-2

The Secretary should conduct focused medical record review of inpatient rehabilitation facilities that have unusual patterns of case mix and coding.

Rationale 9-2

The Commission's finding that high-margin inpatient rehabilitation facilities (IRFs) have patients who are, on average, less severely ill in the acute care hospital but appear more functionally disabled in the IRF suggests the possibility that coding practices contribute to greater profitability in some IRFs. Providers may differ in their assessment of patients' motor and cognitive function, resulting in payments for some IRFs that are too high relative to the costs incurred in treating their patients. To improve the accuracy of payments and protect program integrity, CMS should review medical records merged with IRF patient assessment data, reassess inter-rater reliability across IRFs, and conduct other research as necessary. Because medical record review is resource intensive, CMS should begin by focusing on providers that have an atypical mix of cases, such as a high concentration of neuromuscular disorders and stroke cases without paralysis, and on providers that have anomalous patterns of coding, such as wide discrepancies in their patients' levels of severity as coded in the acute care hospital compared with that coded in the IRF. However, system-wide assessment of payment accuracy is also needed.

Implications 9-2

Spending

- Implementing this recommendation could result in changes to the payment system that would be budget neutral but could also reduce Medicare's spending on IRF services if CMS were to make payment adjustments to account for assessment and coding differences across providers or for coding changes that do not reflect real case-mix change. CMS would incur some administrative expenses to conduct these activities.

Beneficiary and provider

- We do not expect this recommendation to have adverse effects on Medicare beneficiaries with respect to access to care or out-of-pocket spending or on providers' willingness and ability to care for Medicare beneficiaries.

Recommendation 9-3

The Secretary should expand the inpatient rehabilitation facility outlier pool to redistribute payments more equitably across cases and providers.

Rationale 9-3

The Commission's finding that high-margin IRFs may be selecting certain types of cases suggests that some case-mix groups (CMGs) may be more profitable than others. At the same time, our finding that IRFs may differ in their assessments of patients' motor and cognitive function suggests that the IRF CMGs may not be adequately capturing differences in patient acuity and costs across cases and providers. The potential for financial loss may therefore be greater for some providers than for others. Expanding the outlier pool would increase outlier payments for the most costly cases, easing the financial burden for IRFs that have a relatively high share of these cases.

Implications 9-3

Spending

- This recommendation would be implemented in a budget-neutral manner and should not have an overall impact on spending.

Beneficiary and provider

- We do not expect this recommendation to have adverse effects on Medicare beneficiaries with respect to access to care or out-of-pocket spending. This recommendation may relieve the financial pressure on some providers and may improve equity among providers by diminishing the effects of inaccurate coding. ■

**TABLE
10-4**

The number of for-profit and freestanding IRFs continued to grow in 2017

Type of IRF	Share of Medicare FFS discharges 2017	Number of IRFs						Average annual change		
		2009	2013	2014	2015	2016	2017	2009-2013	2013-2016	2016-2017
All IRFs	100%	1,196	1,161	1,177	1,182	1,188	1,178	-0.7%	0.8%	-0.8%
Urban	93	992	977	1,013	1,020	1,026	1,019	-0.4	1.6	-0.7
Rural	7	204	184	164	162	162	159	-2.5	-4.2	-1.9
Freestanding	52	225	243	251	262	273	279	0.8	4.0	2.2
Hospital based	48	971	918	926	920	915	899	-1.4	-0.1	-1.7
Nonprofit	39	732	677	681	681	676	655	-1.9	0.0	-3.1
For profit	54	295	322	338	352	370	392	2.2	4.7	5.9
Government	7	169	155	149	138	133	125	-2.1	-5.0	-6.0

Note: IRF (inpatient rehabilitation facility), FFS (fee-for-service). The number of facilities are for the calendar year. The large decline in the number of rural IRFs between 2013 and 2014 was due primarily to changes in the core-based statistical areas, as defined by the Office of Management and Budget, which determine whether geographic areas are considered urban or rural. Because of these changes, 19 IRFs that were previously considered rural are now designated urban. Components may not sum to totals due to missing data.

Source: MedPAC analysis of Provider of Services data and Medicare Provider Analysis and Review data from CMS.

Beneficiaries' access to care: IRF supply and service volume suggest sufficient access

We have no direct indicator of beneficiaries' access to IRF care. Although there are criteria for admission to an IRF, it is not clear when IRF care is necessary or beneficial for a given patient or when another, potentially lower cost PAC provider (such as a skilled nursing facility (SNF)) could provide appropriate care. The absence of IRFs in some areas of the country makes it particularly difficult to assess the need for IRF care since beneficiaries in areas without IRFs presumably receive similar services in other settings. Nevertheless, our analysis of IRF supply and volume of services provided suggests that capacity remains adequate to meet demand. Moreover, the marginal profit, an indicator of whether IRFs with excess capacity have an incentive to treat more Medicare beneficiaries, was robust for both freestanding and hospital-based IRFs, thus providing a very positive indicator of patient access.

Number of IRFs and occupancy rates suggest adequate capacity and supply

After declining from a peak of 1,235 facilities in 2005 (data not shown) to 1,161 facilities in 2013, the number of IRFs increased in 2014 and continued to grow through

2016 to 1,188 facilities nationwide (Table 10-4). But in 2017, the number of IRFs fell 0.8 percent to 1,178 facilities. IRFs are not the sole provider of rehabilitation services in communities; SNFs also provide rehabilitation services in an institutional setting, and home health agencies, comprehensive outpatient rehabilitation facilities, and independent therapy providers furnish care at home or on an outpatient basis. Given the number and distribution of these other rehabilitation therapy providers, it is unlikely that areas exist where IRFs are the only provider of rehabilitation therapy services available to Medicare beneficiaries.

In 2017, about 76 percent of IRFs were distinct units in acute care hospitals; the rest were freestanding facilities. However, because hospital-based units have, on average, fewer beds and a lower share of Medicare discharges, they accounted for only 48 percent of Medicare discharges. Overall, 33 percent of IRFs were for-profit entities. Freestanding IRFs were far more likely to be for profit than were hospital-based IRFs (78 percent vs. 19 percent; data not shown). In 2017, 54 percent of Medicare discharges were from for-profit facilities. Over time, the number of hospital-based and nonprofit IRFs has declined,

**TABLE
10-5**

The number of IRF cases per FFS beneficiary decreased in 2017

	2004	2006	2008	2010	2012	2014	2016	2017	Average annual change		
									2004-2008	2008-2016	2016-2017
Number of cases	495,349	404,633	356,312	359,307	373,284	375,590	390,514	379,885	-7.9%	1.2%	-2.7%
Cases per 10,000 FFS beneficiaries	135.6	111.9	100.4	99.7	100.1	99.2	100.9	98.5	-7.2	0.1	-2.4
Payment per case	\$13,290	\$15,380	\$16,646	\$17,085	\$17,795	\$18,632	\$19,714	\$20,322	5.8	2.1	3.1
ALOS (in days)	12.7	13.0	13.3	13.1	12.9	12.8	12.7	12.7	1.3	-0.6	0.0
Users	449,362	369,269	323,897	325,506	339,087	338,887	350,353	340,175	-7.9	1.0	-2.9

Note: IRF (inpatient rehabilitation facility), FFS (fee-for-service), ALOS (average length of stay).

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

while the number of freestanding and for-profit IRFs has increased. Between 2009 and 2017, the number of hospital-based IRFs fell by 7 percent and the number of nonprofit IRFs fell by 10 percent, while the number of freestanding IRFs and for-profit IRFs rose by 19 percent and 33 percent, respectively.

In 2017, 28 IRFs closed; most were hospital-based units. At the same time, 19 new IRFs opened. Slightly more than half of the new IRFs were hospital-based units. Of the new hospital-based units, about a third were for profit; of the new freestanding facilities, half were for profit. Acute care hospitals find that IRF units can help reduce inpatient lengths of stay. Previous Commission analyses have found that hospitals with IRF units have higher inpatient margins than hospitals without such units (Medicare Payment Advisory Commission 2015).

In 2017, the average IRF occupancy rate remained at 65 percent, the same level as in 2016. Occupancy rates were higher in freestanding IRFs (69 percent) than in hospital-based IRFs (61 percent). These rates suggest that capacity is more than adequate to meet demand for IRF services.

IRF Medicare volume decreased in 2017

The number of Medicare FFS IRF cases grew rapidly throughout the 1990s and the early years of the IRF PPS, reaching a peak of about 495,000 in 2004. After CMS renewed its enforcement of the compliance threshold in 2004, IRF volume declined substantially, as expected, falling almost 8 percent per year from 2004 to 2008 (Table 10-5). At that point, volume began to increase slowly, rising an average of 1.2 percent per year from 2008 to 2016. Between 2016 and 2017, however, the number of FFS IRF cases fell 2.7 percent, to a little less than 380,000 cases.

In 2017, the number of IRF cases per 10,000 FFS beneficiaries fell to 98.5, down 2.4 percent from the previous year. Relatively few Medicare beneficiaries use IRF services because, to qualify for Medicare coverage, IRF patients must be able to tolerate and benefit from rehabilitation therapy that is intensive, which is usually interpreted to mean at least three hours of therapy a day for at least five days a week. Yet, compared with all Medicare beneficiaries, those admitted to IRFs in 2017 were disproportionately over age 85.

With the decline in the number of IRF cases per FFS beneficiary, FFS Medicare's share of IRF discharges fell to 58 percent of total discharges as the volume of IRF cases across all payers rose slightly in 2017 (data not shown).

Marginal profit provides incentive to treat more Medicare beneficiaries

Another measure of access is whether providers have a financial incentive to expand the number of Medicare beneficiaries they serve. In considering whether to treat a patient, a provider with excess capacity compares the marginal revenue it will receive (i.e., the Medicare payment) with its marginal costs—that is, the costs that vary with volume. If Medicare payments are larger than the marginal costs of treating an additional beneficiary, a provider has a financial incentive to increase its volume of Medicare patients. In contrast, if payments do not cover the marginal costs, the provider may have a disincentive to care for Medicare beneficiaries. Given the difference in financial performance across IRFs, we examined freestanding and hospital-based IRFs' marginal profit to assess whether both types of providers have a financial incentive to increase the number of Medicare beneficiaries they serve.⁹ We found that Medicare payments exceed marginal costs by a substantial amount—19.4 percent for hospital-based IRFs and 38.8 percent for freestanding IRFs—suggesting that IRFs with available beds have a strong incentive to admit Medicare patients. This finding is a very positive indicator of patient access, even in IRFs with lower overall Medicare margins.

Quality of care: Steady or improved for most measures

Between 2012 and 2017, the Commission has tracked three broad categories of IRF quality indicators: risk-adjusted facility-level change in functional and cognitive status during the IRF stay, rates of discharge to the community and to SNFs, and rates of readmission to an acute care hospital (see text box on measures of quality). During this period, most measures were steady or improved.

Risk-adjusted rates of potentially avoidable rehospitalization, discharge to the community, and discharge to SNF

Avoidable rehospitalizations expose beneficiaries to hospital-acquired infections, increase the number of transitions between settings (which are disruptive to patients), and can result in medical errors (such as medication errors). In addition, they unnecessarily

increase Medicare spending. There has been relatively little research on rehospitalization of IRF patients in aggregate, though some studies have focused on one or more rehabilitation impairment categories (Dejong et al. 2009, Galloway et al. 2013, Ottenbacher et al. 2014, Schneider et al. 2013, Schneider et al. 2012). However, research regarding rehospitalization of SNF and nursing home patients has identified several contributing factors that may be within a PAC provider's control. These factors include staffing level, skill mix, and frequency of staff turnover; drug management; and adherence to transitional care protocols such as discharge counseling, medication reconciliation, patient education regarding self-care, and communication among providers, staff, and the patient's family (Grabowski et al. 2008, Kane et al. 2003, Konetzka et al. 2008a, Konetzka et al. 2008b, Lau et al. 2005, Mustard and Mayer 1997).

The Commission's rates of rehospitalization during the IRF stay and during the 30 days after discharge are risk adjusted and reflect those readmissions that are potentially avoidable with adequate care in the IRF setting (Kramer et al. 2015).¹⁰ The measure of rehospitalization in the 30 days after discharge reflects in part how well facilities prepare beneficiaries and their caregivers for safe and appropriate transitions to the home or the next health care setting. Since 2013, the national average rate of risk-adjusted potentially avoidable rehospitalizations during the IRF stay has been about 2.6 percent (Table 10-6, p. 266). (Lower rates are better.) Meanwhile, between 2012 and 2017, the rate of risk-adjusted potentially avoidable rehospitalization within 30 days after discharge from an IRF declined from 4.8 percent to 4.3 percent in 2015, then rose to 4.7 percent in 2016 and 2017.

We also examined rates of discharge to the community and to SNFs. We found that between 2012 and 2017, the national average for the risk-adjusted community discharge rate increased from 74.2 percent to 76.0 percent.¹¹ (Higher rates are better.) Between 2012 and 2014, the national average for the risk-adjusted rate of discharge to SNFs increased from 6.9 percent to 7.1 percent, but subsequently declined to 6.8 percent in 2017 (lower rates are better).

The Commission also considers functional status at admission and discharge, measured using the motor and cognitive scores on the IRF-PAI. This instrument incorporates the 18-item Functional Independence Measure™ (FIM™) scale to assess the level of disability in motor and cognitive functioning and the burden of

Measures of inpatient rehabilitation facility quality

In its assessment of the quality of care in inpatient rehabilitation facilities (IRFs), the Commission has historically examined risk-adjusted rates of readmission to the hospital, discharge to the community and to skilled nursing facilities (SNFs), and change in functional status during the IRF stay.

Two readmission measures are calculated: one that occurs during the IRF stay and one that occurs within 30 days after discharge from the IRF (Kramer et al. 2015). Individuals who died in the IRF or during the 30 days after discharge from the IRF were excluded from the facilities' readmission rates. The readmission measures count patients whose primary diagnosis for rehospitalization was considered potentially avoidable; that is, the condition typically could have been managed in the IRF. The potentially avoidable readmissions are respiratory-related illness (pneumonia, influenza, bronchitis, chronic obstructive pulmonary disease, and asthma); sepsis; congestive heart failure; fractures or fall with a major injury; urinary tract or kidney infection; blood pressure management; electrolyte imbalance; anticoagulant therapy complications; diabetes-related complications; cellulitis or wound infection; pressure ulcer; medication error or adverse drug reaction; and delirium. For the measure of potentially avoidable readmission during the IRF stay, delirium could be a primary or a secondary rehospitalization diagnosis.

To account for beneficiaries who are discharged from the IRF to a SNF, a measure of discharge to SNF is calculated. This measure reflects the share of stays in which the patient was discharged directly from the IRF for additional rehabilitation in a SNF that was financed under Medicare Part A's skilled nursing benefit.

Patients who were discharged from the IRF to a nursing home for a non-SNF episode are not considered discharged to a SNF.

The community discharge measure reflects the share of stays in which the patient was not discharged directly from the IRF to a hospital or a SNF. Individuals who were discharged from the IRF to a nursing home as a non-SNF resident (that is, for long-term care financed by payers other than Medicare) are included in the measure of community discharge. Patients who were discharged from the IRF to the community but were admitted to a hospital within one day of discharge are not considered discharged to the community.

The change in the Functional Independence Measure™ from admission to discharge is calculated for both motor function and cognition. The measures represent the average change among patients for 13 motor items and 5 cognitive items on the IRF–Patient Assessment Instrument. Patients with missing information for any of the items are not included when calculating average change.

The observed rates of readmission to the hospital, discharge to the community and to SNFs, and change in functional status during the IRF stay are risk adjusted for medical comorbidities, functional status at IRF admission, rehabilitation impairment category, and demographic characteristics. The data sources used for risk adjustment were Part A hospital and IRF claims. Risk-adjusted rates compare a facility's observed rates with its expected rates based on the mix of patients. The rates reported are the average risk-adjusted rates for Medicare fee-for-service beneficiaries in all IRFs with 25 or more stays during the year. ■

care for a patient's caregivers (Deutsch et al. 2005). Scores for each of the 18 FIM items can be summed to calculate a motor score (based on 13 FIM items) and a cognitive score (based on 5 FIM items). The motor score at discharge can range from 13 to 91, while the cognitive score can range from 5 to 35, with higher scores

indicating greater functional independence. To measure observed improvement in motor function and cognition, we subtracted the respective FIM scores at admission from the FIM scores at discharge to calculate FIM motor and cognitive gains (Kramer et al. 2015). A larger number indicates more improvement in functional independence

**TABLE
10-6**

Risk-adjusted quality indicators for IRFs held steady or improved slightly from 2012 to 2017

Measure	2012	2013	2014	2015	2016	2017	Percent change 2012-2017
Potentially avoidable rehospitalizations during IRF stay	2.8%	2.6%	2.7%	2.6%	2.7%	2.6%	-7.1%
Discharged to a SNF	6.9%	6.9%	7.1%	7.0%	6.8%	6.8%	-1.4
Discharged to the community	74.2%	74.9%	75.2%	75.0%	75.9%	76.0%	2.4
Potentially avoidable rehospitalizations during 30 days after discharge from IRF	4.8%	4.8%	4.7%	4.3%	4.7%	4.7%	-2.1
Motor FIM™ gain	22.1	22.4	22.9	23.1	23.7	24.0	8.6
Cognitive FIM™ gain	3.5	-3.7	3.7	3.7	3.8	3.9	10.3

Note: IRF (inpatient rehabilitation facility), SNF (skilled nursing facility), FIM™ (Functional Independence Measure™). High rates of discharge to the community indicate better quality. High rates of rehospitalization and discharge to SNF indicate worse quality. Rates are the average of facility rates and calculated for all facilities with 25 or more Medicare fee-for-service stays. The motor FIM measures the level of disability in motor functioning on a 91-point scale. The cognitive FIM measures the level of cognitive impairment on a 35-point scale. FIM gain is calculated as the FIM score at discharge minus the FIM score at admission. Higher FIM gain indicates more improvement. Mean FIM gain averages the change of all facilities with 25 or more Medicare fee-for-service stays.

Source: MedPAC analysis of Inpatient Rehabilitation Facility–Patient Assessment Instrument data from CMS.

and cognition between admission and discharge. Each risk-adjusted rate was calculated by comparing a facility’s observed rate with its expected rate and multiplying this ratio by the national rate.

In 2017, the mean gain (positive change) in the motor FIM score during an IRF stay was 24.0, while the mean gain for the cognitive FIM score was 3.9 (Table 10-6). (Bigger gains are better.) From 2012 to 2017, the average risk-adjusted gain in IRF patients’ motor and cognitive FIM scores (as assigned by IRFs) increased about 9 percent and 10 percent, respectively. However, changes in motor function and cognition must be interpreted with caution. Functional status data are generally obtained by observation of the patient and are somewhat subjective. Because payment is based in part on patients’ functional status at admission—with higher payments associated with lower functional status—providers have a financial incentive to minimize their assessments of patients’ levels of function at admission. If IRFs minimize patients’ functional status at admission, gains in function during the patients’ stays will be overstated.

Overall, the Commission finds that most quality measures have been stable or improved slightly over the past five

years. However, improvements in the functional status measures should be viewed with some caution given that they are self-reported rather than claims-based measures. The Commission is evaluating the reliability of patient assessment data and the appropriateness of using these data for payment on quality assessment of PAC providers.

Variation in quality measures across IRFs

IRFs varied widely in their performance on Medicare’s quality measures (Table 10-7). In 2017, the lowest performing quartile of IRFs had a risk-adjusted rate of discharge to a SNF that was 8.7 percent or higher, compared with 4.2 percent or lower for the best performing quartile of providers. (A lower rate of discharge to a SNF is better.) Risk-adjusted rates of discharge to the community varied as well: The worst performing quartile of IRFs had a community discharge rate of 73.1 percent or lower, compared with 79.2 percent or higher for the best performing quartile of providers. (A higher rate of discharge to the community is better.) Rehospitalization rates also varied: The worst performing quartile had risk-adjusted rates of potentially avoidable rehospitalization during the IRF stay that were at or above 3.5 percent, compared with 1.7 percent or below for the

**TABLE
10-7**

Performance on risk-adjusted quality measures varied across IRFs in 2017

Measure	Risk-adjusted rate			Ratio of best to worst performing quartile
	Mean	Worst performing quartile	Best performing quartile	
Potentially avoidable rehospitalizations during IRF stay	2.6%	3.5%	1.7%	0.49
Discharged to a SNF	6.8%	8.7%	4.2%	0.48
Discharged to the community	76.0%	73.1%	79.2%	1.08
Potentially avoidable rehospitalizations during 30 days after discharge from IRF	4.7%	5.8%	3.4%	0.59
Motor FIM™ gain	24.0	21.2	26.4	1.25
Cognitive FIM gain	3.9	3.0	4.7	1.34

Note: IRF (inpatient rehabilitation facility), FIM™ (Functional Independence Measure™), SNF (skilled nursing facility). High rates of discharge to the community indicate better quality. High rates of rehospitalization and discharge to SNF indicate worse quality. Mean rates are calculated for all facilities with 25 or more Medicare fee-for-service stays. The motor FIM measures the level of disability in motor functioning on a 91-point scale. The cognitive FIM measures the level of cognitive impairment on a 35-point scale. FIM gain is calculated as the FIM score at discharge minus the FIM score at admission. Higher FIM gain indicates more improvement.

Source: MedPAC analysis of Inpatient Rehabilitation Facility–Patient Assessment Instrument data from CMS.

best performing quartile. (A lower rate of readmissions is better.) Variation was also observed in the two FIM gain measures, but because these measures are self-reported, they could reflect reporting differences more than performance differences.

Providers’ access to capital: IRFs appear to have adequate access to capital

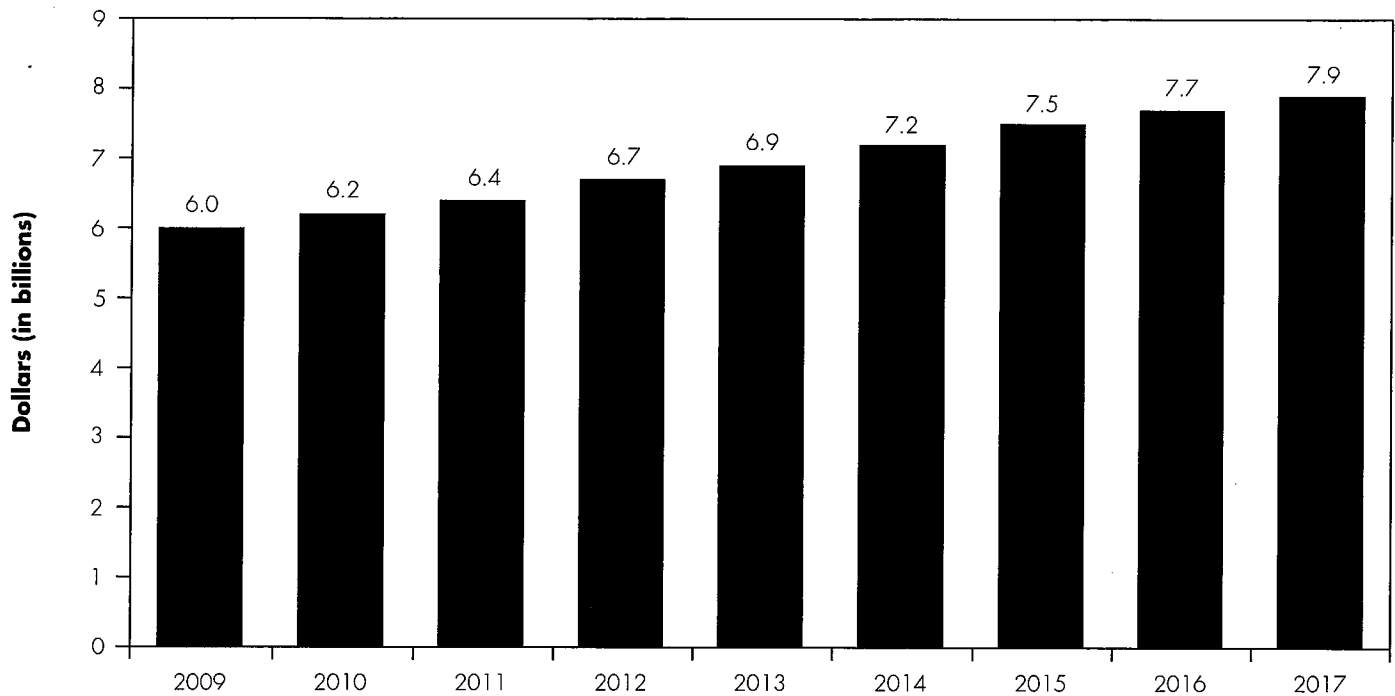
More than three-quarters of IRF providers are hospital-based units that would access any necessary capital through their parent institutions. Overall, as detailed in the hospital chapter, hospitals’ access to capital remained strong in 2017 with a continued high level of bond issuances. New construction spending has declined and has shifted more to outpatient than inpatient capacity (Conn 2017). Large hospital systems in recent years have invested significantly in the ambulatory setting, as opposed to the acute inpatient setting, in an effort to access faster growing markets and offer access to lower cost settings in a business environment shifting toward value-based care (Barclays 2018).

Market analysts indicate that the IRF industry’s largest chain, Encompass Health (formerly HealthSouth)—

which owned almost half of freestanding IRFs in 2017 and accounted for about a quarter of all Medicare IRF discharges—has good access to capital. This assessment is reflected in the chain’s continued expansion. Analysts note that Encompass Health traditionally has prioritized building new facilities over acquiring existing facilities, which allows the company to maintain control over facility size, layout, and amenities. In 2017, the company opened four new facilities and two more in 2018, with two additional facilities scheduled to open in 2019. The new facilities are frequently joint ventures with acute care hospitals (HealthSouth Corporation 2018). As part of a vertical integration strategy, the company has acquired home health agencies and hospice providers to expand its PAC business and drive more effective collaboration between its rehabilitation facilities and home health agencies.

Most other freestanding IRFs are independent or local chains with a limited number of facilities. The extent to which these providers have access to capital is less clear.

IRFs’ access to capital depends in large part on their total (all-payer) profitability. In 2017, total margins for freestanding IRFs remained healthy, with an aggregate

**FIGURE
10-1****Program spending for IRF services has grown steadily since 2009**

Note: IRF (inpatient rehabilitation facility).

Source: Office of the Actuary 2018.

margin of 10.4 percent, up 0.8 percentage point from 2016. Profitability varied by ownership. In 2017, for-profit IRFs had an aggregate total margin of 12.5 percent compared with 5.6 percent for nonprofit IRFs. Data are not available to calculate total margins for hospital-based IRFs. However, in 2017, hospitals' aggregate total margins across all lines of service for hospitals with and without IRF units were similar, at 7.0 percent and 7.2 percent, respectively.

Medicare payments and providers' costs: Medicare margins remained high in 2017

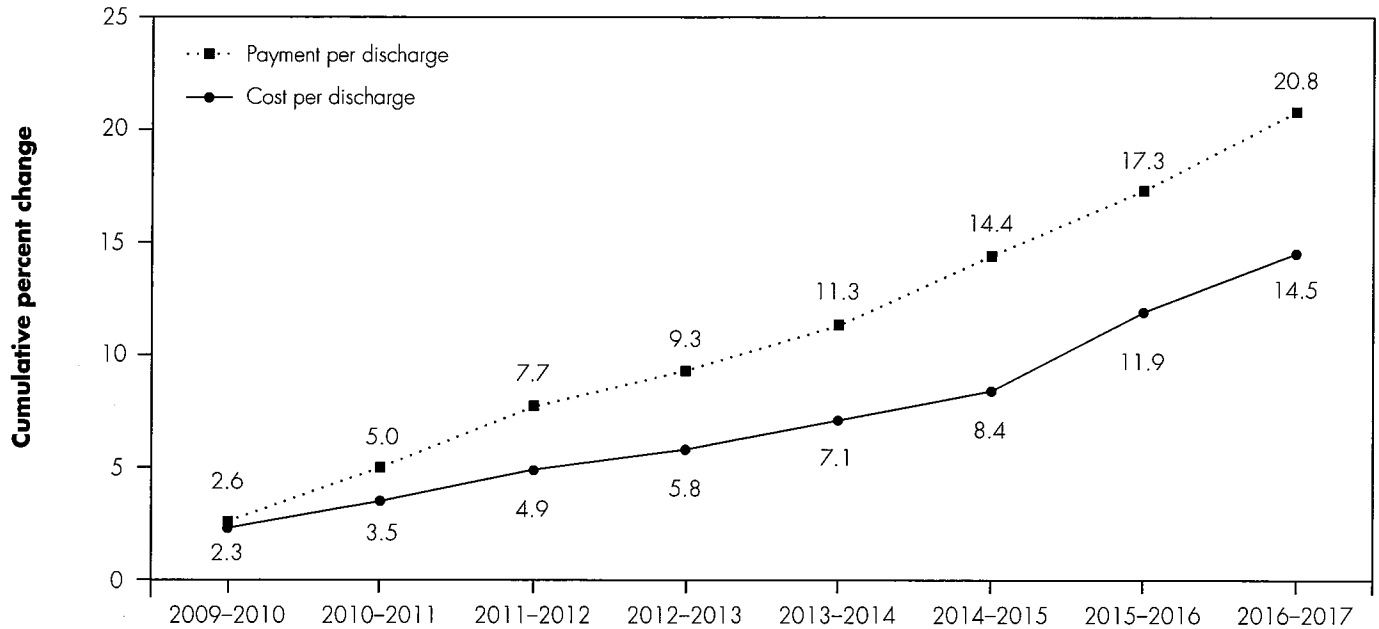
Aggregate Medicare margins grew steadily between 2009 and 2015 and increased again in 2017 to 13.8 percent (Table 10-8, p. 270). Medicare margins in freestanding IRFs were 25.5 percent in 2017, down slightly from a peak of 26.7 percent in 2015. Hospital-based IRF margins were comparatively low at 1.5 percent in 2017, but one-quarter of hospital-based IRFs had Medicare margins greater than

11 percent, indicating that many hospitals can manage their IRF units profitably. Lower margins in hospital-based IRFs were driven largely by higher unit costs.

Trends in spending and cost growth

The Office of the Actuary estimates that Medicare FFS spending for IRF services in fiscal year 2017 was \$7.9 billion (Figure 10-1). Program spending has been growing, on average, more than 3 percent per year since 2009. A combination of increases in the number of Medicare beneficiaries receiving care in IRFs (average growth of 0.5 percent per year) and payment increases averaging 2.6 percent contributed to this growth in spending.

Since 2009, payments have been growing faster than costs (Figure 10-2). From 2009 to 2015, the cumulative growth in cost per discharge was 8.4 percent, an average of just 1.4 percent per year. The cumulative growth in cost per discharge for freestanding for-profit IRFs was especially

FIGURE 10-2**IRFs' payments per discharge increased cumulatively more than costs, 2009-2017**

Note: IRF (inpatient rehabilitation facility). Percent changes are calculated based on consistent two-year cohorts.

Source: MedPAC analysis of Medicare cost report data from CMS.

slow over this period, at just 2.2 percent (data not shown). In contrast, payments per discharge grew more rapidly than costs, climbing a cumulative 14.4 percent over this period (an average of 2.2 percent per year) and 15.1 percent for freestanding for-profit IRFs (latter figure not shown). These differences in per case cost and payment growth led to a steady rise between 2009 and 2015 in aggregate Medicare margins, which climbed from 8.4 percent to 13.9 percent (Table 10-8, p. 270; 2009 data not shown).

Between 2015 and 2016, cost growth outpaced payment growth for the first time since 2009, climbing 3.6 percent, the fastest rate of cost growth since 2008. However, from 2016 to 2017, payments per discharge again increased faster than costs, growing by 3.4 percent compared with 2.6 percent for costs, contributing to an increase in the 2017 Medicare margin to 13.8 percent. From 2015 through 2017, aggregate Medicare margins for IRFs remained above 13 percent (Table 10-8, p. 270).

Margins vary widely

Financial performance varied across IRFs. In 2017, the aggregate margin for freestanding IRFs (which accounted for 53 percent of Medicare discharges from IRFs) was 25.5 percent; hospital-based IRFs had an aggregate margin of 1.5 percent (Table 10-8, p. 270). Margins varied by ownership as well, with for-profit IRFs having a substantially higher aggregate Medicare margin in 2017 than nonprofit IRFs (23.8 percent vs. 2.2 percent). (Hospital-based IRFs are far more likely than freestanding IRFs to be nonprofit.) Among freestanding IRFs, nonprofit facilities (which accounted for 7 percent of Medicare discharges from IRFs) had an aggregate margin of 12.0 percent (data not shown). Freestanding for-profit IRFs (which accounted for 45 percent of Medicare discharges from IRFs) had an aggregate margin of 27.8 percent (data not shown). Among hospital-based IRFs, the aggregate margin for nonprofit units (which accounted for 32 percent of Medicare discharges from IRFs) was 0.1 percent, compared with 6.6 percent for for-profit units (which

**TABLE
10-8**

Aggregate FFS Medicare IRF margins remained high in 2017

Type of IRF	Share of Medicare discharges, 2017	Margins								
		2004	2006	2008	2010	2012	2014	2015	2016	2017
All IRFs	100%	16.7%	12.5%	9.4%	8.6%	11.2%	12.2%	13.9%	13.3%	13.8%
Hospital based	47	12.2	9.9	3.8	-0.6	0.7	0.7	2.2	0.9	1.5
Freestanding	53	24.7	17.5	18.2	21.4	23.9	25.2	26.7	25.8	25.5
Nonprofit	38	12.8	10.9	5.3	2.1	2.1	1.7	3.5	1.6	2.2
For profit	55	24.4	16.3	16.8	19.6	22.9	23.6	24.9	24.2	23.8
Government	7	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Urban	93	17.0	12.8	9.6	9.0	11.6	12.6	14.3	13.6	14.2
Rural	7	13.2	9.0	7.2	4.7	6.3	6.4	8.6	9.4	8.4
Number of beds										
1 to 10	2	3.7	-3.6	-4.9	-10.3	-6.9	-10.9	-7.5	-9.9	-10.5
11 to 24	21	10.5	7.3	1.2	-3.3	-1.2	-0.3	-0.4	-0.2	0.6
25 to 64	48	18.3	13.7	10.0	10.6	12.3	14.0	16.0	15.0	15.8
65 or more	29	21.5	17.8	17.4	17.5	21.0	20.6	23.1	22.4	21.9
Medicare share										
<50%	19	12.9	11.1	5.1	0.4	2.4	2.3	3.7	2.9	3.0
50% to 75%	56	17.1	12.6	9.5	9.6	12.5	14.1	16.1	15.4	15.8
>75%	25	19.6	13.9	13.5	13.6	20.5	20.2	20.8	20.2	21.1

Note: FFS (fee-for-service), IRF (inpatient rehabilitation facility), N/A (not applicable). Government-owned facilities operate in a different financial context from other facilities, so their margins are not necessarily comparable. Their margins are not presented separately here, although they are included in the margins for other groups (e.g., "all IRFs"), where applicable. Percentages may not sum to 100 due to rounding.

Source: MedPAC analysis of cost report data from CMS.

accounted for 10 percent of Medicare discharges from IRFs; data not shown).

Higher unit costs were the primary driver of differences in financial performance between freestanding and hospital-based IRFs. Freestanding IRFs had a median standardized cost per discharge that was 27 percent lower than that of hospital-based IRFs (\$12,069 vs. \$16,645, respectively). Hospital-based IRFs are far more likely than freestanding IRFs to be nonprofit, which could contribute to the disparity in unit costs. But even nonprofit freestanding IRFs had a median standardized cost per discharge that was 15 percent lower than that of hospital-based IRFs (data not shown). Previous Commission analysis of underlying cost

components found that hospital-based IRFs had higher costs than freestanding IRFs across all cost categories, with the biggest difference manifesting in routine costs (Medicare Payment Advisory Commission 2015).

Nevertheless, one-quarter of hospital-based IRFs had Medicare margins greater than 11 percent, indicating that many hospitals can manage their IRF units profitably. Further, despite comparatively low average margins in hospital-based IRFs, evidence suggests that these units make a positive financial contribution to their parent hospitals. For example, aggregate inpatient Medicare margins for hospitals are consistently higher for hospitals with IRF units versus hospitals without (0.8 percentage

point higher in 2017). Aggregate overall Medicare margins for hospitals with IRF units were 2.0 percentage points higher in 2017.

Margins also varied by facility size. In 2017, the aggregate Medicare margin for IRFs with 10 or fewer beds was -10.5 percent, compared with 21.9 percent for IRFs with 65 or more beds (Table 10-8). These differences are in large measure due to differences in economies of scale leading to higher costs in smaller facilities. The median standardized cost for IRFs with fewer than 10 beds was 53 percent higher than for IRFs with 65 or more beds (\$18,636 compared with \$12,200; data not shown). Smaller facilities also tend to have lower occupancy rates than large facilities (54 percent compared with 68 percent in 2017), also contributing to differences in costs.

Medicare margins tended to rise as the share of Medicare patients increased. The aggregate Medicare margin was 3.0 percent for IRFs in which fewer than half of discharges were covered by FFS Medicare, compared with 21.1 percent for IRFs in which more than three-quarters of discharges were covered by FFS Medicare (Table 10-8).

Numerous factors contribute to lower margins in hospital-based IRFs

Several factors account for the disparity in margins between hospital-based and freestanding IRFs, including differences in economies of scale; stringency of cost control, service mix, and patient mix. Differences in IRFs' assessment of patients' motor function and cognition likely play a role as well.

Hospital-based IRFs may be less stringent in cost control

Hospital-based IRFs appear to be less stringent in their cost control. Between 2009 and 2017, costs per case for hospital-based IRFs grew 21.1 percent, compared with 10.3 percent for freestanding IRFs. Notably, hospital-based IRFs are far less likely than freestanding IRFs to be for profit and therefore are likely to be less focused on controlling costs to maximize returns to investors. We see this effect among freestanding IRFs, where the cumulative increase in costs per case from 2009 to 2017 for nonprofits (26.5 percent) far outstripped that of for-profit facilities (8.2 percent).

Hospital-based IRFs have a different mix of patients

There are marked differences in hospital-based and freestanding IRFs' mix of cases. Between 2009 and 2015, freestanding IRFs compared with hospital-based IRFs admitted a larger share of patients with stroke as

the primary reason for rehabilitation (24 percent vs. 17 percent). Similarly, freestanding IRFs compared with hospital-based IRFs admitted larger shares of cases with other neurological conditions (19 percent vs. 10 percent) and other orthopedic conditions (10 percent vs. 6 percent). Notably, the impairment groups of other neurological and other orthopedic conditions encompass a broader range of conditions than do other impairment groups. This clinical heterogeneity can allow favorable selection of patients within these groups based on their likely costs of care. Cases with other neurological conditions also count toward the compliance threshold, so IRFs with higher shares of these cases can more easily meet the requirements of the 60 percent rule while keeping down costs. Further, some case types are more profitable than others, resulting in higher margins for facilities that admit larger shares of those cases. The Commission plans to examine the relative profitability of the IRF case-mix groups in a future analysis.

In general, hospital-based IRFs also have a much larger share of cases with extraordinarily high costs. In 2017, 15 percent of hospital-based IRF cases qualified for high-cost outlier payments, compared with 3 percent of freestanding IRF cases. Indeed, 85 percent of Medicare's IRF outlier payments were made to hospital-based facilities. Though these payments diminish losses per case for such outliers, they do not completely cover the costs. It is not clear whether the large number of outlier cases in hospital-based IRFs stems from differences in efficiency, unmeasured case complexity, or both.

Hospital-based IRFs appear to assess their patients differently Historically, evidence suggests that assessments of patients' motor and cognitive function are not reliably consistent across IRFs. Some in the industry have postulated that hospital-based IRFs devote less time to training assessment staff and verifying the accuracy of assessments, resulting in less reliable measures of patients' motor and cognitive function in hospital-based IRFs. Others assert that some freestanding IRFs aggressively assess their patients in a way that maximizes payment. To the extent that hospital-based IRFs consistently assess their patients as less disabled than do their freestanding counterparts, for whatever reason, their payments—and margins—will be systematically lower.

Efficient provider analysis

The Commission is required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to

Identifying relatively efficient inpatient rehabilitation facilities

The Commission is required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to consider the costs associated with an efficient provider. This year, we attempted to identify and examine the financial performance of inpatient rehabilitation facilities (IRFs) that had consistently low costs per discharge and high quality. We calculated the cost per discharge using cost report and claims data and adjusted for differences in area wages; mix of cases; and prevalence of high-cost outliers, short-stay outliers, and transfer cases. For quality measures, we used risk-adjusted rates of potentially avoidable rehospitalizations during the IRF stay and risk-adjusted rates of discharge to a skilled nursing facility. To be included in the group of IRFs that furnished relatively low-cost, high-quality care, an IRF had to be (1) in the best performing third of the distribution of adjusted cost per discharge or of one of the quality measures for three consecutive years (2014 through 2016) and (2) not in the worst performing third of the distribution of adjusted cost per discharge or either of the quality measures for three consecutive

years. Only IRFs with at least 25 Medicare fee-for-service discharges were included in the analysis.

The method we used to assess performance attempts to limit drawing incorrect conclusions about performance based on poor data. Using three years to categorize IRFs as efficient (rather than just one year) avoids categorizing providers based on random variation or on one “unusual” year. After determining whether an IRF was relatively efficient based on having relatively low costs and good quality care for three years in a row, we calculated performance on several quality and cost measures in 2017. By first assigning an IRF to a group (relatively efficient or other) and then examining the group’s performance in the next year, we avoid having a facility’s poor data affect both its own categorization and the assessment of the group’s performance. Thus, an IRF’s erroneous data in 2014, 2015, or 2016 could result in its inaccurate assignment to a group, but because the group’s performance is assessed with data from 2017, these “bad” data would not directly affect the assessment of the group’s performance. ■

consider the costs associated with efficient providers. The Commission follows two principles when selecting a set of efficient providers. First, the providers must do relatively well on both cost and quality metrics. Second, the performance has to be consistent, meaning that the provider cannot have poor performance on any metric in any of three consecutive years preceding the year under evaluation. The Commission’s approach is to develop a set of criteria and then examine how many providers meet them. It does not establish a set share (for example, 10 percent) of providers to be considered efficient and then define criteria to meet that pool size.

This year is the first one in which the Commission has examined the financial performance of relatively efficient IRFs. The text box explains how we identified relatively efficient IRFs. Our analysis finds that relatively efficient IRFs had lower rehospitalization rates and discharge to SNFs than other IRFs. While payment rates to all IRFs were similar, standardized costs per discharge for this group were 18 percent lower, leading to a large difference

in the median Medicare margin, which was 16.5 percent for the relatively efficient group compared with 1.0 percent for other IRFs (Table 10-9).

Relatively efficient IRFs were on average larger and had higher occupancy rates compared with other IRFs, leading to greater economies of scale. The mix of cases also differed somewhat between the relatively efficient and other IRFs. Relatively efficient IRFs had a higher average case-mix index, more cases with other neurological conditions, but smaller shares of stroke cases compared with other IRFs.

Although all types of facilities were represented in the relatively efficient group of IRFs, they were much more likely to be freestanding and/or for profit. In fact, over half of Encompass Health facilities (formerly HealthSouth) were in the relatively efficient IRF group. Hospital-based nonprofit IRFs were less likely to be in the relatively efficient group, although they accounted for over a third (37.2 percent) of this group.

**TABLE
10-9**

Characteristics of relatively efficient providers, 2017

Performance in 2017	Type of IRF		Ratio of relatively efficient to other IRFs
	Relatively efficient IRFs	Other IRFs	
Median:			
Rehospitalization rate	2.4%	2.6%	0.91
Discharge to SNF rate	4.6%	7.0%	0.65
Payment per discharge	\$20,624	\$20,569	1.00
Standardized cost per discharge	\$13,385	\$16,390	0.82
Medicare margin	16.5%	1.0%	N/A
Facility case-mix index	1.34	1.28	1.05
Length of stay (in days)	12.7	12.7	1.00
Occupancy rate	69%	61%	1.21
Number of beds	30	23	1.30
Share of discharges that were for:			
Stroke	19.5%	23.2%	0.84
Other neurological conditions	10.3%	6.9%	1.49
Share of facilities that were:			
Freestanding	40.5%	20.7%	N/A
For profit	51.2%	34.3%	N/A
Hospital-based nonprofit	37.2%	52.5%	N/A

Note: IRF (inpatient rehabilitation facility), SNF (skilled nursing facility). IRFs were identified as “relatively efficient” based on a cost measure (costs per discharge) and two quality measures (rates of readmission and discharge to SNFs) between 2014 and 2016. Relatively efficient IRFs were those in the best third of the distribution for one measure and not in the worst third for any measure in each of the three years. Costs per discharge were standardized for differences in area wages; mix of cases; and prevalence of high-cost outliers, short-stay outliers, and transfer cases. Quality measures were calculated for all facilities with 25 or more fee-for-service stays. “Rehospitalization rate” refers to potentially avoidable rehospitalizations during the IRF stay. High rates of rehospitalization and discharge to SNF indicate worse quality. “Other neurological conditions” includes multiple sclerosis, Parkinson’s disease, polyneuropathy, and neuromuscular disorders.

Source: MedPAC analysis of Medicare cost report data, Medicare Provider Analysis and Review data, and Inpatient Rehabilitation Facility–Patient Assessment Instrument data from CMS for 2013 to 2016.

How should Medicare payments change in 2020?

To estimate 2019 payments, costs, and margins with 2017 data, the Commission considers policy changes effective in 2018 and 2019, including those in the Patient Protection and Affordable Care Act of 2010 (PPACA) and the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Those changes that affect our estimate of the 2019 margin include:

- an update of 1.0 percent for fiscal year 2018, as required by MACRA¹²; and
- an update of 1.35 percent in 2019 based on an IRF market basket increase of 2.9 percent with offsetting productivity adjustment and PPACA adjustments of 0.8 percent and 0.75 percent, and changes to the high-cost outlier fixed loss amount in 2019, which will lower payments.

Historically, cost growth in this sector has been at or below market basket levels, though between 2015 and 2016, cost

growth exceeded the market basket. We use a three-year historical average to estimate cost growth in 2018 and 2019.

Considering these assumptions, we project an aggregate Medicare margin of 11.6 percent for IRFs in 2019.

For fiscal years 2009 through 2017, the Commission recommended a 0 percent update to the IRF payment rate. In its calculations for fiscal year 2019, however, as the aggregate margin neared historic highs, the Commission recommended in its March 2017 and March 2018 reports that the Congress reduce IRF payment rates by 5 percent. Because such action was not taken and because, in the absence of legislative action, CMS is required by statute to apply an adjusted market basket increase, payments have continued to rise: From 2009 to 2015, the cumulative growth in payments per discharge was 14.4 percent, while cost growth was 8.4 percent—well below market basket levels. In 2016, the gap between payments and costs narrowed somewhat as per case cost growth (3.6 percent in aggregate) exceeded payment growth (2.9 percent in aggregate) for the first time since 2008. As a result, the aggregate margin in 2016 declined but remained high at 13.3 percent. In 2017, payments again increased faster than costs, raising margins to 13.8 percent. This high aggregate margin indicates that aggregate Medicare payments continue to substantially exceed the costs of caring for beneficiaries in IRFs. Absent congressional action, payments to IRFs will continue to increase in fiscal year 2020 by an estimated 2.7 percent, the largest payment rate update in the past decade.

Reducing the payment rate for IRFs would better align Medicare payments with the costs of IRF care. The Commission continues to believe that the high-cost outlier pool should be expanded, as previously recommended in 2016, to further redistribute payments within the IRF PPS and reduce the impact of potential misalignments between IRF payments and costs. Currently, the outlier pool is set at 3 percent of total IRF payments. Expanding the outlier pool would increase outlier payments for the most costly cases, ameliorating the financial burden for IRFs that have a relatively high share of these cases. The expanded outlier pool would be funded by an offset to the national base payment amount, which would further reduce all CMG payment rates by the same percentage across the board. As noted in our March 2016 and March 2017 reports to the Congress, expanding the outlier pool could increase payments for providers who are less efficient as well as for providers whose patients' acuity is not well captured by

the case-mix system. Nevertheless, because of concerns about the accuracy of Medicare's payments for resource-intensive cases, the Commission continues to believe that an expanded outlier pool is warranted in the near term. Over the longer term, however, CMS must ensure the accuracy of Medicare's payments by determining that IRFs' assessment and scoring consistently reflects patients' level of disability. Research is also needed to assess variation in costs within the IRF CMGs and differences in relative profitability across CMGs. In the future, CMS could enact payment system reforms that necessitate reassessment of IRF outlier payments and adjustments to the outlier pool, including a return to a smaller pool.

The Commission also reiterates its March 2016 recommendation that the Secretary conduct focused medical record review of IRFs that have unusual patterns of case mix and coding and conduct other research necessary to improve the accuracy of payments and protect program integrity. With the shift to using the QRP functional measures in 2020 to classify cases into CMGs, it is important that CMS conduct focused medical reviews to ensure consistency in reporting across providers using the new measures.

The Commission estimates that reducing the payment rate for IRFs by 5 percent and expanding the outlier pool from 3 percent to 5 percent would decrease total payments to IRFs by 5 percent. We estimate the combined effect of reducing the payment rate for IRFs by 5 percent and expanding the outlier pool would decrease aggregate payments to freestanding IRFs by 6.2 percent; to hospital-based IRFs by 3.8 percent; to for-profit IRFs by 6.0 percent; and to nonprofit IRFs by 4.2 percent. Changes being made by the Secretary to the CMGs by using the QRP functional measures in place of the FIM, though budget neutral, may result in some small shift in payments toward hospital-based and nonprofit facilities in the short term.

RECOMMENDATION 10

For 2020, the Congress should reduce the fiscal year 2019 Medicare base payment rate for inpatient rehabilitation facilities by 5 percent.

RATIONALE 10

The combination of low historical cost growth and increasing average payments has resulted in overpayments to IRFs. The high aggregate margin in 2017 and our

projected margin for 2019 indicate that Medicare payments substantially exceed the costs of caring for beneficiaries. This excess contributes to Medicare's long-run sustainability challenges. For every fiscal year since 2009, the Commission has recommended that the update to the IRF payment rate be eliminated or that the payment rate be reduced. However, CMS has been required by statute to apply an adjusted market basket increase each year. Between 2009 and 2017, the cumulative increase in payments per case for all IRFs was 20.8 percent, while costs per case rose 14.5 percent, a difference of more than 6 percentage points. Reducing the payment rate for IRFs by 5 percent would better align Medicare payments with the costs of IRF care.

IMPLICATIONS 10

Spending

- The payment update for IRFs in fiscal year 2020 consists of a forecasted 3.2 percent market basket

update and a forecasted -0.5 percent productivity adjustment of the market basket update.¹³ Relative to current law, this recommendation would decrease Medicare spending by between \$250 million and \$750 million in 2019 and by between \$5 billion and \$10 billion over five years.

Beneficiary and provider

- We do not expect this combination of recommendations to have an adverse effect on either Medicare beneficiaries' access to care or out-of-pocket spending. This recommendation could increase the financial pressure on some providers. We expect relatively efficient providers will continue to be willing and able to care for Medicare beneficiaries. ■

Endnotes

- 1 More frequently, Medicare beneficiaries receive inpatient rehabilitation services in skilled nursing facilities (SNFs), in part because there are many more SNFs than IRFs nationwide.
- 2 More information about the prospective payment system for IRFs is available at http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_18_irf_final_sec.pdf?sfvrsn=0.
- 3 Patients with a length of stay of fewer than four days are assigned to a single CMG, regardless of diagnosis, age, level of motor or cognitive function, or presence of comorbidities.
- 4 The 13 conditions are stroke; spinal cord injury; congenital deformity; amputation of a lower limb; major multiple trauma; hip fracture; brain injury; certain other neurological conditions (multiple sclerosis, Parkinson's disease, cerebral palsy, and neuromuscular disorders); burns; 3 arthritis conditions for which appropriate, aggressive, and sustained outpatient therapy has failed; and hip or knee replacement when it is bilateral, the patient's body mass index is greater than or equal to 50, or the patient is age 85 or older.
- 5 In September 2018, the Office of Inspector General (OIG) released a report indicating that many inpatient rehabilitation stays did not comply with all Medicare coverage and documentation requirements for reasonable and necessary care. OIG's analysis found that only 45 of 220 sampled stays met the requirements (Office of Inspector General 2018).
- 6 CMS's major revisions to the compliance threshold policy in 2004 were to (1) increase the number of conditions that count toward the threshold from 10 to 13 and (2) revise the qualifying criteria of major joint replacement—a condition that was commonly treated in IRFs at that time—such that only a certain subset of patients with that condition would count toward the compliance threshold.
- 7 Other orthopedic conditions, cardiac conditions, and debility are not among the 13 conditions that count toward the compliance threshold, but such cases may count if they have specified comorbidities. Prior Commission analysis of 2013 data showed that less than a third of these cases met the compliance threshold.
- 8 This analysis of FFS IRF claims and assessment data from 2013 excluded cases that were not preceded by an acute care hospital stay within 30 days of the IRF admission.
- 9 If we approximate marginal cost as total Medicare cost minus fixed building and equipment cost, then:
$$\text{Marginal profit} = (\text{payments for Medicare services} - (\text{total Medicare costs} - \text{fixed building and equipment costs})) / \text{Medicare payments}$$

The result is a lower bound on the marginal profit because we ignore any potential labor costs that are fixed.
- 10 The potentially avoidable readmissions we measure are respiratory-related illness (pneumonia, influenza, bronchitis, chronic obstructive pulmonary disease, and asthma); sepsis; congestive heart failure; fractures or fall with a major injury; urinary tract or kidney infection; blood pressure management; electrolyte imbalance; anticoagulant therapy complications; diabetes-related complications; cellulitis or wound infection; pressure ulcer; medication error or adverse drug reaction; and delirium.
- 11 Our measure of community discharge does not give IRFs credit for discharging a Medicare beneficiary to the community if the beneficiary is subsequently readmitted to an acute care hospital within 30 days of the IRF discharge.
- 12 The market basket increase for fiscal year 2018 was 2.6 percent. That update would have been offset by PPACA-required reductions totaling 1.35 percentage points, for a net update of 1.25 percent. However, Section 411(b) of MACRA requires that the increase factor for fiscal year 2018 be 1.0 percent.
- 13 This market basket forecast was made in the third quarter of 2018. When setting the update for fiscal year 2020, CMS will use the most recent forecast available at that time, which may differ from the number we report here.

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Attachment 4

CHAPTER

8

Skilled nursing facility services

R E C O M M E N D A T I O N S

8-1 The Secretary should proceed to revise the skilled nursing facility prospective payment system in fiscal year 2020 and should annually recalibrate the relative weights of the case-mix groups to maintain alignment of payments and costs.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

.....
8-2 The Congress should eliminate the fiscal year 2020 update to the Medicare base payment rates for skilled nursing facilities.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

Skilled nursing facility services

Chapter summary

Skilled nursing facilities (SNFs) provide short-term skilled nursing and rehabilitation services to beneficiaries after a stay in an acute care hospital. In 2018, about 15,000 SNFs furnished 2.3 million Medicare-covered stays to 1.6 million fee-for-service (FFS) beneficiaries. Medicare FFS spending on SNF services was \$28.4 billion in 2017, about 1 percent less than in 2016. Just over 4 percent of beneficiaries used SNF services.

Assessment of payment adequacy

To examine the adequacy of Medicare's payments, we analyze beneficiaries' access to care (including the supply of providers and volume of services), quality of care, provider access to capital, and Medicare payments in relation to providers' costs to treat Medicare FFS beneficiaries. Most indicators of the adequacy of Medicare's payments are positive.

Beneficiaries' access to care—Access to SNF services remains adequate for most beneficiaries.

- **Capacity and supply of providers**—The number of SNFs participating in the Medicare program has been stable. The vast majority (89 percent) of beneficiaries live in a county with three or more SNFs or swing bed facilities (rural hospitals with beds that can serve as either SNF beds or acute care beds), and less than 1 percent live in a county without one.

In this chapter

- Are Medicare payments adequate in 2019?
- How should Medicare payments change in 2020?
- Medicaid trends

Between 2016 and 2017, the median occupancy rate declined slightly but remained high (about 85 percent).

- ***Volume of services***—Medicare-covered admissions per FFS beneficiary decreased 2 percent between 2016 and 2017, consistent with a decrease in the number of admissions for hospital stays that last at least three days (required for Medicare coverage). Lengths of stay also declined by 2 percent. Both contributed to fewer covered days in 2017 compared with 2016. Lower SNF use reflects the growing presence of alternative payment models, not the adequacy of Medicare’s payments.
- ***Marginal profit***—An indicator of whether freestanding SNFs have an incentive to treat more Medicare beneficiaries—marginal profit—averaged 19.1 percent for freestanding facilities in 2017.

Quality of care—Since 2011, SNF quality measures have shown mixed performance. The average rate of discharge to the community increased and the average rate of readmission during the SNF stay improved, the average rate of readmissions after the SNF stay worsened, and the measures of mobility remained the same. Changes in the measures between 2016 and 2017 were similarly mixed.

Providers’ access to capital—Because most SNFs are part of nursing homes, we examine nursing homes’ access to capital. Despite relatively low total margins (a measure of the total financial performance across all payers and lines of business), lending and investment activities remain robust. Access to capital was adequate in 2018 and is expected to remain so in 2019. Lending wariness reflects broad changes in post-acute care, not the adequacy of Medicare’s payments. Medicare is regarded as a preferred payer of SNF services.

Medicare payments and providers’ costs—Medicare’s spending in 2017 decreased 1 percent to \$28.4 billion. In 2017, the average Medicare margin for freestanding SNFs was 11.2 percent—the 18th year in a row that the average was above 10 percent. Margins varied greatly across facilities, reflecting differences in costs and shortcomings in the SNF prospective payment system (PPS) that favor treating rehabilitation patients over medically complex patients.

Revisions to the PPS are still needed to improve the accuracy and equity of Medicare’s payments across different types of patients. CMS plans to revise the SNF PPS beginning in fiscal year 2020. The redesign will increase payments for medically complex patients and patients with high costs for nontherapy ancillary items (such as drugs), consistent with the Commission’s previously recommended designs for the SNF PPS and a unified post-acute care PPS.

The Commission recommends that the Secretary proceed with revising the SNF PPS and annually recalibrate the relative weights of the case-mix groups to keep payments aligned with the costs of care. The implementation of a revised SNF PPS will increase the equity of Medicare's payments across different conditions and narrow the disparities in financial performance across SNFs. The redesigned PPS is likely to alter the mix of cases treated in SNFs, providers' cost structures, and the relative costs of different types of stays. To keep costs and payments aligned across types of cases, CMS will need to regularly recalibrate the relative weights of the new case-mix groups.

The level of payments continues to be well above the cost to treat Medicare beneficiaries. Several factors indicate that the aggregate level of Medicare's payments remains too high. First, since 2000, the average Medicare margin has been above 10 percent; the marginal profit in 2017 was even higher (19 percent), suggesting that facilities with available beds have an incentive to admit Medicare patients. Medicare Advantage (managed care) payment rates to SNFs, considered attractive by many SNFs, are considerably lower than the program's FFS payments. The small differences between beneficiaries enrolled in Medicare Advantage and FFS who used SNF services in 2017 would not explain the large difference in payments. Costs varied widely for reasons unrelated to case mix and wages. The very high Medicare margin (18 percent) for efficient SNFs—those providers with relatively low costs and high quality—is further evidence that Medicare continues to overpay for SNF care.

Considering these factors, the Commission recommends that the Congress eliminate the fiscal year 2020 update to the Medicare base rates. While the level of payments indicates a reduction to payments is needed to more closely align aggregate payments and costs, the SNF industry is likely to undergo considerable changes as it adjusts to the redesigned PPS. Given the impending changes, the Commission will proceed cautiously in recommending reductions to payments. A zero update would begin to align payments with cost while exerting pressure on providers to keep their cost growth low.

Medicaid trends

As required by the Patient Protection and Affordable Care Act of 2010, we report on Medicaid use and spending and non-Medicare (private-payer and Medicaid) margins. Medicaid finances most long-term care services provided in nursing homes, but also covers the copayments on SNF care for low-income Medicare beneficiaries (known as dual-eligible beneficiaries) who stay more than 20 days in a SNF. The number of Medicaid-certified facilities has declined slightly since 2013,

by less than 1 percent, but remains close to 15,000. CMS reports total FFS spending on nursing home services declined 1.6 percent between 2016 and 2017 but projects small increases for 2019.

In 2017, the average total margin—reflecting all payers (including managed care, Medicaid, Medicare, and private insurers) and all lines of business (such as hospice, ancillary services, home health care, and investment income)—was 0.5 percent, down from 2016 (0.7 percent). The average non-Medicare margin (which includes all payers and all lines of business except Medicare FFS SNF services) was –2.4 percent, the same as in 2016. ■

Background

Skilled nursing facilities (SNFs) provide short-term skilled nursing care and rehabilitation services such as physical and occupational therapy and speech–language pathology services. Examples of SNF patients include beneficiaries recovering from surgical procedures such as hip and knee replacements or from medical conditions such as stroke and pneumonia. In 2017, almost 1.6 million fee-for-service (FFS) beneficiaries (4.2 percent of Part A FFS beneficiaries) used SNF services at least once; program spending on SNF services was \$28.4 billion (about 7 percent of FFS spending) (Boards of Trustees 2018, Office of the Actuary 2018b). Medicare’s median payment per day was \$480, and its median payment per stay was \$18,121.¹ In 2016, about one-fifth of hospitalized beneficiaries were discharged to SNFs.

Medicare covers up to 100 days of SNF care per spell of illness after a medically necessary inpatient hospital stay of at least 3 days.² For beneficiaries who qualify for a covered stay, Medicare pays 100 percent of the payment for the first 20 days of the spell of illness. Beginning with day 21, beneficiaries are responsible for copayments for day 21 through day 100 of the covered stay. For fiscal year 2019, the copayment is \$170.50 per day.

The term *skilled nursing facility* refers to a provider that meets Medicare requirements for Part A coverage.³ Most SNFs (more than 90 percent) are dually certified as SNFs and nursing homes (which typically provide less intensive, long-term care services). Thus, a facility that provides skilled care often also provides long-term care services that Medicare does not cover. Medicaid pays for the majority of nursing facility days.

The mix of facilities where beneficiaries receive skilled nursing care has shifted over time toward freestanding and for-profit facilities. In 2017, almost all facilities were freestanding (96 percent), and they accounted for an even larger share of revenue (97 percent; Table 8-1) than other types of facilities. Hospital-based SNFs made up a small share (4 percent or less) of facilities, stays, and spending. For-profit facilities accounted for 71 percent of all SNFs and 75 percent of revenues.

Medicare FFS–covered SNF days typically account for a small share of a facility’s total patient days but a disproportionately larger share of the facility’s revenues. In freestanding facilities in 2017, Medicare FFS beneficiary stays constituted 11 percent of total facility days but accounted for 19 percent of facility revenue, a decline from 2010 when FFS Medicare accounted for 23 percent of facility revenue (data not shown). The decrease in the FFS Medicare share of revenues reflects the growth in Medicare Advantage (MA) enrollment.

TABLE 8-1

Freestanding SNFs and for-profit SNFs accounted for the majority of facilities, Medicare stays, and Medicare spending, 2017

Type of SNF	Facilities	Medicare-covered stays	Medicare spending
Total number	15,090	2,266,301	\$25.9 billion
Freestanding	96%	96%	97%
Hospital based	4	4	3
Urban	73	83	85
Rural	27	17	15
For profit	71	71	75
Nonprofit	23	24	21
Government	6	4	4

Note: SNF (skilled nursing facility). Totals may not sum to 100 percent due to rounding and missing values. The spending amount included here is lower than that reported by the Office of the Actuary, and the count of SNFs is slightly lower than what is reported in CMS’s Survey and Certification Providing Data Quickly system.

Source: MedPAC analysis of the Provider of Services and Medicare Provider Analysis and Review files for 2017.

The most common hospital conditions of patients referred to SNFs for post-acute care are septicemia, joint replacement, heart failure and shock, hip and femur procedures (except major joint replacement), kidney and urinary tract infections, chronic obstructive pulmonary disease, renal failure, and pneumonia. In 2017, the top 10 diagnoses accounted for 43 percent of all SNF stays. Compared with other beneficiaries, SNF users are older; more frail; and disproportionately female, disabled, living in an institution, and dually eligible for Medicare and Medicaid (Medicare Payment Advisory Commission 2013).

SNF prospective payment system and its shortcomings

Medicare uses a prospective payment system (PPS) to pay SNFs for each day of service.⁴ Information gathered from a standardized patient assessment instrument—the Minimum Data Set—is used to classify patients into case-mix categories called resource utilization groups (RUGs).⁵ Although the payment system is referred to as “prospective,” two features undermine how prospective it is: The system makes payments for each day of care (rather than a set payment for the entire stay), and it bases payments partly on the minutes of rehabilitation therapy furnished to a patient. Both features result in providers having some control over how much Medicare will pay them for their services.

Almost since its inception, the SNF PPS was criticized for encouraging the provision of excessive rehabilitation therapy services and not accurately targeting payments for nontherapy ancillary (NTA) items such as drugs (Government Accountability Office 2002, Government Accountability Office 1999, White et al. 2002). Over time, the accuracy of Medicare’s payments has steadily eroded: Payments for NTA services are unrelated to the cost of SNF care, and therapy payments have become less and less proportional to the costs of therapy services.⁶ As a result, the PPS continues to advantage providers that furnish therapy services unrelated to a patient’s condition and avoid patients with high NTA costs (Medicare Payment Advisory Commission and The Urban Institute 2015). The Office of Inspector General (OIG) of the Department of Health and Human Services found that the profitability of therapy services increased as the amount of therapy provided per day increased (Office of Inspector General 2015).

In 2008, the Commission recommended revising the PPS to base therapy payments on patient characteristics

(not service provision); remove payments for NTA services from the nursing component; establish a separate component within the PPS that adjusts payments for NTA services; and implement an outlier payment policy (Medicare Payment Advisory Commission 2008). The Commission’s recommended revisions to the PPS would increase the equity of Medicare’s payments and result in considerable redistribution of payments, raising payments for medically complex patients and decreasing them for patients who receive intensive rehabilitation therapy that appears unrelated to their clinical conditions (Medicare Payment Advisory Commission and The Urban Institute 2015).⁷ The revisions should increase access for patients requiring complex medical care or costly drugs. Based on the mix of patients and therapy practices, payments would increase for hospital-based facilities and nonprofit facilities and would decrease for freestanding facilities and for-profit facilities. The effects on individual facilities would depend on their mix of patients and current therapy practices.

Each year since 2008, the Commission has urged CMS to move forward with the much-needed reform and, since 2012, recommended revising and rebasing the SNF PPS to address both the distribution and level of payments (Medicare Payment Advisory Commission 2012). The Commission was not alone in calling for an overhaul of the SNF PPS. OIG recommended that CMS evaluate the extent to which therapy payments should be reduced, change the method for paying for therapy, adjust Medicare payments based on patient characteristics (not the amount of therapy furnished), and strengthen the oversight of SNF billing (Office of Inspector General 2015).

CMS plans to revise the SNF PPS beginning October 1, 2019

CMS’s work on alternative designs for the SNF PPS began 13 years ago in response to a legislative requirement (the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000) to conduct research on potential refinements of the SNF PPS (Liu et al. 2007, Maxwell et al. 2003, Urban Institute 2004). In 2017, CMS issued an advanced notice of proposed rulemaking and sought comments on a redesign of the SNF PPS that it planned to implement in fiscal year 2019 (Centers for Medicare & Medicaid Services 2017). Considering stakeholder comments, CMS revised the design and delayed implementation until fiscal year 2020 (Centers for Medicare & Medicaid Services 2018b).

Consistent with the Commission’s recommended design for the SNF PPS, CMS’s patient-driven payment model will base payments on patient characteristics, not the amount of therapy services furnished to patients. There will be five components—nursing, physical and occupational therapy, speech–language pathology, NTA, and room and board—that will be summed to establish a daily payment. Except for the room and board component (which is uniform for every day of care), each component will have its own case-mix factors in which clinical characteristics play a considerably larger role compared with the current design. To reflect the declining average daily costs for physical and occupational therapy and NTA services over the course of a stay, the daily payments for these components will be lower for days later in the stay. So that individual therapy remains the dominant modality, group and concurrent therapy cannot make up more than 25 percent of total therapy minutes. Given the clinical focus of the redesign, SNFs are likely to evaluate the clinical and coding expertise of its staff and the presence of physicians and medical directors and to reassess their contracts with therapy vendors.

CMS estimates that the design will redistribute payments from patients assigned to the highest rehabilitation case-mix groups to medical patients, patients with high NTA costs, and patients requiring tracheostomy or ventilator services (Centers for Medicare & Medicaid Services 2018b). This redistribution is consistent with the Commission’s recommended designs for the SNF PPS and a unified post-acute care (PAC) PPS. CMS noted that the redesigned SNF PPS will bring the payment system closer to an eventual transition to a unified PAC PPS (Centers for Medicare & Medicaid Services 2018b). Although intended to be budget neutral, provider responses to the new PPS, including changes in the recording of patient diagnoses, will shape how spending will change. Because case mix, service provision, and cost structures are likely to change for many SNFs, CMS may need to recalibrate the relative weights of the case-mix groups to keep payments aligned with the cost of care.

Are Medicare payments adequate in 2019?

To examine the adequacy of Medicare’s FFS payments, we analyze beneficiaries’ access to care (including the supply of providers and volume of services), quality of

care, providers’ access to capital, Medicare FFS payments in relation to costs to treat Medicare beneficiaries, and changes in payments and costs. We also compare the performance of SNFs that have relatively high Medicare margins and those with low Medicare margins, and we compare relatively efficient SNFs with other SNFs.

Beneficiaries’ access to care: Access is stable for most beneficiaries

We do not have direct measures of access in part because the need for SNF care, as opposed to the need for a different PAC service or none at all, is not well defined. Instead, we consider the supply and capacity of providers and evaluate changes in service volume. We also assess whether providers have a financial incentive to expand the number of Medicare beneficiaries they serve.

The number of SNFs participating in the Medicare program in 2018 was stable at 15,326 (Centers for Medicare & Medicaid Services 2018a). There was a handful of new facilities (73, the majority of which were for profit) and a number of terminations. There have been 69 terminations as of November 2018, most of which were at the facilities’ initiative. This number is greater than at the same point in 2017, when there were 51 terminations.

The SNF industry is highly fragmented and characterized by independent providers and local and regional chains. Of the 50 largest operators, most are privately held. The 25 largest nursing home chains in the country operate 19 percent of all facilities (IQVIA Institute for Human Data Science 2018). Single operators make up about 40 percent of the industry, small (often regional or religious) operators make up about one-quarter of facilities, with the remaining third run by large chains (Ritchie and Johnson 2017). The share of hospitals with financial links to SNFs has slowly increased as alternative payment models encourage hospitals to lower spending and improve clinical outcomes for services furnished in post-acute care. In 2015, 18 percent of hospitals had a financial link to a SNF, up from 11 percent in 2005 (Fowler et al. 2017). One study found that the integration of hospitals and SNFs increases Medicare payments for the hospital and PAC stays (combined) by extending the lengths of the SNF stays but also lowers rehospitalization rates (Konetzka et al. 2016).

In 2017, 89 percent of beneficiaries lived in counties with three or more SNFs or swing bed facilities (rural hospitals with beds that can serve as either SNF beds or acute care beds). Less than 1 percent of beneficiaries lived in a

**TABLE
8-2**

SNF admissions and days continued to decline in 2017

Volume measure	2010	2013	2016	2017	Percent change 2016-2017	Percent change 2010-2017
Covered admissions per 1,000 FFS beneficiaries	73.0	69.3	65.9	64.6	-2.0%	-11.5%
Covered days per 1,000 FFS beneficiaries	1,972	1,872	1,693	1,623	-4.1	-17.7
Covered days per admission	27.1	27.0	25.7	25.1	-2.3	-7.4

Note: SNF (skilled nursing facility), FFS (fee-for-service). "FFS beneficiaries" includes users and non-users of SNF services. Data include 50 states and the District of Columbia.

Source: Centers for Medicare & Medicaid Services 2018c.

county without a SNF or swing bed facility, and another 11 percent lived in counties with one or two SNFs or swing bed facilities.

Between 2016 and 2017, median occupancy rates for freestanding SNFs declined slightly but remained high (84.7 percent). The lower occupancy rates reflect shorter stays and fewer admissions. Occupancy rates at hospital-based facilities were slightly lower (80.4 percent). There is wide variation in occupancy rates. In 2017, one-quarter of freestanding facilities had occupancy rates at or below 73 percent while another quarter had rates 91 percent or higher. This variation indicates that some markets have the capacity to accommodate more admissions while other markets do not. The median occupancy rates for freestanding SNFs in rural areas and those in frontier locations were lower than the average (77 percent and 71 percent, respectively).

Between 2016 and 2017, SNF admissions decreased and stays shortened

In 2017, 4.2 percent of FFS beneficiaries used SNF services, the same share as in 2016. Between 2016 and 2017, SNF admissions per 1,000 FFS beneficiaries decreased 2 percent (Table 8-2) (Centers for Medicare & Medicaid Services 2018c). We examine service use for only FFS beneficiaries because the CMS data on users, days, and admissions do not include service use by beneficiaries enrolled in Medicare Advantage (MA) plans. Covered days per 1,000 FFS beneficiaries in 2017 declined 2.3 percent to 25.1 days. The combination of fewer admissions and shorter stays resulted in 4.1 percent fewer days per 1,000 beneficiaries. Since 2010, SNF

use by FFS beneficiaries declined over 11 percent, and covered days per admission decreased almost 18 percent.

The declines in SNF use reflects several trends, including a growing presence of alternative payment models such as accountable care organizations (ACOs) and bundled payments that result in fewer beneficiaries referred to SNF care and shortened stays (Colla et al. 2016, Dummit et al. 2016, McWilliams et al. 2017). Two studies of CMS's mandatory bundling initiative found participating hospitals had lower use of institutional PAC but similar quality outcomes (Dummit et al. 2018, Finkelstein et al. 2018). The use of a narrower network of preferred SNFs has also resulted in shorter SNF stays (Dummit et al. 2018, Huckfeldt et al. 2018). Hospitals participating in the Comprehensive Care for Joint Replacement payment model have adopted several strategies that could enhance the care beneficiaries receive, including improved patient education; dedicated staff for coordinating care among the hospital, physicians, and PAC providers; earlier initiation of discharge planning; and wider use of standardized patient protocols (Dummit et al. 2018).

Some SNFs report negative experiences of pressure from ACOs and managed care organizations to shorten SNF stays. A study of 25 SNFs participating in managed care and ACOs reported increased paperwork and time spent negotiating longer stays for patients, instances of declining to admit patients who were likely to require long stays, and one instance of switching the attending physician to remove the patient from an ACO (Tyler et al. 2018). A survey of chief financial officers reported cumbersome processes that they said made it more difficult for patients to receive the care they needed (Ziegler 2018).

The decline in SNF admissions is also tied to the small decline in FFS per capita inpatient hospital stays that were three days or longer and therefore qualified beneficiaries for Medicare coverage of SNF care. Although total per capita inpatient admissions increased, hospital admissions for stays of at least three days decreased 0.6 percent. The expanded use of observation stays (during which a patient is observed and treated but not admitted to the hospital) by hospitals is another contributing factor to lower SNF use (Mendelson et al. 2018). Because a three-day hospital stay is required for Medicare coverage, some beneficiaries not meeting this requirement may continue to receive care that is not covered by Medicare or be discharged home.

Service mix reflects biases in PPS design

Since the PPS was implemented, providers have responded to the incentives to furnish enough therapy to classify days into rehabilitation case-mix groups and, within those groups, into the highest payment groups. Between 2002 and 2017, the share of days classified into rehabilitation case-mix groups in freestanding facilities increased from 78 percent to 95 percent; days assigned to special care, clinically complex, and extensive services made up the other 5 percent of days. During the same period, the share of intensive therapy days (days assigned to the ultra-high and very high groups) as a share of total days rose from 27 percent to 83 percent. The share of days assigned to the highest rehabilitation case-mix groups (the ultra-high group) increased from 7 percent to 58 percent.

Changes in the frailty of beneficiaries at admission to a SNF do not explain the increases in therapy. Between 2012 and 2017, the average SNF user was the same age and had the same average risk score but by 2017 was slightly less able to perform activities of daily living (ADLs). The average Barthel index, a composite measure of a person's disability, was 5 percent lower, indicating less ability to perform ADLs. For the 10 ADLs we examined, the shares of SNF users requiring the most help decreased for 7 activities, remained the same for 1 activity, and increased for 2 activities.⁸ Yet during this period, the amount of intensive therapy furnished to beneficiaries increased 15 percent. OIG found that SNFs had increased their billing for the highest levels of therapy even though beneficiary characteristics—including age and the reasons for and severity levels of the preceding hospital stay—remained unchanged (Office of Inspector General 2015). A study examining whether additional therapy improved patient outcomes (in this case, the likelihood of being discharged

home) focused on beneficiaries between 2000 and 2009 who were recovering from hip fracture (Jung et al. 2016). It found that patients with more therapy were more likely to be discharged home, but the benefit of additional therapy decreased as the therapy intensity increased, and there was no additional benefit for patients in the highest case-mix groups. The large growth in days assigned to the intensive therapy group raises the question of the value of these additional therapy services.

Facilities differed in the amount of intensive therapy they provided, though the differences by provider type and ownership have narrowed over time as all providers assigned a larger share of days to intensive rehabilitation case-mix groups. In 2017, there was a 16 percentage point difference between freestanding and hospital-based facilities in the share of days assigned to intensive therapy (83 percent in freestanding facilities, 67 percent in hospital-based facilities). There were smaller (2 percentage points) differences in case-mix between for-profit and nonprofit facilities (84 percent and 82 percent, respectively).

In 2017, the share of days assigned to medical case-mix groups or to extensive services case-mix groups was low (5 percent in 2017). Hospital-based units were disproportionately represented in the group of SNFs with the highest shares (defined as the top quartile) of medically complex admissions. While making up 4 percent of facilities, hospital-based SNFs made up 8 percent of the SNFs with the highest shares (the top quartile) of medically complex admissions.

In 2018, the Department of Justice continued to enforce the False Claims Act by investigating fraud and abuse in SNFs' therapy billings. It reached agreements in four cases to settle allegations of improperly billing for intensive therapy services that were not reasonably or medically necessary (Department of Justice 2018a, Department of Justice 2018b, Department of Justice 2018c, Department of Justice 2018d). The department alleged that the defendant engaged in one or more of the following strategies: falsely reporting the minutes of therapy delivered, furnishing services that were medically unnecessary given the patient's clinical care needs, discouraging therapists from providing services beyond the minimum threshold minutes for a given case-mix group, pressuring therapists and patients to complete planned minutes of care even when patients were sick

or declined to participate in therapy, or presumptively assigning patients to the highest rehabilitation case-mix group regardless of each patient's individual care needs. Since 2013, the Justice Department has settled 16 cases involving allegations of improper provision of rehabilitation therapy services.

Medicare's case-mix groups may have a broader impact beyond Medicare-covered stays. One study of nursing homes in New York found that nursing home residents (whose care is not covered by Medicare) treated in for-profit facilities in the last month of life were more likely to receive intensive therapy than low or medium levels of therapy (Temkin-Greener et al. 2018). New York Medicaid bases its payments on an older version of the same case-mix groups that Medicare uses, which considers the amount of therapy in establishing payments.

Though access does not appear to be an issue in general, industry representatives and patient advocates report that some providers are reluctant to admit patients with high NTA costs (such as those who need expensive antibiotics). The design proposed by CMS should improve access for these patients because payments will increase for patients with high NTA care needs by an estimated 27 percent (Centers for Medicare & Medicaid Services 2018b). Providers may avoid patients who are likely to require long stays and exhaust their Medicare benefits because a facility's daily payments decline if the patient becomes eligible for Medicaid or the stay results in bad debt.

Marginal profit: A measure of the attractiveness of Medicare patients

Another measure of access is whether providers have a financial incentive to expand the number of Medicare beneficiaries they serve. In considering whether to treat a patient, a provider with excess capacity compares the marginal revenue it will receive (i.e., the Medicare payment) with its marginal costs—that is, the costs that vary with volume. If Medicare payments are larger than the marginal costs of treating an additional beneficiary, a provider has a financial incentive to increase its volume of Medicare patients. In contrast, if payments do not cover the marginal costs, the provider may have a disincentive to care for Medicare beneficiaries.⁹ For providers with available data, the marginal profit in 2017 was at least 19.1 percent. Because Medicare payments far exceed facilities' marginal costs, facilities with available beds have an incentive to admit Medicare patients, also signifying a positive indicator of patient access.

Quality of care: Measures indicate mixed performance

The Commission tracks three broad categories of SNF quality indicators: risk-adjusted rates of discharge to the community, hospital readmission, and change in functional status during the SNF stay (see text box on measures of SNF quality, pp. 204–205). We use these measures because they reflect the goals of most beneficiaries: to return home, avoid a readmission, and improve or maintain function. Because of evidence that the function information reported by inpatient rehabilitation facilities (IRFs) and home health agencies (HHAs) may reflect financial considerations, the Commission is concerned that the function information may not be reliable. The readmission rate during the SNF stay measures how well the SNF detects, monitors, and furnishes adequate care to prevent readmissions. The postdischarge measure indicates how well facilities prepare beneficiaries and their caregivers for safe and appropriate transitions to the next health care setting (or home).

Changes in quality show mixed results: Some measures have improved since 2011 while others have not. The average rates of discharge to the community and readmission during SNF stays improved, the average rate of readmissions after discharge from the SNF worsened, and two measures of change in function were essentially the same over this period. The most recent changes (between 2016 and 2017) also indicate mixed progress.

Rates of community discharge and readmissions show uneven progress

Since 2011, SNF outcome-based measures show mixed results; some measures improved while others worsened slightly (Table 8-3). The average risk-adjusted rates of discharge to the community steadily improved and reached 40 percent in 2017, up from 33.5 percent in 2011.¹⁰ During the same period, the average risk-adjusted rate of potentially avoidable readmissions during the SNF stay also improved, declining from 12.4 percent to 10.9 percent in 2017. The average risk-adjusted rate of potentially avoidable readmissions during the 30 days after discharge from the SNF worsened. Changes between 2016 and 2017 exhibited a similar mixed pattern: an improved discharge to community rate, a worse rate of readmissions after discharge from the SNF, and no change in the rate of readmissions during the SNF stay. There is a low correlation between the during-stay readmission rates and the readmission rates during the 30 days after discharge from the SNF (0.16, which was statistically significant

**TABLE
8-3**

Mean risk-adjusted rates of community discharge and potentially avoidable readmissions, 2011-2017

Measure	2011	2013	2015	2016	2017
Discharged to the community	33.5%	35.7%	38.8%	39.5%	40.0%
Potentially avoidable readmissions:					
During SNF stay	12.4	11.2	10.4	10.9	10.9
During 30 days after discharge from SNF	5.9	5.5	5.0	5.8	6.1

Note: SNF (skilled nursing facility). Higher rates of discharge to the community indicate better quality. Higher readmission rates indicate worse quality. Rates are the average of facility rates calculated for all facilities with 25 or more stays, except the rate of potentially avoidable readmissions during the 30 days after discharge, which is reported for all facilities with 20 or more stays.

Source: Analysis of fiscal year 2011 through fiscal year 2017 Minimum Data Set and inpatient acute hospital claims data for fee-for-service beneficiaries.

given the sample sizes), confirming that the measures capture different dimensions of quality.

The general trend of lower readmission rates during the SNF stay since 2011 in part reflects the increased attention from hospitals and ACOs to avoid readmission penalties by partnering with SNFs that have low readmission rates. Some hospitals have established preferred provider networks with higher quality SNFs, hoping to lower their own readmission rates in exchange for increased referrals to SNFs. Two studies found that hospitals with more extensive collaboration efforts (such as transition care and visits by hospital staff to SNFs) had fewer readmissions (Rahman et al. 2018, Zhu et al. 2018). Another study found that hospitals with a network of preferred SNFs had lower readmission rates from their partnering SNFs (McHugh et al. 2017). While hospitals on average lowered their readmission rates between 2007 and 2013, hospitals affiliated with ACOs were quicker to lower them (Winblad et al. 2017). Because the ACO-affiliated hospitals were at greater financial risk, they may have had more effective discharge planning and information sharing with the SNFs they used. In addition to partnering with hospitals, many SNFs want to secure volume from MA plans, though there is some evidence that MA plans guide their enrollees to lower quality facilities (Meyers et al. 2018).

As part of the Protecting Access to Medicare Act of 2014, the Congress enacted a SNF value-based purchasing (VBP) policy that uses one measure—readmissions within 30 days of discharge from the preceding hospital stay.¹¹ The VBP program began adjusting payments to providers

in October 2018. The VBP program withholds 2 percent of payments; of the withheld amount, 60 percent will be returned to providers as incentive payments and 40 percent will be retained as program savings. On net, the program lowered net payments for the majority of SNFs (73 percent). These SNFs did not earn back some portion of the amount withheld, and about one-fifth of SNFs did not earn back any portion of the 2 percent withhold. For-profit facilities were overrepresented in the group of SNFs with the largest reduction. Net payments to over one-quarter of SNFs (27 percent) increased under the VBP; they earned back more than the 2 percent withheld. The largest increase (a net gain of 1.6 percent) was earned by 11 percent of SNFs, and for-profit facilities were underrepresented in this group.

In addition to the single VBP measure, CMS publicly reports SNF performance on six other measures. The three assessment-based measures are the share of patients with pressure ulcers that worsened, the share of patients experiencing one or more falls with major injury, and the share of patients with admission and discharge functional assessments and a care plan that addresses function. The three claims-based measures are the rate of successful discharges to the community (i.e., discharged to the community without deaths or unplanned readmissions within the 31 days after discharge), the rate of potentially preventable readmissions following discharge from the SNF, and Medicare spending per beneficiary. Since October 2018, providers that do not submit the necessary data to calculate the three assessment-based measures on

Measures of skilled nursing facility quality

To assess skilled nursing facility (SNF) quality, the Commission examines risk-adjusted rates of readmission to the hospital, discharge to the community, and change in functional status during the SNF stay for beneficiaries in fee-for-service (FFS) Medicare.

The community discharge measure includes beneficiaries discharged to a community setting (including assisted living) and excludes beneficiaries discharged to an inpatient setting (e.g., an acute care hospital or nursing home) within one day of the SNF discharge. The measure also excludes beneficiaries who die within 1 day of the SNF discharge and beneficiaries who are readmitted to an acute care hospital within 30 days of admission to the SNF (Kramer et al. 2015). Beneficiaries who are discharged to a nursing home are not counted as community discharges.¹²

The readmission measures count patients whose primary diagnosis for rehospitalization was considered potentially avoidable; that is, the development of the conditions leading to the hospital admission typically could have been managed with appropriate care to avoid the hospitalization. The potentially avoidable conditions include congestive heart failure, electrolyte imbalance/dehydration, respiratory infection, septicemia, urinary tract or kidney infection, hypoglycemia and diabetic complications, anticoagulant complications, fractures and

musculoskeletal injuries, acute delirium, adverse drug reactions, cellulitis/wound infection, pressure ulcers, and blood pressure management. The count excludes readmissions that were likely to have been planned (e.g., inpatient chemotherapy or radiation therapy) and readmissions that signal a premature discharge from the hospital. We separately measure readmissions that occur during the SNF stay and those that occur within 30 days of discharge from the SNF because they measure different aspects of care—care furnished by the SNF and the SNF handoff to the next setting (or home). We do not use CMS's measure (readmissions that occur within 30 days of discharge from the hospital) because it conflates the two dimensions of care.

The observed readmission and community discharge rates were risk adjusted for medical comorbidity, cognitive comorbidity, mental health comorbidity, function, and clinical conditions (e.g., surgical wounds and shortness of breath). The rates reported are the average risk-adjusted readmission rates for all facilities with 25 or more stays (20 stays for the postdischarge readmission measure). Demographics (including race, gender, and age categories except younger than age 65 years) were not important in explaining differences in readmission and community discharge rates after controlling for beneficiaries' comorbidities, mental illness, and functional status (Kramer et al. 2014).¹³

(continued next page)

at least 80 percent of assessments will have their update for that year reduced by 2 percentage points.

Measures of changes in functional status were essentially unchanged

Most SNF beneficiaries receive rehabilitation therapy, and the amount of therapy furnished to them has steadily increased over time. Yet patients vary considerably in their expected improvement during the SNF stay. Some patients are likely to improve in several ADLs during their

SNF stay, while others (such as those with chronic and degenerative diseases) may expect, at best, to maintain their function. We measure SNF performance on both aspects of patient function—improvement and no decline (see text box on SNF quality measures). The risk-adjusted rates consider the likelihood that a patient's functionality will change, given the functional ability at admission. However, given the evidence in HHAs and IRFs that the reporting of functional status may be influenced by financial considerations, the Commission is increasingly

Measures of skilled nursing facility quality (cont.)

Two risk-adjusted measures of functional change are used to gauge the share of a facility's stays during which patients' function improves (the rate of improvement in one, two, or three mobility measures—bed mobility, transfer, and ambulation) and the share of stays during which patients' functioning does not decline (including stays with improvement and stays with no change), given the prognosis of the facility's patients. Change is measured by comparing initial and discharge assessments. For patients who go on to use long-term nursing home care, the assessment closest to the end of Medicare coverage is used as long as it is within 30 days of the end of the SNF stay. Although the initial assessment often occurs toward the end of the first week of the stay, the Minimum Data Set information pertains to the number of times over the past week that assistance was provided rather than the recorded functional status at a single point in time. Therefore, measurement error due to the reliance on an assessment conducted at the end of the first week of the stay is unlikely and would not affect our ability

to examine quality trends over time, unless providers changed during the week the initial assessments were conducted.

The initial assessment conducted during each stay is used to assign the patient to 1 of 22 case-mix groups using 3 measures of mobility—bed mobility, transfer, and ambulation (Kramer et al. 2014). This classification system acts as a form of risk adjustment, differentiating patients based on their expected ability to perform the three mobility-related activities of daily living (ADLs). A patient's prognosis is measured using the patient's ability to eat and dress because these two ADLs encompass cognitive functioning and other dimensions of physical functioning that facilitate rehabilitation.

Risk-adjusted rates compare a facility's observed rates with its expected rates ((actual rate / expected rate) × the national average rate) based on the mix of patients across functional outcome groups. Each facility-level measure combines the functional status information for the three mobility measures. ■

wary of the accuracy of the provider-reported functional assessments because the data are generally obtained by observing the patient and are somewhat subjective. The Commission has work underway to examine the accuracy of these data.

The average risk-adjusted rates of functional change—rate of improvement in one, two, or three mobility ADLs (bed mobility, transfer, and ambulation) and the rate of no decline in mobility—were essentially unchanged between 2011 and 2017 (Table 8-4, p. 206). In 2017, 43.9 percent of stays had improvement in mobility, and 87 percent of stays had no decline in mobility. So, even though the program paid for more therapy over this period (the share of days assigned to the highest rehabilitation case-mix groups increased), the average functional status of beneficiaries did not improve.

Large variation in quality measures indicates considerable room for improvement

Considerable variation exists across the industry in performance on the quality measures we track. We

found one-quarter of facilities in 2017 had risk-adjusted community discharge rates at or below 31.9 percent, whereas the best performing quarter of facilities had rates of 49.1 percent or higher (Table 8-5, p. 207). Similar variation was seen in readmissions during the SNF stay: The worst performing quartile had rates at or above 13.6 percent, whereas the best quartile had rates at or below 7.8 percent. Finally, rates of readmission in the 30 days after discharge from the SNF varied most—a twofold difference between the 25th percentile and the 75th percentile. The amount of variation across and within the groups suggests considerable room for improvement, all else being equal. There was less variation in the mobility measures, particularly the measure detecting no decline in mobility. The relatively high and fairly uniform rates could indicate that most SNFs are able to prevent declines for most beneficiaries.

Consistent with prior years, in 2017, nonprofit SNFs had higher rates of community discharges and fewer

**TABLE
8-4**

Mean risk-adjusted functional outcomes in SNFs were essentially unchanged between 2011 and 2017

Composite measure	2011	2013	2015	2016	2017
Rate of improvement in one or more mobility ADLs	43.6%	43.7%	43.6%	43.6%	43.9%
Rate of no decline in mobility	87.2	87.1	87.1	87.2	87.0

Note: SNF (skilled nursing facility), ADL (activity of daily living). The three mobility ADLs include bed mobility, transfer, and ambulation. The rate of mobility improvement refers to the average rates of improvement in bed mobility, transfer, and ambulation, weighted by the number of stays included in each measure. Stays with improvement in one, two, or three of these ADLs are counted in the improvement measure. The rate of stays with no decline in mobility is the share of stays with no decline in any of the three mobility ADLs. Rates are the mean of facility rates and are calculated for all facilities with 25 or more stays.

Source: Analysis of fiscal year 2011 through fiscal year 2017 Minimum Data Set data.

readmissions (that is, better rates) during the SNF stay than for-profit facilities. Nonprofit SNFs on average had community discharge rates that were 10 percent higher and during-stay readmission rates that were 15 percent lower than for-profit facilities. The rates for readmissions during the 30 days after discharge were similar on average.

We also found differences in the performance of hospital-based and freestanding SNFs in 2017. Compared with freestanding facilities, hospital-based SNFs had, on average, higher rates of discharge to the community (18 percent higher) and lower during-stay readmission rates (27 percent lower). The average readmission rate during the 30 days after discharge was higher for hospital-based SNFs compared with freestanding facilities, indicating an opportunity for hospitals to improve their discharge planning, the handoffs of these beneficiaries to the next setting or home, and the quality of the providers to which they refer beneficiaries.

Medicare is increasingly focused on measuring the value of the care it purchases. In addition to implementing a VBP program in October 2018, CMS has improved the Nursing Home Compare website, a Medicare website that displays comparative information about SNFs and nursing homes to help beneficiaries select a provider. CMS expanded the number of short-stay quality measures reported in Nursing Home Compare to include measures that reflect the key goals of this post-acute care. The short-stay measures include improvement in function, readmissions, discharge to the community, patient experience with pain, presence of new or worse pressure ulcers, vaccination rates, and use of antipsychotic medications.

Providers' access to capital was adequate in 2018

The vast majority of SNFs operate within nursing homes; therefore, in assessing SNFs' access to capital, we look at the availability of capital for nursing homes. Medicare makes up a minority share of almost all facilities' revenues.

Access to capital was adequate in 2018 and is expected to remain so in 2019 (Kaufman 2018). Many investors and lenders remain optimistic about this sector because of its relatively low costs compared with other institutional PAC providers and the long-term demographics that will fuel demand. Capital markets are reported to be "robust," with "tremendous investor demand," even though facilities' total margins are low and occupancy rates have declined in recent years (Connole 2018, Flynn 2018). Improved state economies have also stabilized Medicaid payments for the long-term care portion of providers' businesses.

The Department of Housing and Urban Development (HUD) continues to be an important lending source. In fiscal year 2018, HUD financed 317 projects, with the insured amount totaling \$3.6 billion, a 6 percent increase from 2017 (Department of Housing and Urban Development 2018). During fiscal year 2018, both the number and size of the loans increased. Refinancing, rather than new construction or renovation, continues to make up most of HUD loans. HUD plays a smaller lending role than it has previously because low-cost borrowing and widely available capital sources have made it only one of many alternative lenders.

**TABLE
8-5**

SNF quality measures varied considerably across SNFs, 2017

Risk-adjusted rates

Quality measure	Risk-adjusted rates			
	Mean	25th percentile	75th percentile	Ratio of 75th to 25th percentile
Discharged to the community	40.0%	31.9%	49.1%	1.5
Average mobility improvement across the three mobility ADLs during the SNF stay	43.9	35.8	52.0	1.5
Rate of no decline in mobility during SNF stay	87.0	82.5	92.6	1.1
Potentially avoidable readmissions during SNF stay	10.9	7.8	13.6	1.7
Potentially avoidable readmissions within 30 days after discharge from SNF	6.1	3.9	7.8	2.0

Note: SNF (skilled nursing facility), ADL (activity of daily living). Higher rates of discharge to community indicate better quality. Higher readmission rates indicate worse quality. "Mobility improvement" is the average of the rates of improvement in bed mobility, transfer, and ambulation, weighted by the number of stays included in each measure. "No decline in mobility" is the share of stays with no decline in any of the three mobility ADLs. Rates are the average of facility rates and are calculated for all facilities with 25 or more stays, except the rates of potentially avoidable readmissions during the 30 days after discharge, which are reported for all facilities with 20 or more stays.

Source: Analysis of fiscal year 2017 Minimum Data Set and inpatient acute hospital data.

Yet some lenders and investors are wary of this setting. Total margins for nursing homes across all lines of business and all patients are modest and have ranged between 0.6 percent and 3.8 percent since 2001. Because a "total margin" includes the mostly Medicaid-funded long-term care (the nursing home portion of the business), the overall financial performance of this setting is heavily influenced by state policies regarding the level of Medicaid payments and the ease of entry into a market (e.g., whether there is a requirement for a certificate of need). The aggregate total margin for freestanding SNFs in 2017 remained positive (0.5 percent), slightly lower than the total margin in 2016 (0.7 percent).

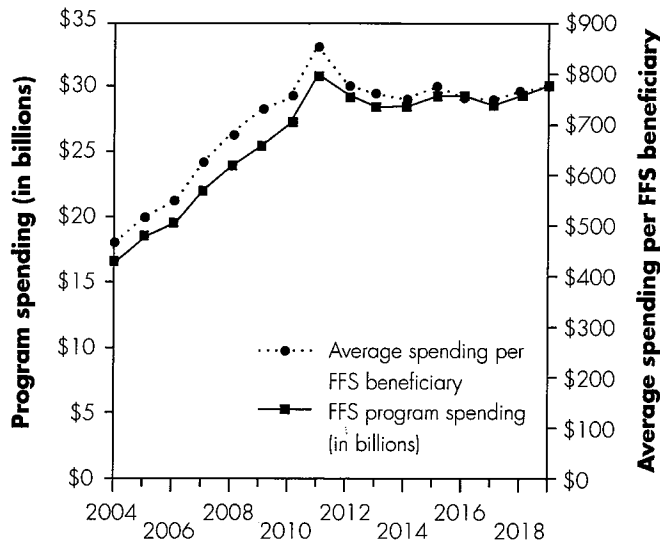
Some investors eye the slim total margins, declining occupancy rates, and increasing share of revenues from payers with lower rates and opt to pare back their investments or avoid the sector altogether. Reflecting these trends, the average price per bed decreased 18 percent between 2016 and 2017 (to \$81,350), though it remains the third highest price ever (Irving Levin Associates Inc. 2018). However, reluctance to invest in this setting does not reflect the adequacy of Medicare's FFS SNF payments: Medicare remains a preferred payer.

As some of the larger national players (such as Kindred Healthcare and Sabra Healthcare REIT) exited or pared back their investments in the sector, smaller regional investors picked up the offerings, assisted by widely available capital. Although small regional operators are less able to spread their financial risks across diverse locations, they have greater familiarity with the local markets, referral patterns from hospitals, and individual facility performance that may offer them a competitive advantage (Spanko 2018). In contrast to reluctant lenders, these investors view the industry as remarkably stable, having the advantage of demographic trends and being a lower cost alternative to other institutional PAC.

The nursing home industry is increasingly dividing into providers that can expand their service lines and successfully participate in alternative payment models and providers that cannot. The transition from FFS to alternative payment models (including ACOs and bundled payments) and VBP will require SNFs to achieve good outcomes and communicate that performance to potential partners (hospitals and health systems) to secure volume. Some facilities have started to develop and market their "niche" clinical capabilities to hospitals, aiming to care for patients with special care needs, such as patients

FIGURE 8-1

After declining in 2017, FFS program spending on SNF services is expected to increase in 2018 and 2019



Note: SNF (skilled nursing facility), FFS (fee-for-service). Fiscal year spending is shown. Data for 2018 and 2019 are estimates.

Source: Office of the Actuary 2018b.

on ventilators or dialysis, those requiring dementia or wound care, or those with respiratory or heart conditions. The revised PPS that CMS plans to implement will also exert pressure on providers to develop skilled nursing capabilities if they do not already have them. Some observers note that some small solo operators will opt to sell rather than transition to a new model of care, which will likely result in more consolidation in the industry.

Because Medicaid payments are lower than Medicare FFS payments, some representatives in the industry argue that high Medicare payments are needed to subsidize losses on Medicaid residents. The Commission does not support this policy for several reasons (see text box on not subsidizing other payments). It should be noted that while Medicare's payments are higher than Medicaid's, the programs pay for different levels of care. Medicare pays for skilled services after a hospitalization; Medicaid covers long-term care. Differences in the level of care are captured by the relative weights for the average Medicare beneficiary and Medicaid resident. The average therapy relative weight for

a Medicare-covered beneficiary was nine times higher than the relative weight for a Medicaid-covered resident (White and Zheng 2018). The average nursing relative weight was 40 percent higher for a Medicare-covered beneficiary compared with a Medicaid-covered resident.

Medicare payments and providers' costs: Medicare margins remained high in 2017

In 2017, the aggregate Medicare margin for freestanding SNFs was 11.2 percent. Margins for individual facilities continue to vary depending on the facility's share of intensive therapy days, size, and cost per day. High-margin SNFs had higher shares of intensive therapy days and lower average costs per day compared with low-margin SNFs. Differences by ownership were considerable, with for-profit facilities having much higher Medicare margins than nonprofit facilities. The 987 freestanding facilities defined as relatively efficient—providers with consistently low costs and higher quality care, in relative terms—had Medicare margins of 18 percent, indicating Medicare overpays freestanding facilities for this care. Some MA plans' payment rates were considerably lower than Medicare's FFS payment rates, and the disparity is unlikely to be explained by differences in patient mix.

Trends in FFS spending and cost growth

In fiscal year 2017, Medicare FFS spending for SNF services was \$28.4 billion, about 1 percent lower than in 2016 (Figure 8-1) (Office of the Actuary 2018b). Between 2004 and 2010, the average increase in program spending was over 8 percent a year. In 2011, program spending was unusually high because rates for the new case-mix classification system included an adjustment that was too large for the mix of therapy modalities (i.e., individual versus group or concurrent) assumed in setting the rates. The industry took advantage of the new policies by quickly shifting its mix of modalities, and spending increased by over 14 percent in 2011. To correct for the excessive payment, CMS revised the adjustment downward in 2012, and total payments declined almost 8 percent in 2012. Although there was no significant overall change in program spending, annual changes have been highly variable, ranging from a 4.5 percent increase in 2015 to a 2.8 percent decrease in 2016. On a per FFS beneficiary basis, spending in 2017 (\$743) was slightly lower (-0.4 percent) than in 2016. The Office of the Actuary estimates that FFS spending has increased in 2018 and will further increase to \$29.9 billion in 2019.

Medicare's skilled nursing facility payments should not subsidize payments from Medicaid or other payers

Medicare payments, which are financed by taxpayer contributions to the Part A Trust Fund, effectively subsidize payments from other payers, most notably Medicaid. High Medicare payments may also subsidize payments from private payers. Industry representatives contend that this subsidization should continue. The Commission believes such cross-subsidization is poor policy for several reasons. First, it results in poorly targeted subsidies. Facilities with high shares of Medicare beneficiary days receive the most in subsidies from higher Medicare payments, while facilities with low shares of Medicare beneficiary days—presumably the facilities with the greatest financial need—receive the smallest subsidies.

In addition, Medicare's subsidization does not differentiate among states with relatively high and low Medicaid payments. If Medicare raises or maintains its high payment levels, states could be encouraged to further reduce their Medicaid payments and, in turn, create pressure to raise Medicare rates even more. Higher Medicare payments could also further encourage providers to select patients based on payer source or rehospitalize dual-eligible patients to qualify them for a Medicare-covered, higher payment stay. Finally, Medicare's high payments represent a subsidy from trust fund dollars (and taxpayer support) of the low payments made by states and private payers. If the Congress wishes to financially support certain nursing facilities (such as those with high Medicaid shares) efficiently, it could do so through a separate, targeted policy. ■

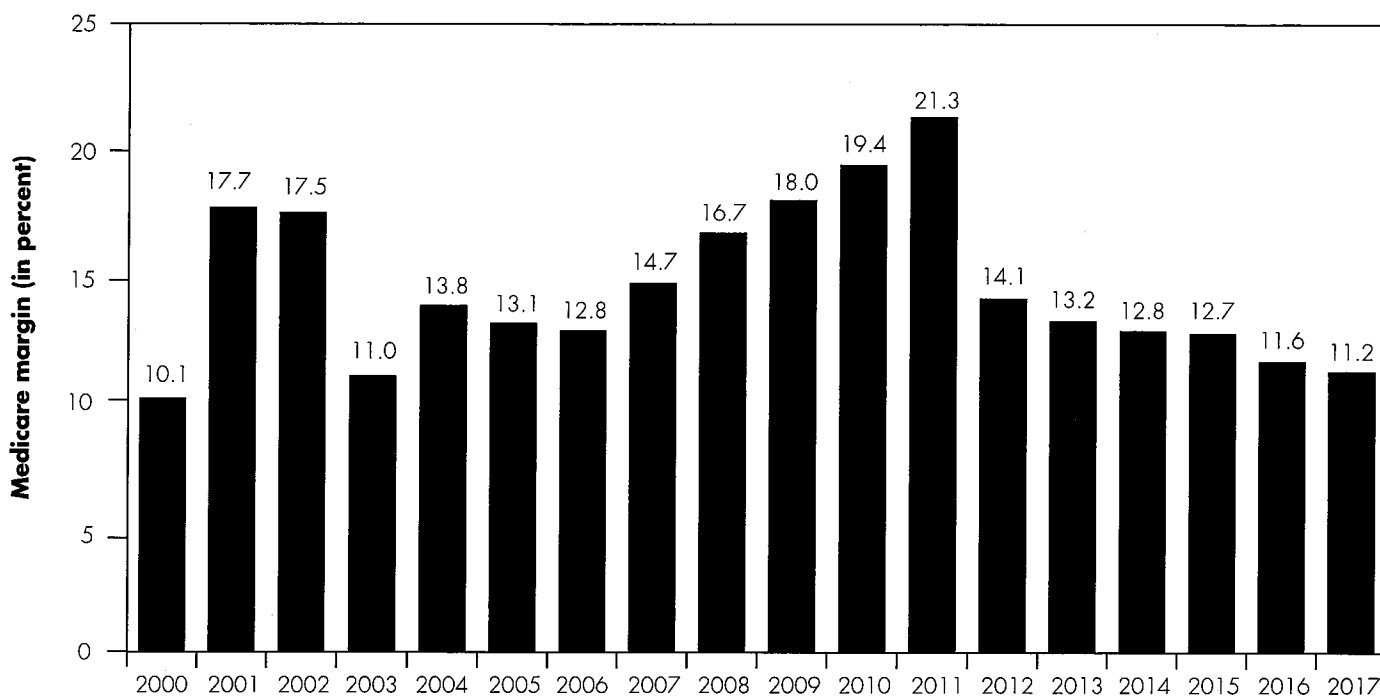
Between 2016 and 2017, SNFs kept the growth in the average cost per day below the market basket (2.3 percent compared with the market update of 2.7 percent). Costs increased more quickly for nonprofit SNFs compared with for-profit SNFs (3.0 percent compared with 2.2 percent, respectively). Cumulatively since 2012, the industry kept the growth in the average cost per day below the market basket (11.1 percent compared with the market basket of 12.3 percent). Over the same period, nonprofit SNFs had higher cost growth compared with for-profit SNFs (14.7 percent for nonprofit facilities compared with 10.1 percent for for-profit SNFs). In addition to higher cost growth, nonprofit facilities had average costs per day in 2017 that were about 10 percent higher than the cost per day in for-profit facilities. Differences in the level of cost per day by ownership have grown over time.

SNF Medicare margins remain high

The Medicare margin is a key measure of the adequacy of the program's payments because it compares Medicare's FFS payments with providers' costs to treat FFS beneficiaries. In 2017, the aggregate Medicare margin for

freestanding SNFs was 11.2 percent, the 18th consecutive year of Medicare margins above 10 percent (Figure 8-2, p. 210). Medicare margins declined slightly because, although SNFs kept their cost growth below the update to payments, the sequester has lowered payments by 2 percent each year since April 2013. SNFs have countered this reduction to the payment rate by keeping their cost growth low and assigning days to higher payment case-mix groups.

In 2017, hospital-based facilities (3 percent of program spending on SNFs) continued to have extremely negative Medicare margins (–68 percent), in part because of the higher cost per day reported by hospitals. Previous analysis by the Commission found that routine costs in hospital-based SNFs were higher, reflecting more staffing, higher skilled staffing, and shorter stays (over which to allocate costs) (Medicare Payment Advisory Commission 2007). However, hospital administrators consider their SNF units in the context of the hospital's overall financial performance and mission. Hospitals with SNFs can lower their inpatient lengths of stay by transferring patients to their SNF beds, thus making inpatient beds available to

**FIGURE
8-2****Aggregate freestanding SNF Medicare margins have been above 10 percent since 2000**

Note: SNF (skilled nursing facility). Medicare margin is calculated as the sum of Medicare payments minus the sum of Medicare's costs, divided by Medicare payments.

Source: MedPAC analysis of freestanding SNF cost reports, 2000–2017.

treat additional inpatient admissions. As a result, hospital-based SNFs can contribute to the bottom-line financial performance of hospitals: Hospitals with SNFs had lower inpatient costs per case and higher inpatient Medicare margins than hospitals without SNFs.

High and widely varying SNF Medicare margins indicate PPS reforms are still needed

The persistently high Medicare margins and their wide variation indicate that the PPS needs to be revised and rebased so that payments more closely match patient characteristics, not the services provided to them. In 2017, one-quarter of freestanding SNFs had Medicare margins of 20.2 percent or higher, while another quarter of freestanding SNFs had margins of 0.8 percent or lower (Table 8-6). Providers' case mix played a key role in shaping Medicare margins. In 2017, facilities with high shares of intensive therapy days had Medicare margins

that averaged 9 percentage points higher than facilities with low shares of these days (13.1 percent compared with 4.1 percent, respectively).

Medicare margins also reflect the economies of scale that larger SNFs are able to achieve. Small (25–50 beds) and low-volume facilities (bottom quintile of total facility days) had low average Medicare margins (–0.3 percent and 0.6 percent, respectively) compared with large and high-volume facilities (12.6 percent and 13.4 percent, respectively). SNFs with the lowest cost per day (SNFs in the bottom 25th percentile) had an average Medicare margin of 22.8 percent compared with 0.3 percent for SNFs with the highest cost per day (the top 25th percentile).

Since 2006, for-profit facilities' Medicare margins have averaged about 10 percentage points higher than nonprofit facilities' margins. Nonprofit facilities had an average

Medicare margin of 1.7 percent, while the average margin for for-profit SNFs was 13.7 percent. The disparity reflects differences in facilities' mix of patients, costs, size, and service provision. Nonprofit facilities tend to have higher costs per day (about 10 percent higher) and, since 2011, have had higher cost growth compared with for-profit facilities. The higher costs for nonprofit facilities partly reflect their smaller size. In 2015, the median nonprofit facility had 85 beds compared with 103 beds for the median for-profit facility, suggesting that the nonprofits may not be able to achieve the same economies of scale as larger facilities. As for revenues, nonprofits had somewhat lower shares of the more profitable ultra-high and very high therapy days compared with for-profit facilities (82 percent compared with 84 percent, respectively) and shorter stays, both lowering revenue.

The highest margin freestanding SNFs (those in the top quartile of the distribution of Medicare margins) appear to pursue both cost and revenue strategies (Table 8-7, p. 212). Compared with lower margin SNFs (those in the bottom quartile), high-margin SNFs had considerably lower daily total, routine, and ancillary costs and lower cost per discharge. Economies of scale play a role; high-margin SNFs were larger on average, with a higher occupancy rate, than lower margin facilities. Somewhat surprisingly, high-margin facilities had larger shares of dual-eligible beneficiaries, minority beneficiaries, and Medicaid days. It is possible that, given their larger Medicaid mix (and the lower payments typically made by Medicaid), these facilities keep their costs lower, which contributes to their higher Medicare margins.

On the revenue side, high-margin SNFs had revenues per day that were 15 percent higher, driven in part by having larger shares of intensive therapy days and, to a smaller extent, a lower mix of medically complex days. The differences in financial performance based on a provider's case mix illustrate the need to revise the PPS, such as using the design proposed by CMS. Differences in payments per discharge between high- and low-margin SNFs were even larger (43 percent higher) because of the longer lengths of stay.

Ownership of low-margin and high-margin facilities did not mirror the industry mix. Although for-profit facilities made up 71 percent of freestanding SNFs in 2017, they constituted a smaller share (57 percent) of the low-margin facilities and a higher share (86 percent) of the high-margin group. Similarly, high-margin SNFs were

**TABLE
8-6**

Variation in freestanding SNF Medicare margins reflects the mix of cases and cost per day, 2017

Provider group	Medicare margin
All providers	11.2%
For profit	13.7
Nonprofit	1.7
Rural	9.7
Urban	11.5
Frontier	3.8
25th percentile of Medicare margins	0.8
75th percentile of Medicare margins	20.2
Intensive therapy: High share of days	13.1
Intensive therapy: Low share of days	4.1
Medically complex: High share of days	9.0
Medically complex: Low share of days	12.1
Small (20–50 beds)	–0.3
Large (100–199 beds)	12.6
Cost per day: High	0.3
Cost per day: Low	22.8
Cost per discharge: High	9.6
Cost per discharge: Low	12.2
Facility volume: Highest fifth	13.4
Facility volume: Lowest fifth	0.6

Note: SNF (skilled nursing facility). The margins are aggregates for the facilities included in the group. "Intensive therapy" days are those classified in the ultra-high and very high rehabilitation case-mix groups. "Low" is defined as facilities in the lowest 25th percentile; "high" is defined as facilities in the highest 25th percentile. "Frontier" refers to SNFs located in counties with six or fewer people per square mile. Facility volume includes all facility days.

Source: MedPAC analysis of 2017 freestanding SNF Medicare cost reports.

disproportionately urban, accounting for 79 percent of this group even though they make up a smaller share of freestanding SNFs (73 percent).

Relatively efficient SNFs illustrate Medicare's payments are too high

The Commission is required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to consider the costs associated with efficient providers. The

**TABLE
8-7**

Cost and revenue differences explain variation in Medicare margins for freestanding SNFs in 2017

Characteristic	SNFs in the top margin quartile	SNFs in the bottom margin quartile	Ratio of SNFs in the top margin quartile to SNFs in the bottom margin quartile
Cost measures			
Standardized cost per day	\$271	\$399	0.68
Standardized ancillary cost per day	\$117	\$167	0.70
Standardized routine cost per day	\$152	\$224	0.68
Standardized cost per discharge	\$11,285	\$14,116	0.80
Average daily census (patients)	87	65	1.35
Occupancy rate (in percent)	86%	84%	1.02
Revenue measures			
Medicare payment per day	\$522	\$452	1.15
Medicare payment per discharge	\$22,470	\$15,714	1.43
Medicare length of stay (days)	42	35	1.21
Share of days in intensive therapy	88%	80%	1.10
Share of medically complex days	3%	4%	0.75
Medicare share of facility revenue	23%	13%	1.77
Medicaid share of days	66%	57%	1.16
Patient characteristics			
Case-mix index	1.41	1.32	1.07
Share dual-eligible beneficiaries	39%	26%	1.50
Share minority beneficiaries	14%	5%	2.80
Share very old beneficiaries	30%	35%	0.86
Facility mix			
Share for profit	86%	57%	N/A
Share urban	79%	70%	N/A

Note: SNF (skilled nursing facility), N/A (not applicable). Values shown are medians for the quartile. Top margin quartile SNFs (n=3,284) were in the top 25 percent of the distribution of Medicare margins. Bottom margin quartile SNFs (n=3,283) were in the bottom 25 percent of the distribution of Medicare margins. "Standardized cost" refers to Medicare costs adjusted for differences in area wages and the case mix (using the nursing component's relative weights) of Medicare beneficiaries. "Intensive therapy" days are days classified in ultra-high and very high rehabilitation case-mix groups. "Medically complex" includes days assigned to clinically complex and special care case-mix groups. "Very old beneficiaries" are 85 years and older. Figures in the first two columns are rounded, but ratios were calculated on unrounded data.

Source: MedPAC analysis of freestanding 2017 SNF cost reports and claims.

analysis informs the Commission's update discussion by examining the adequacy of payments for those providers that perform relatively well on cost and quality measures.

The Commission follows two principles when selecting a set of efficient providers. First, the providers must do relatively well on both cost and quality metrics (see text box on identifying relatively efficient SNFs, p. 214).

Second, performance has to be consistent, meaning that the provider cannot have poor performance on any metric in any of three consecutive years preceding the year under evaluation. The Commission's approach is to develop a set of criteria and then examine how many providers meet them. It does not establish a set share (for example, 10 percent) of providers to be considered efficient and then define criteria to meet that pool size.

**TABLE
8-8**

Financial performance of relatively efficient freestanding SNFs is a combination of lower cost per day and higher revenues per day

Performance in 2017	Type of SNF		Ratio of relatively efficient to other SNFs
	Relatively efficient	Other SNFs	
Community discharge rate	50.3%	39.8%	1.27
Readmission rate	9.0%	10.9%	0.83
Standardized cost per day	\$297	\$324	0.92
Standardized cost per discharge	\$8,948	\$12,310	0.73
Medicare revenue per day	\$526	\$476	1.11
Medicare margin	18.0%	10.5%	1.71
Total margin	2.3%	0.6%	3.61
Facility case-mix index	1.44	1.36	1.06
Medicare average length of stay	30 days	38 days	0.79
Occupancy rate	87%	85%	1.03
Average daily census	100	79	1.27
Share ultra-high therapy days	66%	55%	1.21
Share medically complex days	4.2%	3.8%	1.09
Medicaid share of facility days	58%	63%	0.93
Share urban	84%	67%	N/A
Share for profit	79%	68%	N/A
Share nonprofit	15%	21%	N/A

Note: SNF (skilled nursing facility), N/A (not applicable). The number of facilities included in the analysis was 11,462. SNFs were identified as “relatively efficient” based on their cost per day and two quality measures (community discharge and readmission rates) between 2014 and 2016; their performance was evaluated in 2017 and is displayed in the table. Relatively efficient SNFs were those in the best third of the distribution for one measure and not in the worst third for any measure in each of three years and were not a facility under “special focus” by CMS. Costs per day and per discharge were standardized for differences in case mix (using the nursing component relative weights) and wages. Quality measures were rates of risk-adjusted community discharge and readmission during the SNF stay for patients with potentially avoidable conditions. Quality measures were calculated for all facilities with at least 25 stays. “Ultra-high therapy days” includes days assigned to ultra-high case-mix groups. “Medically complex days” includes days assigned to clinically complex and special care case-mix groups. Table shows the medians for the measure. Figures in the first two columns are rounded, but ratios were calculated on unrounded data.

Source: MedPAC analysis of quality measures and Medicare cost report data for 2014–2017.

To identify efficient SNFs, we examined the financial performance of freestanding SNFs with consistent cost and quality performance. To measure costs, we looked at costs per day that were adjusted for differences in area wages and case mix. The quality measures were risk-adjusted rates of community discharge and potentially avoidable readmissions during the SNF stay.

Our analyses found that many SNFs (987) had relatively low costs and provided relatively good quality care. Compared with other SNFs in 2017, relatively efficient

SNFs had community discharge rates that were 27 percent higher and readmission rates that were 17 percent lower (Table 8-8). Standardized costs per day were 8 percent lower than for other SNFs. The aggregate Medicare margin for efficient SNFs was high (18 percent), indicating that although these providers were relatively low cost and achieved relatively high quality, the program could get better value for its purchase if its payments were lower. The high margin for these providers underscores the need for the program to lower its payments to more closely align them with the costs of care.

Identifying relatively efficient skilled nursing facilities

We defined relatively efficient skilled nursing facilities (SNFs) as those with relatively low costs per day and good quality of care for three years in a row, 2014 through 2016. The cost per day was calculated using cost report data and was adjusted for differences in case mix (using the nursing component relative weights) and area wages. To assess quality, we examined risk-adjusted rates of community discharge and potentially avoidable readmissions that occurred during the SNF stay. Only facilities with at least 25 stays were included in the quality measures. To be included in the relatively efficient group, a SNF had to be in the best third of the distribution of at least one measure and not in the bottom third on any measure for three consecutive years. Another criterion was that SNFs not be part of CMS's Special Focus Facility Initiative for any portion of time covered by the definition (2014 through 2016), which excluded five facilities from the pool of efficient providers.¹⁴

We found that almost 9 percent (987 of the 11,462 facilities that had all of the data items required for this

analysis) provided relatively low-cost, high-quality care—17 more facilities than last year. Less than half (44 percent) were identified as efficient last year. Relatively efficient facilities were more likely to be urban and for profit. Efficient SNFs were located in 44 states, including 2 in frontier locations.

The method we used to assess performance attempts to limit incorrect conclusions about performance based on poor data. Using three years to categorize SNFs as efficient (rather than just one year) avoids categorizing providers based on random variation or on one “unusual” year. In addition, by first assigning a SNF to a group and then examining the group's performance in the next year, we avoided having a facility's poor data affect both its own categorization and the assessment of the group's performance. Thus, a SNF's erroneous data could result in its inaccurate assignment to a group, but because the group's performance is assessed with data from later years, these “bad” data would not directly affect the assessment of the group's performance. ■

Similar to high-margin SNFs, efficient SNFs appear to pursue cost and revenue strategies. On the cost side, efficient SNFs achieved greater economies of scale, with a higher daily census compared with other facilities (100 compared with 79, respectively) and slightly higher occupancy rates. Since the efficient providers were also higher quality, their volume could reflect their success in attracting admissions. On the revenue side, efficient providers had higher shares of the most intensive therapy days that raised their daily Medicare payments relative to all SNFs. They also had lower Medicaid shares, which improved their total financial performance; efficient providers' total margin was 2.3 percent compared with 0.6 percent for other SNFs. Efficient facilities had more complex case mixes (driven in part by higher therapy intensity) and much shorter stays.

FFS payments for SNF care are considerably higher than MA payments for three publicly traded nursing home companies

Another indicator that Medicare's payments under the SNF PPS are too high is the comparison of FFS and MA

payments. (We use “MA” as shorthand for all managed care payments since MA makes up the majority of rates reported as “managed care payments.”) We compared Medicare FFS and MA payments at three nursing home companies for which such information was publicly available. For these companies, Medicare's FFS payments averaged 21 percent higher than MA rates (Table 8-9). We do not know whether the lower average daily payment reflects differences in service intensity (for example, fewer intensive therapy days), lower payments for the same service, or some combination. We also do not know how these rates compare with rates paid to smaller chains and independent facilities. It is possible that smaller companies have less leverage and do not negotiate similarly low rates. However, similar differences in payments were reported by the National Investment Center for Seniors Housing & Care, a nonprofit organization that supports access and choice for seniors' housing and care, including nursing homes and assisted living. It found that for the 1,449 SNF properties included in its sample, FFS payments

**TABLE
8-9**

Comparison of Medicare fee-for-service and managed care daily payments in 2018 to three companies

Company	Medicare payment		Ratio of FFS to MA payment
	FFS	Managed care (MA)	
Diversicare	\$455	\$397	1.15
Ensign Group	616	462	1.33
Genesis HealthCare	525	458	1.15

Note: FFS (fee-for-service), MA (Medicare Advantage). MA makes up the majority of managed care payments. The Genesis rate is reported as "insurance," which includes managed care but excludes Medicaid managed care and private pay.

Source: Third quarter 10-Q 2018 reports available at each company's website.

per day were 21 percent higher than MA rates (National Investment Center for Seniors Housing & Care 2018).

We compared the patient characteristics of beneficiaries enrolled in FFS and MA plans in 2017 and found the differences are unlikely to explain the magnitude of the differences between FFS payments and payments typically made by MA plans.¹⁵ Compared with FFS beneficiaries, MA enrollees were about the same age, had slightly higher Barthel scores (about two points, indicating slightly more independence), and had lower risk scores (5 percent lower, indicating fewer comorbidities). The considerably lower MA payments indicate that some facilities accept much lower payments to treat MA enrollees who may not be much different in terms of case mix from FFS beneficiaries. Some publicly traded firms report seeking managed care patients as a business strategy, indicating that the MA rates are attractive.

Payments and costs for 2019

To project the aggregate Medicare margin for 2019, the Commission considers the relationship between SNF costs and Medicare payments in 2017 as a starting point. To estimate costs for 2018 and 2019, we assumed a cost growth equal to the average for the past five years (slightly below market basket) and no behavioral changes. To estimate 2018 payments, we assumed payments in 2018 would increase by 1.0 percent, as required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). For 2019, we assumed payments would increase by 2.4

percent, as required by the Balanced Budget Act of 2018. We also reduced 2019 payments by the portion of the VBP withhold that will be retained as program savings.

The projected Medicare margin for 2019 is 10 percent. The margin is expected to be lower than the 2017 margin because of the MACRA-mandated update in 2018 and program savings from VBP that will lower revenues in 2019.

How should Medicare payments change in 2020?

In considering how payments should change for 2020, we note that costs are estimated to increase 3.1 percent that year. The update to payments is estimated to be lower than 3.1 percent because productivity adjustments will lower the update by an estimated 0.5 percent, for a net update of 2.6 percent. The change in Medicare margins will depend on whether cost growth exceeds the growth in payments on a case-mix-adjusted basis.

In fiscal year 2020, CMS plans to make substantial changes to the SNF PPS. The Commission has called for a revised PPS since 2008 and urges the Secretary to proceed with the redesign. While CMS estimated the redesign to be budget neutral, provider responses to the new PPS may alter program spending and facilities' cost structures and mix of cases. Thus, behavioral responses will dictate

whether rebasing and recalibration will be needed to keep payments aligned with the cost of care.

Regarding the level of payments, indicators of the adequacy of Medicare's payments are positive. The aggregate Medicare margin for SNFs has been above 10 percent since 2000 and is projected to be 10 percent in 2019. In 2017, the marginal profit was 19.1 percent, indicating facilities with an available bed have an incentive to admit Medicare patients. Relatively efficient SNFs had a median Medicare margin of 18 percent, further evidence that the level of payments is too high relative to the cost of care. Furthermore, FFS payments were considerably higher than the MA payments made to some SNFs, suggesting that some facilities are willing to accept much lower rates than FFS payments to treat Medicare beneficiaries. These factors show that the PPS continues to exert too little pressure on providers.

RECOMMENDATION 8 - 1

The Secretary should proceed to revise the skilled nursing facility prospective payment system in fiscal year 2020 and should annually recalibrate the relative weights of the case-mix groups to maintain alignment of payments and costs.

RATIONALE 8 - 1

After proposing to revise the SNF PPS and postponing the implementation, CMS refined its design and appears poised to implement a revised PPS in October 2019. The revisions will increase the equity in payments for different types of stays, increasing payments for medically complex stays and decreasing payments for stays that include intensive therapy unrelated to a patient's care needs. While the redesign would narrow the disparities in financial performance that result from the mix of cases facilities treat and therapy practices, it would not, and should not, address disparities that result from providers' inefficiencies.

The recommendation also calls for the Secretary to annually recalibrate the relative weights of the case-mix groups. The redesign may encourage many SNFs to change their mix of cases and their cost structures and thereby shift the relative costs of days assigned to the case-mix groups. To keep payments aligned with the cost of care for all types of days, CMS should recalibrate the relative weights of the case-mix groups on a regular schedule. Recalibration is administratively straightforward

and should become part of CMS's annual upkeep of the SNF PPS, just as it is part of the annual updates made to acute care hospitals.

As CMS noted in its final rule for updating rates for fiscal year 2019, the redesigned SNF PPS and the unified PAC PPS establish similar incentives for providers. SNFs will gain valuable experience under the revised SNF PPS that will ready them for an eventual transition to a PAC PPS.

IMPLICATIONS 8 - 1

Spending

- Relative to current law, this recommendation would not change program spending. The recommendation is budget neutral to the current level of spending.

Beneficiary and provider

- A redesigned PPS and an annual recalibration of the relative weights would increase the equity of Medicare's payments for all beneficiaries, thereby helping to ensure access for all beneficiaries, including those with medically complex conditions and those with high NTA costs. We do not expect the recommendation to affect providers' willingness or ability to care for Medicare beneficiaries.

RECOMMENDATION 8 - 2

The Congress should eliminate the fiscal year 2020 update to the Medicare base payment rates for skilled nursing facilities.

RATIONALE 8 - 2

Current law will increase base payments by a projected 2.6 percent (the market basket net of productivity) in fiscal year 2020. The aggregate Medicare margin in 2017 was 11.2 percent, indicating that the current level of Medicare's payment rates is more than adequate to accommodate cost growth and provide care to Medicare beneficiaries without an update to the base rate.

While the level of Medicare's payments indicates that a reduction to payments (i.e., not simply maintaining payment rates at current levels) is needed to align aggregate payments to aggregate costs, we expect the SNF industry to undergo considerable changes as it adjusts to the redesigned PPS. Given the impending changes, the Commission will proceed cautiously in recommending reductions to payments to more closely align them to costs. A zero update would begin to align

**TABLE
8-10**

The number of nursing homes treating Medicaid enrollees declined slightly from 2017 to 2018

	2013	2015	2017	2018	Average annual percent change	
					2013-2017	2017-2018
Number of facilities	15,082	15,076	15,024	14,955	-0.1%	-0.5%

Note: The 2018 number is through November of that year; it does not include data from the full calendar year.

Source: Certification and Survey Provider Enhanced Reporting on CMS's Survey and Certification Providing Data Quickly system, 2013-2018.

payments with costs while exerting pressure on providers to keep their cost growth low and to engage in practice patterns encouraged by alternative payment models. The Commission will monitor beneficiary access, quality of care, and financial performance and may consider future recommendations based on industry responses to the new payment system.

IMPLICATIONS 8-2

Spending

- Relative to current law, this recommendation would lower program spending by between \$750 million and \$2 billion for fiscal year 2020 and by between \$5 billion and \$10 billion over five years. Savings occur because current law requires market basket increases for 2020.

Beneficiary and provider

- We do not expect this recommendation to have adverse effects on beneficiaries' access to care. Given the current level of payments, we also do not expect the recommendation to affect providers' willingness or ability to care for Medicare beneficiaries.

Medicaid trends

Section 2801 of the Patient Protection and Affordable Care Act of 2010 requires the Commission to examine spending, use, and financial performance trends in the Medicaid program for providers with a significant portion of revenues or services associated with Medicaid. We

report nursing home spending trends for Medicaid and financial performance for non-Medicare payers. Medicaid revenues and costs are not reported in the Medicare cost reports. In a joint publication with the Medicaid and CHIP Payment Access Commission, we report on characteristics, service use, and spending for dual-eligible beneficiaries (Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission 2018).

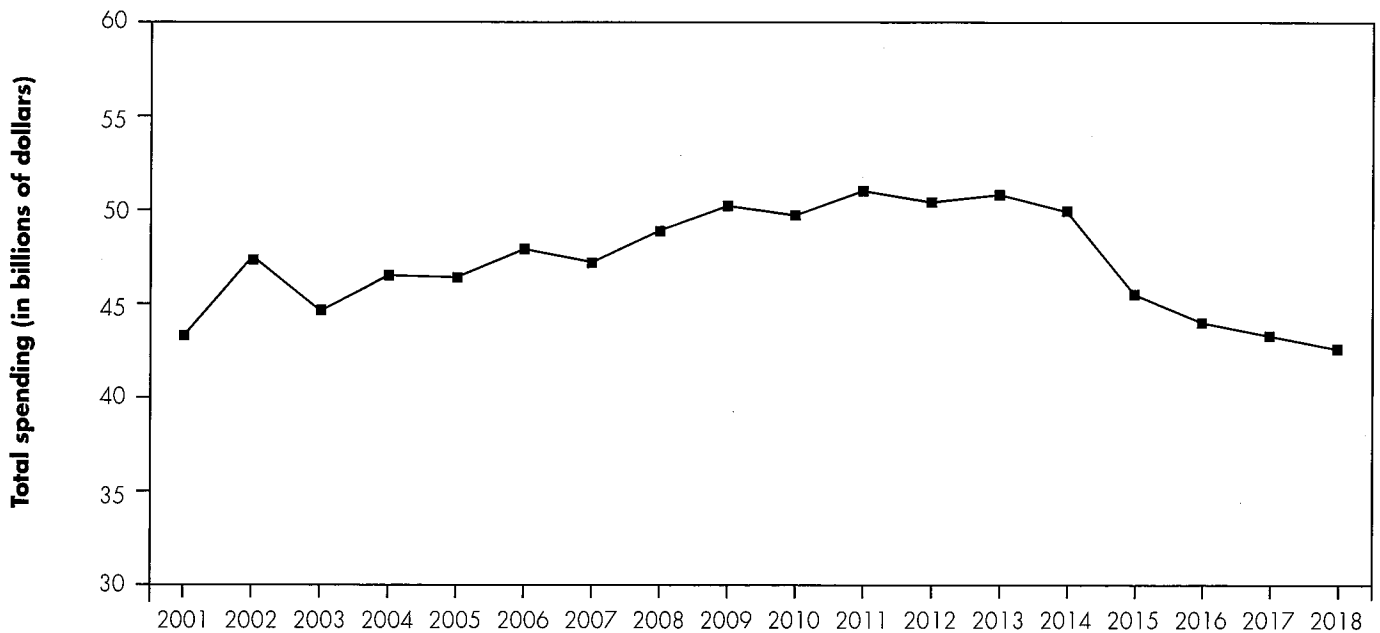
Medicaid covers nursing home (long-term care) and skilled nursing care provided in nursing facilities. Medicaid also pays for long-term care services that Medicare does not cover. For beneficiaries who are dually eligible for Medicaid and Medicare, Medicaid pays the Medicare copayments required of beneficiaries beginning on day 21 of a SNF stay.

Count of Medicaid-certified nursing homes

The number of nursing facilities certified as Medicaid providers has stayed relatively stable, with a small decline between 2017 and 2018 (Table 8-10). The decline may reflect the expansion in some states of home- and community-based services (HCBS), which allow more beneficiaries to remain in their homes rather than an institution. State HCBS waivers and federal initiatives have accelerated the trend toward HCBS. In fiscal year 2018, all 50 states and the District of Columbia expanded the number of beneficiaries served by HCBS, an increase from 47 states in fiscal year 2017 and 46 states in fiscal years 2015 and 2016 (Gifford et al. 2017). The reduced number of Medicaid providers may also reflect some facilities shifting their focus to the skilled care market.

**FIGURE
8-3**

Total Medicaid fee-for-service spending on nursing home services declined about 2 percent, 2001-2018



Note: Spending does not include any managed care organization spending on nursing homes. Data for 2018 are projected.

Source: Office of the Actuary 2018.

Spending

Spending on Medicaid-funded nursing home services (combined state and federal funds) totaled \$43.3 billion in 2017 (Figure 8-3) (Office of the Actuary 2018a). CMS estimates that FFS Medicaid spending on nursing home services decreased by 1.6 percent between 2017 and 2018 and that spending will increase by 0.45 percent in 2019. This trend of lower spending is in part due to an increased use of managed care organizations, whose spending is not included in these data. As of 2017, 24 states operated capitated managed long-term services and supports (Lewis et al. 2018). This number is a 50 percent increase from 2012, when only 16 states had such programs. Furthermore, total enrollment in these programs more than doubled between 2012 and 2017, from 800,000 beneficiaries to 1.8 million beneficiaries.

Analysis of Medicaid rate-setting trends found that 17 states restricted (froze or reduced) rates paid to nursing homes in 2018, while 34 states and the District of

Columbia increased rates (Gifford et al. 2018). More states increased rates to nursing homes in 2018 than in 2017 (only 34 states raised rates in 2017, and 15 states restricted rates) (Gifford et al. 2017). Furthermore, the National Investment Center for Seniors Housing & Care reported that Medicaid revenue per day has been increasing steadily since 2011 (National Investment Center for Seniors Housing & Care 2018). Rates will likely shift in 2019; 40 states and the District of Columbia have indicated that they will increase nursing home rates. Eleven states plan to restrict rates in 2019 (Gifford et al. 2018).

States continue to use provider taxes to raise federal matching funds. In fiscal year 2018, 44 states and the District of Columbia levied provider taxes on nursing homes to increase federal matching funds (Gifford et al. 2018).¹⁶ States can use the augmented revenue to increase payments to providers or to mitigate reductions to payments for services to Medicaid patients (Kaiser Family Foundation 2017).

**TABLE
8-11**

Over the past 10 years, total margins remained positive in freestanding SNFs but non-Medicare margins were negative

Type of margin	2008	2010	2012	2014	2016	2017
Total margin	2.2%	3.6%	1.8%	1.9%	0.7%	0.5%
Non-Medicare margin	-2.4	-1.5	-2.0	-1.5	-2.4	-2.4

Note: SNF (skilled nursing facility). "Total margin" includes the revenues and costs associated with all payers and all lines of business. "Non-Medicare margin" includes the revenues and costs associated with Medicaid and private payers for all lines of business.

Source: MedPAC analysis of Medicare freestanding SNF cost reports for 2008 to 2017.

Total margins and non-Medicare margins in nursing homes

Total margins reflect all payers (including Medicare, Medicaid, private insurers, and managed care) across all lines of business (for example, nursing home care, hospice care, ancillary services, home health care, and investment income). In 2017, total margins were positive (0.5 percent) (Table 8-11). The median total margin was 0.6 percent, with margins at the 25th and 75th percentiles ranging from -5.3 percent to 5.5 percent, respectively (data not shown). Rural and urban freestanding SNFs had similar total margins (0.6 percent and 0.5 percent, respectively). Total margins have declined since 2013 (when the total margin was 1.9 percent), reflecting the impact of reductions to Medicare payments mandated by the Patient Protection and Affordable Care Act of 2010 and the growing share of managed care payments that are lower than Medicare's FFS payments. The aggregate non-Medicare margin (the profitability of all services except Medicare FFS SNF) in 2017 was -2.4 percent, the same as in 2016.

Total margins varied by ownership, though the differences were much smaller than the differences by ownership in Medicare margins. In 2017, the average nonprofit SNF total margin was 1.9 percent compared with 0.2 percent for the average for-profit facility. In 2016, the total margin was 0.8 percent for both nonprofit and for-profit providers. The diverging performances reflect differences in the changes in mixes of revenue and days by payer. Compared with for-profit providers, the share of Medicare revenue and days decreased less for nonprofit facilities and the share of non-Medicare revenues (the lower-payment revenue sources) grew at half the rate of for-profit facilities. (Note that Medicaid revenues are not reported on the Medicare cost report.) Reflecting differences in

payer mix, median facility payments increased 3.4 percent between 2016 and 2017 for nonprofit facilities compared with 2.1 percent for for-profit facilities. Differences in cost growth (median facility costs per day) did not explain the diverging performances. Consistent with the growth in Medicare cost per day (see p. 209), nonprofit facilities experienced higher cost growth compared with for-profit facilities.

The declines in the average total and non-Medicare margins reflect the lower average occupancy rates (which raises the average cost per day) and the lower volume of high-payment Medicare FFS patients. Beneficiaries receiving skilled nursing services are increasingly enrolled in alternative payment models (including bundled payments and ACOs) and MA plans, which typically seek to shorten stays or avoid this setting entirely. In addition, payments from MA plans are generally lower than Medicare's FFS rates (see p. 214). ■

Endnotes

- 1 Throughout this chapter, *beneficiary* refers to an individual whose SNF stay coverage is paid for by Medicare (Part A). Some beneficiaries who no longer qualify for Medicare coverage remain in the facility to receive long-term care services, which are not covered by Medicare. During long-term care stays, beneficiaries may receive care such as physician services, outpatient therapy services, and prescription drugs that are paid for separately under the Part B and Part D benefits. Services furnished outside the Part A–covered stay are not paid under the SNF prospective payment system and are not considered in this chapter. Except where specifically noted, this chapter examines FFS Medicare spending and service use and excludes services and spending for SNF services furnished to beneficiaries enrolled in Medicare Advantage plans. Some beneficiaries also qualify for Medicaid and are referred to as “dual-eligible beneficiaries.”
- 2 A spell of illness ends when there has been a period of 60 consecutive days during which the beneficiary was an inpatient of neither a hospital nor a SNF. Coverage for another 100 days does not begin until a beneficiary has not had hospital care or skilled care in a SNF for 60 consecutive days. Observation days and emergency room stays do not count toward the three-day hospital stay requirement.
- 3 For services to be covered, the SNF must meet Medicare’s requirements of participation and agree to accept Medicare’s payment rates. Medicare’s requirements relate to many aspects of staffing and care delivery, such as requiring a registered nurse in the facility for 8 consecutive hours per day and licensed nurse coverage 24 hours a day, providing physical and occupational therapy services and speech–language pathology services as delineated in each patient’s plan of care, and providing or arranging for physician services 24 hours a day in case of an emergency.
- 4 The program pays separately for some services, including certain chemotherapy drugs; certain customized prosthetics; certain ambulance services; Part B–covered dialysis; emergency services; and certain outpatient services provided in a hospital (such as computed tomography, MRI, radiation therapy, and cardiac catheterizations).
- 5 The SNF *Payment Basics* is available at http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_18_snf_final_sec.pdf?sfvrsn=0.
- 6 Payments for NTA services are included in the nursing component, even though NTA costs vary much more than nursing care costs and are not correlated with them.
- 7 We include patients who are assigned to the clinically complex and special care case-mix groups in our definition of medically complex. Clinically complex patients have burns, surgical wounds, hemiplegia, or pneumonia, or they receive chemotherapy, oxygen therapy, intravenous medications, or transfusions while in a SNF. Special care patients are comatose; have quadriplegia, chronic obstructive pulmonary disease, septicemia, diabetes requiring daily injections, fever with specific other conditions, cerebral palsy, multiple sclerosis, Parkinson’s disease, respiratory failure, a feeding tube, pressure ulcers of specific sizes, or foot infections; receive radiation therapy or dialysis while a resident; or require parenteral or intravenous feedings or respiratory therapy for seven days. Intensive therapy days are classified in the ultra-high and very high rehabilitation case-mix groups. Rehabilitation groups are based on minutes of rehabilitation provided per week. “Ultra-high rehabilitation” includes patients who receive more than 720 minutes per week; “very high rehabilitation” includes patients who receive 500–719 minutes per week.
- 8 The share of SNF users requiring the most assistance dropped for transferring, walking in corridor, eating, performing personal hygiene, toileting, dressing, and bed mobility; remained the same for always being incontinent; and increased for help with bathing and always being bowel incontinent.
- 9 If we approximate marginal cost as total Medicare costs minus fixed building and equipment costs, then marginal profit can be calculated as follows:

$$\text{Marginal profit} = (\text{payments for Medicare services} - (\text{total Medicare costs} - \text{fixed building and equipment costs})) / \text{Medicare payments}$$

This comparison is a lower bound on the marginal profit because we do not consider any potential labor costs that are fixed.
- 10 The Commission’s measure of discharge to community captures a key goal of many beneficiaries: to go home. It measures the share of beneficiaries discharged home from a SNF. In contrast, CMS’s quality reporting measure gauges the share of beneficiaries who were discharged home, did not have an unplanned readmission within 31 days of discharge, and remained alive.
- 11 CMS’s VBP readmission measure differs from the Commission’s measures that separately track readmissions during the SNF stay and readmissions that occur within 30

days after discharge. By including readmissions that occur within 30 days of discharge from the hospital, CMS's measure can include readmissions that occur during the SNF stay and after discharge, depending on the length of the SNF stay. For short SNF stays, CMS's measure includes readmissions after discharge from the SNF but still within 30 days of discharge from the hospital stay. For long SNF stays, the measure includes only readmissions that occur within the first 30 days of the SNF stay (assuming an immediate transfer from the hospital) and misses readmissions that occur later in the SNF stay.

- 12 Separate models (with their own covariates) are used to estimate expected community discharge rates for different discharge destinations (e.g., discharged home with home health care, discharged home without home health care, and discharged to a nursing home).
- 13 With inclusion of the other covariates, age categories were not found to be significant in explaining variation in outcomes and were dropped from the models except for the model explaining differences in readmission during the 30 days after discharge for beneficiaries younger than 65 years residing in the community.

14 The Special Focus Facility Initiative is a program to stimulate improvements in the quality of care at nursing homes with a history of serious quality problems. The initiative targets homes with a pattern over three years of more frequent and more serious problems (including harm or injury to residents) detected in their annual facility surveys. Facilities that improve and maintain those improvements can "graduate" from the program. Providers that do not improve face civil monetary penalties (fines) and eventual termination from Medicare and Medicaid.

15 We compared the assessments conducted at the beginning of stays (the "day 5" assessment). MA plans are not required to submit these assessments, and we cannot determine what share of plans submits them or the possible bias in the assessments that are submitted.

16 A provider tax works as follows: A state taxes all nursing homes and uses the collected amount to help finance the state's share of Medicaid funds. The provider tax increases the state's contribution, which, in turn, raises the amount of federal matching funds. The augmented federal funds more than cover the cost of the provider tax revenue, which is returned to providers. The provider tax is limited to 6 percent of net patient revenues.

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Attachment 5

Report in Brief

Date: September 2018
Report No. A-01-15-00500

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Review

Our prior reviews have found that some hospitals did not comply with Medicare coverage and documentation requirements for inpatient rehabilitation facilities (IRFs). The Centers for Medicare & Medicaid Services' (CMS's) Comprehensive Error Rate Testing (CERT) program found that the error rate for IRFs increased, ranging from 9 percent in 2012 to a high of 62 percent in 2016.

Our objective was to determine whether IRFs complied with Medicare coverage and documentation requirements for fee-for-service (FFS) claims for services provided in 2013.

How OIG Did This Review

Our audit covered \$6.75 billion in Medicare payments to 1,139 IRFs nation-wide for 370,872 IRF stays. We selected for review a stratified random sample of 220 IRF claims (IRF stays) totaling almost \$11.3 million in payments to 164 IRFs for calendar year 2013, the most recent claims data available at the time the audit started. We used an independent medical review contractor to determine whether the medical records for the sampled IRF stays met coverage requirements. In addition, we determined whether the medical records complied with Federal documentation requirements.

Many Inpatient Rehabilitation Facility Stays Did Not Meet Medicare Coverage and Documentation Requirements

What OIG Found

IRFs complied with all Medicare coverage and documentation requirements specified for reasonable and necessary care for 45 of the 220 sampled stays. However, for 175 of the sampled stays, corresponding to 135 IRFs, medical record documentation did not support that IRF care was reasonable and necessary in accordance with Medicare's requirements. These errors occurred because many IRFs did not have adequate internal controls to prevent inappropriate admissions; Medicare Part A FFS lacked a prepayment review for IRF admissions; CMS's extensive educational efforts and postpayment reviews were unable to control an increasing improper payment rate reported by CERT since our 2013 audit period; administrative law judge (ALJ) hearings for IRF appeals did not always involve CMS participation to ensure that Medicare coverage and documentation requirements were accurately interpreted; and the IRF payment system did not align cost with payments, which may have provided IRFs with a financial incentive to admit patients inappropriately.

On the basis of our sample results, we estimated that Medicare paid IRFs nation-wide \$5.7 billion for care to beneficiaries that was not reasonable and necessary.

What OIG Recommends and CMS's Comments

We recommend that CMS (1) educate IRF clinical and billing personnel on Medicare coverage and documentation requirements and work with providers to develop best practices to improve internal controls; (2) increase oversight activities for IRFs, such as postpayment medical review; (3) work with the Office of Medicare Hearings and Appeals to ensure that Medicare coverage and documentation requirements for IRF care are fairly represented at ALJ hearings; and (4) reevaluate the IRF payment system, which could include a demonstration project requiring preauthorization for Medicare Part A FFS IRF stays modeled on Medicare Advantage practices, a study of the relationship between IRF PPS payments and costs and take any necessary steps to more closely align them, and a consideration of the high error rate found in this report and CERT reviews in future acute inpatient rehabilitation service payment reform. In their written comments to our draft, CMS concurred with our recommendations, described actions that it planned to take to address them, and reiterated its commitment to providing Medicare beneficiaries with high-quality healthcare while preventing improper payments.

Report in Brief

Date: February 2019

Report No. A-05-16-00043

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Review

According to section 1861(i) of the Social Security Act, to be eligible for coverage of posthospital extended care services, a Medicare beneficiary must be an inpatient in a hospital for not less than 3 consecutive calendar days (3-day rule) before being discharged from the hospital. Prior OIG reviews estimated that \$169 million in Medicare payments for skilled nursing facility (SNF) services did not meet the 3-day rule in calendar years (CYs) 1996 through 2001. Though the Medicare contractors generally agreed with our findings, the Centers for Medicare & Medicaid Services (CMS) told the SNFs not to recover improper payments because CMS could not determine whether SNFs were “at fault” in not meeting the 3-day rule.

Our objective in this followup review was to determine whether CMS paid SNF claims with dates of service during CYs 2013 through 2015 when the 3-day rule was not met.

How OIG Did This Review

Our review covered \$134.9 million in Medicare payments for more than 22,000 SNF claims for beneficiaries who had preceding acute-care inpatient hospital stays of less than 3 consecutive calendar days. We selected a random sample of 100 SNF claims with payments totaling \$779,419. We reviewed Common Working File (CWF) records and medical records submitted by the SNFs and associated hospitals for the sampled claims.

CMS Improperly Paid Millions of Dollars for Skilled Nursing Facility Services When the Medicare 3-Day Inpatient Hospital Stay Requirement Was Not Met

What OIG Found

CMS improperly paid 65 of the 99 SNF claims we sampled when the 3-day rule was not met. Improper payments associated with these 65 claims totaled \$481,034. On the basis of our sample results, we estimated that CMS improperly paid \$84 million for SNF services that did not meet the 3-day rule during CYs 2013 through 2015.

We attribute the improper payments to the absence of a coordinated notification mechanism among the hospitals, beneficiaries, and SNFs to ensure compliance with the 3-day rule. We noted that hospitals did not always provide correct inpatient stay information to SNFs, and SNFs knowingly or unknowingly reported erroneous hospital stay information on their Medicare claims to meet the 3-day rule. We determined that the SNFs used a combination of inpatient and non-inpatient hospital days to determine whether the 3-day rule was met. In addition, because CMS allowed SNF claims to bypass the CWF qualifying stay edit during our audit period, these SNF claims were not matched with the associated hospital claims that reported inpatient stays of less than 3 days.

What OIG Recommends and CMS Comments

CMS should ensure that the CWF qualifying inpatient hospital stay edit for SNF claims is enabled when SNF claims are processed for payment. In addition, CMS should require hospitals to provide beneficiaries a written notification of the number of inpatient days of care provided during the hospital stay and whether the hospital stay qualifies subsequent SNF care for Medicare reimbursement so that beneficiaries are aware of their potential financial responsibility before consenting to receive SNF services. CMS should require SNFs to obtain a written notification from the hospital and retain it as a condition of payment for their claims. Further, CMS should educate both hospitals and SNFs about verifying and documenting the 3-day inpatient hospital stay relative to supporting a Medicare claim for SNF reimbursement.

CMS concurred with our recommendations concerning the CWF qualifying inpatient hospital stay edit and educating hospitals and SNFs but did not concur with the remaining recommendations related to a coordinated notification mechanism among hospitals, beneficiaries, and SNFs. After reviewing CMS’s comments, we maintain that our findings and recommendations are valid. Without a coordinated notification mechanism, CMS will continue to make improper payments when the 3-day rule is not met.

Attachment 6

License Verification Details

SUBJECT TO TERMS AND CONDITIONS

Information current as of: 10/23/2019

Session: 2019-10-23 02:52:04.546 | 73.25.214.71 /wq01wghk5b3cs1dt4gxpvtqko



This site is a primary source for verification of license credentials consistent with Joint Commission and NCQA standards.

Lawlor, Jennifer Kathleen, MD

Gender: Female

Address Type	City	County	State	Phone
Practice	Portland	Multnomah	Oregon	503-413-6294

License

Number: MD20535

License Type: MD License

Originally Issued: 07/18/1997

Current Status: Active

Status Effective: 1/1/2018

Expires: 12/31/2019

Expedited Endorsement: No

Basis: Combination

Specialty : Physical Medicine & Rehabilitation

Specialty is self-reported by the licensee. It does not necessarily indicate specialty board certification. Check directly with the Specialty Member Board for current certification status.

Dispensing: Yes

Supervising Physician Status: Not Approved

Future Status : Active

Begins: 01/01/2020

Expires: 12/31/2021

Other Licenses

License Number	Effective Date	Expiration Date	License Type
LL07588	07/09/1997	07/18/1997	MD Special License

Education

School Name	Location	Degree Date	Degree Earned
U/CA SAN FRANCISCO SCH/MED	SAN FRANCISCO, CA United States	06/13/1993	MD

Post-Graduate Training

Training	School Name	Location	From	To	Specialty
Internship	U/CA SAN FRANCISCO PROG	SAN FRANCISCO, CA United States	06/1993	06/1994	Internal Medicine
Residency	STANFORD UNIV HSP	STANFORD, CA United States	07/1994	06/1997	Physical Medicine & Rehabilitation

The licensee may have completed additional education or training programs. Only those that have been verified with the primary source are shown.

Board Orders

Please note that Corrective Action Orders, Corrective Action Agreements, and Consent Agreements are public records, however they are not disciplinary and are removed from this website upon completion. Copies of any public Orders or Agreements are available through a license verification request .

There are no current or prior Board orders or agreements on file for this licensee.

Malpractice

Malpractice claim information is compiled by the Oregon Medical Board from claim reports it receives from primary insurers; public bodies required to defend, save harmless and indemnify an officer, employee or agent of the public; a self-insured entity; or a health maintenance organization. Claim reporting and disclosure requirements are governed by ORS 742.400.

The settlement of a medical malpractice claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the provider. Therefore, there may be no disciplinary action appearing for a licensee, even though there is a closed malpractice claim on file. A payment in the settlement of a medical malpractice action does not create a presumption that medical malpractice occurred. This database represents information from reporters to date. Please note: Not all reporters may have submitted claim information to the Board.

For malpractice claim information, [click here](#).

Oregon Medical Board

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Statement in opposition to Post Acute Medical of Portland application

Oregon Health Authority must deny the PAM application for a 50-bed inpatient rehabilitation facility (IRF) because the applicant has not met the required burden of proof required to justify such a facility under the Oregon certificate of need laws. Basic criteria for reviewing this project are provided in OAR 333, division 580. The specific need methodology and standards for demonstrate of need for acute inpatient beds and facilities are found in OAR chapter 333, division 590. The specific need methodology and standards for demonstration of need for inpatient rehabilitation beds are found in OAR chapter 333, division 645. Post Acute Medical (PAM) has not met the requirements of these rules.

Further, the PAM proposal does not support Oregon's Triple Aim; better health, better care, lower cost.

Need for the proposed facility; OAR 333-580-0040; OAR 333-590-0050; 333-645-0030

1. Does the service area population need the proposed project? No, applicant has not met its burden to identify the past, present and future bed-need within the proposed service area.

- PAM asserts a service area of seven northwest Oregon counties and two in Washington. OHCA disputes this service area determination. Pursuant to analysis by OHA through Steve Robison, indicating that service area is at least in large part determined by area hospital discharges and inpatient flow need not be considered, this expansive service area is unrealistic. See, IRF Need Analysis Notes, Robison, July 15, 2019) Even looking at hospital discharges, it is unreasonable, for example, to conclude that a hospital in Cowlitz County, Washington, will discharge significant numbers of rehabilitation patients to Tigard, Oregon, which is 71 miles away and 2 hour's drive time in light traffic.
- PAM has not met the standards for both a general acute care bed need and for specific inpatient rehabilitation need.
- The CN rules do not differentiate between types of inpatient beds when assessing need. All proposed new inpatient facilities are required to demonstrate a need for general acute care beds. Applicant has not attempted to show a need for additional acute care beds, but rather has attempted to show there is not a need for more inpatient rehabilitation beds in an acute care setting.
- Applicant may assert that inpatient rehabilitation beds are sufficiently different from general inpatient acute care beds that the need cannot be met through acute care beds and so they need not be measured. That argument denies the current existence of rehabilitation beds in two area acute care hospitals, Legacy Health System and Providence St. Vincent.

- The CN rules demonstrate a strong preference for use of existing beds over construction of new beds. OAR 333-645-0030; OAR 333-580-0050; 333-590-0060
- Existing acute care rehabilitation beds are meeting the current and future need for such beds:
 - Several area hospitals offer inpatient rehabilitation beds. The existence of, location and experience at these facilities demonstrates lack of current actual need.
 - Legacy Health System operates an inpatient rehabilitation facility in Multnomah County, only 10 miles from the proposed PAM site. Testimony at the October 15 hearing indicates this facility offers 36 beds and those beds are only 60% occupied. This occupancy level has been consistent over time. If PAM's need calculation were correct, the Legacy beds would be filled beyond 60%.
 - In addition to the Legacy facility, Providence Health System operates a rehabilitation unit at their Providence Portland site, offering 18 beds. This facility is just eight miles from the proposed PAM site
 - These area hospitals may increase their inpatient rehabilitation beds without going through certificate of need process if there is actual need for additional rehabilitation beds. OAR 333-550-0010
- Applicant's need demonstration further fails because area referral sources do not assert a need for new rehabilitation beds and likely would not discharge their patients there:
 - Rehabilitation patients typically are discharged to nursing facilities from area hospitals. No hospitals in the service area or other referral sources such as payors testified that they need additional sites to which to refer, including hospitals in Washington County; Kaiser Westside Medical Center, Tuality Community Hospital and Providence St. Vincent.
 - Major hospitals in the area likely will not discharge to PAM.
 - We understand that Kaiser Westside Medical Center, one of the largest hospitals in the service area, has a contract with another existing inpatient rehabilitation unit to care for its discharged patients so likely would not discharge to PAM.
 - Providence St. Vincent likely will not discharge to PAM as it operates its own inpatient rehabilitation unit.
 - Legacy Health System similarly will utilize its own inpatient rehabilitation unit.
 - While PAM indicates it had conversations with "payors," it also indicates any willingness to contract is based on reasonable rates. Medicare Managed Care plans are unlikely to contract with IRFs because similar services are currently available in area nursing

facilities at lower cost. See AGERIGHT Care Management Solutions submitted testimony.

- Applicant may assert that their showing of future need, based changing demographics, requires construction of beds now to meet that later surge need. This argument fails because:
 - There is no sufficient current need or Medicare payment source, as demonstrated in this document, to maintain a viable IRF now so future need is not relevant.
 - OAR 333-645-0030(2) provides that priority is to be given to expansion of existing facilities over building of new beds.
 - The potential surge need can be met with existing licensed bed capacity in area nursing facilities, or these facilities generally could expand their licensed capacity without going through the certificate of need process (OAR 333-550-0010; note some limitations in law).
 - Area hospitals also may increase their inpatient rehabilitation beds without going through certificate of need process. OAR 333-550-0010

2. Has applicant affirmatively demonstrated that there is not a more efficient, cost effective alternative to the proposed facility?

No, applicant has not demonstrated this key factor. Without a need for general acute care beds, applicant must now apply the rules specific to inpatient rehabilitation facilities. These rules require applicants to evaluate need in a manner *consistent, where applicable*, with the methods and principles established in OAR 333-590-0030 to 333-590-0060 (OAR 333-645-0030(4) and demonstrate that their proposed services are the least costly of any reasonable alternatives (OAR 333-645-020(1)). These key words, emphasized, indicate that applicant is not required to strictly adhere to the acute care bed need analysis expressed in OAR 333-590. Rather, a rational approach is required that promotes the principle expressed in the specialty inpatient rehabilitation rules, that rehabilitation units should provide the least restrictive and most cost-effective setting possible to meet patient needs. This approach also honors the goals of the certificate of need program, to promote effective, lower cost health care through encouraging less expensive, more accessible alternatives to care. See, analysis supporting Newco decision #675. Applicants must demonstrate that their proposed services are the least costly of any reasonable alternatives. (OAR 333-645-020(1))

OHA further states in its analysis supporting the Newco decision #675 that, under OAR 333-590-0060, applicant is required to evaluate the use of non-inpatient alternatives for its proposal when general inpatient need is not shown under OAR 333-590-0050 or OAR 333-590-0060.

PAM rejects area nursing facilities as an effective alternative. It is incorrect in this assessment and cannot demonstrate there is actual need for inpatient rehabilitation beds in the service area:

- This approach is directly contrary to the rational approach directed by both the rules and OHA interpretation.

- Based on the state's nursing facility data, there are 56 nursing facilities with 4,541 licensed beds that are able to offer therapy services in the tri-county area. The average occupancy across the three counties is 71%. In the seven-county service area inappropriately asserted by PAM, there are 64 facilities with 5,077 beds. These facilities present the least restrictive and most cost-effective setting possible to meet patient needs and must be considered as a rational alternative to new IRF beds.
- Similar to the psychiatric hospital at issue in the Newco decision, CN#675, alternatives to specialty inpatient rehab beds are available as nursing facilities have increasingly moved to caring for higher acuity, short stay patients in response to state direction. See, OHCA and Marquis submitted testimony and discussion herein.
- PAM does not successfully demonstrate that these nursing facilities should not be considered when assessing need for rehabilitation beds:
 - PAM provides only national data when asserting that Oregon nursing facilities should not be considered as an alternative. For the reasons expressed in this document and other submitted testimony, that data does not present an accurate picture and indicates a fundamental misunderstanding of the Oregon marketplace.
- Oregon nursing facilities care for higher acuity patients than nationally, including many patients with the same diagnoses as served in IRFs.
 - The state allow allows nursing facilities to care for these patients, defining a nursing facility as an establishment with permanent facilities, including inpatient beds, that provides medical services..." (OAR 411-085-0005).
 - Nursing facilities function in much the same way as an IRF in that virtually all admissions come from hospital discharges. See, OHCA hearing testimony, Mendez-Luck, Luck, Mahakalanda, Govier, *The State of Nursing Facilities in Oregon, State Fiscal Year 2018*, Oregon State University, College of Public Health and Human Sciences, 2019.
 - Nursing facilities do care for rehabilitation patients. See submitted testimony by nursing facilities in the service area and *The State of Nursing Facilities in Oregon, State Fiscal Year 2018*.
 - Nursing facilities provide extensive therapy services. Marquis has submitted testimony regarding its extensive therapy services and even PAM notes in its application that use of ultra-high therapy days in nursing facilities in the area is high relative to national and state benchmarks. See, Dr. Kolonic's testimony.
- CMS and MedPAC believe patients currently cared for in IRFs can also receive similar therapy care in a nursing facility:

- In the FY 2020 SNF PPS Final Rule 84 FR 38746, CMS standardized the definition of group therapy services between SNFs and IRFs as follows: “...in an effort to support CMS’ cross-setting initiatives under the IMPACT Act and Meaningful Measures Initiative, we looked at ways to align the definition of group therapy used under the SNF PPS more closely with the definitions used within the...IRF PPS, as this type of standardization would reduce administrative burden on providers by utilizing the same or similar definitions across settings...we stated that *given the greater degree of similarity between the IRF and SNF settings in terms of the intensity of therapy and patient acuity*, we believe that the IRF PPS definition would be more appropriate in the SNF setting.” (emphasis added)
- MedPAC, in its 2016 report, stated in an endnote on page 103, “In an analysis of 22 conditions frequently treated by IRFs and SNFs, beneficiaries had similar risk profiles (or the lower cost SNF patients had higher risk profiles)...the Post-Acute Care-Payment Reform Demonstration conducted by CMS found considerable overlap in the patients treated....”
- Based upon IMPACT Act requirements, CMS has applied the same functional outcomes quality measures to SNF as had been applied to IRFs to permit comparison of outcomes across settings.
- Nursing facilities in the service area offer significantly more available beds than PAM indicates in its application will be necessary, now and in the future, even applying PAM’s overly broad service area. See the number of nursing facilities, beds and occupancy cited above.
- We note that OHA, through analysis by Mr. Robison, calculates an assumed need of 126 beds. This evaluation is based on area hospital discharges. As indicated, nursing facilities receive virtually all admissions through area hospital discharges. As there has been no testimony, either written or oral, that rehabilitation patients are not being cared for in the service area (other than limited evidence of need for treatment of brain trauma patients) it is safe to assume these patients are discharged to existing hospital-based IRFs and nursing facilities for care.
- Nursing facilities are a more cost-effective provider of rehabilitation services in the service area.
 - PAM cites a nursing facility cost per stay of over \$28,000 when asserting its proposed IRF is less expensive. That calculation, however, is based on misapplied and outdated information. PAM cites a 2016 report that calculates the cost of orthopedic patients who stay for an average of 31 days.
 - The average length of stay in area nursing facilities is less than that, as demonstrated in submitted data, and just calculating cost based on orthopedic patients does not capture the full diversity of rehabilitation patients. Using Marquis facilities as an example (see their submission), the average cost from all payors of a nursing facility stay is approximately \$13,000.

- As cited in the previously submitted OHCA testimony, the 2019 MedPac report indicates unanimous support for reducing IRF reimbursement as the current reimbursement is excessive.
- Nursing facilities provide quality services.
 - Notably, OAR 333-580-0050(1)(C) references “adequate quality” in the context of whether there is a reasonable alternative to the proposed facility. While OHCA asserts that nursing facilities services are of very good quality, that is not the standard they must meet to qualify as an alternative provider. PAM cites no data indicating the care provided by nursing facilities in the service area is of inadequate quality.
 - Nursing facilities are heavily regulated in both state and federal law. These regulations impose significant care and oversight requirements on providers. See, ORS chapter 441, OAR chapter 411, divisions 70-90; 45 CFR 483, including new and extensive federal nursing facility requirements of participation that require, among many other things, facility-based quality plans that measure and support quality of care.
 - Nursing facilities are subject to a five-star rating which measures, among other factors, information on 15 different physical and clinical measures for nursing facility resident quality of care. Almost 80% of nursing facilities in the tri-county region maintain a rating of 3-stars or better. (Consonus Copilot Report, October 30, 2019)
 - Medicaid payors typically contract with facilities with a 3 or higher rating.
 - Data cited by PAM for the proposition that IRFs provide better quality care is national data with no specific reference to Oregon. Oregon data submitted by providers in the service area, such as successful return to community rates and hospital readmission rates, indicate strong outcomes.
 - PAM cites an American Heart Association/American Stroke Association study for the proposition that an IRF is the evidence-based choice over nursing facilities. Again, this study did not consider Oregon nursing facilities and their uniquely high level of services. For example, it states as a distinguishing factor that IRFs offer at least three hours of rehabilitation a day from various therapists; see, the Marquis testimony that it averages 2.5 hours of therapy 5 days a week for its ultra-high rehab patients. It further states that nurses are continuously available in an IRF; they must be continuously available in a nursing facility pursuant to our staffing laws. They note that a doctor typically visits daily; nursing facilities have medical directors, one of which you heard from at the Oct. 15 hearing.
 - PAM also cites the Dobson, DeVanzo study, *Assessment of Patient Outcomes of Rehabilitative Care Provided in Inpatient Rehabilitation and after Discharge, 2014*. This study is national, not Oregon, and also acknowledges that its results

are not generalizable to the universe of SNF patients within the studied conditions. We also did not see indication that this study was peer reviewed.

- Nursing facilities provide much more convenient access to therapy care than would the PAM site.
 - Nursing facilities are scattered throughout the service area, providing easy access to care for patients as well as their families. See, submitted map showing dispersion of nursing facilities throughout the alleged service area.
- Contrary to PAM’s assertion, the recent implementation of the PDPM payment system will not change the availability of therapy services in area nursing facilities. As noted in the submission from the American Health Care Association, PDPM is just a payment system; it does not change the nursing facility benefit at all. Also, note that PDPM went into effect October, 2019, not 2018 as asserted by PAM.

Will sufficient qualified personnel, adequate land, and adequate financing be available to develop and support the proposed project; OAR 333-580-0050(2)?

1. Has PAM demonstrated, as required, that there will be sufficient numbers of caregiving personnel to support the proposal? **No.**
 - PAM indicates it believes there may be a nursing surplus in Oregon and thus staffing should not be a challenge. A review of the data provided, however, indicates this surplus is calculated as of 2030. Today, Oregon faces an ongoing, severe staffing shortage that PAM does not acknowledge. See the Marquis data and narrative for evidence of unfilled staff positions. Staffing challenges are a result of a grossly inadequate supply of caregiving staff in the area. There is no evidence this shortage will ease in the near future.

Applicant has not considered the health care marketplace it hopes to occupy and will disrupt that marketplace.

- OAR 333-580-0060 requires applicants to answer the question: Will the impact of the proposal on the cost of health care be acceptable? **PAM cannot answer this question with a “yes.”**
 - As discussed earlier in this document, the average cost of care for an IRF is much higher than for a nursing facility.
 - When insurers are forced to pay higher costs to providers, the cost to patients, through copays and coinsurance, commensurately increases.
- Will the proposed IRF thrive in the marketplace it proposes? **No.**

- In its application, PAM asserts it will achieve 75% occupancy by the third year of operation, as required. That is unlikely. Given the anticipated payor mix it describes in its application, PAM intends to limit its patients to Medicare fee for service and private pay patients. Given the saturation of managed care, finding sufficient patients to fill its beds is unlikely.
- PAM indicates that 78% of its patient days will be Medicare but does not seem to indicate what percentage, if any, of those patients will be Medicare managed care (it just indicates it will accept risk bearing contracts). The failure to even mention what levels of Medicare managed care it intends to accept indicates PAM fundamentally does not understand this marketplace. Oregon generally is a very high Medicare managed care state, and the tri-county area average 57% Medicare managed care. (see, AGERIGHT testimony)
 - Given available successful alternatives who are currently caring for rehabilitation patients, Medicare managed care plans are unlikely to contract with an IRF.
- Applicant likely intends to limit its patients to Medicare fee for service and private pay patients. Given the saturation of managed care, finding sufficient patients to fill its beds is unlikely. (See, AGERIGHT)

3. Will applicant support Oregon's triple aim? **No.**

- PAM proposes accepting a payor mix of only 2% Medicaid and 5-7% Medicaid managed care, and thus will not support Oregon's low-income population.
- By limiting its patients largely to fee for service and private pay, PAM will push low income patients and lower Medicare managed care reimbursement to area nursing facilities, causing those facilities to be less viable. Not only will this cause essential community providers to leave, it will cause access problems for vulnerable citizens in this area.

2. Will applicant promote fewer health care options in the service area? **Yes.**

- As noted above, PAM will pull away the higher reimbursement patients from existing essential community providers, likely leading to closure of those other community providers.
 - Note the already high percentage of Medicaid served in area nursing facilities. They cannot succeed with even higher numbers.

For all these reasons, and those expressed in prior submissions and by other opponents, OHCA urges the Oregon Health Authority to deny the PAM application.



November 4, 2019

11-04-2019 RCVD

Marquis Companies

On behalf of Marquis Companies, thank you for the opportunity to submit the attached data describing the patients our nursing facilities care for in the Multnomah, Clackamas and Washington county area. This data strongly supports our assertion that there is no need for additional rehabilitation beds in this area.

Post Acute Medical at Portland, LLC, (PAM) seeks to open a new 50-bed inpatient rehabilitation facility (IRF) in Tigard, Washington County. PAM asserts a service area for this new IRF that extends to include a seven-county area in northwest Oregon and two counties in Washington. Marquis believes this service area is overly broad, but even using this expansive service area we believe PAM cannot meet their burden of proof to show a need for the new facility.

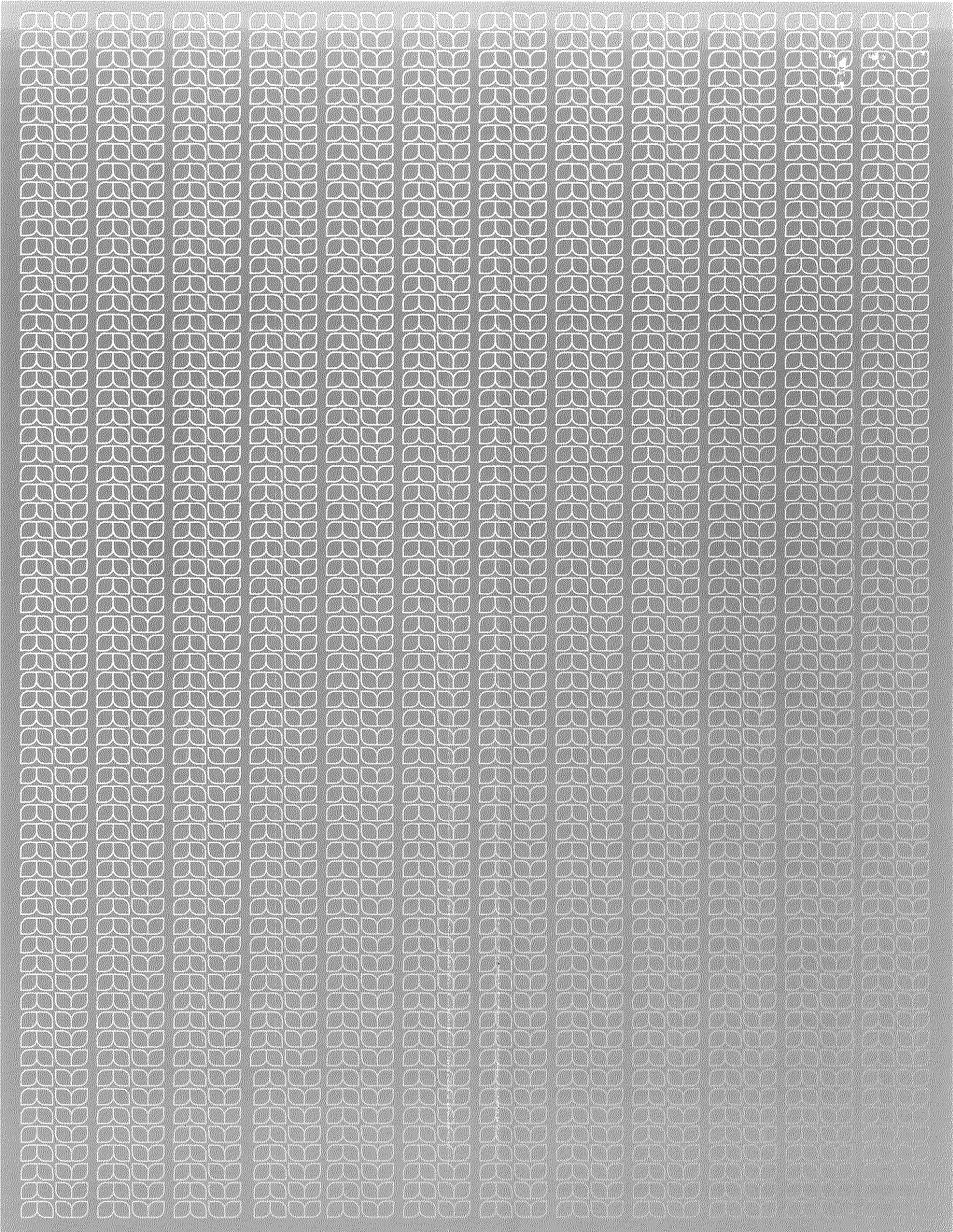
OAR 333-645-0030 provides the baseline requirement that the total need for inpatient rehabilitation services shall not exceed seven beds in 100,000 general population. Using that calculation combined with an assumed percentage of hospital discharges, PAM calculates the unmet rehabilitation need to be approximately 100 beds in 2017. Notably, Marquis operates 11 nursing facilities with 809 licensed nursing facility beds in the seven-county service area in Oregon. Of these, we average 82% occupancy.

OAR 333-580-0050 requires applicants to demonstrate that the proposed project represents the most effective and least costly alternative, considering all appropriate and adequate ways of meeting the identified needs. See also, OAR 333-590-0060. The data accompanying this memorandum demonstrate that the Marquis facilities alone, without even considering the many other nursing facilities in the region, meet the rehabilitation bed need for the service area.

We are submitting facility data to accompany this narrative and note that the data is for what we believe to be the more appropriate service area; Washington, Multnomah and Clackamas counties. See the OHCA submission for why this is the more appropriate service area. If the Oregon Health Authority would like data for all seven counties in the PAM designated service area, we are glad to provide it. We welcome your review of all the data we submit, but will highlight a few key numbers and their implications:

Our nursing facility beds serve patients with the same diagnoses served in inpatient rehabilitation facilities. See the attached data showing that an average of 37% of our short stay patients have the same primary diagnoses as those in the 13 required diagnosis categories inpatient rehabilitation facilities are subject to, with one facility serving as high as 49%. We believe that if we actually did a careful study of all diagnosis, (IRF -vs- SNF) the similar diagnosis codes would exceed 60%.

We provide therapy services to these patients every day. In Dr. Kolonic's written testimony we demonstrate that we average 2.4 hours for a five-day therapy week for residents in the "ultra-high" rehabilitation category and PAM itself notes that area nursing facilities provide higher levels of ultra-high therapy than other areas of the state or nationally. The large majority of our Marquis facility rehab



days are in this ultra-high category. Dr. Kolonic described the good work we do every day with these patients.

Reflecting this good work, our successful “return to community” rates for short stay patients are quite high, averaging 65%, and our hospital readmission rates are commensurately low.

Marquis is a much lower cost provider for the same services. PAM indicates it will accept a payor mix of only 2% Medicaid. Marquis facilities in the service area average almost 50%. We will care for these patients; PAM will not. PAM says it anticipates that 78% of its patient days will be Medicare but does not appear to indicate what percentage, if any, will be Medicare managed care. In contrast, Marquis has an average of 56% Medicare Advantage for its short stay days. By not even mentioning Medicare managed care, it appears PAM will generally rely on the higher cost Medicare fee for service or private pay to fund its services. We also know from other testimony submitted that MedPac considers inpatient rehabilitation facilities to be overpaid.

In addition to ignoring a successful existing resource, PAM will disrupt an already stressed labor market. We work hard every day to recruit and retain our essential caregivers, but our data nonetheless shows a significant number of unfilled positions. This is not because we are not dedicated to full staffing but rather that there simply are not the caregivers in the marketplace to hire. PAM will face the same challenge.

We have presented data that strongly supports rejection of the PAM application. In addition, we believe the Oregon “difference,” unrecognized by PAM in its application, requires Oregon Health Authority to deny the application. Specifically, the tri-county marketplace is different than nearly every other market in the country with regard to “need” for IRF services for the following reasons:

High penetration of Medicare Advantage coverage for the over 65 population in the tri-county area—57% coupled with Medicare Advantage payors clearly not being interested in contracting with IRF’s. This removes a material portion of the potential payor market for this IRF that is not seen in other markets where IRF’s drive occupancy.

In Oregon, we have no actual need for IRFs because, pursuant to unique state direction, nursing facilities already care for these patients. Oregon has a long history of supporting active community-based care options for seniors that has led to significantly lower occupancies in Oregon nursing facilities. We currently have the lowest nursing facility occupancy in the country (The State of Nursing Facilities in Oregon, 2017, OSU College of Public Health and Human Sciences, 2018) This has led to nursing facility operators gravitating to provide more extensive therapy / post-acute short stay episode services to seniors in an effort to remain economically viable. It is not surprising that Oregon has a very low inpatient rehabilitation facility referral rate. Approval of the PAM application, or any IRF application, would be in direct contradiction to Oregon’s policy direction.

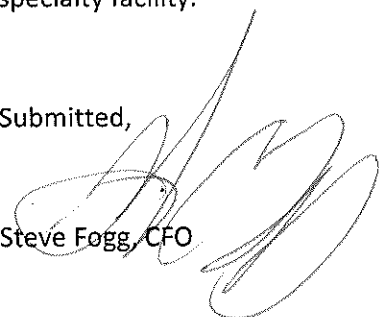
Consistent with this policy direction, nursing facilities in the tri-county area care for a high percentage of the IRF diagnosis episodes and achieve much more impressive outcomes.

Due to our impressive skilled nursing facility outcomes (hospital readmission rates, return to community success, etc.) the economic cost add of providing IRF services is more tangibly higher than in other markets. Length of stay may be shorter in an IRF, but the daily cost is significantly higher which leads to an overall episode cost of a greater magnitude in an IRF.

The services that IRF's traditionally provide are already being met in the tri-county area. The combination of the existing inpatient rehabilitation hospital units (Legacy Rehabilitation Institute of Oregon and Providence) and skilled nursing facilities, are more than meeting the needs. While there may be some extraordinary events / conditions that occur, where a higher level of service need is necessary, these cases are limited and will not drive a market demand level needed to warrant a specialty facility.

Submitted,

Steve Fogg, CFO

A handwritten signature in black ink, appearing to be 'S. Fogg', written over the printed name 'Steve Fogg, CFO'.

Data Info for IRF C O N Opposition
 Marquis Companies - Tri-County Area SNF's only

Facility	LOS for Short-Stay Episodes					Readmission Rates				Primary Referral/Admission Sources					Total Employees	
	Short-stay Episode % of Residents with Identical Primary Diagnosis Code as the 13 IRF codes	Occupancy Rate	MCR	MCR Adv	Combined	In Facility	30-day CMS	Successful Return to Community Rates	Hospital 1	Hospital 2	Hospital 3	% of Referrals/Admissions from Hospital	Medicaid Occupancy % to Total Occupancy	Medicare Advantage Days to total Short Stay days		# of unfilled open staff positions as of 9-30-19
Marquis Oregon City, Oregon City	38.57%	57.84%	22.92	22.41	22.52	11.51%	20.47%	55.40%	Providence Willamette Falls	Providence Milwaukie		90.78%	62.79%	66.85%	3	101
Marquis Hope Village, Canby	32.63%	92.00%	28.36	21.20	22.99	7.19%	14.16%	64.89%	Legacy Meridian Park	Providence Willamette Falls		95.63%	42.49%	54.39%	14	65
Marquis Wilsonville, Wilsonville	33.61%	84.00%	23.40	20.71	21.84	9.79%	17.08%	67.00%	Legacy Meridian Park	OHSU		93.42%	42.87%	62.68%	7	70
Marquis Centennial, Portland	37.18%	95.00%	24.96	23.03	23.67	14.02%	17.34%	57.33%	Providence Portland	Legacy Mt Hood	Legacy Good Sam.	96.36%	57.73%	67.25%	2	120
Marquis Mt Tabor, Portland	32.40%	72.50%	21.74	14.64	16.52	16.25%	20.21%	69.50%	Providence Portland	Legacy Emanuel	Legacy Good Sam.	94.99%	60.77%	66.97%	29	165
Marquis Mill Park, Portland	37.07%	92.59%	26.25	21.09	24.49	9.05%	12.88%	67.40%	Providence Portland	Adventist Health	OHSU	98.38%	9.38%	23.25%	5	120
Marquis Piedmont, Portland	38.72%	90.00%	21.27	17.50	18.96	10.77%	18.04%	56.00%	Legacy Emanuel	Legacy Good Sam	Providence Portland	88.85%	63.62%	47.85%	22	100
Marquis Vermont Hills, Portland	36.82%	76.71%	21.64	22.65	22.16	13.67%	17.54%	70.56%	Providence St. Vincents	OHSU	Legacy Good Sam.	94.87%	49.17%	46.12%	5	89
Marquis Tualatin, Tualatin	49.36%	88.89%	24.61	19.29	24.42	11.02%	18.93%	62.90%	Legacy Meridian Park	Providence St. Vincents	OHSU	96.04%	24.02%	46.91%	19	85
Marquis Forest Grove, Forest Grove	35.26%	80.95%	20.81	14.89	18.05	11.55%	16.10%	61.56%	Tuality Community Hosp.	Providence St. Vincents	OHSU	90.42%	57.90%	52.72%	5	80
Total	37.16%	80.73%	23.83	19.01	20.99	11.48%	17.28%	64.93%				93.98%	49.25%	56.32%	111	995

November 4, 2019

AgeRight Care Management Solutions

I am Lisa Hynes, Vice President of AgeRight Care Management Solutions. I am submitting this testimony on behalf of Marquis Advantage, Inc. dba: Ageright Advantage Health Plan. We provide Medicare Advantage insurance coverage for nearly 500 people receiving care in long-term care facilities in the State of Oregon, with the large majority of those residing in the Multnomah, Clackamas and Washington county service area.

We understand Oregon Health Authority has received two applications to open inpatient rehabilitation facilities in this area, Encompass and Post Acute Medical. The Authority should reject these applications because they propose a care and reimbursement model that is not sustainable and that we, and most other managed care entities, would not choose to contract with.

The greater Portland Tri-County service area maintains one of the highest Medicare Managed Care penetrations in the nation, at 57%. Encompass indicates it expects to accept only 7.7% Medicare Managed Care and Post Acute Medical will accept only between 5% and 7%. This level of acceptance means neither applicant is prepared to accept sufficient levels of Medicare Managed Care to meet the needs of the members the plans serve.

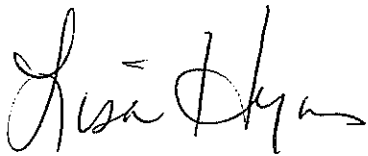
Further, Medicare Advantage plans would be challenged to contract with them because inpatient rehabilitation facilities provide much the same rehabilitation care we pay for now in nursing facilities but at a much higher price. We have no such facilities in Oregon now but, based on the reimbursement experienced nationally, we would be asked to agree to much higher rates than we currently pay to nursing facilities. Why would a managed care plan move our members to a new, higher cost, provider type when we have sufficient nursing facility beds available to serve our members and these nursing facilities provide rehabilitative care that fully meets and exceeds the quality standards our members have? Further, even if we were to agree to pay a higher price for no better care, our members would suffer because higher costs to plans typically also bring higher copays and coinsurance for our members.

We also know that inpatient rehabilitation facilities were recently criticized by the Office of Inspector General for engaging in significant levels of inappropriate billing and misrepresentation of services. This criticism is reflected in recent substantial settlements by both applicants for allegations of much the same behavior the OIG has noted. We have not experienced such fraudulent behavior in Oregon nursing facilities and, particularly in light of the disincentives discussed above, we would be very surprised if any Medicare Advantage plan would not find it challenging to engage with providers who present a known risk of illegal conduct.

Because it is unlikely these applicants would receive any significant Medicare Advantage contract, we believe they would either face quick closure or would push a disproportionate share of higher risk Medicare Advantage members to area nursing facilities for care. Either scenario is not good for members or the Portland Tri-County health care marketplace.

In summary, we believe approval of either or both of the applications to open inpatient rehabilitation facilities in this area would not provide any additional access to rehabilitation services for Medicare Managed Care members and would disrupt the marketplace for existing providers. Thank you for considering my testimony

Respectfully Submitted,



Lisa Hynes

Vice President, AgeRight Advantage Health Plan



EmpRes Healthcare Management, LLC

4601 NE 77th Avenue, Ste 300, Vancouver, WA 98662 • Ph. 360-892-6628 • Fax 360-882-5793

November 4, 2019

On behalf of the EmpRes Hillsboro Health and Rehabilitation Center and Portland Health and Rehabilitation, EmpRes Healthcare Management, LLC expresses its appreciation for the opportunity to submit this response to the Certificate of Need application submitted by Post Acute Medical. We assert that there is no need for additional rehabilitation beds in the Multnomah, Clackamas and Washington County area.

Post Acute Medical indicated during its testimony during the October 15 hearing that OHA may only consider other acute care beds when assessing need under the certificate of need administrative rules. It does not argue, and indeed cannot do so successfully, that there is the need for more acute care beds in the service area. It argues instead that there is a need for specialty rehabilitation beds and this need must be measured only against rehabilitation offered in acute care beds. In making this argument, it ignores the requirement in law that it must also demonstrate that there is not another acceptable alternative already available in the marketplace.

OAR 333-645-0030 provides the baseline bed per population requirement that the total need for inpatient rehabilitation services shall not exceed seven beds in 100,000 general population. Post Acute Medical calculates that this approach yields a current net bed need in the tri-county area of 73 beds, with 91 beds needed in 2028, and a need for 49 beds in Washington County. EmpRes and several other Skilled Nursing companies have significant operations in the service area, including Marquis, Avamere and Prestige. In total, there are 56 nursing facilities which offer 4554 beds to the community with an average occupancy rate of 73% in Multnomah County, 72% in Washington County and 69% in Clackamas County.

As is the case with other local nursing facilities, the EmpRes nursing facilities operating in the service area care for a high percentage of patients with the same diagnoses served by inpatient rehabilitation facilities ("IRFs") and provide very favorable outcomes.

The median short stay patient successful return to community rate for the EmpRes facilities operating in the service area is 61.3% and the median hospital readmission rate is only 18.6%. Although these rates may be a marginally less favorable than those of IRFs nationally, it is important to take into account that the EmpRes nursing facilities and other local nursing facilities provide these services at a much lower cost than what IRF are able to charge and these numbers include challenging diagnoses in addition to the 13 IRF diagnoses.

We accept a much higher percentage of Medicaid than what Post Acute Medical proposes (3%). This is an unreasonable expectation based on the demographics in the service area. In contrast, our Medicaid percentage is 85%. Similarly, we have very high levels of Medicare managed care than Post Acute Medical proposes; we average 6%. As we all know, Medicaid and Medicare managed care pay much lower rates than fee for service and private pay. Simply put, IRFs receive too much reimbursement for providing services that we provide for less. As confirmed through other testimony submitted, MedPac reported to congress that IRFs are overpaid and recommended that IRF Medicare reimbursements be reduced significantly.

It also cannot be understated how the introduction of additional IRFs in the service area will disrupt the health care marketplace. The labor market for nurses and other care providers is already at crisis level. It is a daily struggle to fill all shifts and the EmpRes nursing facilities in the service area have all recently had to resort to contracting with national temporary employment agencies to fill shifts. The IRFs will face the same challenges and will put further strain on the already stressed labor market.

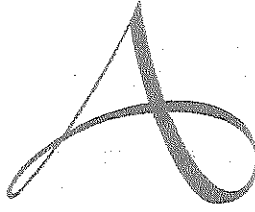
Further, access by populations relying on Medicaid and Medicare Advantage programs as a payor source for nursing services will be compromised by the introduction of new IRFs in the service area. As noted, the proposed IRF will serve very few Medicaid patients or Medicare Advantage patients, all of which reimburse for services at a much lower rate. As is the case with other nursing facilities in the service area, the majority of patients served EmpRes nursing facilities have Medicaid or Medicare Advantage plans as their primary source of payment. If the Medicare fee for service and private pay patients go elsewhere for services, this will threaten the viability of EmpRes and other nursing facilities in the service area, all of which typically operate much below capacity.

Accordingly, we urge the OHA to reject the Post Acute Medical proposal.

Sincerely,

A handwritten signature in cursive script, appearing to read "Misty Thomas".

Misty Thomas
Vice President of Clinical Operations



PART OF THE AVAMERE FAMILY
OF INDEPENDENT COMPANIES

25117 SW Parkway, Suite F
Wilsonville, Oregon 97070
503/570-3667
fax: 503/ 783-2481
lawlopardo@avamere.com

November 4, 2019

Avamere Family of Companies

Statement in opposition to the Post-Acute Medical of Portland application:

My name is Lawrence Lopardo and I am Chief Legal Officer for each company within the Avamere Family of Companies. Within this family of companies are a number of skilled nursing facilities in the Multnomah, Clackamas and Washington county area (the "Tri-County Area"). I am writing to strongly urge the Oregon Health Authority (the "OHA") to deny the inpatient rehabilitation facility application submitted by PAM Squared at Portland, LLC ("PAM"). Attached to this letter is data that details the demographics of the patients serviced by the Avamere skilled nursing facilities in the Tri-County Area, which data supports the argument that the PAM application should be denied. Thank you for the opportunity to present this data and to present our argument that there is no need for additional rehabilitation beds in the Tri-County Area.

Oregon's certificate of need administrative rules require that when evaluating an application for a certificate of need for additional acute beds in an area, there must be an assessment of the existing acute care beds in the area and whether there is a need for more acute beds in the service area. PAM has failed to make a persuasive argument that there is a need for more general acute care beds in the Tri-County Area. Further, the existing acute beds dedicated to inpatient rehabilitation services in the Tri-County Area are more than sufficient to service the current needs of the area. In fact, the excess capacity of Avamere facilities and other facilities in the area provides assurance that there are already sufficient beds for years to come, even as the Tri-County Area's population expands. As an example, Avamere facilities currently have approximately 610 licensed nursing facility beds in the Tri-County Area that average just under 85% occupancy. The excess occupancy of Avamere facility beds indicates a lack of need for additional beds.

The project proposed by PAM is simply unnecessary. When no acute bed need is demonstrated, applicants must look to the specific rules for inpatient rehabilitation facilities; OAR 333- 645. These

rules require applicants to evaluate need in a manner consistent, where applicable, with the methods and principles established in OAR 333-590-0030 to 333-590-0060 (OAR 333-645-0030(4) and demonstrate that their proposed services are the least costly of any reasonable alternatives(OAR 333-645-020(1)). Notably, OAR 333-645-0030 does not require strict adherence to the rules for demonstrating acute care bed need but rather just a rational application of those rules. As such, area nursing facility beds must be considered as a reasonable alternative to the proposed IRF beds. The data accompanying this memorandum demonstrate that the currently existing beds in the Tri-County Area, including the facilities within the Avamere Family of Companies, already meet the rehabilitation bed needs for the Tri-County Area, and do so in a more cost-effective manner than the proposed PAM beds.

We believe that the data that accompanies this letter will support our arguments and speak for itself. However, please allow us to call attention to a number of key findings revealed by our data:

- Avamere skilled nursing facility beds serve patients with the same diagnoses served in inpatient rehabilitation facilities. The attached data shows that between 21% to 32% of the short stay patients of Avamere facilities have the same primary diagnoses as those in the 13 required diagnosis categories inpatient rehabilitation facilities are subject to, and we can accept more.
- The “successful return to community” rates for short stay patients at Avamere facilities are quite high, ranging from 64% all the way up to 80%.
- Avamere facilities offer a much lower cost provider for the same services. PAM indicates it will accept a very low percentage of Medicaid patients, apparently well under 5%. The majority of Avamere facilities in the Tri County Area average over 50%. Avamere Crestview of Portland averages almost 73% Medicaid patients.
- Avamere facilities have an average of 68% Medicare Advantage for its short stay days. It does not appear that PAM has even attempted to assert how much Medicare Advantage they will take. In our opinion, the failure of PAM to address this need is evidence that PAM does not understand the marketplace. If the omission of a reference to Medicare Advantage was intentional, PAM’s plan is apparently to rely on the higher cost Medicare fee for service or private pay to fund its services.
- PAM will disrupt an already stressed labor market. While Avamere facilities expend significant efforts and resources in recruiting and retaining our essential caregivers, Avamere facilities in the Tri-County Area had 113 unfilled staff positions as of September 30, 2019. This struggle of finding a sufficient number of qualified caregivers is not specific to Avamere but is the norm across the industry in the Tri-County Area. There is no reason to expect that PAM will not face the same recruiting challenge.

To provide support to its shaky argument that additional acute beds are needed in the Tri-County Area, PAM attempts to broaden the service area to include seven counties. We believe that even PAM knows that it would be impractical to service such a geographically expansive area. The travel time required to traverse such an area is immense, and more local alternatives will almost always be selected. Further, it is very unlikely that hospitals will discharge a patient to a bed in a facility that is such a great distance away when alternatives exist right down the road. The service area proposed by PAM has not been set not out of practicality or reality, but rather as an argument that additional beds are needed. We see it as an admission that there is no evidence to support the argument that there is a

need for additional beds in the Tri-County Area, which is the actual geographic region that would be served by PAM were its application to be approved.

The data accompanying this letter support the rejection of the PAM application. The reality in the Tri-County area is that there is no need for more acute beds as there are already sufficient beds, and the existing beds are more cost-efficient than the proposed PAM beds. The services that inpatient rehabilitation facilities traditionally provide are already being met in the Tri-County Area. The needs that would be met by such additional IRF beds are already being met by the existing combination of inpatient rehabilitation hospital units (Legacy Rehabilitation Institute of Oregon and Providence Portland Medical Center) and skilled nursing facilities, with capacity left over. As such, the Oregon Health Authority must deny the application submitted by PAM.

Submitted,

DocuSigned by:


Lawrence Lopardo
Chief Legal Officer

Data Info for IRF CON Opposition

Avamere Companies - Tri-County Are SNF's only

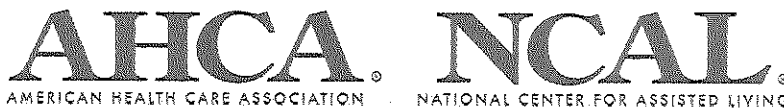
Date Range Oct 2018 - Sept 2019 (1 Year) Oct 2018 - Sept 2019 (1 Year) Oct 2018 - Sept 2019 (1 Year) Oct 2018 - Aug 2019 (1 Year) Sept 2018 - Aug 2019 (1 Year) Oct 2018 - Sept 2019 (1 Year) 2018 publicly reported rate Oct 2018 - Sept 2019 (1 Year)

Source Co-Pilot ??? "Patient Dx Data" SNF Scorecard (KRA Data) SNF Scorecard (PCC In and Out Data) SNF Scorecard (PCC In and Out Data) SNF Scorecard (PCC In and Out Data) Abaqis Abaqis Medicare.gov Abaqis

Facility	Short-stay Episode % of Residents with Identical Primary Diagnosis Code as the 13 IRF codes	Occupancy Rate (Using Available Beds)	LOS for Short-Stay Episodes				Readmission Rates			Successful Return to Community Rates
			MCR	MCR Adv	Combined	In Facility (Raw rate - All Payers)	In Facility (Risk Adjusted Rate - All Payers)	30-day CMS		
Avamere Rehabilitation of Clackamas	32.00%	80.20%	18.4	15.2	16.5	9.80%	8.90%	21.20%	80.00%	
Avamere Rehabilitation of Oregon City	24.00%	91.30%	18.7	15.7	16.7	14.70%	11.20%	17.60%	77.00%	
Avamere Rehabilitation of King City	28.00%	72.90%	21.2	16.4	18.3	12.10%	9.00%	16.70%	74.00%	
Avamere Rehabilitation of Beaverton	29.00%	83.70%	16.8	12.5	13.2	17.60%	14.00%	22.10%	72.00%	
Avamere Rehabilitation of Hillsboro	30.00%	86.70%	21.4	14.8	16.3	16.40%	12.70%	27.90%	78.00%	
Avamere Crestview of Portland	21.00%	77.40%	21.4	15.3	17.8	21.20%	19.60%	20.10%	64.00%	
The Pearl at Kruse Way	27.00%	92.20%	18.8	17.6	18.1	15.10%	12.70%	26.30%	80.00%	
Laurelhurst Village	25.00%	89.90%	17.4	14.4	15.1	20.50%	19.00%	23.20%	71.00%	
Total		84.90%	19.2	14.8	16.1					

Oct 2018 - Sept 2019 (1 Year) Oct 2018 - Sept 2019 (1 Year) Oct 2018 - Sept 2019 (1 Year) As of 9/30/2019 As of Sept 2019
 IN and Out/ PCC IN and Out/ PCC KRA Automated (PCC) (Medical Census / Total Census) KRA Automated (PCC) Open Positions Report. Includes all Nursing and Non-Nursing open positions. UltiPro

Hospital 3	% of Referrals/Admissions from Hospital	Medicaid Occupancy % to Total Occupancy	Medicare Advantage Days to total Short Stay days	# of unfilled open staff positions as of 9-30-19	Total Employees
Providence Willamette Falls Hospital	97.22%	58.73%	57.99%	12	56
Legacy Meridian Park Hospital	95.84%	63.11%	68.26%	7	77
OHSU	87.74%	59.73%	57.61%	12	70
Kaiser Sunnyside Medical Center	96.60%	55.35%	84.55%	12	108
Providence St Vincent Medical Center	96.12%	38.58%	73.82%	5	106
Providence St Vincent Medical Center	95.61%	72.70%	56.65%	20	105
OHSU	96.11%	4.40%	57.10%	25	120
Legacy Emanuel Medical Center	95.21%	58.07%	73.23%	20	191
	95.38%		68.09%	113	833



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October 30, 2019

To The Oregon Health Authority:

The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) represents nearly 14,000 non-profit and proprietary skilled nursing centers, assisted living communities, sub-acute centers and homes for individuals with intellectual and developmental disabilities. Each day, our members provide essential housing and health care services to residents in nearly 1.07 million skilled nursing facility (SNF) beds and more than 255,000 assisted living beds.

With such a membership base, the Association represents the majority of SNFs and a rapidly growing number of assisted living communities. By delivering solutions for quality care, AHCA/NCAL aims to improve the lives of the millions of frail, elderly, and individuals with disabilities who receive long term or post-acute care in our member facilities each day.

We are writing this brief letter to dispel myths about the quality of rehabilitation care provided in SNFs as compared to Inpatient Rehabilitation Facilities (IRFs) well as the impact on SNF admission patterns and care now that the Centers for Medicare and Medicaid Services (CMS) has converted from the Medicare Part A SNF Prospective Payment System (PPS) Resource Utilization Groups, Version 4 (RUG-IV) payment model to the Patient Driven Payment Model (PDPM), effective October 1, 2019.

First and foremost, per CMS, PDPM represents a change in the payment classification model, not the SNF benefit. As stated in the FY 2020 SNF PPS Final Rule, "*PDPM... improves the overall accuracy and appropriateness of SNF payments by classifying patients into payment groups based on specific, data-driven patient characteristics*" (84 FR 38734). PDPM does not disincentivize SNFs from admitting beneficiaries with intensive therapy needs, but more accurately allocates payments based on their therapy needs by separating the single blended therapy component under RUG-IV into the three separate Physical Therapy, Occupational Therapy, and Speech-Language Pathology case-mix adjusted components under PDPM. For example, SNF PPS therapy component payments for beneficiaries with clinical characteristics typically requiring intensive therapy services from all three therapy disciplines, such as after suffering a stroke and presenting with hemiplegia and swallowing and speech disorders will receive more adequate payments under PDPM than under RUG-IV.

Additionally, Chapter 8, Section 30 of the Medicare Benefit Policy Manual (Pub. 100-02) has not been updated since January 2014 and continues to state that to be covered, the services provided to a SNF resident must be "*...reasonable and necessary for the treatment of a patient's illness or injury, that is, are consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice.*" Additionally, CMS has indicated that, in addition to current SNF Quality Reporting Program (QRP) and Value-Based Payment (VBP) penalties that could apply to substandard care, CMS will also be monitoring SNF therapy utilization and quality outcomes measures closely as PDPM is implemented.

The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) represent nearly 14,000 non-profit and proprietary skilled nursing centers, assisted living communities, sub-acute centers and homes for individuals with intellectual and developmental disabilities. By delivering solutions for quality care, AHCA/NCAL aims to improve the lives of the millions of frail, elderly and individuals with disabilities who receive long term or post-acute care in our member facilities each day.

Secondly, CMS continues the process of implementing the IMPACT Act of 2014 requirements to standardize regulations, assessments, and quality measurement across post-acute settings including SNFs and IRFs. For example, in the FY 2020 SNF PPS Final Rule 84 FR 38746, CMS standardized the definition of group therapy services between SNFs and IRFs as follows: “...in an effort to support CMS’ cross-setting initiatives under the IMPACT Act and Meaningful Measures Initiative, we looked at ways to align the definition of group therapy used under the SNF PPS more closely with the definitions used within the...IRF PPS, as this type of standardization would reduce administrative burden on providers by utilizing the same or similar definitions across settings...we stated that given the greater degree of similarity between the IRF and SNF settings in terms of the intensity of therapy and patient acuity, we believe that the IRF PPS definition would be more appropriate in the SNF setting.”

Additionally, it is important to note that in previous rulemaking, based upon IMPACT Act requirements, CMS has applied the same functional outcomes quality measures to SNF as had been applied to IRFs to permit comparison of outcomes across settings. The specific measures, listed in Table 12 of the FY 2020 SNF PPS Final Rule (84 FR 38755) are as follows:

- Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634)
- Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636).
- Application of the IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633).
- Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635).

Third, it must be noted that as part of the IMPACT Act Congress asked the Medicare Payment Advisory Commission (MedPAC) and CMS for guidance on the establishment of a unified prospective payment system (U-PAC) and develop a prototype design to standardize payments across all post-acute settings by 2023. In its June 2016 Report to Congress, MedPAC stated “Despite the overlap in patients, Medicare continues to pay considerably different rates for similar patients depending on the setting” (page 63). Additionally MedPAC stated in an endnote on page 103, “In an analysis of 22 conditions frequently treated by IRFs and SNFs, beneficiaries had similar risk profiles (or the lower cost SNF patients had higher risk profiles)...the Post-Acute Care-Payment Reform Demonstration conducted by CMS found considerable overlap in the patients treated...”

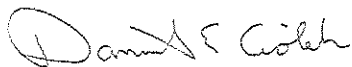
In general, the above three points all indicate that there is a great degree of similarity in the types of patients that receive rehabilitation services between SNFs and IRFs, that the patient assessment data and outcomes measures that each setting must adhere to are in alignment, and that the Congress, MedPAC and CMS recognize the similarities and that efforts are being made to standardize the payment models across post-acute settings. In addition, the introduction of the PDPM payment model in SNF in no way creates an environment where SNFs would seek fewer admissions for beneficiaries requiring rehabilitation services or that the quality of rehabilitation services will decrease because: 1) the payment model is more adequately aligned with patient care needs, 2) SNF benefit policies and skilled care requirements have not changed, 3) SNFs are subject to payment adjustment and other penalties if quality declines, and 4) CMS is closely monitoring the PDPM implementation process.

Finally, with respect to the key geographic locations most impacted by the SNF and IRF discussion in Oregon, the following table reflects that Medicare Part A is not the primary payor for SNF services in Clackamas, Multnomah, and Washington counties, but instead, Medicare Advantage Organizations (MAOs) are the primary payor for Medicare services. It is important to note that MAOs establish their own payment pricing models with each provider, which may or may not be similar to PDPM. However, SNF MAO providers remain subject to requirements to provide skilled care and provide quality outcomes to Medicare beneficiaries, and in many cases, cannot participate in MAOs unless their Medicare SNF 5-Star Quality Ratings are also at least 3 stars or better.

County Name	Medicare Eligible	MA Enrolled	Uptake
Clackamas	93,796	52,824	56.32%
Multnomah	141,090	76,441	54.18%
Washington	98,592	52,755	53.51%

In summary, we believe that any efforts to imply that SNFs are unwilling or unable to continue to provide quality rehabilitation services to patients in Oregon because of the implementation of the Medicare SNF PPS PDPM payment model on October 1, 2019 is unsupported by the evidence. We would be happy to provide additional supporting evidence or respond to any additional questions you may have.

Respectfully,



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 Washington, DC 20005
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Reference Links:

Medicare Program, Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2020.
<https://www.federalregister.gov/documents/2019/08/07/2019-16485/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities>

Medicare Benefit Policy Manual, Chapter 8
<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08.pdf>

Medicare Payment Advisory Commission. Report to Congress: Medicare Payment Policy. Chapter 3: Mandated Report: Developing a unified payment system for post-acute care. June 2016.
<http://www.medpac.gov/docs/default-source/reports/chapter-3-mandated-report-developing-a-unified-payment-system-for-post-acute-care-june-2016-report-.pdf?sfvrsn=0>

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<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAAdvPartDENrolData/index.html>

Inpatient Rehabilitation Facilities and Nursing Facilities: Overlapping Care and Services

Inpatient Rehabilitation Facility Requirements (2019 MedPAC Report)

Nursing Facility Requirements

<p>Admission: Must have a preadmission screening process to determine that each prospective patient is likely to benefit significantly from an intensive inpatient rehabilitation program.</p>	<p>Admission: May only admit residents if they can meet needs. Must perform both a baseline assessment of new resident and comprehensive person-centered assessment after the resident's needs are fully known.</p>
<p>Staffing: Must ensure that the patient receives close medical supervision and provides—through qualified personnel—rehabilitation nursing, physical therapy, occupational therapy, and, as needed, speech–language pathology and psychological (including neuropsychological) services, social services, and orthotic and prosthetic services.</p>	<p>Staffing: Must ensure that staffing meets acuity, range of diagnosis, and care needs of residents. (OAR 411-086-0110; 42 CFR 483.35) Nursing facilities routinely employ physical therapists, occupational therapists and other providers that are necessary to meet resident needs.</p>
<p>Medical director: Must have a medical director of rehabilitation with training or experience in rehabilitation who provides services in the facility on a full-time basis for freestanding IRFs.</p>	<p>Medical director: Must have a physician medical director that assists the facility to assure that adequate medical care is provided. (OAR 411-086-0220)</p>
<p>Interdisciplinary team: Use a coordinated interdisciplinary team led by a rehabilitation physician that includes a rehabilitation nurse, a social worker or case manager, and a licensed therapist from each therapy discipline involved in the patient's treatment.</p>	<p>Interdisciplinary team: Comprehensive care plan must be prepared by interdisciplinary team that includes at least an attending physician, RN, nurse aide, food/nutrition staff, and other staff as determined by resident need. (42 CFR 483.21) Nursing facilities employ broad spectrum of providers, including but not limited to social workers, activity directors, physical and occupational therapists, dieticians, RNs, and CNAs as necessary to meet resident care needs.</p>
<p>Must have a plan of treatment for each patient that is established, reviewed, and revised as needed by a physician in consultation with other professional personnel who provide services to the patient.</p>	<p>Must prepare preliminary care plan and comprehensive person-centered care plan upon resident admission. Plan must include therapy and rehab needs. Comprehensive care plans must be prepared by interdisciplinary team. Care plans must be updated at least quarterly or upon a change in resident condition. (42 CFR 483.21; OAR 411-086-0040; -086-0060)</p>
<p>Meet the compliance threshold, which requires that no less than 60 percent of patients admitted to an IRF have as a primary diagnosis or comorbidity at least 1 of 13 conditions specified by CMS.4.</p>	<p>Medicare covers skilled therapy services provided by skilled nursing facilities based on beneficiary's need for skilled care (Jimmo v. Sebelius settlement agreement, 2013). Significant percentages of nursing facility residents in the service area have one of the diagnoses specified by CMS.4.</p>

M A R C H 2 0 1 9

REPORT TO THE CONGRESS

Medicare Payment Policy

MEDPAC Medicare
Payment Advisory
Commission

R E C O M M E N D A T I O N

10 For 2020, the Congress should reduce the fiscal year 2019 Medicare base payment rate for inpatient rehabilitation facilities by 5 percent.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

.....
(Additionally, the Commission reiterates its March 2016 recommendations on the inpatient rehabilitation facility prospective payment system. See text box, p. 261.)

Inpatient rehabilitation facility services

Chapter summary

Inpatient rehabilitation facilities (IRFs) provide intensive rehabilitation services to patients after illness, injury, or surgery. Rehabilitation programs are supervised by rehabilitation physicians and include services such as physical and occupational therapy, rehabilitation nursing, speech–language pathology, and prosthetic and orthotic services. In 2017, Medicare spent \$7.9 billion on IRF care provided to fee-for-service (FFS) beneficiaries in about 1,180 IRFs nationwide. About 340,000 beneficiaries had around 380,000 IRF stays. On average, the Medicare FFS program accounted for 58 percent of IRF discharges.

Assessment of payment adequacy

Our indicators of Medicare payment adequacy for IRFs are positive.

Beneficiaries' access to care—Our analysis of IRF supply and volume of services provided and of IRFs' marginal profit under Medicare's IRF prospective payment system suggest that access remains adequate.

- *Capacity and supply of providers*—After declining for several years, the number of IRFs increased in 2014 and continued to grow through 2016, reaching 1,188 facilities nationwide. In 2017, however, the number of IRFs declined slightly, to 1,178 facilities. Over time, the number of hospital-based and nonprofit IRFs has declined, while the number

In this chapter

- Are Medicare payments adequate in 2019?
- How should Medicare payments change in 2020?

of freestanding and for-profit IRFs has increased. In 2017, the average IRF occupancy rate remained at 65 percent, indicating that capacity is more than adequate to meet demand for IRF services.

- *Volume of services*—From 2016 to 2017, the number of Medicare FFS cases declined 2.7 percent, falling to about 380,000 cases after having experienced small annual growth every year since 2010.
- *Marginal profit*—The marginal profit, an indicator of whether IRFs with excess capacity have an incentive to treat more Medicare beneficiaries, was 19.4 percent for hospital-based IRFs and 38.8 percent for freestanding IRFs—a very positive indicator of patient access.

Quality of care—The Commission tracks three broad categories of IRF quality indicators: risk-adjusted facility-level change in patients' functional and cognitive status during the IRF stay, rates of discharge to the community and to skilled nursing facilities, and rates of readmission to an acute care hospital. Most measures were steady or improved between 2012 and 2017.

Providers' access to capital—The parent institutions of hospital-based IRFs continue to have good access to capital. The major freestanding IRF chain, which accounted for almost half of freestanding IRFs in 2017 and about a quarter of all Medicare IRF discharges, also has good access to capital. This assessment is reflected in the chain's continued expansion. We were not able to determine the ability of other freestanding facilities to raise capital. IRFs' access to capital in large part depends on their total (all-payer) profitability, and in 2017, total margins for freestanding IRFs were 10.4 percent. Data on all-payer profitability are not available for hospital-based units, but we can examine the all-payer margins of hospitals with IRF units, which, in 2017, had an aggregate all-payer margin across all lines of business of 7.0 percent.

Medicare payments and providers' costs—The aggregate Medicare margin for IRFs has grown steadily since 2009. In the three-year period between 2015 and 2017, the aggregate IRF Medicare margin remained above 13 percent and in 2017 stood at 13.8 percent. Also in 2017, Medicare margins in freestanding IRFs were 25.5 percent, down slightly from their peak in 2015 of 26.7 percent. In 2017, hospital-based IRF margins were comparatively low at 1.5 percent, but one-quarter of hospital-based IRFs had Medicare margins greater than 11 percent, indicating that many hospitals can manage their IRF units profitably. Lower margins in hospital-based IRFs were driven largely by higher unit costs. In addition, there are notable differences in hospital-based and freestanding IRFs' mix of cases, which may indicate differences in profitability across case types. Finally, while

not definitive, evidence indicates that IRFs' assessments of patients' motor and cognitive function are not reliably consistent across providers. To the extent that hospital-based IRFs routinely assess their patients as less disabled than do their freestanding counterparts, their payments—and margins—will be systematically lower.

Growth in IRFs' costs historically has been low. From 2009 to 2015, the cumulative growth in cost per discharge was 8.4 percent, well below the 13.5 percent increase in the market basket for IRFs over the period. In 2016, per case cost growth (3.6 percent in aggregate) exceeded payment growth (2.9 percent in aggregate) for the first time since 2008. In 2017, however, per case payments again grew faster than costs (3.4 percent compared with 2.8 percent), resulting in an aggregate IRF margin of 13.8 percent. In 2018 to 2019, we anticipate costs in IRFs will grow faster than payments since updates in those years were constrained to 1.0 percent and 1.35 percent, respectively. For 2019, we project an aggregate Medicare margin of 11.6 percent.

This year, the Commission for the first time examined the financial performance of relatively efficient IRFs. Our analysis found that relatively efficient IRFs performed better on quality metrics and had costs 18 percent lower than other IRFs. Relatively efficient IRFs were on average larger and had higher occupancy rates, contributing to greater economies of scale and lower costs. Freestanding and for-profit facilities were more likely to be in the relatively efficient group.

On the basis of these factors, the Commission recommends a 5 percent reduction to the IRF payment rate for fiscal year 2020. In addition, the Commission reiterates its March 2016 recommendations that (1) the high-cost outlier pool be expanded to further redistribute payments in the IRF payment system and reduce the impact of misalignments between IRF payments and costs and (2) the Secretary conduct focused medical record review of IRFs that have unusual patterns of case mix and coding and conduct other research necessary to improve the accuracy of payments and protect program integrity. ■

Questions loom over proposed Carmel rehabilitation hospital

May 22, 2019 | John Russell

KEYWORDS CARMEL / DEVELOPMENT/REDEVELOPMENT / HAMILTON COUNTY / HEALTH CARE & INSURANCE / HEALTH CARE & LIFE SCIENCES / HOSPITALS / PROPOSALS / REAL ESTATE & RETAIL / REGIONAL NEWS / SPECIALTY HOSPITALS



Two out-of-state companies say they want to jointly build a 60-bed rehabilitation hospital in Carmel to help patients recover from brain injuries, strokes and other serious conditions.

But the companies seem to have their own ailments, including a history of mass layoffs, at least one high-profile bankruptcy, and accusations of kickbacks and billing irregularities, according to an IBJ review.

It's unclear how far along the Carmel project is, because the developers have not yet filed a site plan nor applications for building permits, which are required for new construction, a city of Carmel spokesman said. Nor have they applied to the Indiana State Department of Health for a hospital license.

Nevertheless, the partners—Medistar Corp., based in Houston, and Post Acute Medical LLC, based near Harrisburg, Pennsylvania—rolled out the project on May 9 as if it were a done deal. They said the facility, which they are calling the PAM Rehabilitation Hospital of Indianapolis, would treat “patients with complex conditions,” including traumatic brain injury, stroke or neurodegenerative disorders, such as Parkinson’s disease.

“This modern, 60,000 square foot inpatient rehabilitation hospital will provide comprehensive inpatient and outpatient therapy services for families in Greater Indianapolis and surrounding communities,” the announcement said. It included a rendering of a two-story, free-standing building with a large blue sign over the entrance.

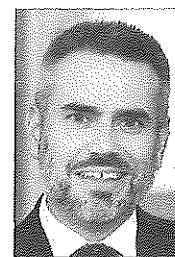
But details were scarce. The announcement did not include an address for the hospital, other than to say it would be “strategically located in the vibrant and growing medical corridor along U.S. 31 in Carmel,” raising questions about whether the developers had secured a site. No timetable for groundbreaking or opening was provided.

In an interview, a Medistar spokeswoman said the company was in final negotiations for the hospital site and would not provide details in advance. In their announcement, the companies said they have jointly developed 10 other medical facilities around the country. This would be their first in Indiana.

Some Indiana hospital officials said they weren't familiar with either company or the Carmel project, signaling that Medistar and Post Acute Medical might not have been striking up relationships here before making their announcement.

"We have rehab hospitals as members but I'm not familiar with them, and I haven't heard that they are partnering with anyone," said Brian Tabor, president of the Indiana Hospital Association.

He added that it's common for out-of-state rehabilitation health companies—such as Louisville-based Kindred Healthcare and Birmingham, Alabama-based Encompass Health (formerly HealthSouth)—to form partnerships with Indianapolis acute-care hospitals when they enter the market.



Partners' backgrounds

The Carmel project brings together two companies with different skills and backgrounds.

Medistar, founded in 1974, is a real estate developer focusing on medical projects, including hospitals, medical plazas and medical office buildings. Many of them are in its home state of Texas, including a 35-story, luxury apartment tower next to the Texas Medical Center in Houston.

Post Acute Medical, founded in 2006, operates more than 30 long-term, acute-care hospitals, medical rehabilitation hospitals, surgical hospitals and outpatient physical therapy locations in eight states.

In recent years, however, each company has left a separate trail of legal and business problems in its wake.

Last summer, Post Acute Medical agreed to pay more than \$13 million to settle civil allegations of kickbacks and improper physician referrals in Texas and Louisiana. The U.S. Department of Justice said the company had set up questionable contracts with physicians that were "intended to induce the physicians to refer patients" to its facilities, in violation of the False Claims Act.

The Justice Department also alleged that the company set up "reciprocal referral relationships" with outside providers, including home health companies, with the understanding that those providers would refer other patients to its facilities.

In a statement on its website, Post Acute Medical said many of the issues began long before the company acquired the facilities in question. It disputed that there were "any substantive defects" in its relationships with doctors or home health care providers.

"In the interest of moving forward and avoiding continued expense, Post Acute agreed to an amicable resolution with the government (in) which it did not acknowledge any violations of applicable rules," Post Acute said. The company did not return calls or emails from IBJ.

Even as it is opening some facilities, Post Acute Medical has been closing others. In February, the company said it would shut down two specialty hospitals in Corpus Christi, Texas, that offer long-term acute care, laying off 220 employees. Long-term, acute-care hospitals offer a higher level of care than inpatient rehabilitation hospitals. The company

attributed its decision to “draconian changes” imposed by the Centers for Medicare and Medicaid Services upon such facilities that limit the type of patients who can be treated.

A month later, the company announced plans to close a 62-bed long-term, acute-care hospital in suburban Milwaukee, eliminating 172 workers. In a notice to the state, the company attributed the closure to “dramatic changes designed to substantially limit the type of patients who could be treated in long-term acute-care hospitals,” according to the BizTimes Milwaukee.

And Post Acute Medical’s partner, Medistar, also has seen projects falter. The company spent \$200 million to build and run the Bay Area Regional Medical Center, a 104-bed hospital in Houston. But just four years after opening in 2014, the hospital announced in May 2018 that it would close and file for bankruptcy.

About 700 employees lost their jobs, surprising many of them. But some workers fought back, claiming the company did not provide sufficient notice. Two employees filed suit, alleging that Bay Area Regional and Medistar violated the Worker Adjustment and Retraining Notification Act of 1988 by “failing to give ... at least 60 days’ advance written notice of termination, as required under the WARN Act.”

In the lawsuit, the employees allege that, in light of the violation, they are entitled to their wages and retirement benefits for 60 days, “none of which [have] been paid.” The suit is pending in U.S. District Court in Houston.

PAM Rehabilitation Hospital

Planned services: comprehensive rehabilitation, including a unit for treatment of traumatic brain injury, stroke or neurodegenerative disease

Location: somewhere along U.S. 31 in Carmel

Size: 60,000 square feet

Beds: 60

Developers: Medistar Corp. of Houston and Post Acute Medical LLC of suburban Harrisburg, Pennsylvania

Cost: did not disclose

Sources: Medistar Corp., Post Acute Medical LLC

In the year or so before it closed, the Houston hospital had been the focus of several serious disputes and lawsuits from insurers and lab companies. In 2017, insurer Aetna Inc. said it had discovered it had overpaid the hospital by \$26 million and demanded the money back, accusing the hospital of breach of contract and fraud.

Connecticut-based Aetna said the overpayments were the result of Bay Area’s improper submission of thousands of claims for lab services performed by outside laboratories.

“Put more simply, Bay Area billed and was paid for services it did not render,” Aetna said in its Dec. 13, 2017, letter. “And as previously indicated, Aetna views Bay Area’s practice of billing for services rendered by independent laboratories as improper pass-through billing that amounts to a breach of contract and fraud.”

It’s unclear whether Aetna got its money back or otherwise resolved the conflict. The hospital shut its doors five months after the insurer sent the letter. Two days after the hospital closed, Aetna filed suit against several laboratories and medical management service companies, accusing them of engaging in fraudulent medical billing. Bay Area Regional and Medistar were not named in the suit, which is pending.

Medistar said that, while it owned the hospital, it did not operate it. The operator was Bay Area Regional Medical Center LLC. Medistar President Monzer Hourani also was a director and manager of Bay Area Regional.

Competitive market

Central Indiana is already home to numerous rehab hospitals, including Rehabilitation Hospital of Indiana (a collaboration between Indiana University Health and Ascension St. Vincent), Community Rehabilitation Hospital North and Franciscan Health Acute Inpatient Rehabilitation Indianapolis.

And others are on the way. Earlier this month, WB Development of Texas announced plans to build Indianapolis Rehabilitation Institute, a 40-bed facility on 4.79 acres of vacant land at 12315 Pennsylvania St. in Carmel.

Ed Abel, director of health care practice at Indianapolis-based Blue & Co., an accounting and consulting firm, said health care developers are attracted to central Indiana because of patient demand for services and a high proportion of people with lucrative, commercial insurance coverage. "I think that's why we continue to see folks like this come in," he said.

But based on Medistar's and Post Acute Medical's record of problems, he said, he isn't making any bets on the Carmel project's success.

"I wouldn't be surprised if six or 12 months after they start, they just walk from the thing," Abel said. "And then we've got another empty medical building."•

Editor's note: IBJ is now using a new comment system. Your Disqus account will no longer work on the IBJ site. Instead, you can leave a comment on stories by signing in to your IBJ account. If you have not registered, please sign up for a free account now. Past comments are not currently showing up on stories, but they will be added in the coming weeks. Please note our updated comment policy that will govern how comments are moderated.

JUSTICE NEWS

Department of Justice

Office of Public Affairs

FOR IMMEDIATE RELEASE

Wednesday, August 15, 2018

Post Acute Medical Agrees to Pay More Than \$13 Million to Settle Allegations of Kickbacks and Improper Physician Relationships

Post Acute Medical, LLC, a Pennsylvania-based operator of long-term care and rehabilitation hospitals across the country, and certain affiliated entities through which the company operates its facilities (collectively, "PAM"), have agreed to pay the United States, Texas, and Louisiana a total of \$13,168,000 to resolve claims that they violated the False Claims Act, and the Texas and Louisiana false claims statutes, by knowingly submitting claims to the Medicare and Medicaid programs that resulted from violations of the Anti-Kickback Statute and the Physician Self-Referral Law, the Justice Department announced today.

The Anti-Kickback Statute, in relevant part, prohibits offering or paying anything of value to encourage the referral, or to encourage recommending or arranging for the referral, of items or services covered by Medicare, Medicaid, and other federally funded programs. The Physician Self-Referral Law, commonly known as the Stark Law, prohibits a hospital from billing Medicare for certain services referred by physicians with whom the hospital has an improper financial relationship. Both the Anti-Kickback Statute and the Stark Law are intended to ensure that medical decision-making is not compromised by improper financial incentives and is instead based on the best interests of the patient.

Since it was founded in 2006, PAM entered into numerous physician-services contracts on behalf of its hospitals. Although the purpose of these contracts was ostensibly to retain physicians as medical directors or in other administrative or medical roles, the United States alleged that in reality the company's payments under these contracts were intended to induce the physicians to refer patients to PAM's facilities. The company allegedly violated the AKS further by entering into what it called "reciprocal referral relationships" with unaffiliated healthcare providers such as home health companies. In the course of those arrangements, PAM allegedly referred patients to those other providers with the understanding that those providers would refer other patients to PAM's facilities.

"Kickbacks undermine the independence of physician and patient decision-making, and raise healthcare costs," said Acting Assistant Attorney General Chad A. Readler, head of the Justice Department's Civil Division. "The Department of Justice is committed to preventing illegal financial relationships that undermine the integrity of our public health programs."

"Medicare and Medicaid beneficiaries depend on their healthcare providers to make decisions based on sound medical judgment," said U.S. Attorney David J. Freed. "Our office will take decisive action to address allegations that medical providers are paying or receiving improper financial benefits that could influence medical decision-making."

"PAM's alleged kickbacks and improper physician relationships threatened the impartiality of medical decision-making and the financial integrity of Medicare and Medicaid," said Special Agent in Charge C.J.

Porter for the U.S. Department of Health and Human Services Office of Inspector General. "Our agency will continue to investigate companies who step over the line to maximize their profits at the expense of federal health care programs."

PAM's conduct allegedly resulted in false claims to Medicare as well as certain Medicaid programs. The latter are jointly funded by both the federal and state governments. Under the settlement, PAM will pay \$13,031,502 to the United States, \$114,016 to Texas, and \$22,482 to Louisiana.

The settlement resolves allegations originally brought by Douglas Johnson in a lawsuit filed under the whistleblower provisions of the False Claims Act, which allow private parties to bring suit on behalf of the federal government and to share in any recovery. The whistleblower will receive \$2,345,670 as his share of the federal government's recovery in this case.

In addition to resolving its False Claims Act liability, PAM has entered into a five-year Corporate Integrity Agreement with the Department of Health and Human Services Office of Inspector General which includes, among other compliance obligations, an arrangements review to be conducted by an Independent Review Organization.

This matter was handled on behalf of the government by the Justice Department's Civil Division, the U.S. Attorney's Offices for the Middle District of Pennsylvania and Southern District of Texas, and the Department of Health and Human Services Office of the Inspector General.

The case is captioned *United States ex rel. Johnson v. Post Acute Medical, LLC et al.*, Civil Action No. 17-cv-1269 (M.D. Pa.). The claims resolved by this settlement are allegations only and there has been no determination of liability.

Topic(s):

False Claims Act

Component(s):

Civil Division

USAO - Pennsylvania, Middle

Press Release Number:

18-1054

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Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MANY INPATIENT
REHABILITATION FACILITY
STAYS DID NOT MEET
MEDICARE COVERAGE AND
DOCUMENTATION
REQUIREMENTS**

*Inquiries about this report may be addressed to the Office of Public Affairs at
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**Daniel R. Levinson
Inspector General**

**September 2018
A-01-15-00500**

Office of Inspector General

<https://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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Section 8M of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Report in Brief

Date: September 2018
Report No. A-01-15-00500

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Review

Our prior reviews have found that some hospitals did not comply with Medicare coverage and documentation requirements for inpatient rehabilitation facilities (IRFs). The Centers for Medicare & Medicaid Services' (CMS's) Comprehensive Error Rate Testing (CERT) program found that the error rate for IRFs increased, ranging from 9 percent in 2012 to a high of 62 percent in 2016.

Our objective was to determine whether IRFs complied with Medicare coverage and documentation requirements for fee-for-service (FFS) claims for services provided in 2013.

How OIG Did This Review

Our audit covered \$6.75 billion in Medicare payments to 1,139 IRFs nation-wide for 370,872 IRF stays. We selected for review a stratified random sample of 220 IRF claims (IRF stays) totaling almost \$11.3 million in payments to 164 IRFs for calendar year 2013, the most recent claims data available at the time the audit started. We used an independent medical review contractor to determine whether the medical records for the sampled IRF stays met coverage requirements. In addition, we determined whether the medical records complied with Federal documentation requirements.

Many Inpatient Rehabilitation Facility Stays Did Not Meet Medicare Coverage and Documentation Requirements

What OIG Found

IRFs complied with all Medicare coverage and documentation requirements specified for reasonable and necessary care for 45 of the 220 sampled stays. However, for 175 of the sampled stays, corresponding to 135 IRFs, medical record documentation did not support that IRF care was reasonable and necessary in accordance with Medicare's requirements. These errors occurred because many IRFs did not have adequate internal controls to prevent inappropriate admissions; Medicare Part A FFS lacked a prepayment review for IRF admissions; CMS's extensive educational efforts and postpayment reviews were unable to control an increasing improper payment rate reported by CERT since our 2013 audit period; administrative law judge (ALJ) hearings for IRF appeals did not always involve CMS participation to ensure that Medicare coverage and documentation requirements were accurately interpreted; and the IRF payment system did not align cost with payments, which may have provided IRFs with a financial incentive to admit patients inappropriately.

On the basis of our sample results, we estimated that Medicare paid IRFs nation-wide \$5.7 billion for care to beneficiaries that was not reasonable and necessary.

What OIG Recommends and CMS's Comments

We recommend that CMS (1) educate IRF clinical and billing personnel on Medicare coverage and documentation requirements and work with providers to develop best practices to improve internal controls; (2) increase oversight activities for IRFs, such as postpayment medical review; (3) work with the Office of Medicare Hearings and Appeals to ensure that Medicare coverage and documentation requirements for IRF care are fairly represented at ALJ hearings; and (4) reevaluate the IRF payment system, which could include a demonstration project requiring preauthorization for Medicare Part A FFS IRF stays modeled on Medicare Advantage practices, a study of the relationship between IRF PPS payments and costs and take any necessary steps to more closely align them, and a consideration of the high error rate found in this report and CERT reviews in future acute inpatient rehabilitation service payment reform. In their written comments to our draft, CMS concurred with our recommendations, described actions that it planned to take to address them, and reiterated its commitment to providing Medicare beneficiaries with high-quality healthcare while preventing improper payments.

The full report can be found at <https://oig.hhs.gov/oas/reports/region1/11500500.asp>.

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INTRODUCTION

WHY WE DID THIS REVIEW

This review of Medicare coverage and documentation requirements for inpatient rehabilitation facilities (IRFs) expands on our prior reviews of an individual hospital-based IRF and recent hospital compliance reviews that included a limited number of IRF claims. (Appendix B contains a list of prior Office of Inspector General (OIG) reports.)

Our prior reviews found that some hospitals did not comply with Medicare coverage and documentation requirements for IRFs. The Centers for Medicare & Medicaid Services' (CMS's) Comprehensive Error Rate Testing (CERT) program found that the error rate for Medicare payments to IRFs increased from 9 percent in 2012 to 62 percent in 2016.¹ According to the Medicare Payment Advisory Commission (MedPAC)—a nonpartisan, legislative branch agency that provides the U.S. Congress with Medicare Program analysis and policy advice—in 2013 Medicare spent \$6.8 billion on fee-for-service (FFS) IRF care provided in about 1,160 facilities.² In recent years, Medicare FFS has paid for the majority of the services IRFs provide.³

OBJECTIVE

Our objective was to determine whether IRFs complied with Medicare coverage and documentation requirements for FFS claims for services provided in calendar year (CY) 2013.

¹ CMS, *Medicare Fee-for-Service, Improper Payments Report and Appendices*, 2012 through 2016. CERT published a payment report and an appendix for each year. Available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/CERT-Reports.html>. Accessed March 8, 2018. CERT reported an IRF error rate of 17.2 percent for 2013, the year we reviewed in this report.

² Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Medicare Payment Policy*, "Inpatient Rehabilitation Facility Services: Assessing Payment Adequacy and Updating Payments," chapter 10, p. 239, March 2015. Available at <http://www.medpac.gov/docs/default-source/reports/chapter-10-inpatient-rehabilitation-facility-services-march-2015-report-.pdf?sfvrsn=0>. Accessed May 9, 2017.

³ For example, MedPAC stated, "On average, Medicare fee-for-service accounts for about 61 percent of IRFs' discharges." See MedPAC, *Report to the Congress: Medicare Payment Policy*, "Inpatient Rehabilitation Facility Services: Assessing Payment Adequacy and Updating Payments," chapter 10, p. 239, March 2015 (2013). See also MedPAC, *Report to the Congress: Medicare Payment Policy*, "Inpatient Rehabilitation Facility Services: Assessing Payment Adequacy and Updating Payments," chapter 9, p. 237, March 2016 (60 percent, 2014), and MedPAC, *Report to the Congress: Medicare Payment Policy*, "Inpatient Rehabilitation Facility Services: Assessing Payment Adequacy and Updating Payments," chapter 10, p. 257, March 2017 (60 percent, 2015).

BACKGROUND

Inpatient Rehabilitation Facilities

Inpatient rehabilitation hospitals and rehabilitation units of acute-care hospitals, collectively known as IRFs, provide intensive rehabilitation therapy in a resource-intensive inpatient hospital environment for patients who, because of the complexity of their nursing, medical management, and rehabilitation needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care (the *Medicare Benefit Policy Manual* (the Manual), Pub. No. 100-02, chapter 1, § 110).

Inpatient Rehabilitation Facility Prospective Payment System

The Social Security Act (the Act) established a Medicare prospective payment system (PPS) for IRFs (§ 1886(j)). CMS implemented the payment system for cost-reporting periods beginning on or after January 1, 2002. Under the PPS, CMS established a Federal prospective payment rate, based on clinical characteristics and resource needs, for each of 92 intensive rehabilitation subcategories called case-mix groups (CMGs).⁴

Under the PPS, IRFs are reimbursed at a rate generally 2.5 times greater than the acute inpatient prospective payment system (IPPS) rate. In exchange, Medicare requires IRFs to provide intensive rehabilitation to higher severity patients.⁵ MedPAC has recommended IRF payment reform based on a closer alignment of cost with payment.⁶

⁴ Medicare Learning Network (MLN), *Inpatient Rehabilitation Facility Prospective Payment System*, ICN 006847, Jan. 2017. According to the MLN:

Federal rates are adjusted to reflect patient case-mix, which is the relative resource intensity typically associated with each patient's clinical condition as identified through the patient assessment process. Cases are grouped into Rehabilitation Impairment Categories, according to the primary condition for which the patient was admitted to the IRF. Cases are further grouped into case-mix groups which group similar cases according to their functional motor, cognitive scores, and age. Finally, cases are grouped into one of four tiers within each CMG, according to patient's comorbidities (conditions that are secondary to the principal diagnosis or reason for the inpatient stay).

⁵ B. Gage, L. Smith, et al., *Analysis of the Classification Criteria for Inpatient Rehabilitation Facilities*, Report to Congress, September 2009, p. 13. Prepared for CMS by RTI International, RTI Project Number 0211995.

⁶ Among several other recommendations, MedPAC recommended for fiscal year (FY) 2018 a payment rate reduction of 5 percent, "coupled with an expansion of the high-cost outlier pool, as previously recommended by MedPAC, to redistribute payments within IRF PPS and reduce the impact of potential misalignments between IRF payments and costs." (MedPAC, *Report to Congress: Medicare Payment Policy*, "Inpatient Rehabilitation Facility Services: Assessing Payment Adequacy and Updating Payments," chapter 10, p. 259, March 2017). See Appendix G, MedPAC Recommendations for Reform of Inpatient Rehabilitation Facility and Post-Acute-Care Payments, in this report.

During our audit period, CMS contracted with Medicare administrative contractors (MACs) to process and pay Medicare FFS claims and perform other services, including medical reviews for selected claims. CMS also contracted with (1) Recovery Audit Contractors (RACs) to identify and correct Medicare FFS improper payments and (2) the Supplemental Medical Review/Specialty Contractor (SMRC) to perform and provide support for a variety of tasks to lower the improper payment rates and increase the efficiencies of the medical review functions of Medicare and Medicaid.

Reasonable and Necessary Care

No Medicare payment may be made for items or services that are not reasonable and necessary for diagnosing or treating illness or injury or for improving the functioning of a malformed body member (the Act § 1862(a)(1)(A)).

Effective for discharges on or after January 1, 2010, all coverage⁷ and documentation⁸ requirements must be met for IRF care to be considered by Medicare as reasonable and necessary under the Act (42 CFR §§ 412.622(a)(3), (4), and (5) and 74 Fed. Reg. 39762, 39788 (Aug. 7, 2009)).⁹ If the claim is deemed not reasonable and necessary, the entire payment will be in error.

For discharges starting in 2010, CMS updated IRF requirements to reflect best practices in medicine that enhance the quality of care for patients.¹⁰ These requirements address the unique responsibility¹¹ of the rehabilitation physician to closely supervise and coordinate a medical and functional rehabilitation course of care for the patient and to clearly and comprehensively document these decisions and processes in the medical records.¹²

As of 2010, CMS no longer considers trial admissions (IRF admissions of 3 to 10 days to allow the physician to determine whether the patient would benefit from IRF treatment) to be reasonable

⁷ 42 CFR § 412.622(a)(3), as interpreted in the Medicare Benefit Policy Manual (the Manual), Pub. No. 100-02, chapter 1, §§ 110.2, 110.3.

⁸ 42 CFR §§ 412.622(a)(4) and (5), as interpreted in the Manual, chapter 1, §§ 110.1, 110.2.4, 110.2.5.

⁹ "All requirements must be met" as interpreted by the Manual, chapter 1, § 110. These requirements apply equally to all Medicare patients regardless of whether the patient is treated in the IRF for 1 or more of the 13 medical conditions listed in 42 CFR 412.29 (b)(2) and used by Medicare for classifying a hospital or unit of a hospital as an IRF.

¹⁰ 74 Fed. Reg. 39762, 39790 (Aug. 7, 2009).

¹¹ 74 Fed. Reg. 39796 (Aug. 7, 2009).

¹² CMS National Provider Training Call Transcript, "Revised Inpatient Rehabilitation Facility Prospective Payment System Coverage Requirements," Nov. 12, 2009, p. 4. Available at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Coverage.html. Last accessed June 2017.

and necessary. A rehabilitation physician must review and approve the need for care only after a comprehensive preadmission screening within the previous 48 hours has been documented.^{13, 14} CMS stated that the purpose of the coverage requirements is to clarify that patients who do not require, cannot participate in, or cannot benefit from the intensive rehabilitation therapy program offered in an IRF should be referred to another setting. Additionally, CMS stated that the purpose of the documentation requirements is to provide clear, up-to-date instructions for determining and documenting the medical necessity of the IRF admission.¹⁵

Oversight of Inpatient Rehabilitation Facility Compliance

CMS aims to improve the quality and coordination of care for Medicare beneficiaries and to reduce improper payments. This work includes corrective action for Medicare compliance and the testing of new care and reimbursement models. Examples are:

- educational outreach programs and publications for IRF stakeholders,¹⁶

¹³ For the purposes of this report, “rehabilitation physician” is the IRF physician, with specialized training and experience in rehabilitation, in charge of the patient during the inpatient rehabilitation stay, as opposed to ancillary physicians, such as cardiologists, neurologists, internal medicine specialists, and others who assist the rehabilitation physician at the IRF.

¹⁴ The Manual, Pub. No. 100-02, chapter 1, § 110.1.1.

¹⁵ CMS National Provider Training Call Transcript, “Revised Inpatient Rehabilitation Facility Prospective Payment System Coverage Requirements,” Nov. 12, 2009, pp. 4–5. Available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Coverage.html>. Last accessed March 8, 2018.

¹⁶ CMS’s Medicare compliance education for IRFs includes detailed transcripts of IRF national provider training sessions, which have been consistently posted on the CMS website since late 2009. These transcripts give providers access to specific and comprehensive Medicare requirement clarifications. The transcripts for November 12, 2009, and May 31, 2012, are available at the IRF coverage web page at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Coverage.html>. Last accessed on March 5, 2018.

CMS provides access to regulatory updates in the IRF payment system and educational materials, such as MLN publications. For example, (1) Inpatient Rehabilitation Therapy Services: Complying With Documentation Requirements, MLN ICN 905643, July 2012; (2) Inpatient Rehabilitation Facility Prospective Payment System, MLN ICN 006847, Jan. 2017; (3) Inpatient Rehabilitation Facility (IRF) Medical Review Changes, SE 17036, Dec. 11, 2017; (4) Provider Compliance Tips for Inpatient Rehabilitation Hospitals and Inpatient Rehabilitation Units, ICN 909406, Feb. 2018; and (5) “MLN Connects”—Centers for Medicare & Medicaid Services IRF PPS: New IRF-Patient Assessment Instrument (PAI) Items Effective October 1, 2015, National Provider Call, Jan. 15, 2015; and Centers for Medicare & Medicaid Services IRF-PAI Therapy Information Data Collection, National Provider Call, Jan. 12, 2017. In addition, MACs provide access to educational materials on their websites.

CMS also administers the Program for Evaluating Payment Patterns Electronic Report (PEPPER) resources, which provides provider-specific Medicare data statistics for discharges and services vulnerable to improper payments. The PEPPER reports, which can be downloaded by each IRF, compare an IRF to other IRFs in three comparison groups: Nation, MAC jurisdiction, and State. These comparisons enable an IRF to determine if it differs from other IRFs.

- innovative demonstration projects such as the Comprehensive Care for Joint Replacement Model,¹⁷ and
- postpayment reviews.

For example, the goal of the CERT A/B MAC Outreach & Education Task Force for Error-Free Medicare Claims is to give providers educational opportunities aimed at reducing the Part A and Part B error rates.¹⁸ This task force has specifically targeted education outreach about IRF Medicare compliance by continuing to offer web-based training to explain IRF Medicare regulations that have been in effect since 2010. Additional CMS educational outreach programs include open-door compliance forums for other types of providers and consumers.¹⁹

In addition to CMS's educational and outreach efforts for the IRF community and CERT's improper payment evaluations, several RACs and MACs performed postpayment reviews from 2013 through 2017. These reviews tested medical necessity, CMG coding, and compliance with documentation requirements and identified overpayments of \$18.5 million. In 2016, CMS also directed the SMRC to perform IRF postpayment medical review.

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$6.75 billion in Medicare payments to 1,139 IRFs for 370,872 IRF stays in CY 2013.²⁰ We selected for review a stratified random sample of 220 IRF claims (IRF stays) totaling \$11,277,251 for stays at 164 IRFs. We used an independent medical review contractor

¹⁷ This model program for joint replacement care at acute-care hospitals began in April 2016 and tests bundled payment and quality measurement for an episode of care associated with hip and knee replacements to encourage hospitals, physicians, and post-acute-care providers to work together to improve the quality and coordination of care from the initial hospitalization through recovery (80 Fed. Reg. 73274 (Nov. 24, 2015); 82 Fed. Reg. 180 (Jan. 3, 2017)). Regulations, notices, and fact sheets are available at <https://innovation.cms.gov/initiatives/cjr>. Last accessed on March 5, 2018.

¹⁸ CMS designed The CERT A/B Task Force to assist Medicare FFS contractors in strengthening customer service to improve provider experience. It is composed of volunteers from MACs who reimburse for services in Medicare Part A (hospital insurance) and Part B (medical insurance).

¹⁹ CMS sponsors regularly scheduled "Open Door Forums," providing an opportunity for conversation between CMS and the stakeholder community on a variety of topics. During 2016 and 2017, CMS presented a series of open-door forums, "The IMPACT ACT and Improving Care Coordination," for IRFs and other post-acute-care providers and solicited feedback pertaining to the Improving Medicare Post-Acute Care Transformation Act of 2014, P.L. No. 113-185, Oct. 6, 2014. This legislation requires the Secretary of Health and Human Services to submit a report to Congress, expected in 2022, that will include recommendations and a technical prototype for a post-acute-care PPS. Available at <https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts.html>. Last accessed on March 5, 2018. See Appendix G, MedPAC Recommendations for Reform of Inpatient Rehabilitation Facility and Post-Acute-Care Payments, in this report.

²⁰ CY 2013 IRF claims data were the most recent data available at the start of the audit.

to determine whether sampled IRF stays met coverage requirements. In addition, we determined whether the IRFs complied with Medicare documentation requirements. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains our audit scope and methodology, Appendix C contains our statistical sampling methodology, Appendix D contains sample results and estimates, and Appendix E contains deficiencies in documentation for the IRFs associated with our sampled claims.

FINDINGS

IRFs complied with Medicare coverage and documentation requirements for 45 of the 220 sampled stays. However, for the remaining 175 sampled stays, corresponding to 135 IRFs, medical record documentation did not support that IRF care was reasonable and necessary in accordance with Medicare coverage and documentation requirements. Specifically, 146 stays did not meet both coverage and documentation requirements, and 29 stays met coverage requirements but did not meet documentation requirements.

These errors occurred because of a number of contributing factors: Many IRFs did not have adequate internal controls to prevent inappropriate admissions; Medicare Part A FFS lacked a prior authorization review process for IRF admissions that could reduce inappropriate admissions; CMS's extensive educational efforts and recent postpayment reviews were unable to control an increasing improper payment rate reported by CERT since our 2013 audit period; administrative law judge (ALJ) hearings for IRF appeals did not always involve CMS participation to ensure that Medicare coverage and documentation requirements were accurately interpreted; and the IRF payment system did not align cost with payments, which may have provided IRFs with a financial incentive to admit patients inappropriately.

On the basis of our sample results, we estimated that Medicare paid IRFs nation-wide \$5.7 billion (84 percent of the dollars covered by our audit) in 2013 for care to beneficiaries that was not reasonable and necessary.

Information about the 45 stays that complied with Medicare coverage and documentation requirements could be informative to CMS as it works with providers to reduce noncompliance. (See Appendix F.)

MEDICARE COVERAGE REQUIREMENTS

The coverage requirements (42 CFR § 412.622(a)(3)) specify that, at the time of admission, the IRF must have a reasonable expectation that the patient meets all of the following requirements:²¹

- needs the multiple active and ongoing therapies of an acute inpatient rehabilitation interdisciplinary program, one of which must be physical or occupational therapy;
- requires supervision by a rehabilitation physician to assess the patient, both medically and functionally, and modify the course of treatment as needed to maximize the benefit from the rehabilitation process; and
- is sufficiently stable to be able to actively participate and benefit from an intensive rehabilitation therapy program and demonstrate measurable improvement that is of practical value to the patient in improving functional capacity or adaptation to impairments.

MEDICARE DOCUMENTATION REQUIREMENTS

The Medicare IRF requirements (42 CFR §§ 412.622(a)(4) and (5)) specify that the patient's medical record at the IRF must include the following types of documentation with all required elements:²²

- comprehensive preadmission screening;
- a postadmission rehabilitation physician evaluation;
- an individualized overall plan of care developed and documented by a rehabilitation physician; and
- a demonstration that the patient requires an interdisciplinary approach to care, with weekly interdisciplinary team meetings led by a rehabilitation physician.

²¹ The Manual, Pub. No. 100-02, chapter 1, "Medical Necessity Criteria," §§ 110.2–110.2.5, 110.3.

²² We identify the required component elements of these types of documentation in Appendix E, Details of the Inpatient Rehabilitation Facility Documentation Deficiencies Found in the Sample.

MOST SAMPLED STAYS WERE NOT REASONABLE AND NECESSARY

For 175 of the 220 sampled claims, the IRFs did not meet all coverage and documentation requirements. Medicare paid 135 IRFs \$8,325,940 for these stays.²³ Neither coverage nor documentation requirements were met for 146 of the 175 stays.

The other 29 of the 175 stays generally met coverage requirements but did not meet all of the documentation requirements.²⁴ We will provide CMS with a list of the 135 IRFs with sampled stays that did not meet coverage or documentation requirements separately for further review.

Coverage Requirements Not Met

Of the 175 stays, 146 did not meet the coverage requirements. Specifically, the medical records for the stays did not reflect that the patients had the medical needs and functional rehabilitation goals that require the complexity and intensity of inpatient rehabilitation. Medical reviewers determined that, for these IRF stays, appropriate care would have required only individual therapy interventions rather than an intense interdisciplinary program with rehabilitation physician supervision. In some of these stays, the therapy would be expected to consist of general exercises and regular activities, such as walking or exercises to improve tolerance for sitting. In other stays, nonskilled caregivers would have been able to provide needed assistance with only intermittent skilled therapy oversight.

For all of these stays, the high level of physician supervision that accompanies acute intensive rehabilitation therapy services would not have been required. These patients did not require interdisciplinary rehabilitation or the intensity of an acute-level rehabilitation program. In some stays, the patients were unable to participate in an intensive therapy program regardless of medical and rehabilitation needs.

We found that stays that did not meet coverage requirements were predominantly, but not exclusively, related to the following:

- generalized weakness, overall fatigue, and impaired mobility for which appropriate therapy would be regular activities, such as walking, use of a wheelchair, or just general exercises (56 stays);

²³ When they receive Medicare contractor denials, IRFs are eligible to bill Part B inpatient services if the service (1) was denied under Part A because the inpatient admission was not reasonable and necessary *and* (2) is not by definition solely an outpatient service that would not be provided to an inpatient (42 CFR § 414.5). There are time limits for rebilling: rebilling will be rejected as untimely when the bill is filed later than 1 CY after the date of the service (42 CFR §§ 414.5(c) and 424.44(a)).

²⁴ Of these 29 stays, 22 had more than 1 documentation deficiency and 7 had a single documentation deficiency. By documentation deficiency, we mean that an element of required documentation was missing. Based on these 29 stays, we estimated that \$571 million of the total estimated \$5.7 billion was paid for stays that might have qualified as reasonable and necessary if documentation requirements had been met.

- simple fractures, single extremity deficits, simple or minor trauma, elective or emergency single joint or other orthopedic repair without postoperative complications, or no new and acute significant impairing event or condition (48 stays);
- miscellaneous conditions without complications or other new impairing events to include other orthopedic, central nervous system, cardiac, and pulmonary conditions (25 stays); or
- inability to participate in intense rehabilitation and demonstrate measurable improvement of practical value to the patient (17 stays).

Examples of Information Contained in the Medical Records for Stays That Were Not Reasonable and Necessary

Example 1: According to the medical review contractor, the patient had his right hip partially replaced after a fall, and there were no significant postoperative complications. At the time of IRF admission, he was able to tolerate bearing weight, perform transfers from sitting to standing and from a bed to a chair with minimal assistance, and walk 40 feet with minimal assistance. There was no expected need to modify the patient's treatment to maximize the patient's capacity to benefit from rehabilitation. The patient did not require a physician's supervision at an acute rehabilitation level of care, interdisciplinary rehabilitation, or the intensity of acute-level rehabilitation. In addition, the documentation did not include all the required elements for the individualized, overall plan of care and the interdisciplinary team meetings.

Example 2: According to the medical review contractor, the patient had been treated during a 2-week, acute-care hospital stay for pneumonia caused by a fungal infection and then had acute kidney failure. Before that admission, she had been functionally independent. After the acute-care hospital stay, she was admitted to an IRF. The IRF preadmission screen identified that the patient had generalized weakness and impaired mobility and was suffering from malnutrition and anemia. At admission, the patient was (1) walking 100 feet without an assistive device, (2) performing activities of daily living with minor assistance, and (3) able to respond cognitively at a high level of complexity. The patient was limited by fatigue. The admitting IRF provider found the patient to be in stable condition and did not identify any further functional defects on the postadmission evaluation. She did not require interdisciplinary rehabilitation or the intensity of an acute-level rehabilitation program. In addition, the documentation did not include all the required elements for the individualized overall plan of care.

Documentation Requirements Not Met

The medical record documentation for 175 stays did not contain all of the information required by CMS. Of these stays, medical records for 147 had more than 1 documentation deficiency, and medical records for 28 had 1 documentation deficiency. Twenty of the 147 stays were missing 1 or more elements of all 4 types of required documentation. As a result of these documentation deficiencies, we were unable to determine that IRF care for those 175 stays was reasonable and necessary. For many of the stays, we were unable to determine that a rehabilitation physician had:

- reviewed and concurred with the findings of the preadmission screenings that took place within 48 hours before the IRF admission;
- conducted a postadmission evaluation that identified any relevant changes that might have occurred since the preadmission screening;
- prepared an overall and individualized plan of care; and
- participated in weekly team meetings and concurred with the results, findings, and decisions made at the meetings.

Appendix E contains details of the deficiencies in IRF documentation associated with the sample items.

CAUSES OF NONCOMPLIANCE WITH MEDICARE REQUIREMENTS

A number of factors might have contributed to the admission practices that resulted in IRFs being reimbursed for patients who did not need the complexity and intensity of inpatient rehabilitation. These factors included the following:

- IRFs' internal controls failed to prevent inappropriate admissions, and IRFs lacked monitoring procedures for Medicare documentation compliance. We concluded this solely on the basis of our review of the medical records and the high error rate.
- Medicare Part A FFS lacked a prior authorization review process for IRF admissions that could reduce inappropriate admissions. By instituting an FFS prior authorization

process, similar to the process used by Medicare Advantage plans, CMS may be able to improve IRF provider compliance.²⁵

- Although Medicare contractors have performed yearly postpayment reviews since 2013, these reviews, together with CMS's extensive educational and outreach efforts, were insufficient to control the rising and significant increase in the IRF improper payment rate. CERT reported increasing error rates for Medicare payments to IRFs: 9 percent in 2012, 17.2 percent in 2013, 20.7 percent in 2014, 45.5 percent in 2015, and 62.4 percent in 2016.
- ALJ hearings for IRF appeals did not always involve CMS participation to ensure that Medicare coverage and documentation requirements were accurately interpreted. Previous OIG work²⁶ has shown that (1) for 56 percent of FY 2010 appeals, ALJs reversed prior-level decisions by the CMS Qualified Independent Contractors (QICs) and decided fully in favor of appellants; (2) differences between ALJ and QIC decisions were due to varying interpretations of Medicare policies, in their degree of specialization and the use of clinical experts; (3) these differences may provide appellants an incentive to appeal to the ALJ level where they are likely to receive favorable decisions; and (4) 44 percent of FY 2010 ALJ decisions was fully favorable to appellants when CMS participated, but 60 percent of ALJ decisions (based on all provider appeals including IRFs) was fully favorable when CMS did not participate. Based on CMS data for 2014 through 2017 IRF appeals, the overturn rate with CMS contractor participation was 39 to 53 percent and 55 to 73 percent when CMS contractors did not participate.²⁷ An official we interviewed

²⁵ Medicare Advantage healthcare coverage plans are offered by private companies approved by Medicare to receive reimbursement for services. Some Medicare Advantage plans require the IRF to obtain prior authorization for IRF admissions from the Medicare Advantage plan (a party external to the IRF itself). IRF stays covered by these plans generally follow Medicare FFS coverage and documentation requirements. In addition to requiring an IRF to request prior authorization, some Medicare Advantage plans may require further evaluation for patients with certain conditions. Evaluation criteria may include an assessment of whether the care needed could be safely provided in a less restrictive clinical setting. Some plans also require additional review of medical records after the authorization to increase a length of stay beyond initially approved limits.

²⁶ OIG, *Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals* (OEI-02-10-00340), November 2012. As noted in that report on pages 19 and 20, we acknowledge that CMS may have strategic considerations "about which contractors are in the best position to represent CMS and which appeals most warrant CMS participation in ALJ hearings, such as Part A hospital appeals or those from frequent flyers."

²⁷ The Office of Medicare Hearings and Appeals administers the ALJ hearing program for provider appeals about individual claims for Medicare coverage and payment for items and services furnished to beneficiaries. The ALJs decide appeals at the third level of the Medicare appeals system; the first level is adjudicated by the CMS Medicare Administrative Contractors and the second by CMS QICs. These data include appeal decisions at the QIC and ALJ levels, and CMS contractor participation, in this case, includes paper or testimony presentation by MAC, QIC, or RAC contractors.

at a for-profit facility belonging to a large national IRF corporation stated that the organization expected to have any denials overturned at the ALJ level of appeal.

- The IRF payment system did not align costs with payments, which may have provided IRFs with a financial incentive to admit patients inappropriately. (See Appendix G.)

ESTIMATE OF MEDICARE PAYMENTS MADE FOR CARE THAT WAS NOT REASONABLE AND NECESSARY

On the basis of our sample results, we estimated that for the audit period Medicare paid IRFs nation-wide \$5.7 billion for stays that did not meet the coverage and documentation requirements for care to be considered reasonable and necessary.

RECOMMENDATIONS

We recommend that CMS:

- educate IRF clinical and billing personnel on Medicare coverage and documentation requirements and work with providers to identify, develop, and share compliance best practices that may lead to improved internal controls;
- increase oversight activities for IRFs, such as postpayment medical review, to determine compliance with coverage and documentation requirements, including a review of a subsample of the 135 IRFs in this review that had 1 or more sampled stays that did not comply with Medicare requirements;
- work with the Office of Medicare Hearings and Appeals to further evaluate the ALJ hearing process and make any necessary improvements to ensure that Medicare coverage and documentation requirements for IRF care are fairly represented; and
- reevaluate the IRF payment system, which could include:
 - conducting a demonstration project requiring prior authorization for Part A IRF stays modeled on Medicare Advantage practices,
 - studying the relationship between IRF PPS payment rates and costs and seek legislative authority to make any changes necessary to more closely align them, and
 - considering the high error rate found in this report and CERT reviews in future acute inpatient rehabilitation service payment reform, which may be a component of a unified post-acute-care PPS system.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft, CMS concurred with our recommendations and reiterated its commitment to providing Medicare beneficiaries with high-quality healthcare while protecting taxpayer dollars by preventing improper payments. CMS also provided us written technical comments that we addressed.

In addition to its many educational efforts, CMS stated that it has approved the MACs to review IRF providers under its Targeted Probe and Educate program. This program includes one-on-one education to reduce claim errors and denials for providers who have high denial rates or unusual billing practices. The level of educational intervention increases depending on the claim denial rates. These actions, together with actions taken in response to our recommendations, may significantly reduce the number and amount of improper payments to IRFs.

CMS's comments, excluding its technical comments, are included in their entirety as Appendix H.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our nation-wide review covered 370,872 IRF claims from 1,139 IRFs totaling \$6,751,375,988 in payments for services that were provided from January 2013 through December 2013.

The objective of our audit did not require an understanding or assessment of the complete internal control structure at the facilities that were associated with our sampled claims. Instead, we obtained a general understanding of controls related to admission decisions and documentation requirement compliance at facilities associated with a subsample of our claims. Our review enabled us to establish reasonable assurance of the authenticity and accuracy of data obtained from CMS's National Claims History (NCH) file, but we did not assess the completeness of the file.

We conducted our data collection from September 2015 through December 2016. CY 2013 IRF claims data were the most recent data available at the start of the audit.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- discussed with CMS officials the 2010 revisions to the Medicare regulations for documenting IRF care;
- extracted from CMS's NCH file paid IRF claims data;
- identified a sampling frame of 370,872 IRF claims from 1,139 IRFs totaling \$6,751,375,988 in payments for services provided from January 2013 through December 2013;
- selected a stratified random sample of 220 claims for our review, for which Medicare paid \$11,277,251 to the associated 164 IRFs (Appendix C);
- reviewed data from CMS's Common Working File for the 220 sampled claims to validate claim information extracted from the NCH file and determine whether any of the selected claims had been canceled or adjusted;
- obtained and reviewed billing and medical record documentation provided by the 164 IRFs associated with our sampled claims;

- used an independent medical review contractor to determine whether the documentation for the 220 sampled claims met medical necessity requirements;
- discussed a subsample of the billed claims with certain IRF clinical and billing representatives to determine the underlying causes of noncompliance with Medicare requirements and the internal control procedures needed to foster compliance;
- used our sample results to estimate the total improper payments in our sampling frame (Appendix D); and
- discussed the results of our review with CMS officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: PRIOR OFFICE OF INSPECTOR GENERAL REPORTS

Report Title and Number	Issue Date
<i>Norwalk Hospital Did Not Comply with Medicare Inpatient Rehabilitation Facility Documentation Requirements (A-01-11-00531)²⁸</i>	February 2013
<i>Medicare Compliance Review of University of Minnesota Medical Center for 2012 and 2013 (A-05-14-00050)</i>	January 2016
<i>Medicare Compliance Review of Hennepin County Medical Center for 2012 and 2013 (A-05-14-00048)</i>	February 2016
<i>Medicare Compliance Review of New York-Presbyterian Hospital for 2011 and 2012 (A-02-13-01027)</i>	August 2016
<i>Medicare Compliance Review of Abbott Northwestern Hospital for 2013 and 2014 (A-05-15-00043)</i>	December 2016
<i>Medicare Compliance Review of North Shore University Health System for 2013 and 2014 (A-05-15-00044)</i>	December 2016
<i>Medicare Compliance Review of Mount Sinai Hospital for 2012 and 2013 (A-02-14-01019)</i>	April 2017

²⁸ Unlike this review, the other reviews include only a limited number of claims from the rehabilitation units of the acute-care hospital.

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

TARGET POPULATION

The population consisted of Medicare FFS claims for services that IRFs provided to beneficiaries in CY 2013.

SAMPLING FRAME

We extracted from the NCH file Medicare inpatient claims for IRF services that were provided to beneficiaries in CY 2013. We created a database of these 442,259 claims, which had \$6,866,084,932 in total payments. We analyzed the claims data and removed claims that met one or more of the following criteria:

- claims in which the claim payment was less than or equal to \$2,500;
- claims submitted by providers that are under investigation by OIG's Office of Investigations; and
- claims already under review by other entities, including those claims marked as being under review by other entities.

The resulting sampling frame consisted of 370,872 IRF claims with payments totaling \$6,751,375,988.

SAMPLE UNIT

The sample unit was an IRF claim.

SAMPLE DESIGN

We used a stratified random sample as follows to review Medicare Part A payments made to nation-wide IRFs for services provided January 1, 2013, through December 31, 2013. To accomplish this, we separated the sample units into four strata as follows:

Stratum	Stratum Bounds	Number of Frame Units	Sample Size	Dollar Value of Frame Units
1	≥ \$2,500 and < \$15,857	156,756	50	1,870,356,189
2	≥ \$15,857 and < \$25,397	162,715	50	3,222,316,883
3	≥ \$25,397 and < \$97,891	51,331	50	1,650,539,578
4 (100% Review)	≥ \$97,891	70	70	8,163,338
Total		370,872	220	\$6,751,375,988

SAMPLE SIZE

We selected 50 claims each from strata 1, 2, and 3 and selected all 70 claims from stratum 4. Our total sample size was 220 IRF claims.

SOURCE OF RANDOM NUMBERS

We generated the random numbers using OIG, Office of Audit Services (OAS), statistical software.

METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the claims in strata 1, 2, and 3. After generating 50 random numbers for each stratum, we selected the 150 corresponding claims for review. We reviewed every claim in stratum 4 (70 in total).

ESTIMATION METHODOLOGY

We used the OAS statistical software to estimate the total amount of Medicare overpayments paid to nation-wide IRFs during the audit period.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

OVERALL SAMPLE RESULTS

Table 1: Overall Sample Details and Results

Stratum	Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Claims for Care Not Reasonable and Necessary	Value of Claims for Care Not Reasonable and Necessary
1	156,756	\$1,870,356,189	50	\$582,320	46	\$531,520
2	162,715	\$3,222,316,883	50	\$982,171	46	\$909,879
3	51,331	\$1,650,539,578	50	\$1,549,421	33	\$993,221
4	70	\$8,163,338	70	\$8,163,339	50	\$5,891,320
Total	370,872	\$6,751,375,988	220	\$11,277,251	175	\$8,325,940

**Table 2: Overall Estimates
(Limits Calculated for a 90-Percent Confidence Interval)**

	Estimated Value of Improper Payments
Point Estimate	\$5,652,951,081
Lower Limit	\$5,322,701,315
Upper Limit	\$5,983,200,848

APPENDIX E: DETAILS OF THE INPATIENT REHABILITATION FACILITY DOCUMENTATION DEFICIENCIES FOUND IN THE SAMPLE

One or more of the four types of required rehabilitation physician documentation did not include all required elements of each of these documentation types:

- a comprehensive preadmission screening (101 stays);
- a postadmission rehabilitation physician evaluation (62 stays);
- an individualized overall plan of care developed and documented by a rehabilitation physician (166 stays); and
- a demonstration that the patient requires an interdisciplinary approach to care, as evidenced by weekly interdisciplinary team meetings led by a rehabilitation physician (106 stays).

DEFICIENT DOCUMENTATION OF PREADMISSION SCREENING

At the time of admission, a patient's medical record at the IRF must contain documentation of a comprehensive preadmission screening performed within the 48 hours immediately preceding the IRF admission. A comprehensive and accurate preadmission screening process is the key factor in initially identifying appropriate candidates for IRF care.²⁹ The medical record must also include evidence of the rehabilitation physician's review and concurrence with the findings of the completed preadmission screening and before the IRF admission. The screening should include a detailed clinical review of the patient's condition and medical history; serve as the

²⁹ CMS continued: "As we are placing more weight on the rehabilitation physician's decision to admit the patient to the IRF, we believe that it is important to require that the rehabilitation physician document the reasoning behind the decision. We realize that this level of detail may exceed what some IRFs may have included in the past, but we believe that it will benefit both IRFs and Medicare contractors who are reviewing IRF claims to have the rationale for the reasoning behind the admission recorded in each patient's medical record" (74 Fed. Reg. 39791 (Aug.7, 2009)). CMS also stated: "The focus of the review of the preadmission screening information will be on its completeness, accuracy, and the extent to which it supports the appropriateness of the IRF admission decision, not how the process is organized" (The Manual, chapter 1, § 110.1.1).

basis for the initial determination of whether the patient meets the requirements for an IRF admission; and be used to inform a rehabilitation physician, who reviews and documents concurrence with the findings and results of the screening (42 CFR § 412.622(a)(4)).³⁰

For 101 stays, IRF medical records did not include documentation of (1) a rehabilitation physician review and concurrence with the findings of the completed preadmission screening and before the IRF admission (or evidence of preadmission screening actually being performed within the 48 hours immediately preceding the IRF admission) (84 stays), (2) a comprehensive medical and functional assessment (33 stays), and (3) any preadmission screening (7 stays).

The documentation for 84 stays did not include proof that a rehabilitation physician reviewed and concurred with preadmission findings. The approval statements and signatures of rehabilitation physicians were absent, untimely, or illegible, and the names of the rehabilitation physicians were not identified elsewhere in the medical charts. Therefore, we were unable to determine that a rehabilitation physician had reviewed and concurred with the findings of the preadmission screenings taking place within 48 hours before the IRF admission.

The medical records for 33 of the 84 stays did not support IRF admissions because the preadmission screening did not detail the conditions causing the need for intensive rehabilitation, the patient's prior and current level of function, and the risk of clinical complications. Medical records for seven other stays did not include any preadmission screening documentation.

For an additional 10 stays, the IRFs provided documentation of history and physical examinations, progress notes, and consultations from the immediately preceding acute-hospital stay instead of preadmission screening documentation. However, this substitute documentation was not comprehensive, did not include most required clinical information, and did not support that a rehabilitation physician had approved the IRF admission.

³⁰According to the Manual, chapter 1, § 110.1.1, IRFs must support the IRF admission by retaining in the patient's medical record the results of a preadmission screening that was conducted within the 48 hours immediately preceding the admission:

The preadmission documentation must indicate the patient's prior level of function (prior to the event or condition that led to the patient's need for intensive rehabilitation therapy), expected level of improvement, and the expected length of time necessary to achieve that level of improvement. It must also include an evaluation of the patient's risk for clinical complications, the conditions that caused the need for rehabilitation, the treatments needed (i.e. physical therapy, occupational therapy, speech therapy-language pathology, or prosthetics/orthotics), expected frequency and duration of treatment in the IRF, anticipated discharge destination, any anticipated post-discharge treatments, and other information relevant to the care needs of the patient.

DEFICIENT DOCUMENTATION OF THE REHABILITATION PHYSICIAN'S POSTADMISSION EVALUATION

The patient's medical record at the IRF must include documentation of a rehabilitation physician's postadmission evaluation that meets all of the following requirements: (1) completed within 24 hours of the patient's admission to the IRF, (2) includes a documented history and physical exam, (3) documents the patient's status on admission to the IRF, (4) includes a comparison of observed medical and functional status with the information noted in the preadmission screening documentation, and (5) serves as the basis for the development of the overall individualized plan of care (42 CFR § 412.622(a)(4)).³¹

Although medical records for most stays included documentation of a history and physical exam performed within the first 24 hours after admission, for 62 of the IRF stays the medical records did not include documentation showing that the rehabilitation physicians' postadmission evaluations met all of the requirements. Specifically: (1) documentation of postadmission evaluations did not include a medical and functional status comparison with the information noted in the preadmission screening documentation and (2) the postadmission rehabilitation physicians' evaluations were not completed within 24 hours after admission as required.

For eight of the 62 stays, physician extenders³² documented the history and physical examination, but the documentation did not include evidence that a rehabilitation physician documented a visit with the patient, the patient's status on admission to the IRF, a comparison with the information noted in the preadmission screening documentation, and a basis for the development of the overall individualized plan of care within the 24 hours after the IRF admission.

DEFICIENT DOCUMENTATION OF INDIVIDUALIZED, OVERALL PLAN OF CARE

The patient's medical record for the IRF stay must contain an individualized overall plan of care that is developed by the rehabilitation physician with input from the interdisciplinary team within 4 days of the patient's admission (42 CFR § 412.622(a)(4)).

It is the sole responsibility of a rehabilitation physician to combine information that is required in the overall plan of care, including an estimated length of stay, and to document it in the patient's IRF medical record. The overall plan of care must detail the patient's medical

³¹ As interpreted by the Manual, chapter 1, §110.1.2.

³² Rehabilitation "physician extenders" in this case include nurse practitioners, physician assistants, and physicians other than rehabilitation physicians (CMS, *National Provider Training Call Transcript, Inpatient Rehabilitation Facility Prospective Payment System, "Physician Extenders,"* p. 16, May 31, 2012).

prognosis, anticipated interventions, functional outcomes, and discharge destination from the IRF stay, thereby supporting the medical necessity of the admission.³³

For 166 IRF stays, rehabilitation physicians did not document an individualized overall plan of care that met all of the requirements. For the 146 IRF stays not meeting the coverage requirements, medical reviewers could not identify individualized, overall plans of care supporting the medical necessity of the admission. The requirements for the documentation of individualized, overall plans of care were also not met for 20 of the 29 stays that generally met coverage requirements at admission but did not meet all documentation requirements.

For 104 stays, rehabilitation physicians documented only general and brief plans of care, not individualized and detailed plans that included medical prognoses, anticipated interventions, functional outcomes, estimated lengths of stay, and discharge destinations. For these stays, the rehabilitation physicians did not coordinate medical and functional courses of care for the patients, which could have identified and linked medical management to functional interventions and goals and to the complex conditions that require intervention by a rehabilitation physician. For 27 stays, treatment plans were developed and documented by therapists and nurses, not rehabilitation physicians as required, and were intended to be individualized, overall plans of care. These treatment plans did not contain decision making by rehabilitation physicians for a coordinated medical and functional rehabilitation course of care for the patient.

DEFICIENT DOCUMENTATION OF INTERDISCIPLINARY TEAM MEETINGS

For an IRF claim to be considered reasonable and necessary, the patient must require an interdisciplinary team approach to care, as evidenced by documentation retained in the patient's medical record. That documentation should contain summaries of interdisciplinary team meetings whose purpose is to foster communication among disciplines to establish, prioritize, and achieve treatment goals.³⁴ These summaries must (1) include the names and professional designations of the participants and (2) the results, findings, and decisions made at the team meetings and the rehabilitation physician's concurrence with those decisions (42 CFR § 412.622(a)(5)).³⁵ In addition, the team meeting must (1) be led by a rehabilitation physician; (2) consist of a registered nurse, social worker, or case manager and a licensed or certified therapist from each therapy discipline involved in treating the patient; and (3) occur at least once a week throughout the stay to implement appropriate treatment services and review progress toward goals.

³³ As interpreted by the Manual, chapter 1, § 110.1.3.

³⁴ CMS also stated: "Though we agree that informal communications among the disciplines on a daily basis are beneficial for the patient, we believe that it is important to require that all treating disciplines meet formally at least once per week to maximize the patient's potential for meeting the treatment goals." (74 Fed. Reg. 39795 (August 7, 2009)).

³⁵ As interpreted by the Manual, chapter 1, § 110.2.5.

For 106 IRF stays, medical record documentation was not compliant with the requirements for weekly interdisciplinary team meetings. The documentation was missing key elements that are intended to demonstrate a collaborative, interdisciplinary approach to care. Specifically, documentation retained in the patients' medical records of interdisciplinary team meetings did not provide enough detail to identify one or more of the following key elements:

- the results, findings, and decisions made at the meetings (74 stays);
- the names and professional designations of the participants (70 stays); and
- the concurrence of the rehabilitation physician with the results, findings, and decisions (50 stays).

Although therapists, nurses, and case management specialists may have individually documented weekly notes about the patient's medical and functional status, those notes were not documented as final decisions made by the interdisciplinary team at a weekly team meeting. The notes also did not clearly identify the rehabilitation physician's concurrence and participation in a meeting.

Documentation for some team meetings included only check boxes as patient status indicators. For other meetings, rehabilitation physicians briefly documented that team meetings took place and what was discussed. For all these stays, this documentation did not show a clear communication among disciplines for a coordination of care through an interdisciplinary team approach.

APPENDIX F: SAMPLED STAYS THAT WERE REASONABLE AND NECESSARY

The IRFs in our review complied with all Medicare coverage and documentation requirements for 45 of the 220 sampled stays. The medical records for these stays supported that IRF care was reasonable and necessary in accordance with Medicare's coverage and documentation requirements. Even though patients with other types of conditions may be suitable candidates for IRF care, these 45 stays were predominantly related to patient needs resulting from injuries and other impairments related to the head and spinal cord.³⁶

The preadmission screening documentation for these patients demonstrated that the patients had (1) complex nursing, medical management, and rehabilitation needs, requiring an interdisciplinary team approach to care supervised by a rehabilitation physician during an inpatient stay and (2) the ability to make measurable improvement that is of practical value to them according to predefined goals.

TWO EXAMPLES OF INFORMATION CONTAINED IN THE MEDICAL RECORDS FOR STAYS THAT WERE REASONABLE AND NECESSARY

The records for both these examples had the appropriate documentation elements required for the preadmission screening; a postadmission rehabilitation physician evaluation; an individualized, overall plan of care; and an interdisciplinary team approach to care. The documentation presented a detailed description of the patient's required needs for acute inpatient rehabilitation.

Example 1: According to the medical review contractor, the patient, who had previously been independent, had had multiple strokes. He had a significant blood circulation disorder in his left lower leg and had undergone emergency procedures to remove blood clots. When admitted for rehabilitation, the patient was at high risk of losing that leg. He was able to follow simple commands and perform transfers only with maximal assistance. He required complex pain management and skilled physical therapy, occupational therapy, and speech therapy services, as well as a high level of medical oversight and nursing care in the treatment of his medical conditions. He was medically stable and able to participate in and benefit from acute-level rehabilitation. With this therapy, it was anticipated that the patient would obtain measurable improvement that was of practical value to him.

³⁶ CMS National Provider Training Call Transcript, "Revised Inpatient Rehabilitation Facility Prospective Payment System Coverage Requirements," Nov. 12, 2009, p. 7. A patient meeting all of the coverage criteria for admission to an IRF, as supported by required medical record documentation, could be a candidate for IRF care. Available at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Coverage.html. Last accessed June 2017.

Example 2: According to the medical review contractor, the patient, who had previously been independent, injured his spinal cord in a fall. He depended on a ventilator and had bowel and bladder problems, with secondary complications of pneumonia and sepsis. He was able to participate in treatments that included weaning him off the ventilator, physical therapy, and occupational therapy for preventing further secondary complications and for improving mobility. He required speech therapy for swallowing and communication. His therapy goals were to obtain measureable improvement of practical value in recovering from infection, achieving bowel and bladder independence, progressing in the ability to swallow and communicate, developing tolerance for sitting in a wheelchair, and attaining mobility with the use of adaptive equipment. He had both medical needs and rehabilitation goals that required the complexity of acute-level rehabilitation and the specialty care of a spinal cord injury unit. A home discharge had been planned.

PROVIDER INTERNAL CONTROLS

We discussed internal control procedures with staff at several of the IRFs in our sample and determined that the IRFs that demonstrated compliance with Medicare coverage and documentation requirements had established strict admissions and quality control monitoring policies and procedures for Medicare coverage and documentation compliance. These IRFs had strengthened their controls as a result of the establishment of the 2010 Medicare requirements.

AN EXAMPLE OF ONE PROVIDER'S INTERNAL CONTROL PROCESS

We visited an IRF unit of an acute-care hospital that created internal controls in 2010 to comply with IRF coverage and documentation requirements that CMS revised in 2009.

The IRF described its preadmission screening process, which begins soon after it receives the order for the IRF admission. The IRF obtains all applicable medical records from the referring facility. The admission liaison nurse and rehabilitation physician review these records before the patient's admission and document their preadmission screening analysis and admission decision. If the order is for a patient in the acute-care hospital unit of the same facility, the admission nurse liaison and the rehabilitation physician also visit the patient, perform a physical examination, and document their findings. This admission team also visits outside facilities to perform preadmission screening for patients being referred to the team's IRF. Clinicians at this IRF stated that the appropriateness of the IRF admission depends on the completeness and accuracy of the preadmission screening they perform.

The IRF also designed its electronic medical record system to prompt the user to enter documentation required by Medicare and their facility. An electronic message prompts the rehabilitation physician and other users to enter scheduled documentation if it has not been properly completed in a timely manner. The physician director of the rehabilitation unit said these prompts include a reminder to the rehabilitation physician in charge of the patient to document an individualized, overall plan of care almost immediately after the patient's admission. Additional prompts require rehabilitation physicians to document weekly team meetings with a detailed description of patient status and to explain the need for continued inpatient rehabilitation.³⁷

³⁷ In addition, this rehabilitation physician director said he makes it his practice to seek out information at national professional society meetings to determine whether the IRF is providing a high quality of care in comparison to other facilities. He and his fellow physical medicine and rehabilitation physicians make daily visits to the patients, although many rehabilitation physicians at other facilities visit only the minimum number of three times per week as required by Medicare.

APPENDIX G: MedPAC RECOMMENDATIONS FOR REFORM OF INPATIENT REHABILITATION FACILITY AND POST-ACUTE-CARE PAYMENTS

INPATIENT REHABILITATION FACILITY PAYMENTS

MedPAC has made recommendations that could reduce Medicare spending on IRF stays. The Commission reported the following in 2017:

- Medicare payments to hospital-based IRFs in 2015 exceeded marginal costs by 20.5 percent, while Medicare payments to freestanding IRFs exceeded marginal costs by 41.5 percent.
- IRFs may differ in their assessment and coding of patients' motor and cognitive function. Although aggregate payments may be more than sufficient, payments for some IRFs may be too low relative to the costs incurred in treating their patients, while the payments for other IRFs may be too high.
- There are differences in freestanding and hospital-based IRFs' mix of cases, with some case types being more profitable than others, resulting in higher margins for facilities that admit larger shares of the cases.³⁸

Since 2009, as IRF profit margins have been greater than 10 percent for most of the last 10 years,³⁹ MedPAC has recommended reform in a 0-percent update to IRF payments and concluded, "In the absence of legislative action, CMS is required by statute to apply an adjusted market basket increase. Thus payments have continued to rise."^{40, 41}

POST-ACUTE-CARE PAYMENTS

IRFs provide one post-acute-care setting for Medicare beneficiaries. Other settings, each with a separate payment system, include home health agencies, skilled nursing facilities, and long-term-care hospitals. According to MedPAC, there is a variation in the supply and use of post-acute-care providers across the country and a substantial overlap in types of patients treated

³⁸ MedPAC, *Report to Congress: Medicare Payment Policy*, chapter 10, "Inpatient Rehabilitation Facility Services: Assessing Payment Adequacy and Updating Payments," March 2017, p. 258.

³⁹ MedPAC, *Report to Congress: Medicare Payment Policy*, chapter 7, "Post-Acute Care: The Congress and CMS Must Act To Implement Recommended Changes to PAC Payments," March 2017, p. 190.

⁴⁰ MedPAC, *Report to Congress: Medicare Payment Policy*, chapter 10, "Inpatient Rehabilitation Facility Services: Assessing Payment Adequacy and Updating Payments," March 2017, p. 259.

⁴¹ Individual market baskets for Medicare payment systems, such as the IRF PPS, are inflation-adjusted price indices that are developed to measure the price changes over time for each type of provider.

across these four settings, while Medicare continues to pay significantly different rates for similar patients depending on the setting.^{42, 43}

MedPAC has stated that an unnecessarily high level of spending—post-acute-care Medicare margins being greater than 10 percent for most of the last 10 years—has been high relative to the cost of treating beneficiaries. In response to the initial mandate of the Improving Medicare Post-Acute Care Transformation Act of 2014, MedPAC has recommended features of a unified post-acute-care payment system based on patient characteristics rather than setting, a closer alignment of costs and payments, more equitable payments across different kinds of patients, and outcomes-based quality measures.

MedPAC estimates that this system would redistribute payments among types of stays (from physical rehabilitation to medically complex care) and from higher cost settings and providers to lower cost settings and providers. Under this system, MedPAC says that (1) profitability should be more uniform across different types of stays or patients; (2) providers should therefore have less financial incentive to admit certain types of patients over others; and (3) payment would no longer be based in part on the number of services furnished, so providers would have less financial incentive to provide unnecessary services.⁴⁴

⁴² MedPAC, *Report to Congress: Mandated Report*, chapter 3, “Developing a Unified Payment System for Post-Acute Care,” June 2016, pp. 57, 63.

⁴³ B. Gage, M. Morley, et al., *The Post-Acute Care Payment Reform Demonstration, final report, “12.5 Next Steps,”* volume 4, March 2012, p. 251. Authorized by section 5008 of the Deficit Reduction Act of 2005, P.L. No. 109-171, and prepared for CMS by RTI International (RTI project number 0209853.005.001).

⁴⁴ MedPAC, *Report to Congress*: chapter 3, “Developing a Unified Payment System for Post-Acute Care,” June 2016, p. 59.

APPENDIX H: CMS COMMENTS



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

DATE: AUG 16 2018

TO: Daniel R. Levinson
Inspector General

FROM: Seema Verma
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Many Inpatient Rehabilitation Facility Stays Did Not Meet Medicare Coverage and Documentation Requirements (A-01-15-00500)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report.

CMS is committed to providing Medicare beneficiaries with high quality health care while protecting taxpayer dollars by preventing improper payments. CMS uses a robust program integrity strategy to reduce and prevent Medicare improper payments, including automated system edits within the claims processing system, and conducting prepayment and postpayment reviews. CMS is constantly looking for ways to improve this process; for example, in February 2018 CMS updated the Medicare Program Integrity Manual and provided guidance to Medicare contractors to clarify instructions for conducting medical review of inpatient rehabilitation facility claims. Specifically, it clarified the process for assessing intensity of services in relation to the inpatient rehabilitation facility benefit which will help ensure consistent interpretation of the policy.

Additionally, CMS has taken action to prevent improper Medicare payments by educating health care providers on proper billing for inpatient rehabilitation services. CMS educates health care providers on avoiding Medicare billing errors through various channels including the Medicare Learning Network, weekly electronic newsletters, and quarterly compliance newsletters. For example, the Medicare Administrative Contractors conducted outreach and education events, both one-on-one and seminar-structured events, with inpatient rehabilitation facilities on issues such as Medicare coverage rules, billing instructions, and certification requirements. CMS also maintains a provider resource mailbox specifically for inpatient rehabilitation facilities, through which we provide responses to a wide range of questions related to proper billing and other issues. Further, CMS has approved the Medicare Administrative Contractors to perform reviews of inpatient rehabilitation providers under its Targeted Probe and Educate Program. This program includes one-on-one education to reduce claim errors and denials for providers who have high denial rates or unusual billing practices. The level of educational intervention increases depending on the claim denial rates. Finally, CMS developed standardized denial reason statements for contractors to promote uniformity and help with provider understanding of billing issues and future compliance.

The OIG's recommendations and CMS' responses are below.

OIG Recommendation

The OIG recommends that CMS educate IRF clinical and billing personnel on Medicare coverage and documentation requirements and work with providers to identify, develop, and share compliance best practices that may lead to improved internal controls.

CMS Response

CMS concurs with this recommendation. CMS will continue to educate providers regarding Medicare coverage and documentation requirements for inpatient rehabilitation facilities. Additionally, CMS will explore ways to identify and share compliance requirements so providers can develop or improve internal controls.

OIG Recommendation

The OIG recommends that CMS increase oversight activities of IRFs, such as post payment medical review, to determine compliance with coverage and documentation requirements, including a review of a subsample of the 135 IRFs in this review that had 1 or more sampled stays that did not comply with Medicare requirements.

CMS Response

CMS concurs with this recommendation. CMS will instruct a Medicare review contractor to review a sample of the inpatient rehabilitation facilities identified in the OIG's audit to determine compliance with coverage and documentation requirements. Based on the findings of the sample review, CMS will determine the appropriate follow up course of action.

OIG Recommendation

The OIG recommends that CMS work with the Office of Medicare Hearings and Appeals to further evaluate the ALJ hearing process and make any necessary improvements to ensure that Medicare coverage and documentation requirements for IRF care are fairly represented.

CMS Response

CMS concurs with this recommendation. CMS will work with the Office of Medicare Hearings and Appeals, to the extent possible, to explore opportunities for improvement, such as policy education or contractor participation at hearings, so that Medicare coverage and documentation requirements for inpatient rehabilitation facilities are fairly represented and interpreted during Administrative Law Judge hearings.

OIG Recommendation

The OIG recommends that CMS reevaluate the IRF payment system, which could include conducting a demonstration project requiring preauthorization for Part A IRF stays modeled on Medicare Advantage practices, studying the relationship between IRF PPS payment rates and costs and seek legislative authority to make changes necessary to more closely align them, and considering the high error rate found in this report and CERT reviews in future acute inpatient rehabilitation services payment reform, which may be a component of a unified postacute care PPS system.

CMS Response

CMS concurs with this recommendation. CMS continuously evaluates the inpatient rehabilitation facility payment system on an annual basis and has recently issued the Fiscal Year 2019 Inpatient

Rehabilitation Facilities Prospective Payment System final rule, which updates Medicare policies and payment rates for fiscal year 2019. These changes, specifically the changes to the documentation requirements, may potentially decrease the number of improper payments. CMS will take the OIG's suggestions into account when determining appropriate next steps.

The State of Nursing Facilities in Oregon, State Fiscal Year 2018

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Diana Govier, MPH

**Oregon State University
College of Public Health and Human Sciences**

April 2019



**Oregon State University
College of Public Health
and Human Sciences**



The State of Nursing Facilities in Oregon, 2018

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Commented [MAE1]: You mention OHA Health Analytics later.
Do you want to include them here?

We are grateful to Alexandra Kaiser for her assistance in preparing this report.

Suggested Citation:

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Formatted: English (United States)

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Executive Summary

Nursing facilities are an integral component of Oregon's long term services and supports continuum, serving residents who need high-level skilled care on a short term or long term basis. This report presents the most recent federal and state data for all licensed nursing facilities that operated in Oregon during State Fiscal Year (SFY) 2018.

Commented [MAE2]: There is a lot of focus on individuals with dementia, and I would like to see something related to dementia included here.

Licensed Capacity and Occupancy. There were 11,102 licensed beds in Oregon's 136 nursing facilities in SFY 2018. The number of beds has decreased gradually since 2000, and the decline accelerated somewhat beginning in SFY 2015. Nevertheless, Currently, Oregon has the second lowest nursing facility occupancy rate among all 50 states and the District of Columbia, reflecting the state's ongoing commitment to community-based long-term care options, such as assisted living, adult foster care, residential care, and memory care. The total number of resident days per year in Oregon nursing facilities has remained stable at approximately 3 million since 2002. Nursing facilities are concentrated in urban areas, and seven counties had no freestanding nursing facilities.

Commented [DW3]: Does Oregon have the lowest rate of occupancy or the second lowest rate of occupancy? Other parts of this report state that Oregon has the lowest rate. Which one is it: lowest or second lowest?

Admissions, Discharges, and Reentries. There were 40,786 admissions to Oregon nursing facilities in SFY 2018, a 45% increase from 2012. Approximately 1 in 4 admissions was a reentry by a person who had been discharged from the nursing facility less than 30 days before. Slightly more than 95% of admissions were from acute care hospitals. During SFY 2018, Oregon nursing facilities statewide had 39,888 discharges, an increase of 23% from 2012. The large majority of discharges (71%) were to community settings, including home as well as community-based long-term care facilities. Of the 26% of discharges that were to acute care hospitals, more than 9 in 10 returned to a nursing facility within 30 days.

Commented [LK4]: Why is 2012 used as the benchmark year?

Residents. Nearly 47,000 individuals resided in an Oregon nursing facility for at least one day during SFY 2018. Most nursing facility residents (57%) were female, and more than 80% were 65 years of age or older. The nursing facility population is less racially and ethnically diverse than the general Oregon population.

Length of Stay. The average length of stay for residents discharged from Oregon nursing facilities in SFY 2018 was 49 days, but the median length was only 19 days. More than 7 in 10 stays lasted 30 days or less. This reflects the fact that most residents of Oregon nursing facilities are there to receive post-acute care or rehabilitation care after discharge from a hospital. Linkage to hospital discharge data showed that 59% of nursing facility stays were by residents who had been hospitalized for medical conditions, such as infections or pulmonary problems, while 33% had been hospitalized for surgical procedures such as joint replacement.

Commented [DW5]: Importantly, this explanatory trend is mentioned in the executive summary

Acuity of Residents. Most Oregon nursing facility residents required a great deal of assistance with the six basic activities of daily living (ADLs), that is, bed mobility, transferring, eating, dressing, toileting, and bathing. Forty-five percent of short nursing facility stays involved dependence on five or more ADLs, as did 60% of long stays. In addition, 92% of all nursing facility stays involved at least one chronic medical condition, such as hypertension, hyperlipidemia, and diabetes. Sixty-two percent of all nursing facility stays involved at least one

Commented [MAE6]: Can this term be defined? We talk a lot about mobility, but bed mobility is slightly different. Could we differentiate?

acute medical condition, such as anemia or urinary tract infections, and 43% of all stays involved behavioral health conditions such as depression or anxiety.

Payers. Medicaid was the primary payer for 61% of resident days in Oregon nursing facilities during SFY 2018. Traditional (fee-for-service) Medicare paid for 14% of days in 2018, while Medicare Advantage managed care plans paid for 10% of days. Private payers (including commercial insurers, long-term care insurance plans, and self-pay residents) paid for 12% of resident days.

Quality Measures. Oregon nursing facilities performed as well or better than the national average on 11 of 23 specific quality measures defined by the Centers for Medicare and Medicaid Services (CMS). Additionally, long-stay nursing facility residents in Oregon were less likely than the national average to receive antipsychotic, antianxiety, or hypnotic medications. Some measures for which Oregon nursing facilities did not perform as well as the national average included seasonal flu and pneumococcal vaccines, worsened ability to move independently, and self-reported moderate to severe pain for nursing facility long-stay residents, and having an outpatient emergency department visit and self-reported moderate to severe pain for short-stay residents.

Commented [MAE7]: Some items in this list have qualifiers (e.g., worsened ability) and others do not. I think it would be helpful to make it consistent one way or another, so it is clear to a reader not familiar with the measures.

Commented [DW8]: This is also a product of post-acute care and rehabilitation compared to other states where nursing facilities continue to play a larger role in housing than post-acute skilled rehab.

Would be good to add an explanatory sentence about the connection between pain and post-acute and rehabilitative care.

Commented [LK9]: Agree. Oregon's pain QM has historically been high for the short term stay residents. It is an area that should be examined further for improvement but much of it is due to the post acute episode.

Commented [MAE10]: I think this would be fine.

Background

This is the fifth annual report on Oregon nursing facilities funded by the Oregon legislature and prepared by Oregon State University in collaboration with the Oregon Department of Human Services (DHS), [LeadingAge Oregon](#), the Oregon Health Care Association, [SEIU](#), and the Oregon Health Authority's Office of Health Analytics. These new annual reports replace those published between 1998 and 2009 by the Office for Oregon Health Policy and Research (OHPR), in collaboration with the Seniors and People with Disabilities Division¹ of the Department of Human Services. The data in those prior reports were based on annual surveys of the state's nursing facilities and are included in this report as trend data.

Commented [MAE11]: Wondered if you wanted to include them on the cover page...

The purpose of this annual report is to paint a portrait of Oregon's the 136 Oregon nursing facilities that were in operation in the 2018 state fiscal year to assist in local and statewide planning and policy-making efforts in long-term care services.

In this report, we use data from the Centers for Medicare & Medicaid Services' (CMS) Minimum Data Set (MDS) 3.0 and Nursing Home Compare 3.0, Oregon hospital discharge data, and Oregon provider tax cost and revenue reports. We examine an array of characteristics of the state's nursing facilities, including licensed capacity, bed availability, occupancy, admissions, discharges, readmissions, resident characteristics, length of stay, acuity, payer sources, and quality metrics.

Introduction

Oregon continues to be a bellwether for reform and innovation in long-term services and supports (LTSS) in the United States. LTSS refers to an array of medical, social, and support services for individuals who, for an extended period of time, are dependent on others for assistance. The focus of this report is on nursing facilities, which are an important part of LTSS in Oregon. Nursing facilities provide 24-hour medical care and monitoring for people who need it due to a disability or have been discharged from the hospital but are not yet able to return to the community. Thus, nursing facilities serve two different populations—individuals with post-acute care needs, which are characterized by short stays (≤ 90 days), and individuals with ongoing and indefinite needs, which are characterized by longer or indefinite stays (>90 days). While nursing facilities are the most clinically intensive setting in Oregon's long-term care continuum, and they are critical for both short-stay and long-stay individuals with a high need for skilled care. The services offered in nursing facilities are often comprehensive, and include medical treatment, physical, speech and occupational therapy, assistance with the Activities of Daily Living, case management, and social services. Nursing facilities will continue to be an

Commented [MAE12]: The Katz Scale refers to mobility in general, which is why I think it important to differentiate between that and bed mobility.

¹ Now called the Aging and People with Disabilities Program. Prior to 1998, the Office of Health Policy also conducted surveys of nursing facilities.

² The Activities of Daily Living (ADLs; Katz et al., 1963) measure the functional impairment of individuals (Katz, Ford, Moskowitz, Jackson, & Jaffe, 1963). ADLs commonly refer to assistance with bathing, eating, dressing, mobility, transferring, grooming, and toileting.

Research Highlights

Commented [MAE13]: On all of the data points in this section that mention a national stat, we should use the word Oregon to clarify which stats are Oregon's and which are national. It is confusing in some spots, and I want this to be accessible to readers who don't know too much about our systems or settings.

This report provides a comprehensive and current look at the state's 136 certified nursing facilities in State Fiscal Year 2018 (SFY), which covers the period of July 1, 2017 to June 30, 2018.³

Nursing facilities serve long-term care residents with the most acute care needs, such as those receiving post-acute care after being hospitalized. The state's nursing facility population reflects its the state's continued efforts to direct as many individuals as possible into community-based long-term care options, including assisted living, residential care, and adult foster care.

Commented [DW14]: This is a notable point

There were 11,102 licensed beds in Oregon nursing facilities in SFY 2018 (Exhibit 1.0). The number of facilities per county ranged widely, from zero here in seven counties to 34 in Multnomah County, for an average of 4 facilities per county statewide.

In 2018, 46,931 individuals required services in an Oregon nursing facility for at least one day, representing a 1% decrease from SFY 2017, and the first year since 2012 that a decrease has been observed. Compared to national averages, the residents of Oregon nursing facilities were more likely to be under age 85 and non-Hispanic white, but less likely to be female.

Other notable findings in this report are highlighted below.

Exhibit 1.0. Characteristics of Oregon Nursing Facilities, OR Fiscal Years, 2018

Characteristic	
Total number of facilities	136
Total number of licensed beds	11,102
Average licensed capacity per facility	82
Minimum number of licensed beds	5
Maximum number of licensed beds	214
Average number of facilities per county	4

Sources: Cost Reports, Revenue Statements, and Nursing Home Compare 3.0

Facilities

- The number of facilities ranged widely across counties, with an average of 4 per county.
- Over two-thirds of all facilities (67%) were small- to medium-sized facilities with fewer than 100 beds, accounting for more than half (55%) of all beds statewide.

Licensed Capacity & Bed Availability

- The total number of licensed beds has declined consistently (15.4%) over the past 18 years, to 11,102 in 2018. This decline accelerated beginning in 2015, which may in part be due to

³ Unless otherwise noted, all references to 2017 refer to the State Fiscal Year.

Oregon House Bill 2216 that reimbursed quality nursing facilities for voluntarily reducing bed capacity.

- The average number of licensed beds was 82, compared to the national average of 109 in 2014.
- The number of licensed beds per facility ranged from five to 214.
- The number of licensed beds per 1,000 population 75 years and older increased by 1% from 40 in 2017 to 41 in 2018. However, there has been a relatively consistent decline (32%) in the number of licensed beds per 1,000 population 75 years and older in the last 19 years.
- 80% of licensed beds statewide were staffed and ready for use (i.e., set-up), however, the percentage of set-up beds ranged widely across the state, from a low of 58% in Umatilla County to a high of 100% in Curry, Douglas, Grant, Lincoln, and Malheur Counties.

Commented [LK15]: This should be past tense.

Commented [MAE16]: agree

Commented [LK17]: Quality should be deleted.

Commented [MAE18]: agree

Commented [DW19]: Is quality the basis for the bed capacity reduction deal?

Commented [MAE20]: I don't believe so.

Commented [MAE21]: It seems odd to me that we are comparing a national average from 2014 to our state average in SFY 2017. Are there any more recent national numbers or estimates?

Occupancy

- Average occupancy rates decreased from 72% in 2000 to 67% in 2017 and 2018, a 1% increase from 2016. Oregon continues to have the lowest occupancy rate in the nation.
- Across counties, average occupancy rates ranged from 40% to 84%.
- Oregon nursing facilities with less-fewer than 50 beds had an average occupancy rate between 4 to 7 percentage points higher than larger facilities of any other size. Facilities with 100 to 149 beds had the lowest average occupancy rate (64%) compared to facilities of other sizes.
- Between 2010 and 2018, the number of resident days has remained relatively stable; however, there was a 0.4% decrease in resident days from 2017 to 2018.
- Facilities with 50-99 beds accounted for the greatest share of resident days (48%) among all facilities.
- Multnomah, Clackamas, Lane, and Washington Counties had the highest numbers of total resident days, accounting for 26, 11, 10, and 9% of all resident days statewide, respectively.

Commented [DW22]: Is Oregon first or second?

Admissions, Discharges and Reentries⁴

- 95% of all admissions came from acute care hospitals.
- Facilities with less than 50 beds had the lowest average numbers of admissions and discharges (139 and 143, respectively), whereas facilities with 150+ beds had the highest average numbers of admissions and discharges (442 and 457, respectively).
- 26% of all discharges were to an acute care hospital; 93% of these discharges to hospitals subsequently reentered a nursing facility within a 30-day period.
- 71% of all discharges returned to the community.

Commented [LK23]: Another telling data point.

Commented [MAE24]:

Commented [MAE25]: Does this include community-based long term care settings or just non-facility settings?

⁴ An admission refers to an entry into a nursing facility by an individual for the very first time or for the first time after having been discharged from the facility at least 30 days before. A reentry occurs when an individual returns to a facility from which he or she was discharged less than 30 days before. A discharge refers to an individual being released from a nursing facility whether they re-enter or not.

Residents

- The state's nursing facility population was younger than national estimates, with 81% of nursing facility residents being age 65 or older, compared to 85% of residents nationwide.
- 43% of residents were male compared to 33% of U.S. nursing facility residents.
- Racial/ethnic minority individuals were under-represented in Oregon nursing facilities compared to the Oregon general population and to nursing facilities nationally.
- Racial/ethnic minority residents were younger compared to the state's general nursing facility population.

Length of Stay

- 73% of Oregon nursing facility stays lasted 30 days or less.
- 92% of all nursing facility stays were less than or equal to 90 days, referred to as a "short stay."
- Short- and mid-length stays—meaning stays for less than a full year—averaged 30 days compared to 916 days (or approximately 2.5 years) for long-stays.
- Average lengths of stay were highest for the younger residents (18 to 24 years) at 98 days.
- The median length of stay in Oregon facilities was 19 days.
- 59% of nursing facility stays linked to hospital discharges were for residents who had been hospitalized for medical conditions, such as infections or pulmonary problems, while 33% had been hospitalized for surgical procedures.
- The overall average nursing facility length of stay was 24 days for stays linked to hospital discharges, with a median of 18 days.

Acuity of Residents

- Average ADLs of nursing facility residents decreased 6.7% from 3.74 in 2012 to 3.48 in 2018.
- 48% of stays involved residents who were somewhat or completely dependent on five ADLs, compared to 23% of all nursing facility residents in the U.S.
- 45%, 60%, and 64% of short-, mid-, and long-stays, respectively, involved dependence on five or more ADLs.
- Stays of residents under 18 years of age had higher levels of complete dependence than stays of other age groups for all ADLs except bed mobility.
- Bathing was the most common ADL need for all stays (72%), followed by toileting (70%) and bed mobility (69%).
- 62% of stays involved at least one acute medical condition, with anemia, cancer, and urinary tract infections being the most common individual diagnoses.
- 92% of stays involved at least one chronic medical condition, with seven in 10 having hypertension, more than four in 10 having hyperlipidemia, and more than three in 10 having diabetes.
- Physical therapy was provided five or more days per week for 83% of short stays.
- Occupational therapy was provided five or more days per week for 77% of short stays.

Payers

- Medicaid was the primary payer for 61% of resident days in Oregon nursing facilities during 2018, a proportion that has remained relatively stable since 2010.
- Medicaid paid for 61, 57, and 73% of resident days in urban areas, large rural cities/towns, and small/isolated rural towns, respectively.
- Medicare Fee-For-Service paid for 14% of Oregon nursing facility resident days in 2018. Medicare Advantage managed care plans paid for 10% of days.
- Private payers (including commercial insurers, long-term care insurance plans, and self-pay residents) paid for 12% of all resident days.

Quality Measures

- Oregon nursing facilities performed the same or better than the national average on 11 of 23 CMS-defined quality measures.
- Oregon facilities' average performance on individual quality measures in 2018 was similar to 2017 and 2016.
- For long-stay residents, average rates of pneumococcal pneumonia vaccination decreased in Oregon facilities compared with 2017, and seasonal flu vaccination in Oregon facilities stayed the same compared with 2017, remaining somewhat lower than the average for all nursing facilities nationwide.
- For short-stay residents, average rates of vaccination for pneumococcal pneumonia and seasonal flu in Oregon facilities stayed the same compared with 2017, but were lower than the average for all nursing facilities nationwide.
- Reported rates of pain were higher among both short- and long-stay residents in Oregon facilities than nationwide, which may reflect the higher acuity of nursing facility residents in Oregon, particularly residents receiving post-acute care after hospitalization for surgery such as joint replacement, which may increase their need for pain control.
- Like 2017, short- and long-stay nursing facility residents in Oregon were less likely than the national average to receive antipsychotic, antianxiety, or hypnotic medications. In addition, fewer long-stay residents reported having depressive symptoms compared with the average rates for all nursing facilities nationwide.
- Rates of several negative outcomes among long stay residents (for example, losing too much weight/excessive/unsafe weight loss, high-risk patients with development of pressure ulcers, presence of urinary tract infections, or occurrence of falls with major injury) were somewhat higher in Oregon than the national average.
- Short stay residents in Oregon nursing facilities were more likely than the national average to visit a hospital emergency department, but less likely to be re-hospitalized after entering the nursing facility.

Commented [MAE26]: What are actual numbers? How far below are we?

Commented [MAE27]: What are actual numbers? How far below are we?

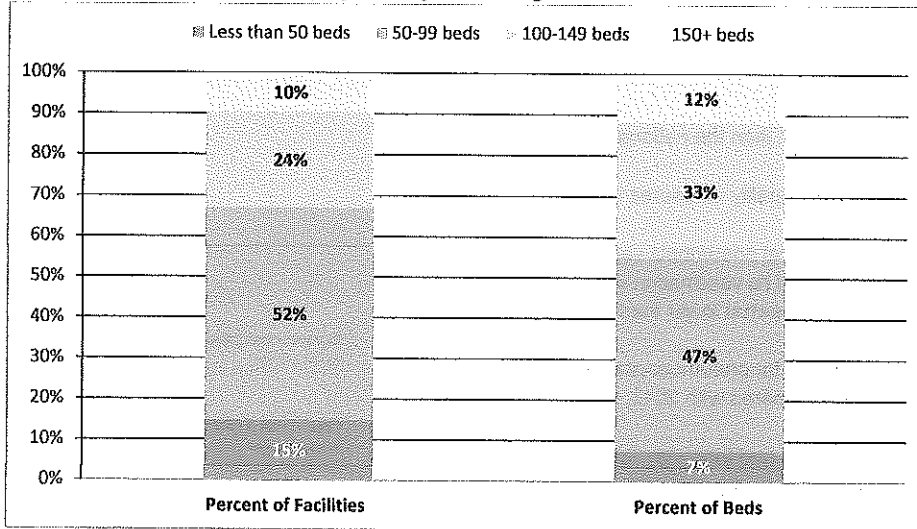
Commented [DW28]: A note about this should be included in the summary of

Commented [MAE29]: I'm fine with this. It will also be a good point to bring up in the policy/trend document.

Section 1. Licensed Capacity

Oregon had 136 nursing facilities in SFY 2018, with a total of 11,102 licensed beds (Exhibit 1.1). Sixty-seven percent of all facilities had fewer than 100 beds, accounting for more than half (55%) of all beds statewide. The average number of licensed beds was 82, compared to 108 nationally in 2016, the most recent data available (Harrington & Carrillo, 2018).

Exhibit 1.1. Licensed Capacity by Facility Size, Oregon 2018



Sources: Cost Reports, Revenue Statements, and Nursing Home Compare 3.0

The total number of nursing facilities in Oregon (n=136) was similar to the total number in 2016 and 2017 (n=137). Two nursing facilities changed ownership at the beginning of or during SFY 2018. One facility closed, and no facilities opened during SFY 2018.

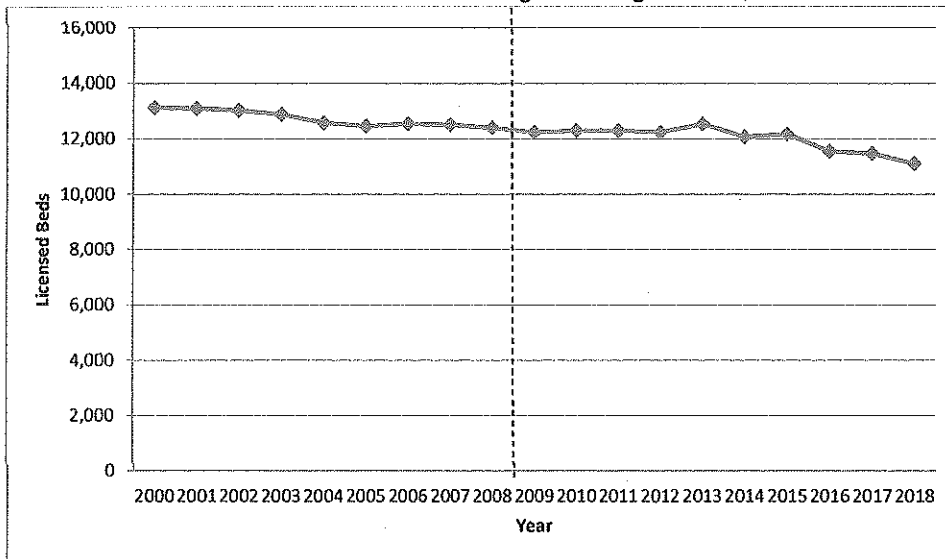
The total number of licensed nursing facility beds in Oregon declined 15.4% over the last 19 years, from 13,127 in 2000 to 11,102 in 2018 (Exhibit 1.2). The total number of licensed beds in 2018 declined slightly (3%) from 2017. The dashed vertical line between 2000-08 and 2009-18 signifies a change in the methodology used to obtain the data reported in this exhibit and in Exhibit 1.3 (page 10). Thus, the trends for these two time periods may not be completely comparable.⁵

⁵ Data for the 2000-08 period are based on information used by the state for facility licensing. The trend for 2009-18 come from state and federal data collected as part of the reporting requirements for nursing facility certification and payment.

One contributor to the decrease in licensed beds was reductions in licensed beds at existing facilities. During 2017, one facility reduced its number of licensed beds, while two facilities increased their number of licensed beds.

The long-term decrease in licensed bed-capacity contrasts with the national trend, which has remained relatively stable since 2004 (American Health Care Association, 2015). Oregon has the third lowest number of nursing facility residents per 1,000 population 65 years and older in the United States (Reinhard et al., 2014), providing further evidence of the state's commitment to non-institutionalized long-term care.

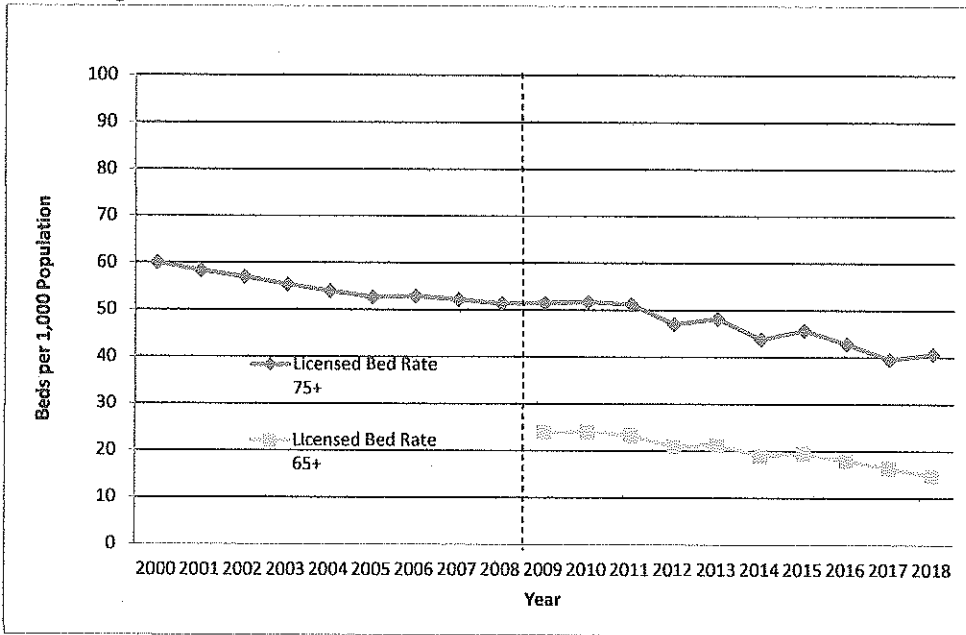
Exhibit 1.2. Total Number of Licensed Beds in Oregon Nursing Facilities, 2000–2018



Sources: OHPR Nursing Facility Reports, 2000-08; Cost Reports, Revenue Statements, and Nursing Home Compare 3.0, 2010-18

The number of licensed beds per 1,000 population has declined steadily for the 75 years and older population since 2000 (60 vs. 41; Exhibit 1.3) and for the 65 years and older population since 2009 (24 vs 15; Exhibit 1.3). The 32% decrease over the past 19 years in licensed beds per 1,000 population 75 years and older reflects the overall reduction in licensed capacity and the growth in the state's older population during this same time period. Over the last 10 years, the decrease in the number of licensed beds per 1,000 was smaller for the population 75 years and older (21%) than for the population 65 years and older (39%). This reflects faster population growth among individuals in the oldest age categories, consistent with national demographic trends in the U.S. population.

Exhibit 1.3. Licensed Bed Rate per 1,000 Population 75 Years and Older and 65 Years and Older, Oregon 2000–2018



Sources: OHPR Nursing Facility Reports, 2000-08; Cost Reports, Revenue Statements, and Nursing Home Compare 3.0, 2009-18

Section 2. Bed Availability

In 2018, there were 41 licensed beds per 1,000 population 75 years and older in Oregon (Appendix, Table A). This rate varied widely across the state's 36 counties. Seven counties—Baker, Gilliam, Harney, Morrow, Sherman, Wallowa, and Wheeler—had no nursing facilities and thus no beds. Among counties that had nursing facilities, the number of licensed beds per 1,000 population 75 years and older ranged from a low of 12 in Lincoln County to a high of 155 in Wasco County (Appendix, Table A).

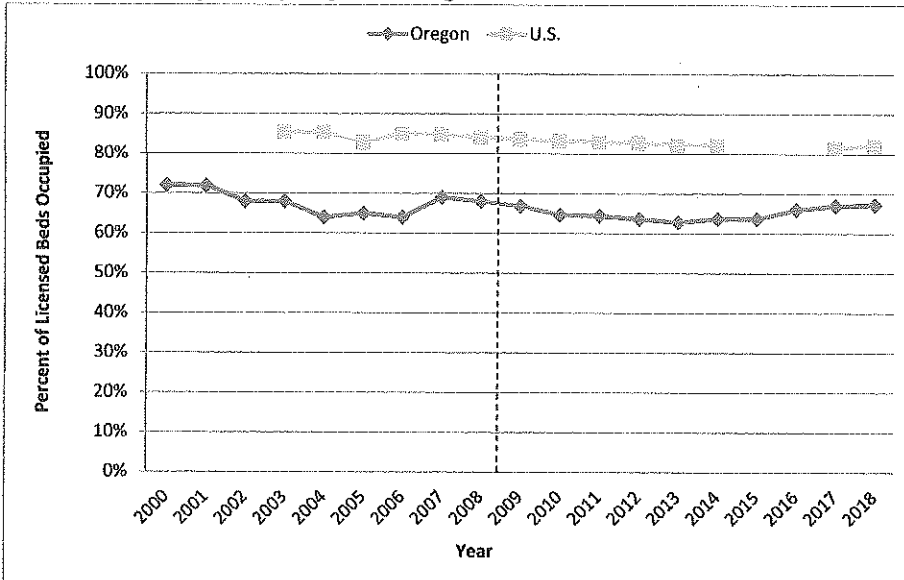
Statewide, 82% of licensed beds were staffed and available for use, what we refer to as "set-up." However, the proportion of licensed beds that were "set-up" varied widely across the state. For example, Umatilla County had the lowest percentage of licensed beds that were set-up (58%), followed by Hood River (60%). Five counties had 100% of licensed beds that were set-up: Curry, Douglas, Grant, Lincoln, and Malheur. There was a more than fifteen-fold difference in the number of set-up beds per 1,000 adults 75 and older across Oregon, from a low of eight in Jefferson County to a high of 124 in Wasco County (Appendix, Table A).

Section 3. Occupancy

The average occupancy rate⁶ statewide decreased from 72% in 2000 to 67% in 2018 (Exhibit 3.1). The average occupancy rate remained relatively stable between 2016 (66%) and 2018 (67%). The dashed line between the 2000-09 and 2010-18 periods signifies a change in the methodology used to obtain the data reported in this exhibit. Thus, the trends for these two time periods may not be completely comparable.⁷

Nonetheless, in 2016, the most recent data available on state rankings, Oregon's average nursing facility occupancy rate ranked as the second lowest in the nation, greater only than Utah (The Henry J. Kaiser Family Foundation, 2018).

Exhibit 3.1. Average Occupancy Rate, Oregon and U.S. 2000–2018



Sources: Oregon occupancy rate 2000-2008: OHPR Nursing Facility Reports; Oregon occupancy rate 2009-2018: Cost Reports, Revenue Statements, and Nursing Home Compare 3.0; National occupancy rate: 2003-2016: The Henry J. Kaiser Family Foundation; National occupancy rate 2017-2018: National Investment Center for Seniors Housing & Care (NIC), Skilled Nursing Data Report, 2017 & 2018.

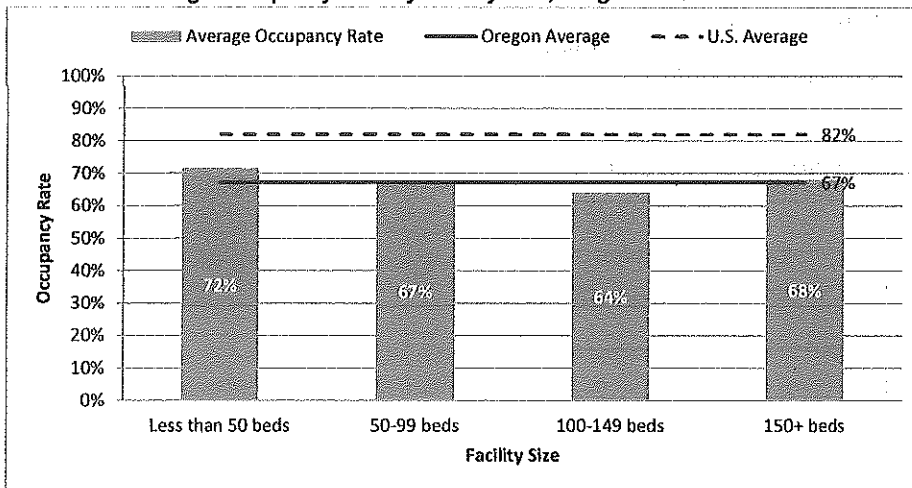
In SFY 2018, the average statewide occupancy rate of 67% (Exhibit 3.2) was 15 percentage points lower than the national average (82%) in 2018 (the most current data available for

⁶ A facility's occupancy rate is the total number of resident days reported by that facility during the state fiscal year divided by the total number of bed days available at that facility during the same fiscal year. Occupancy rates are adjusted for facility openings and closings during the state fiscal year.

⁷ Data for the 2000-08 period were collected from annual surveys of the state's nursing facilities, and year-by-year fluctuations reflect variation in responses rates to the survey. Data for 2009 and later years come from state and federal reporting for nursing facility certification and payment, which are not affected by response rates.

national average occupancy rates) (National Investment Center for Seniors Housing & Care, 2017). Smaller nursing facilities with less than 50 beds had a higher average occupancy rate (72%) than facilities of any other size whereas facilities with 100 to 149 beds had the lowest occupancy rate (64%). The occupancy rate for facilities with 150 or more beds increased by seven percentage points from 2017 to 2018 but the rates for other-sized facilities were similar to those in 2017.

Exhibit 3.2. Average Occupancy Rate by Facility Size, Oregon 2018



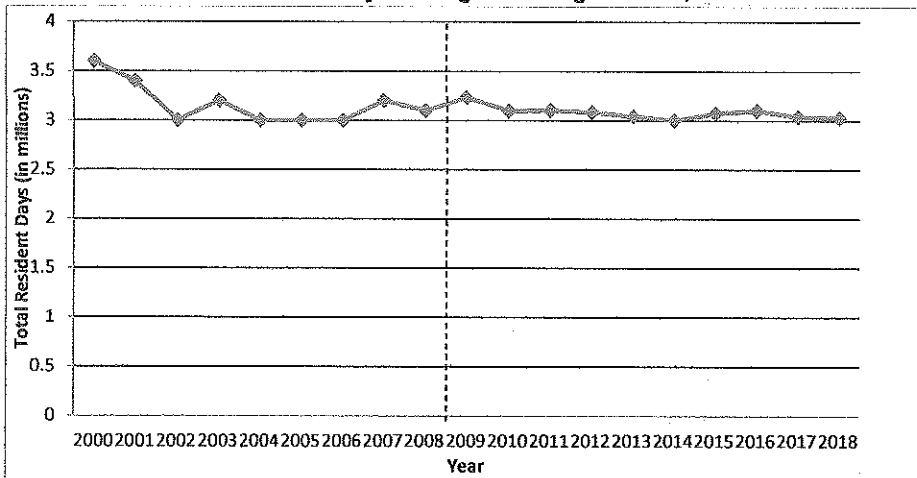
Sources: Cost Reports, Revenue Statements, and Nursing Home Compare 3.0; National Investment Center for Seniors Housing & Care (NIC), Skilled Nursing Data Report, 2018.

Average occupancy rates also varied across the state's 36 counties (Appendix, Table A). Jefferson (84%), Klamath (77%), Linn (75%), Jackson (73%), Multnomah (73%), Lincoln (73%), Washington (72%), Douglas (72%), Marion (69%), Crook (69%), and Clackamas (69%) counties had occupancy rates higher than the statewide average of 67%. Twelve counties had rates under 60%, with Clatsop County having the lowest occupancy rate (40%) of all counties statewide.

Exhibit 3.3 shows the total number of resident days for Oregon nursing facilities, which declined between 2000 and 2008, from 3.6 million to 3.1 million. The number of resident days decreased by 6.4% in the last 10 years, from 3.23 million in 2009 to 3.02 million in 2018.

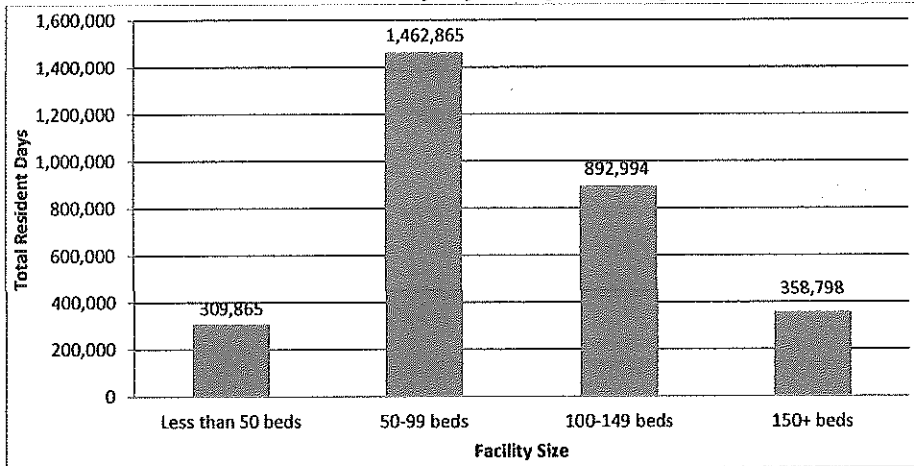
Facilities with 50-99 beds accounted for the greatest share of resident days (48%) among all facilities in 2018 (Exhibit 3.4). In contrast, the smallest- and largest-sized facilities had the fewest numbers of resident days, representing 10% and 12% of all resident days statewide, respectively. This overall pattern is consistent with 2016 and 2017 data although the proportion of resident days by facility size changed somewhat since 2017. Resident days decreased for facilities with less than 50 beds, 50-99 beds, and 150+ beds, with facilities with less than 50 beds having the largest decrease from 2017 (1.4%). On the other hand, resident days increased for facilities with 100-149 beds, representing a 4.6% increase from 2017.

Exhibit 3.3. Number of Resident Days in Oregon Nursing Facilities, 2000–2018



Sources: OHPR Nursing Facility Reports, 2000-08 (adjusted for annual survey response rates); Cost Reports, Revenue Statements, and Nursing Home Compare 3.0, 2009-18

Exhibit 3.4. Total Number of Resident Days by Facility Size, Oregon 2018

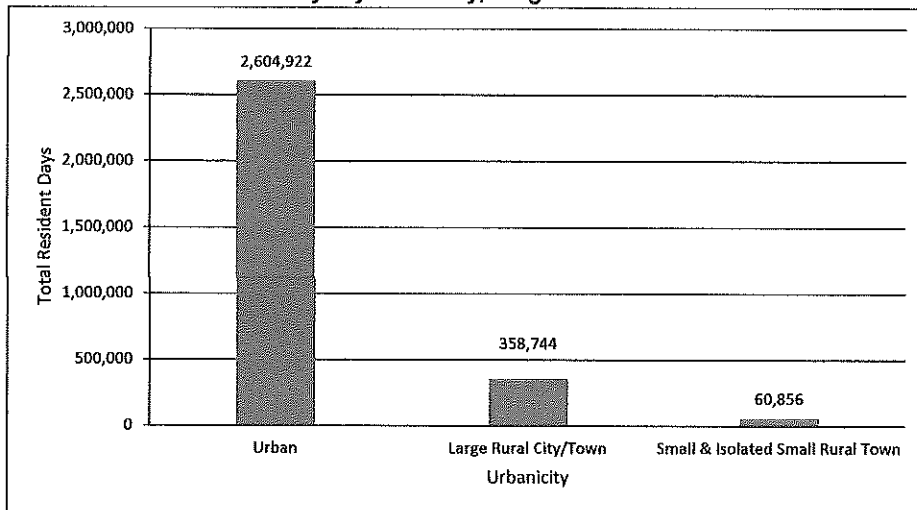


Sources: Cost Reports, Revenue Statements, and Nursing Home Compare 3.0

The total number of resident days in 2018 also varied by county (Appendix, Table A). Consistent with 2017 numbers, Multnomah, Clackamas, Lane, and Washington Counties had the highest numbers of total resident days, accounting for 26, 11, 10, and 9% of all resident days statewide, respectively.

Exhibit 3.5 shows resident days by Rural-Urban Commuting Area (RUCA) categories that we refer to as "urbanicity." RUCA categories are defined by U.S. Census tracts, where "urban" refers to an area with a population $\geq 50,000$, "large rural city/town" refers to an area with a population from 10,000-49,999, and "small and isolated small rural town" refers to a population size of 2,500-9,999 (Rural Health Research Center, n.d.).⁸ As expected, 86% of all resident days were in urban areas (Exhibit 3.5), compared to 12% and 2% in large rural towns and small rural towns, respectively.

Exhibit 3.5. Total Resident Days by Urbanicity, Oregon 2018



Sources: Cost Reports, Revenue Statements, RUCA 2.0, and Nursing Home Compare 3.0

⁸ See Technical Notes for more detailed information on these definitions.

Section 101 - Introduction

101-101-1

The purpose of this document is to provide a clear and concise overview of the project's objectives and scope. This document will serve as a reference for all project-related activities and will be updated as the project progresses.

The project is designed to address the current challenges faced by the organization and to provide a sustainable solution. The project will be completed within the specified timeline and budget.

The project team consists of experienced professionals who are committed to the success of the project. The team will work closely with the stakeholders to ensure that the project meets their needs and expectations.

The project will be managed using a structured approach that includes regular communication and reporting. The project manager will be responsible for ensuring that the project stays on track and that all deliverables are met.

The project will be completed by the end of the year. The project team will provide a final report to the stakeholders, detailing the project's progress, achievements, and lessons learned. The project team will also provide ongoing support to the organization to ensure the successful implementation of the project's findings.

The project team will be responsible for the following tasks:

- Conducting a thorough analysis of the current situation.
- Developing a detailed project plan.
- Implementing the project plan.
- Monitoring and reporting on project progress.
- Providing ongoing support and training to the organization.

Section 4. Admissions, Discharges, and Reentries

Methodology

An admission refers to an entry into a nursing facility by an individual. There are two categories of admissions, according to CMS Minimum Data Set (MDS) definitions:

- An entry is when an individual enters a facility for the very first time, or for the first time after having been discharged from the facility at least 30 days before.
- A reentry is when an individual returns to a facility from which he or she was discharged less than 30 days before.

A discharge refers to when a person leaves a nursing facility to return to the community, to be admitted to a hospital, or to go to other destinations. A nursing facility stay is a period of continuous residence in a nursing facility, beginning with an admission and ending with a discharge.

For this report we first identified discharges in the MDS, and then identified the admission date that corresponded to each discharge; the nursing facility stay was constructed as the period from admission to discharge.⁹ We also identified reentries directly, using dates of discharge from and reentry to the same facility within 30 days. We excluded from our analyses nursing facility stays for which the MDS does not include a discharge date. See the Technical Notes for further details.

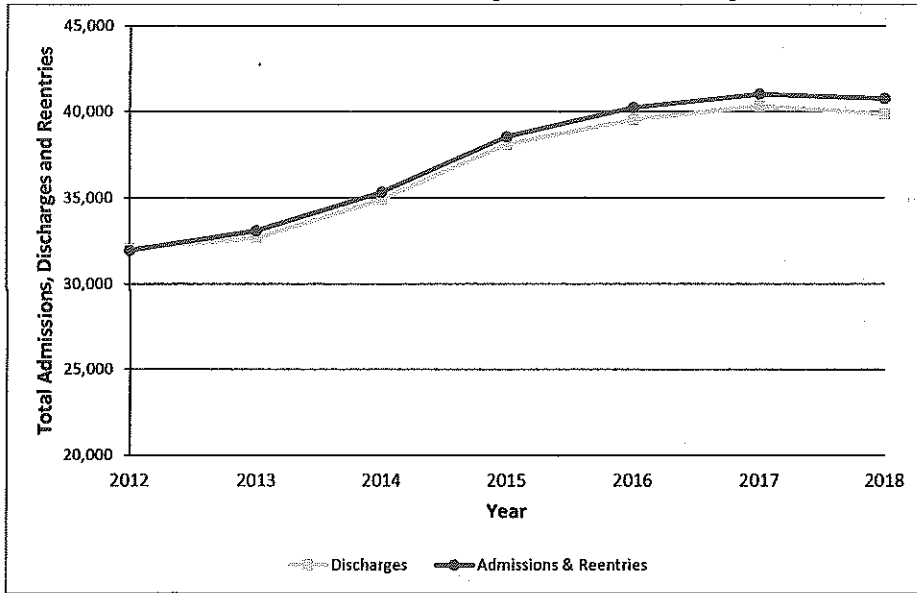
The total number of nursing facility admissions in SFY 2018 included in this report is 40,786¹⁰ (all admissions with a discharge date in MDS), which is within 6% of the total number of Oregon nursing facility admissions derived from detailed annual cost reports submitted to the Centers of Medicare and Medicaid Services by nursing facilities (Hansen Hunter & Co., 2019).

As shown in Exhibit 4.1, admissions and reentries and discharges increased overall from 2012 to 2018 (22.8%, 24.5%, and 45.2%, respectively). The numbers of admissions and reentries increased steadily from 2012 (31,954) to 2017 (41,029), and decreased slightly to 40,786 in 2018, suggesting a leveling off in recent years. Similarly, discharges increased from 32,048 in 2012 to 40,332 in 2017, and then decreased slightly to 39,888 in 2018. The percent increases in admissions, discharges, and reentries

⁹ As described in the Technical Notes, we began using the current approach for identifying stays in the 2015 report. For persons still residing in a nursing facility on the date the MDS dataset was created for Oregon State University, March 15, 2019, we constructed a stay that began on the admission date and ended on December 4, 2018.

¹⁰ There were a total of 41,684 nursing facility admissions in Oregon before excluding 898 admissions without a discharge date in MDS.

Exhibit 4.1. Trend in Total Admissions, Discharges and Reentries, Oregon 2012–2018

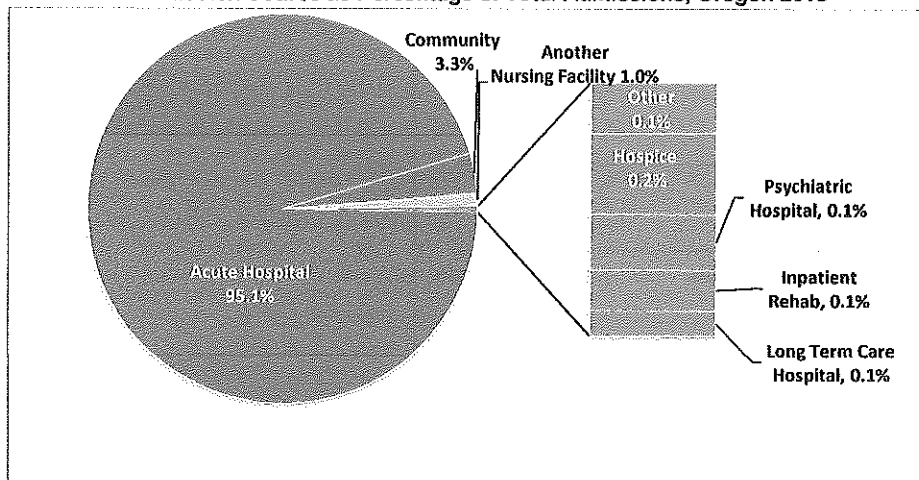


Source: CMS Minimum Data Set

Admissions

In SFY 2018, nursing facilities statewide had 40,786 admissions, based on MDS data. Of these, 9,973 (24.5%) were reentries. Exhibit 4.2 displays the admission source as a percentage of total admissions. Acute hospitals accounted for the highest percentage at 95.1%. Community admission sources contributed 3.3% while another nursing home accounted for 1.0% of total admissions. This pattern has been consistent since 2012 (See Appendix Table B).

Exhibit 4.2. Admission Source as Percentage of Total Admissions, Oregon 2018

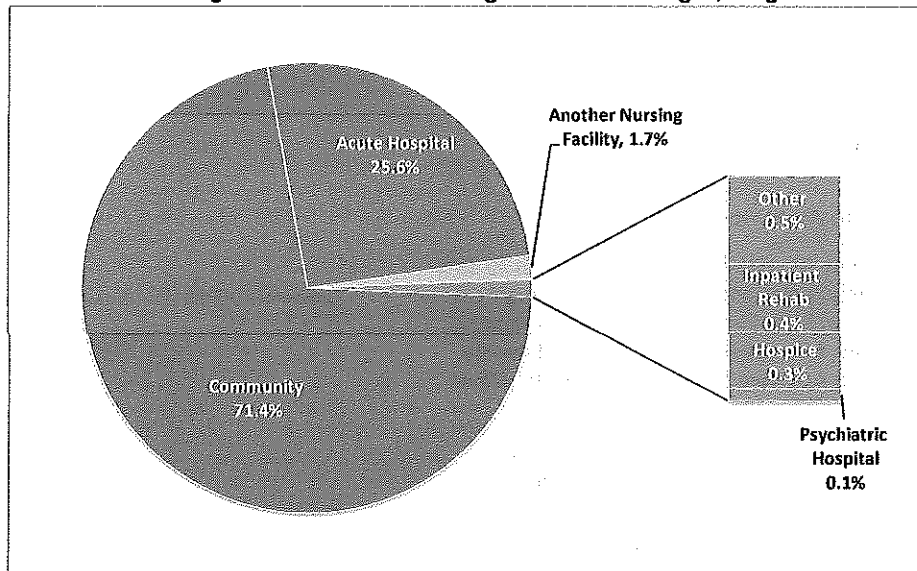


Source: CMS Minimum Data Set

Discharges

In 2018, nursing facilities statewide had 39,888 discharges, based on MDS data. Exhibit 4.3 presents discharge destination as a percentage of total discharges. The majority of individuals who discharged from nursing facilities returned to the community (71.4%), which includes other long-term care settings such as assisted living, residential care, and adult foster care. Slightly more than 1 in 4 discharges from nursing facilities (25.6%) were to acute care hospitals. A small proportion of residents (1.7%) were transferred to another nursing facility or other facility (0.5%), which included long-term care hospitals or facilities not otherwise specified. Inpatient rehabilitation, hospice, and psychiatric hospitals represented less than one percent of all discharges. The distribution of discharge destinations has been very similar since 2012, except that the proportion of discharges to the community has increased slightly, and the proportion to hospital has decreased slightly (see Appendix Table C).

Exhibit 4.3. Discharge Destination as Percentage of Total Discharges, Oregon 2018

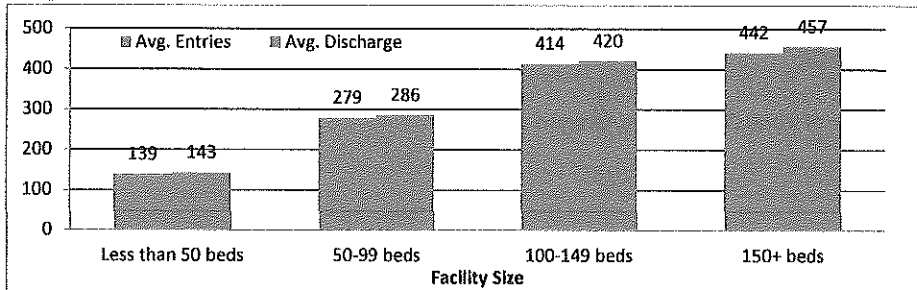


Source: CMS Minimum Data Set

Admissions and Discharges by Facility

Statewide, the average number of admissions per facility was 293 in SFY 2018, and the average number of discharges was 300. Exhibit 4.4 shows that the average numbers of admissions and discharges increased with the size of facility. Facilities with less than 50 beds had the lowest average numbers of admissions and discharges (139 and 143, respectively) and facilities with 150+ beds had the highest average numbers of admissions and discharges (442 and 457, respectively).

Exhibit 4.4. Average Numbers of Admissions and Discharges by Facility Size, Oregon 2018



Source: CMS Minimum Data Set

Reentries to Nursing Facilities after Discharge to Acute Hospitals

As mentioned earlier in this section, some individuals return to nursing facilities within 30 days of being discharged. This event, defined as a reentry,¹¹ may occur as part of a treatment plan or as a result of a new or unexpected health problem. In State Fiscal Year 2018, approximately one in four nursing facility admissions was a reentry, for a total of 9,973 reentries statewide. Ninety-five percent of these reentries (9,444; Exhibit 4.5) were from an acute hospital. Other reentries came from the community (3%), and other places (2%; data not shown).

Commented [DW30]: This (see footnote) is an important clarifying statement

Exhibit 4.5 shows the numbers of discharges to acute care hospitals, the number of those discharges followed by reentries to nursing facilities, and the percent reentering within 30 days. Of the 10,173 nursing facility discharges to acute care hospitals, 93% reentered the same nursing facility within a 30-day period. Reentry rates varied only modestly by facility size. Facilities with 150+ beds had the highest reentry rate (96%), and facilities with less than 50 beds or 100 to 149 beds had the lowest reentry rates (91%). Some reentries in SFY 2018 were for discharges that occurred in SF 2017.

¹¹ In this report we use the term "reentry" to a nursing facility to avoid confusion with "readmission" to an acute hospital.

Exhibit 4.5. Discharges to and Reentries from Acute Hospitals by Facility Size, Oregon 2016

	Number of Discharges to Acute Hospitals	Number of Reentries from Acute Hospitals within 30 Days	Percent Reentering within 30 days
<50 Beds	777	704	91%
50 - 99 Beds	5,191	4,864	94%
100 - 149 Beds	3,309	3,016	91%
150+ Beds	896	860	96%
Total	10,173	9,444	93%

Commented [LK31]: It would be interesting to see this broken out by urban and rural areas.

Commented [MAE32]: I agree – maybe for next year if not possible for this year.

Source: CMS Minimum Data Set

Although directly comparable national data on reentries were not available at the time of this report, it is important to note that residents of Oregon nursing facilities were much less likely to be hospitalized than were nursing facility residents in other states. Compared to other states, Oregon has the sixth-lowest rate of hospitalization¹² among its long-stay nursing facility residents (Reinhard et al., 2017) and the third lowest hospitalization rate among its Medicare-paid nursing facility residents (Levinson, 2013).

¹² This rate includes new hospitalizations and re-hospitalizations.

Section 5. Residents

Exhibit 5.1 shows the composition of Oregon's nursing facility population by age group, which remained relatively stable from SFY 2017. In 2018, the state's nursing facility population was younger on average (77 years) than national estimates, with 81% of nursing facility residents being age 65 or older, compared to 85% of residents nationwide (Centers for Medicare & Medicaid Services, 2013).

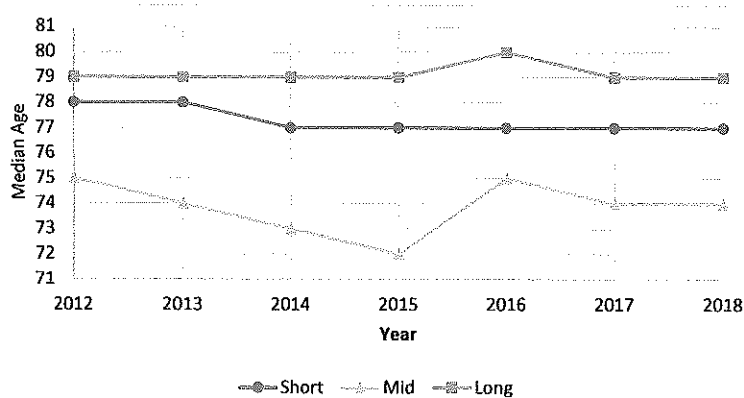
Exhibit 5.1. Distribution of Oregon Nursing Facility Residents by Age, 2018

Age Group	Percent
Under 18	0.2%
18 - 24	0.2%
25 - 44	1.8%
45 - 64	16.9%
65 - 74	24.4%
75 - 84	28.7%
85 and over	27.8%
Total	100.0%

Source: CMS Minimum Data Set

Exhibit 5.2 shows the trend in resident median age by length of stay. The overall trend indicates that resident median age for long-stays is older than that for mid- and short-stays. This trend has remained consistent between 2012 and 2018, with some fluctuations occurring year-to-year.

Exhibit 5.2. Trend in Resident Median Age for Short-, Mid-, and Long-Stays, Oregon 2012-2018



Source: CMS Minimum Data Set

Exhibit 5.3 displays the distribution of Oregon's nursing facility population by marital status. Most of the residents were married (38.4%) or widowed (31.2%). The remaining residents were divorced (15.7%), never married (13.5%) or separated (1.3%).

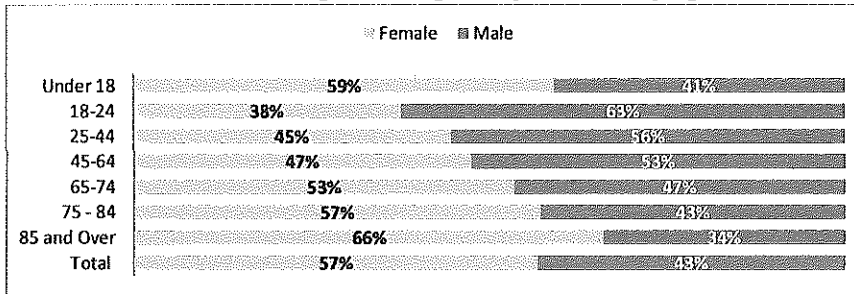
Exhibit 5.3. Distribution of Oregon Nursing Facility Residents by Marital Status, 2018

Marital Status	Percent
Never Married	13.5
Married	38.4
Widowed	31.2
Separated	1.3
Divorced	15.7
Total	100

Source: CMS Minimum Data Set

Exhibit 5.4 shows the composition of Oregon's nursing facility population by age and sex. In 2018, the majority (57%) of all residents were women, which was lower than the national average of 67% (Centers for Medicare & Medicaid Services, 2013). The proportion of female residents increased with age, with 66% of residents in the oldest age category being female.

Exhibit 5.4. Distribution of Oregon Nursing Facility Residents by Age and Sex, 2018



Source: CMS Minimum Data Set

Exhibits 5.5 and 5.6 show the distribution of race/ethnicity for all nursing facility residents and for residents 65 years and older, compared to their counterparts in the general Oregon population. In 2018, the majority of nursing facility residents were non-Hispanic white (83.5%), followed by African American (1.8%) and Hispanic (1.5%). In comparison, the state's general population in 2017, the most recent data available, was 76.5% non-Hispanic white, 12.7% Hispanic, 4.1% Asian American, and 1.8% African American or Black. The racial/ethnic composition of Oregon's nursing facility population also differed from that of the U.S. nursing facility population in 2012, where 78%, 13.9%, and 5% of all U.S. nursing facility residents were non-Hispanic white, African American, and Hispanic, respectively (Centers for Medicare & Medicaid Services, 2013). The slightly higher proportion of non-Hispanic white residents in the 65+ age category indicates that racial/ethnic minority residents were younger compared to the general nursing facility population.

Exhibit 5.5. Oregon Nursing Facility Residents and General Population by Race/Ethnicity, 2018

Race/Ethnicity	All Nursing Facility Residents	All Oregon Residents
White, Not Hispanic	83.5%	76.5%
American Indian/Alaska Native, Not Hispanic	0.6%	4.5%*
Asian American, Not Hispanic	1.1%	4.1%
African American or Black, Not Hispanic	1.8%	1.8%
Native Hawaiian/Pacific Islander, Not Hispanic	0.1%	0.4%
Hispanic of any race	1.5%	12.7%
More than 1 race, Not Hispanic	0.3%	3.6%
Unknown	11.2%	**
Total	100.0%	N/A

Source: CMS Minimum Data Set; U.S. Census Bureau, 2017 American Community Survey 1-Year Estimates

* This category includes American Indian/Alaska Native alone or in combination with one or more races, not Hispanic.

** The American Community Survey does not provide estimates for the Oregon population in these racial/ethnic groups.

Exhibit 5.6. Oregon Nursing Facility Residents and General 65+ Population by Race/Ethnicity, 2018

Race / Ethnicity	Nursing Facility Residents 65+	Oregon Residents 65+
White, Not Hispanic	84.3%	93.5%
American Indian/Alaska Native, Not Hispanic	0.4%	2.2%*
Asian American, Not Hispanic	1.1%	2.7%
African American or Black, Not Hispanic	1.4%	0.9%
Native Hawaiian/Pacific Islander, Not Hispanic	0.1%	0.1%
Hispanic of any race	1.2%	3.0%
More than 1 race, Not Hispanic	0.3%	1.5%
Unknown	11.3%	**
Total	100%	N/A

Sources: CMS Minimum Data Set; U.S. Census Bureau, 2017 American Community Survey 1-Year Estimates

* This category includes American Indian/Alaska Native alone or in combination with one or more races, not Hispanic.

** The American Community Survey does not provide estimates for the Oregon population in these racial/ethnic groups.

The distribution of race/ethnicity was similar by sex, with non-Hispanic whites comprising the majority of all male and female nursing facility residents (data not shown). However, the composition of men and women varied within racial/ethnic categories. The ratio of males to females was roughly equal for non-Hispanic African American or Black and Native Hawaiian/Pacific Islander, and for Hispanic residents. However, there were more males than females for Native American/Alaska Native (1.3:1), and fewer males than females for non-Hispanic White (0.7:1) and Asian (0.6:1) residents.

Section 6. Length of Stay

Nursing facilities provide 24-hour medical care and monitoring for individuals who need it due to a disability, medical condition or illness, or for those who have been discharged from the hospital but are not yet able to return to the community: either their own home or a licensed community based care setting. Nursing facilities thus serve individuals with post-acute care needs and those with ongoing needs. The length of a nursing facility stay reflects whether services are needed on a temporary or an indefinite basis. Individuals who enter nursing facilities and remain for 100 or more days are far less likely to return to the community than are those who have shorter stays (Reinhard et al., 2014).

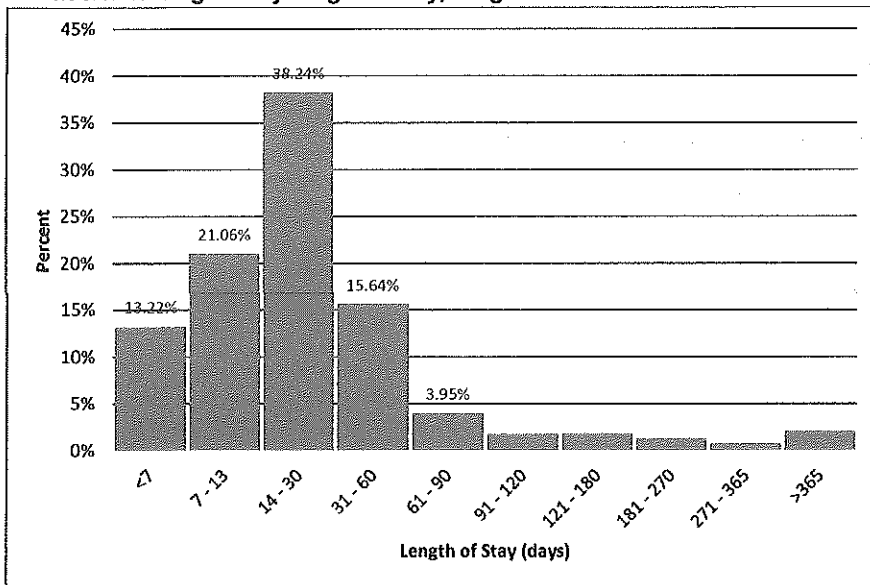
In this report, we define short-term nursing facility stays as less than or equal to 90 days, mid-length stays as 91 to 365 days, and long stays as more than one year. An individual may have more than one nursing facility stay during the fiscal year. To ensure that length of stay data are directly comparable across years, we report length of stay results only for nursing facility stays that had a discharge during the report year.¹³ The Technical Notes at the end of this report provide further detail on how length of stay was calculated for this report.

Long stays averaged 916 days (or approximately 2.5 years), compared to short- and mid-length stays that averaged 30 days (data not shown).

Exhibit 6.1 shows the distribution of length of stay for Oregon's nursing facility population. In 2018, 92% of all nursing facility stays were short, while 6% and 2% were mid-length and long, respectively. More than one in three (38%) stays lasted between 14 and 30 days.

¹³ In other words, persons who are residents in a nursing facility at the end of the state fiscal year (30 June 2018 for this report) are not included in length of stay results. This approach differs from the 2014 and 2015 reports, in which length of stay was calculated for all residents who spent at least 1 day in a nursing facility during the report year. However, the distributions of length of stay results changed little as a result of the new approach.

Exhibit 6.1. Nursing Facility Length of Stay, Oregon 2018



Source: CMS Minimum Data Set

Exhibit 6.1 also shows that 73% of Oregon nursing facility stays lasted 30 days or less. This reflects the dominant role of post-acute care in nursing facility utilization in Oregon. The percentage of new nursing facility stays in Oregon that lasted 100 days or longer is lower than in any other state except Arizona (Reinhard et al., 2017). The greater utilization of nursing facilities for short stays is likely due to the utilization of home and community-based services and assisted living for ongoing long-term care (American Health Care Association, 2013).

Commented [DW33]: Would be good to also include that 92% of all stays lasted less than 90 days.

"Exhibit 6.1 also shows that 73% of Oregon nursing facility stays lasted 30 days or less and 92% of all stays lasted less than 90 days."

Commented [MAE34]: Fine with me

Exhibit 6.2 shows the average and median lengths of stay in SFY 2018. The median length of stay—that is, the number of days for which half of stays were longer and half were shorter—provides further detail about the utilization of nursing facility care in Oregon. Although the overall average length of stay was 49 days, the median length of stay was 19 days because a relatively small proportion of residents with very long lengths of stay inflated the average.

Exhibit 6.2 also presents average and median lengths of stay by age group. Average length of stay was highest for the 18 to 24 age group. The median length of stay was 20 days or less for all age groups, but the average length of stay was approximately 2 to 7 times longer than the median length of stay within the same age category.

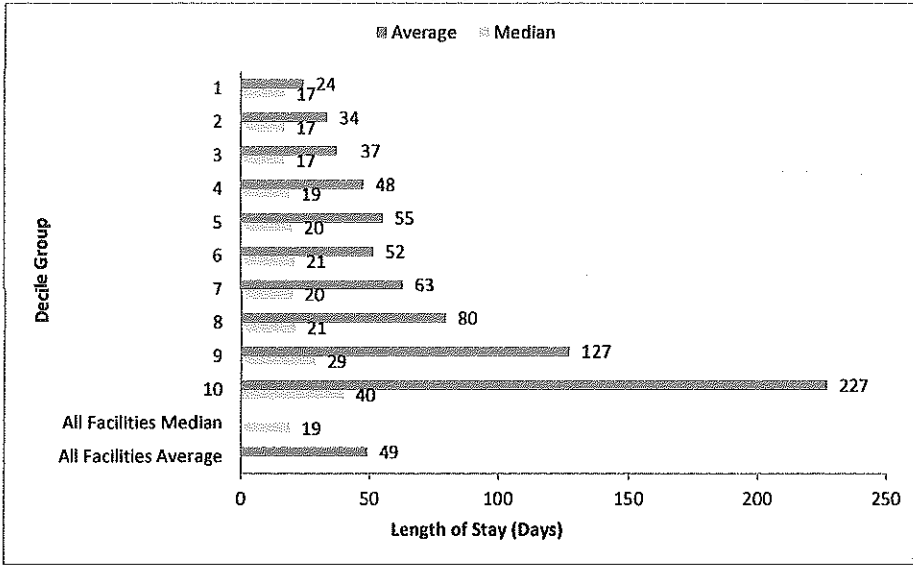
Exhibit 6.2. Nursing Facility Length of Stay (Days) by Age, Oregon 2018

Age Group	Average Length of Stay	Median Length of Stay
Under 18	18	9
18-24	98	15
25-44	46	17
45-64	53	18
65-74	48	18
75-84	45	19
85 and Over	52	20
Total	49	19

Source: CMS Minimum Data Set

Length of stay also varied across facilities. To characterize this variation, we ranked nursing facilities in order of average length of stay, then divided the facilities into 10 equal-sized groups based on average length of stay (Exhibit 6.3). Each group represents 13 to 14 facilities. Average length of stay increased from 24 days in group one, to 227 days in group 10. However, the median length of stay was 29 days or less for facilities in all of the first nine groups, reflecting the preponderance of short stays in Oregon nursing facilities. Group 10 had much higher average and median lengths of stay compared to all other groups of nursing facilities. This is consistent with the fact that many facilities in group 10 serve residents with extensive, ongoing care needs including pediatric, enhanced care, and non-dementia behavioral health care needs.

Exhibit 6.3. Nursing Facility Length of Stay by Decile Groups of Facilities, Oregon 2018

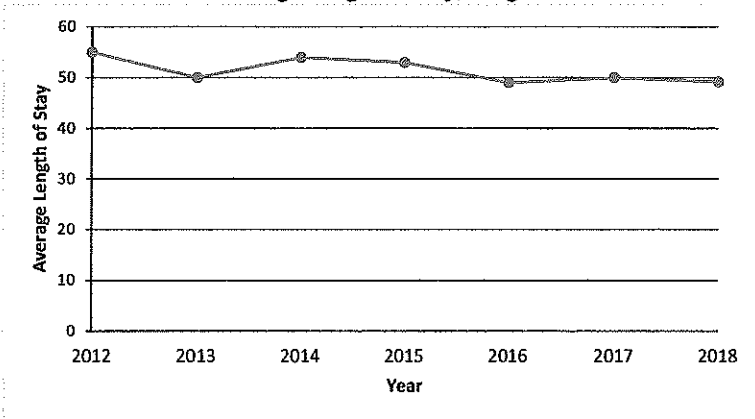


Source: CMS Minimum Data Set

Commented [DW35]: This is a great chart!

Exhibit 6.4 shows the trend in average length of stay for nursing home residents in Oregon from 2012 to 2018. The average length of stay declined from 55 days in 2012 to 49 days in 2018, indicating a 10.5% decrease during this time period.

Exhibit 6.4. Trend in Average Length of Stay, Oregon 2012–2018



Source: CMS Minimum Data Set

Commented [DW36]: What about a chart trending the median length of stay over the past six years too? Or perhaps a combined chart?

Hospitalizations Linked to Nursing Facility Stays

Although more than nine in 10 entries or reentries to nursing facilities were from hospitals, MDS data does not provide information about why these residents were hospitalized. Because nursing facility care often focuses on helping residents recover from conditions for which they were hospitalized, such information is helpful in understanding the mix of clinical needs among nursing facility residents.

We therefore linked MDS data to Oregon hospital discharge data records in a two-step linkage process involving Oregon State University, the Oregon Department of Human Services, and the Oregon Health Authority's Office of Health Analytics. First, hospital discharge records were matched to the MDS by name and date of birth. Second, specific hospital discharge dates were matched to nursing facility entry or reentry dates for individual nursing facility residents in the MDS. *[HDD results forthcoming]*

[HDD results forthcoming]

[HDD results forthcoming]

Exhibit 6.5. Nursing Facility Length of Stay (Days) by Hospital MS-DRG, Oregon 2018

Category of Hospital MS-DRG	Percent of Hospital Discharges	Average Length of Nursing Facility Stay
Orthopedic		
Infectious		
Cardiology & Cardiac Surgery		
Other		
Pulmonary		
Trauma		
Neurology & Neurosurgery		
Stroke & TIA		
Gastroenterology		
Vascular		
Endocrine		
General Surgery		
Renal Failure		
Urology		
Ventilator		
All Discharges		

Sources: CMS Minimum Data Set and Oregon Hospital Discharge Records

Note: Results are shown for nursing facility stays where resident entered from a hospital within SFY 2018 and where MDS data can be linked to hospital discharge data.

Section 7. Acuity of Residents

Acuity Measurements

Acuity commonly refers to an individual's requirements for nursing care. Individuals that ~~that~~ who enter a nursing facility are assessed to identify the level of care needed during their stay. For example, many post-acute care patients are discharged from acute care hospitals after surgery or treatment for acute medical conditions, and temporarily require skilled rehabilitation or nursing care that cannot be provided effectively at home or in community-based facilities. Such individuals comprise a significant portion of short-stay nursing facility residents.

Nursing facilities use acuity information to plan personnel resources, manage costs, and measure quality. There are many measures of acuity. In this section, we report data about several of those indicators, including: Activities of Daily Living (ADLs), reasons for hospitalization, diagnoses among residents, and therapies received by residents.

Most data in this section are based on facilities' assessments of their residents as reported in the MDS. Beginning with the SFY 2016 report, we changed methodology to capture assessments for calculating Activities of Daily Living (ADL), diagnoses and treatments. Assessments coded as an entry, reentry or annual assessment were identified first. For any stay that did not have one of these coded assessments, the first assessment of the stay was identified and used instead. This approach allows us to use information from all enrollees in SFY 2018 and to characterize acuity among short and mid-length stays at the time residents entered the nursing facility, and among long-stay residents at the time of their annual reassessment. Residents who had more than one stay during SFY 2018 may be counted more than once in the ADL, diagnoses, or treatment measures presented in this section. See the Technical Notes for further details.

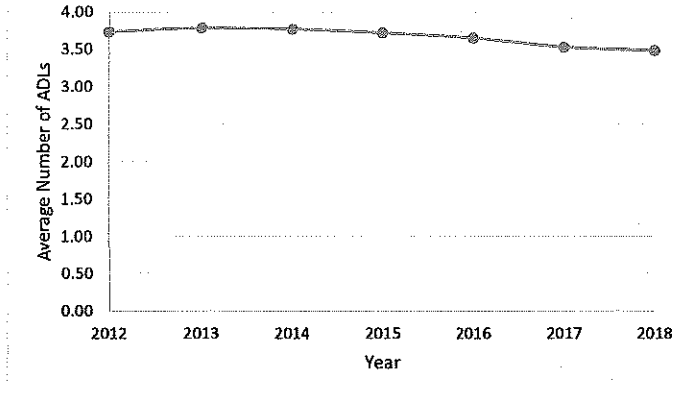
Activities of Daily Living

ADLs measure the extent to which care recipients cannot perform self-care tasks (Katz, Ford, Moskowitz, Jackson, & Jaffe, 1963). ADLs are used to characterize individuals' levels of caregiving need (National Center for Health Statistics, 2015), whether on a temporary or indefinite basis. Once admitted to a nursing facility, residents are assessed for their level of dependence for each ADL, ranging from independence in performing the activity to complete dependence on staff. In this report, we focus on ~~bed mobility~~, transferring, eating, dressing, toileting, and bathing ADLs.

Commented [MAE37]: Again, the Katz et al scale measures mobility, but this refers to bed mobility, which may be confusing.

Exhibit 7.1 displays the trend in average number of ADLs with which individuals needed help during their stays from 2012 to 2018. The average number of ADLs individuals needed help with during resident stays has declined by nearly 7%, from 3.74 in 2012 to 3.48 in 2018.

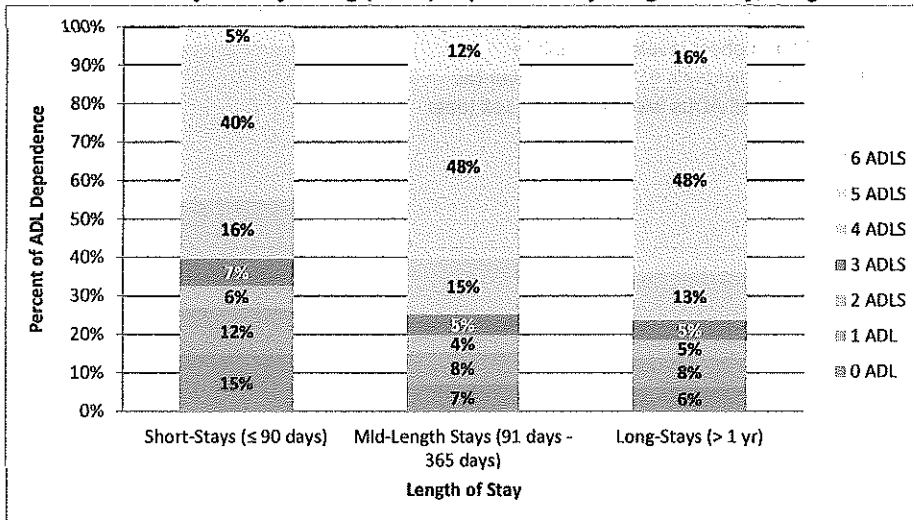
Exhibit 7.1. Trend in Average Number of Activities of Daily Living for which Help Was Needed, Oregon 2012–2018



Source: CMS Minimum Data Set

In 2018, stays with dependence on five ADLs represented the greatest proportion of short-stays (40%), mid-stays (48%) and long-stays (48%; Exhibit 7.2). These percentages are approximately twice as high than for all nursing facility residents in the U.S. (23%; Centers for Medicare & Medicaid Services, 2014). Forty-five percent of short stays, 60% mid-length stays, and 64% of long stays involved dependence on five or more ADLs.

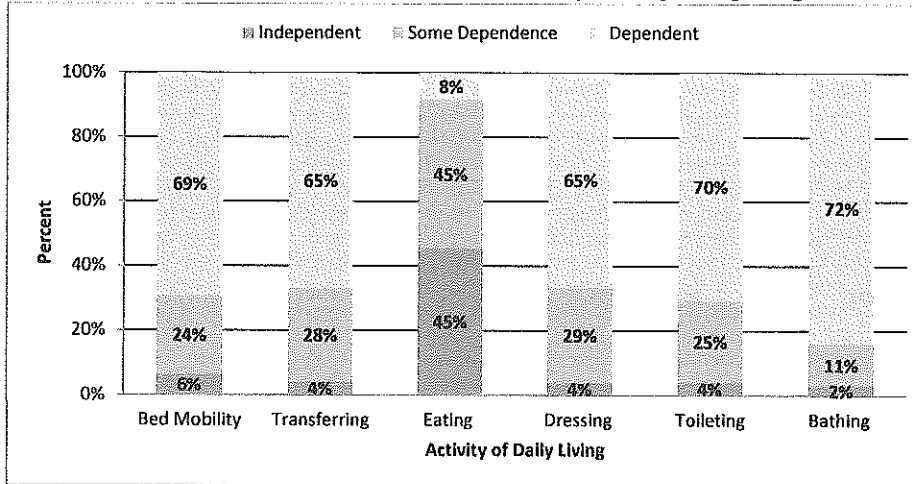
Exhibit 7.2. Activity of Daily Living (ADLs) Dependence by Length of Stay, Oregon 2018



Source: CMS Minimum Data Set

Exhibit 7.3 presents the distribution of dependence level of six individual ADLs. Complete dependence on staff was reported for at least 65% of all stays, except for eating.

Exhibit 7.3. Distribution of Dependence Level by Activity of Daily Living, Oregon 2018



Source: CMS Minimum Data Set

Exhibit 7.4 provides more detail on ADL dependence. Toileting was the most common ADL need for all stays in 2018. Compared with other lengths of stay, long stays had the highest proportions of complete dependence in five of six ADLs. Mid-length stays had the highest proportions of complete dependence for bed mobility (76%). For all ADLs other than bed mobility, stays of individuals under 18 years of age had the highest levels of complete dependence compared with other age groups, followed by individuals 85 years and over (all ADLs except eating). The rates of complete dependence for all ADLs were similar by sex (data not shown).

Exhibit 7.4. Complete Dependence for ADLs by Length of Stay and Age, Oregon 2018

	Bed Mobility	Transferring	Eating	Dressing	Toileting	Bathing
Length of Stay						
Short stay	67%	63%	7%	62%	67%	70%
Mid-length stay	77%	72%	15%	78%	8%	81%
Long stay	76%	73%	19%	80%	82%	86%
Age Group						
Under 18	63%	92%	91%	90%	91%	99%
18-24	62%	63%	46%	68%	67%	74%
25-44	47%	45%	13%	45%	50%	56%
45-64	53%	50%	8%	50%	55%	62%
65-74	65%	61%	7%	61%	66%	70%
75-84	73%	39%	8%	69%	74%	75%
85 and Over	79%	76%	9%	77%	80%	79%
Total Complete Dependence	69%	65%	8%	65%	70%	72%

Source: CMS Minimum Data Set

Clinical Conditions Among Nursing Facility Residents

The number and severity of clinical conditions impact the type and intensity of services received by a nursing facility resident. The MDS provides information about whether a resident had each of 56 specific diagnoses within seven days prior to his or her assessment. We grouped these diagnoses into several major categories, and tabulated whether each stay had one or more diagnoses in each category. Residents who had more than one stay during SFY 2018 may be counted more than once in the diagnoses measures presented in this report.

Exhibit 7.5 presents the prevalence of each diagnosis category and the most common individual diagnoses. Six in 10 nursing facility stays (62.2%) involved at least one acute medical condition, with anemia, cancer, and urinary tract infections being the most common individual diagnoses. Nearly all stays (91.6%) involved at least one chronic medical condition, with seven in 10 involving hypertension, more than four in 10 involving hyperlipidemia, and over three in 10 involving diabetes. Approximately three in ten stays involved a cardiac rhythm disorder and/or arthritis. Approximately one quarter of stays involved heart failure, end stage renal disease (ESRD), and/or ulcer or reflux disease. Approximately one in five stays involved coronary artery disease and/or asthma or chronic obstructive pulmonary disease (COPD). One in nine stays involved osteoporosis, benign prostatic hyperplasia, and/or degenerative disease of the eye.

More than one in 10 stays involved a hip fracture, and nearly one in seven another type of fracture. Approximately, one in seven stays involved neurologic conditions such as seizure disorders or Parkinson's disease. Over four in 10 stays involved one or more behavioral health conditions, with nearly four in ten involving depression and one in five involving anxiety. Approximately one in five stays involved dementia.¹⁴ Severely disabling conditions such as full or partial paralysis or traumatic brain injury were present in six percent of stays.

¹⁴ The MDS diagnosis category of "Alzheimer's Disease" shown in Exhibit 7.5 may underestimate the prevalence of Alzheimer's dementia in nursing facility residents. MDS assessments require that a diagnosis be confirmed by a physician within the past 60 days and have a direct relationship to the resident's current functional, cognitive, or mood or behavior status, treatment, monitoring, or mortality risk within the 7 days before the assessment. Diagnoses for which prior physician documentation is not available or that are not being specifically treated may therefore not be captured on an MDS assessment. MDS also provides another possible category of "Non-Alzheimer's Dementia" described as "e.g., Lewy-Body dementia; vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia, such as Pick's disease; and dementia related to stroke, Parkinson's disease or Creutzfeldt-Jakob diseases."

Commented [DW38]: These are comments for footnote 14:

It is important this explanation for the low reported prevalence of Alzheimer's disease and other dementias is included within the report.

You may want to add a sentence noting how it compares to the national percent of nursing home residents with a diagnosis of dementia, which is 47.8% (or nearly half)

Source: National Center for Health Care Statistics, 2016.
<https://www.cdc.gov/nchs/fastats/alzheimers.htm>

Commented [MAE39]: I would like to see more about dementia in the report in general, but I want to be careful that we don't report percentages of diagnoses without explaining that there are a lot of people in all of our settings who have undiagnosed dementia – or at least ADL needs related to cognitive impairment. I believe we could provide the number of Medicaid consumers currently living in NF settings whose assessment indicates needs related to cognition, if that is something that would be helpful.

Commented [MAE40]: I'm also confused about the footnote. It sounds like vascular or multi-infarct dementia is something different than dementia related to stroke. My understanding has always been that these two are the same – infarcts are small strokes and vascular dementia is dementia related to stroke.

Exhibit 7.5. Percent of Nursing Facility Stays with Specific MDS Diagnoses by Category, Oregon 2018

Category	Percent of Stays	Category	Percent of Stays
Specific MDS Diagnosis		Specific MDS Diagnosis	
Acute Medical	62.2	Chronic Medical Cont'd	
Anemia	24.3	Benign Prostatic Hyperplasia	11.1
Cancer	11.6	Cataracts, Glaucoma, Macular Deg.	9.9
UTI	11.0	Peripheral Artery Disease	6.8
TIA or Stroke	10.1	Fractures	23.1
Respiratory Failure	8.9	Other Fracture	14.2
Pneumonia	7.8	Hip Fracture	10.3
Septicemia	7.3	Neurologic	14.4
Malnutrition	6.9	Seizure/Epilepsy	5.8
Hyponatremia	6.4	Parkinson's Disease	3.8
DVT	4.6	Neurogenic Bladder	3.1
Chronic Medical	91.6	Behavioral	42.8
Hypertension	72.2	Depression	35.9
Hyperlipidemia	45.3	Anxiety	17.4
Diabetes	34.7	Dementia	18.6
Atrial Fibrillation	31.0	Non-Alzheimer's	16.8
Arthritis	27.2	Alzheimer's	3.4
Heart Failure	25.0	Paralysis & TBI	6.0
ESRD	24.7	Hemi/Para/Quadriplegia	4.7
Ulcer or Reflux Disease	23.6	Traumatic Brain Injury (TBI)	1.1
Thyroid Disorder	23.2	Severe & Persistent Mental Illness (SPMI)	14.6
Coronary Artery Disease	20.1	Schizophrenia	7.9
Asthma, COPD...	19.8	Manic Depression	5.1
Osteoporosis	11.6	None of the Above	0.8

Source: CMS Minimum Data Set

Notes Percent indicates stays with one or more specific MDS diagnoses in that category. Because diagnoses are not mutually exclusive, percentages add up to more than 100%. Diagnoses that occur in less than 2.5% of stays are not shown individually, but are included in the category. See Technical Notes for a list of all diagnoses. Data in this table are based on 32,609 stays that have a diagnosis-coded entry, reentry, or annual assessment.

As shown in Exhibit 7.6, the prevalence of some diagnoses varied by length of stay. Acute medical conditions were somewhat more common in mid-length stays, but the prevalence of chronic medical conditions was high regardless of length of stay. All short stays involved residents with a chronic medical condition. Fractures were much more common in short stays. However, the prevalence of other categories of diagnoses, including neurologic conditions, behavioral health conditions, dementia, and paralysis were markedly higher among residents with longer lengths of stay compared with residents with short lengths of stay. The prevalence of some diagnoses also varied by resident age (data not shown). Residents age 75 and older were more likely than younger residents to have had fractures, chronic medical conditions, and/or dementia, but less likely to have suffered from neurologic or behavioral conditions, paralysis, or SPMI.

Exhibit 7.6. Distribution of MDS Diagnosis Categories by Length of Stay, Oregon 2018

Diagnosis Category	Percent of Stays with One or More Diagnoses in Category		
	Short Stay	Mid Stay	Long Stay
Acute Medical	62%	64%	58%
Chronic Medical	100%	91%	92%
Fractures	25%	15%	14%
Neurologic	12%	24%	25%
Behavioral	40%	53%	53%
Dementia	15%	28%	38%
Paralysis & TBI	0%	14%	16%
SPMI	15%	13%	15%
None of the Above	0%	0%	1%
Total Stays	25,382	3,968	3,259

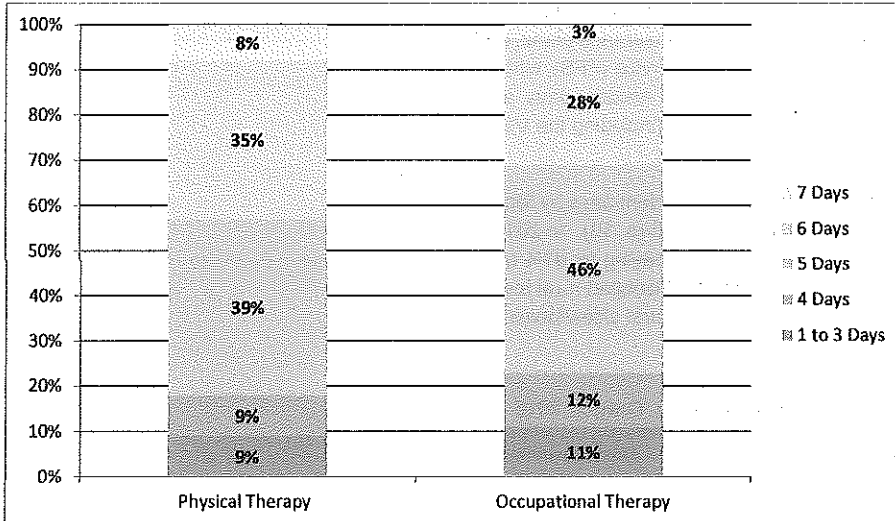
Source: CMS Minimum Data Set. Data in this table are based on 32,609 stays that have a diagnosis-coded entry, reentry, or annual assessment.

Treatments Provided to Nursing Facility Residents

MDS captures information about select types of treatments provided to nursing facility residents. We measured the number of stays for which specific types of treatment were provided within 7 days prior to the assessment.

As shown in Exhibit 7.7, nearly all short-stays involved physical and occupational therapy in the period following an admission or entry to a nursing facility. For more than eight in 10 short stays, physical therapy was provided five or more days per week. Occupational therapy was provided five or more days per week during nearly eight in 10 short stays.

Exhibit 7.7. Distribution of Number of Days of Physical and Occupational Therapy within 1 Week Prior to Assessment, Short Stay Residents, Oregon 2018



Source: MDS Minimum Data Set. Data in this table are based on 31,926 stays that have a therapy-coded entry, reentry, or annual assessment in MDS.

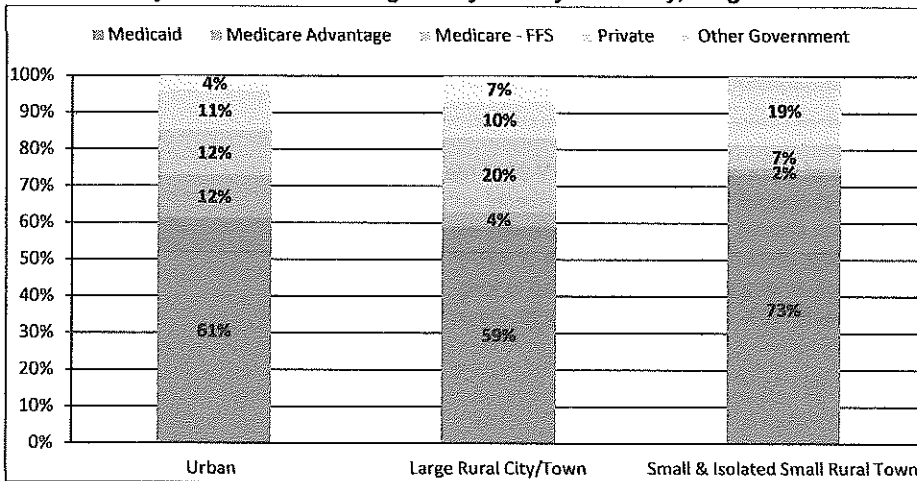
Additionally, oxygen was administered during 18.3% of nursing facility stays in SFY 2018 (data not shown). BiPAP treatment (to prevent breathing stoppages during sleep for residents with sleep apnea) was provided for 5.8% of stays (data not shown). Dialysis, which indicates the presence of renal failure, was needed for 3.1% of stays (data not shown). The rate of BiPAP and dialysis treatments was roughly twice as common among short stays compared to long stays. Oxygen treatment was administered during nearly 20% of short and mid-length stays, but only 12% of long stays.

Section 8. Payers

Medicaid was the primary payer for 61% of resident days in Oregon nursing facilities during 2018. Private payers (including commercial insurers, long-term care insurance plans, and self-pay residents) paid for 12% of all resident days. Medicare Fee-For-Service (FFS), which covers up to 100 days of skilled nursing facility care per year, paid for 14% of resident days, and Medicare Advantage plans¹⁵ paid for 10%. Other government payers (including the Veterans Administration) paid for the remaining 4% of resident days in 2018.

Exhibit 8.1 breaks down payer sources for Oregon nursing facility resident days by facility location, using the same urbanicity categories described for Exhibit 3.5 (p. 18). In 2018, Medicaid was the predominant payer in urban as well as rural areas, paying for 61% of resident days in urban areas, 57% in large rural cities/towns and 73% in small/isolated rural towns. The proportion of days paid by Medicare FFS was highest (20%) in large rural cities/towns, and the private pay proportion was highest (19%) in small/isolated rural towns.

Exhibit 8.1. Payer Sources for Nursing Facility Care by Urbanicity, Oregon 2018



Source: Cost Reports and Revenue Statements

Medicare Advantage, the managed care option for Medicare beneficiaries, is an important payer in the Oregon health care market. At 44% of eligible beneficiaries, Oregon has the third highest rate of Medicare Advantage enrollment among states (Gold, Jacobson, Damico, & Neuman,

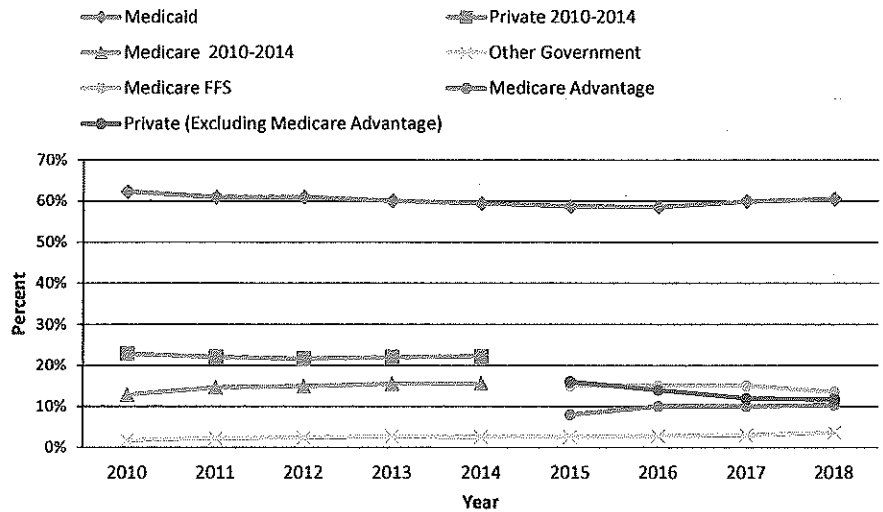
¹⁵ This is the third year that we can report the proportion of resident days paid for by Medicare Advantage, based on enhanced DHS data collection. Prior to 2015, Medicare Advantage days were mostly included in the private payer category.

2014). The lower proportion of Medicare Advantage payment in rural areas likely reflects the lower Medicare Advantage enrollment rates in Oregon's rural areas.

Exhibit 8.2 shows the trend in payer sources in Oregon nursing facilities. Beginning in 2015, nursing facilities were required to separately report resident days paid for by Medicare Advantage, Medicare FFS, and private pay. Because of this methodological change, we show data 2015 and forward separately from pre-2015 data. We further note that data reported for Medicare and private payers for 2015-2018 are not directly comparable to those of prior years. Additionally, the possibility of under-reporting of Medicare Advantage resident days continues to exist. As nursing facilities gain more experience with the new reporting categories, the proportion of Medicare Advantage versus private payer days may change further in future years.

The share of nursing facility resident days paid for by Medicaid declined slightly between 2010 and 2018 (62% vs. 61%). The apparent sharp decline in the proportion of days paid by private payers in 2015 through 2018 reflects both the improved measurement of Medicare Advantage payments, as well as a slight increase in the proportion of days paid for by Medicaid. The proportion of days paid for by Medicare Fee-For-Service remained stable from 2015 to 2017, and declined slightly in 2018 (14%).

Exhibit 8.2. Payer Sources for Nursing Facility Care, Oregon 2010–2018



Sources: Cost Reports and Revenue Statements
 Note: For years 2010 through 2014, "Medicare" includes Medicare FFS only.

Section 9. Quality Measures

CMS provides data on a wide range of nursing facility quality measures. These measures are derived from MDS 3.0 assessments and made available from Nursing Home Compare.

Quality measures are calculated separately for short-stay and long-stay residents. In this section, a short stay is defined as lasting 100 or fewer days; a long stay is one that lasts more than 100 days.¹⁶ In SFY 2018, more than 9 in 10 stays in Oregon were short stays.

Below we present the average performance level of Oregon nursing facilities on each quality measure, as well as the national average. In order to describe the variation in performance across facilities within our state, we also divide Oregon facilities into four equal groups—or quartiles—for each measure, and present the average performance within each group.¹⁷ There was wide variation between facilities in the best and lowest performing groups for almost every measure presented below.

Exhibit 9.1 presents 6 measures for which a higher percentage represents better performance. For long-stay residents, average rates of pneumococcal pneumonia vaccination decreased in Oregon facilities compared with 2017, whereas seasonal flu vaccination in Oregon facilities stayed the same. Vaccination rates for short- and long-stay residents were slightly lower than the averages for all nursing facilities nationwide. Average rates of vaccination for pneumococcal pneumonia and seasonal flu among short stay-residents stayed the same compared with 2017, and were slightly lower than the average for all nursing facilities nationwide. Similar to 2017, in 2018 the proportion of short stay residents whose functional status improved was higher in Oregon than the national average. The proportion of short stay residents discharged to the community was also higher in Oregon than the national average in 2017 and 2018.

Exhibit 9.1. Vaccination Rates, Functional Status, and Discharge Destination by Length of Stay and Specific Nursing Facility Groups, Oregon and U.S. 2018

	All Oregon Facilities	Best	Second	Third	Fourth	All U.S. Nursing Facilities
Long stay						
Seasonal flu vaccine	92%	99%	96%	92%	82%	95%
Pneumococcal pneumonia vaccine	91%	100%	97%	93%	75%	94%
Short stay						
Seasonal flu vaccine	79%	93%	86%	78%	61%	82%
Pneumococcal pneumonia vaccine	80%	96%	89%	81%	55%	83%
Improved functional status	71%	84%	75%	70%	56%	68%
Discharged to community	63%	71%	66%	62%	54%	54%

Source: Nursing Home Compare

¹⁶ This CMS definition is slightly different from the definition of short stay (90 days or less) used in other sections of this report. Most stays reported as “mid-length” (91 to 365 days) in other sections of this report are included in the long stay category for these quality measures.

¹⁷ The total number of facilities for which a given measure is reported ranged from 119 to 133 facilities, and so the number of facilities in each quartile group also varies somewhat across measures.

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Exhibits 9.2 and 9.3 present 17 measures for which a lower percentage represents better performance. Long-stay measures are shown in Exhibit 9.2, and short stay measures in Exhibit 9.3. Overall, Oregon nursing facilities performed the same or better than the national average on 9 of these 17 quality measures.

The higher overall average rates of reported pain in Oregon facilities than nationwide, for both long stay and short stay residents, may reflect the higher acuity of nursing facility residents in Oregon compared with other states. In particular, a high proportion of Oregon Nursing facility residents are receiving post-acute care after hospitalization for surgery such as joint replacement, and therefore may have significant need for pain control. Reported rates of pain varied widely across facilities, which may reflect variations in the acuity of residents across facilities. Relative to 2017, in 2018, rates of self-reported moderate to severe pain increased for both long-stay and short stay residents.

Commented [DW41]: This is an important section

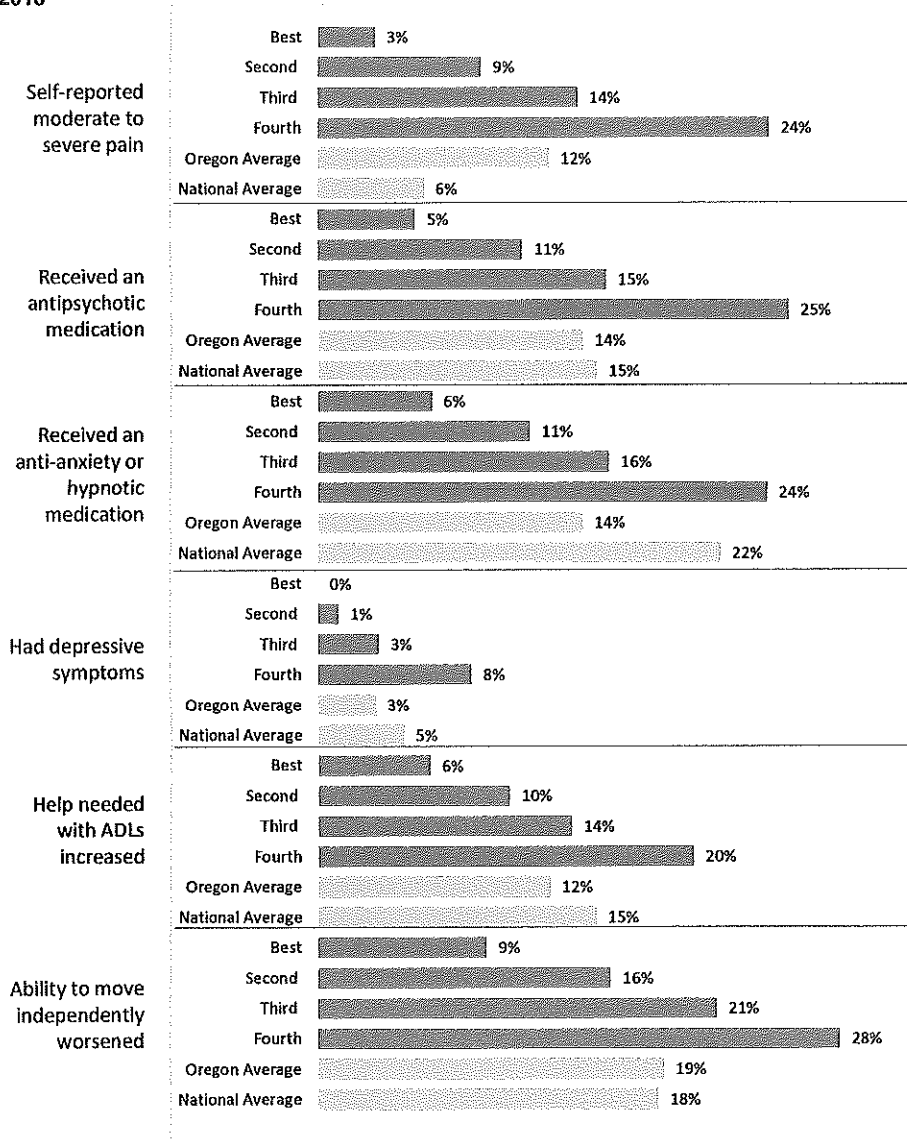
Fourteen percent of long stay residents newly received an antipsychotic medication compared with two percent of short stays.¹⁸ These rates are lower than or the same as the national average; the rate for long-stay residents is lower than in 2017 and 2016, however the rate for short stay residents is higher than in 2017. Use of antipsychotic medications among long-stay residents has been the target of a national quality improvement initiative since 2011, and has declined steadily in Oregon nursing facilities over that time period (Centers for Medicare & Medicaid Services, 2016). Long stay residents in Oregon were also far less likely than the national average to receive an antianxiety or hypnotic medication in both 2017 and 2018.

Rates of several negative outcomes among long stay residents (for example, losing too much weight, high-risk patients with pressure ulcers, urinary tract infections, or falls with major injury) were similar to the national average, and performance in 2018 was similar to that in 2017 and 2016. The same pattern was observed for pressure ulcers among short stay residents. In 2017 and 2018, short stays in Oregon facilities were more likely than short stays nationwide to have an outpatient emergency department visit; yet, short stays in Oregon were less likely than short stays nationwide to be rehospitalized after entering the nursing facility; these measures were not available in 2016.

Commented [MAE42]: See comment related to qualifiers in summary portion of document.

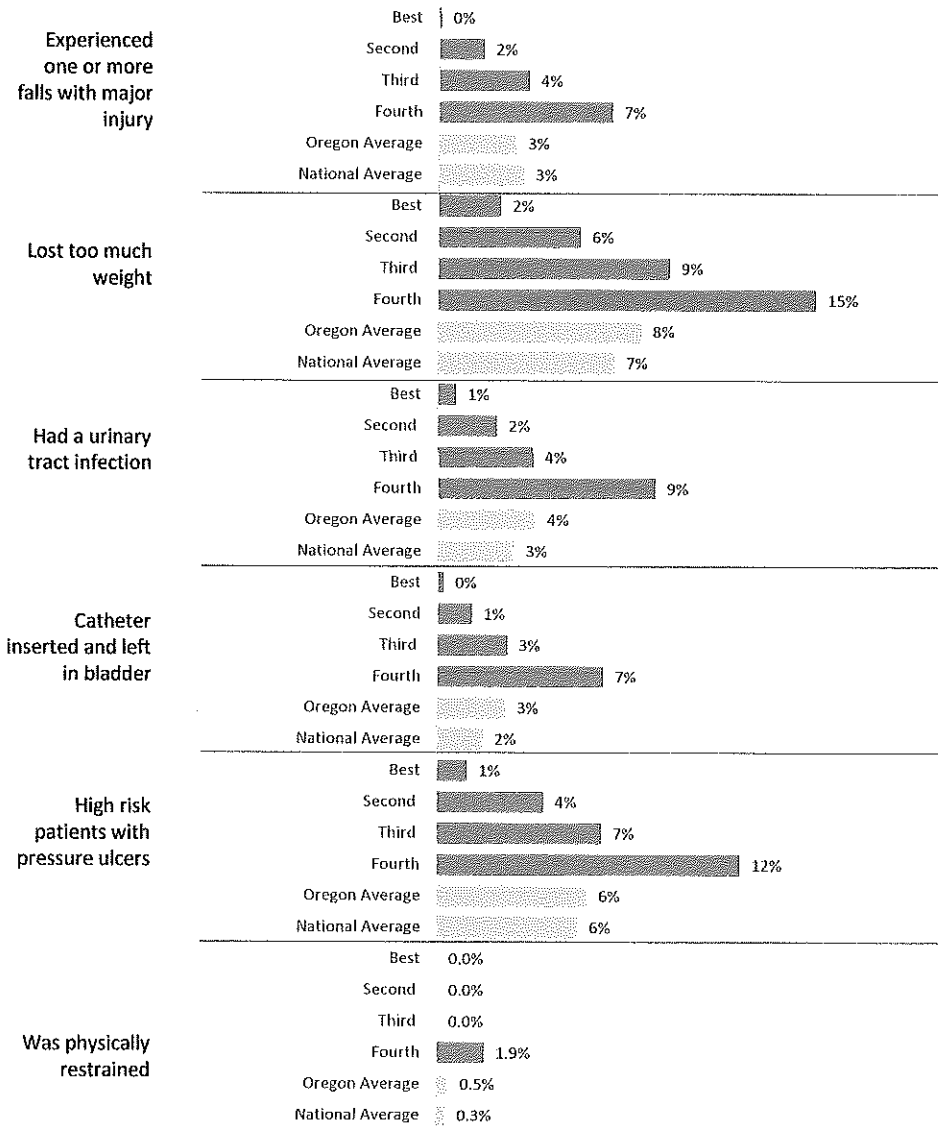
¹⁸ This measure excludes residents diagnosed with schizophrenia, Huntington's disease, or Tourette's syndrome.

Exhibit 9.2. Quality Measures of Long Stays by Nursing Facility Groups, Oregon and U.S. 2018



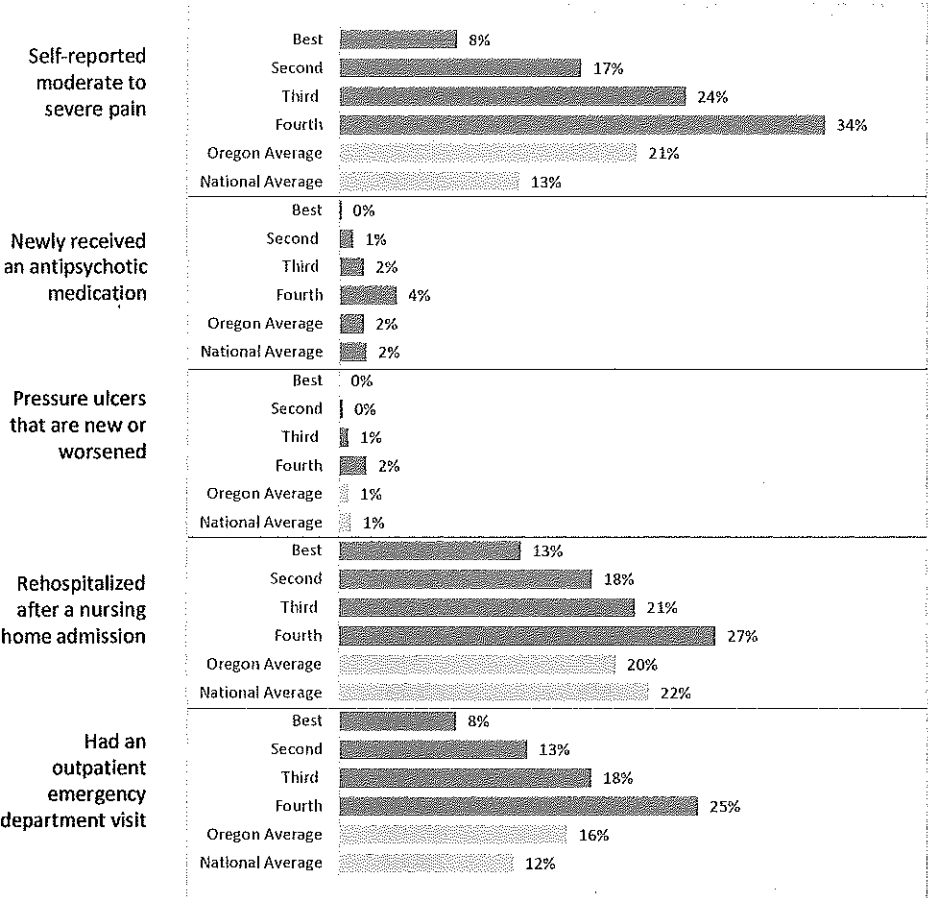
Source: Nursing Home Compare

**Exhibit 9.2. Quality Measures of Long Stays by Nursing Facility Groups, Oregon and U.S.
2018**



Source: Nursing Home Compare

Exhibit 9.3. Quality Measures of Short Stays by Nursing Facility Groups, Oregon and U.S. 2018



Source: Nursing Home Compare

Appendix

Table A. Number of Licensed Beds and Set-Up Beds per 1,000 Population 75 years and Older, Occupancy Rate, and Resident Days by County, Oregon 2018

County	Licensed Beds per 1000 75+	Set-Up Beds per 1000 75+	% Beds That Are Set-Up	Occupancy Rate	Resident Days
Benton	37	30	82%	64%	42,476
Clackamas	29	23	80%	69%	321,675
Clatsop	25	23	96%	40%	10,319
Columbia	40	37	92%	52%	22,636
Coos	50	37	74%	49%	78,133
Crook	22	18	82%	69%	11,097
Curry	20	20	100%	59%	12,618
Deschutes	38	31	84%	64%	50,344
Douglas	23	23	100%	72%	66,087
Grant	46	46	100%	48%	7,025
Hood River	97	58	60%	42%	20,054
Jackson	21	20	95%	73%	150,332
Jefferson	13	8	65%	84%	28,036
Josephine	47	43	92%	60%	92,303
Klamath	17	17	99%	77%	26,674
Lake	66	42	64%	47%	8,136
Lane	41	35	85%	67%	296,300
Lincoln	12	12	100%	73%	13,780
Linn	49	48	98%	75%	131,861
Malheur	16	16	100%	59%	7,115
Marion	42	36	86%	69%	274,748
Multnomah	71	60	85%	73%	796,618
Polk	33	28	86%	62%	47,858
Tillamook	21	19	92%	53%	9,582
Umatilla	60	35	58%	54%	46,882
Union	36	28	78%	47%	13,154
Wasco	155	124	80%	61%	76,762
Washington	33	29	89%	72%	281,037
Yamhill	54	42	77%	59%	80,880
Oregon	1213	990	82%	67%	3,024,522

Sources: Cost Reports and PSU Population Estimates for June 30, 2017, American Community Survey estimates for 2017
 Note: Baker, Gilliam, Harney, Morrow, Sherman, Wallowa, and Wheeler counties not shown because they have no nursing facilities.

Table B. Admission Source as Percentage of Total Admissions, Oregon 2012 – 2018

	2012	2013	2014	2015	2016	2017	2018
	Percent	Percent	Percent	Percent	Percent	Percent	Percent
Acute Hospital	93.81	93.21	93.23	93.35	94.09	94.72	95.13
Community	4.51	4.69	4.29	4.15	3.82	3.38	3.33
Another NF	1.05	1.34	1.44	1.56	1.41	1.23	1.04
Other	0.18	0.22	0.41	0.43	0.19	0.17	0.10
Hospice	0.19	0.18	0.22	0.17	0.19	0.21	0.16
Psych Hospital	0.14	0.15	0.19	0.14	0.09	0.11	0.11
Inpatient Rehab	0.11	0.14	0.11	0.13	0.09	0.08	0.08
LTCH	0.01	0.07	0.11	0.08	0.13	0.10	0.05
ID/DD	0.01	0.00	0.00	0.00	0.00	0.00	0.00
Died	0.00	0.00	0.02	0.00	0.00	0.00	0.00
Total	100%	100%	100%	100%	100%	100%	100%

Source: CMS Minimum Data Set

Commented [DW43]: This table provides trends year over year is helpful for visualizing the changes over the past six years

Commented [MAE44]: I agree – this is nice!

Table C. Discharge Destination as Percentage of Total Discharges, Oregon 2012 - 2018

Destination	2012	2013	2014	2015	2016	2017	2018
	Percent	Percent	Percent	Percent	Percent	Percent	Percent
Community	67.96	69.25	68.72	68.28	70.59	71.07	71.39
Acute Hospital	28.50	26.47	26.50	26.74	25.19	25.47	25.59
Another NF	1.88	2.13	2.37	2.48	2.12	1.91	1.72
Other	0.58	0.96	1.44	1.55	1.16	0.71	0.50
Inpatient Rehab	0.48	0.60	0.53	0.49	0.49	0.40	0.38
Hospice	0.24	0.29	0.26	0.30	0.32	0.32	0.32
Psych Hospital	0.14	0.13	0.11	0.09	0.07	0.08	0.07
LTCH	0.01	0.03	0.03	0.04	0.04	0.03	0.03
ID/DD	0.01	0.02	0.02	0.03	0.02	0.01	0.02
Died	0.20	0.12	0.02	0.00	0.00	0.00	0.00
Total	100%	100%	100%	100%	100%	100%	100%

Source: CMS Minimum Data Set

Commented [DW45]: Same comment as on Table B – very helpful

Technical Notes *Pending Revision*

Data Sources and Analyses

This report is based on analyses of data from multiple sources, including:

- Annual Cost Reports and Revenue Statements provided to the Department of Human Services (DHS) by all Oregon nursing facilities
- Assessments of nursing facility residents as reported in the Centers for Medicare & Medicaid Services (CMS) Minimum Data Set (MDS)
- Facility-specific data on nursing facility characteristics and performance from the CMS Nursing Home Compare (NHC) datasets
- Hospital Discharge Data (HDD) for persons discharging from a hospital to an Oregon nursing facility or persons entering a hospital from an Oregon nursing facility

Each of these data sources is described briefly below. Also described are important assumptions or methods used in data analyses whose results are presented in this report.

DHS Cost Reports and Revenue Statements

Each Oregon nursing facility that contracts with DHS to receive Medicaid reimbursement must submit an annual Cost Report that contains data including numbers of beds, resident days, costs, and revenues. DHS uses data from these reports to establish and update Medicaid payment rates.

Each facility that does not contract with Medicaid must submit an annual Revenue Statement, which contains similar information but not data on licensed or setup beds or costs. For these facilities, numbers of licensed beds were obtained from Nursing Home Compare data (see below); numbers of setup beds were estimated based on other facilities of similar size.

The reporting period for Cost Reports and Revenue Statements is the State Fiscal Year (SFY), which begins July 1st and ends June 30th. This report focuses on SFY 2017, which ended June 30th, 2017, but also includes data for SFYs 2009 through 2016. If a facility changed ownership during a year, resident days from partial-year cost reports from the different owners were combined for that facility.

Occupancy rates for each facility were calculated using resident days and number of available bed days from Cost Reports and Revenue Statements. Occupancy rates were adjusted for facilities that increased or decreased the number of licensed beds available during the SFY or were only open for part of the year. If information about when the change in licensed beds occurred was not available, the average of beginning and end of year bed numbers was used. As Revenue Statements do not contain information about the number of licensed beds in a facility, this was obtained from Nursing Home Compare July 2016 and June 2017 (see below). Facilities in operation for less than 2 months of a SFY were excluded from that year. If a data

element, such as number of beds or resident days was missing for a facility for one year, we estimated it based on data from prior and/or subsequent years' reports. If a Cost Report facility did not report set-up beds numbers, they were imputed based on the set-up bed to licensed-bed ratio of other like-sized facilities.

Many sections of the Cost Reports and Revenue Statements provide details by payer and by payment category within payer. We used these detailed data to exclude Assisted Living and Residential Care resident days from our analyses of occupancy rates and of payer sources.

Population data used to calculate nursing facility bed availability rates were obtained from Portland State University's annual population estimates. The numbers of licensed and set-up beds at the beginning of each fiscal year were divided by population estimates for the beginning of that year.

MDS Assessments

CMS mandates that the Minimum Data Set (MDS) assessment questionnaire be completed for all nursing facility residents within 7 days of entry (admission). This assessment includes a wide range of data, including admission source, discharge destination, demographics, ADLs, diagnoses, treatments received, and quality measures. This report is based on Version 3.0 of the MDS questionnaire.

Nursing facility residents are assessed at entry and at discharge. Reassessments are to be performed if there is a significant change in a resident's health status, or quarterly if a resident's stay exceeds 3 months. If the resident is discharged within 7 days, only one assessment need be performed.

MDS data files were provided to Oregon State University (OSU) by DHS. These data files included assessments reported to DHS through December 5, 2017, which permitted analyses of nursing facility stays that extended past the end of SFY 2017. The data received by OSU were de-identified, so that resident names or other unique identifiers were removed. DHS provided a unique random ID number for each person, so that multiple assessments per person could be linked together. Duplicate assessments were removed from the de-identified dataset prior to analyses. OSU created a crosswalk between MDS facility identifiers and DHS report identifiers so that MDS results could be disaggregated by county or facility size.

This report is based only on assessments of residents for whom discharge dates were available in the MDS data. Residents with an uncertain discharge status (that is, no assessment within 150 days of the December 5, 2017 date when the dataset was created) were excluded from analyses. Residents of facilities with unknown or missing facility identification numbers were also excluded from analyses.

This report employs a systematic approach for capturing and counting entries, reentries, discharges, and stays in the MDS data. Entries and reentries into a nursing facility data are captured based on the date of discharge,¹⁹ because while only the final assessment of a stay

¹⁹ This methodology was first implemented for the SFY 2015 report.

includes a discharge date, all assessments include the date of entry. Therefore, for any discharge assessment, the entrance date associated with that assessment is also used to define the beginning and end of that stay.²⁰ Residents still enrolled at the time the MDS dataset was created for OSU, December 5, 2017, were assigned this date as their discharge date for the purpose of counting entries and reentries.

Reentries are counted based on the MDS definition of a reentry: if a person is discharged from a nursing facility and then reenters the same facility within 30 days, it is a reentry.²¹

Nursing facility length of stay (LOS) was calculated from the resident's entry or reentry date and discharge date. If a resident was discharged from a nursing facility and subsequently re-entered that facility within 30 days, this was treated as two separate stays.²² To accurately present trends trend based on multiple years of MDS data, LOS in Section 6 is reported based only on stays that had a discharge in the reported SFY.²³

Demographic data presented in Section 5 were derived from the discharge assessment. Individuals who had more than one stay during the fiscal were counted only once in exhibits that present demographic data.

The Activities of Daily Living (ADL), diagnoses, and treatment data presented in Section 7 are based on the first assessment of each resident who was enrolled in SFY 2017.²⁴ This approach allows us to use information from all stays in SFY 2017. It thereby characterizes acuity among short and mid-length stays at those time residents entered the nursing facility, and among long-stay residents at the time of their annual reassessment. However, a resident who had more than one entry or reentry in SFY 2017 may have been counted more than once in these analyses.²⁵

²⁰ For the 2014 report, any entry or reentry that was coded in MDS as being an entry assessment, or the very first assessment for a resident if no coded entry assessment existed for that resident, was counted as the beginning of a stay. Discharge dates were then filled in to align with those entry or reentry dates. However, this method was determined to undercount total stays because it did not capture all discharges.

²¹ The 2014 report counted as reentries only assessments coded as such in MDS.

²² For the 2014 report, if a resident was discharged from and subsequently re-entered a nursing facility within 30 days, this was counted as one stay. However, the LOS in the 2014 report was calculated from the last entry date (even if it was a re-entry) to the final discharge date.

²³ In the 2014 and 2015 reports, LOS calculations also included residents who remained in the facility through December 5, with their LOS truncated as of that date. However, this method did not produce LOS results that were fully comparable across years.

²⁴ In the 2015 report, only assessments that were coded as entry, reentry or annual assessments in SFY 2015 were used to capture this information. The 2014 report captured ADLs using the last assessment of a person's first stay in that fiscal year.

²⁵ In the 2014 report, an individual could have only one ADL score.

Nursing Home Compare (NHC) data

The NHC system reports data collected by CMS during periodic surveys of nursing facilities, which must happen at least every 15 months. Because Oregon facilities that only submit Revenue Statements do not include information on the number of licensed or set up beds, NHC data on licensed beds were used instead. July 2016 NHC data were utilized to fill in beginning of SFY licensed bed numbers for these facilities, and June 2017 data were used to fill in end of SFY licensed bed numbers. These NHC data are for each facility's survey date closest to the relevant SFY.

NHC also reports the percentage of each facility's residents who meet each of several quality measures for each calendar quarter. Quality measure definitions can be found at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/MDS-30-QM-Users-Manual-V10.pdf>

Section 9 of this report presents MDS-based quality measures for the weighted four-quarter average of Oregon SFY 2017,²⁶ derived from the December 2017 report from NHC. Long and short stay measures had differing quarter lengths: long stay measures were calculated from four three-month quarters, and short stay measures from four six-month quarters. The end of each six-month quarter coincided with the end of the calendar quarter. This definition of short stay quarters means that our reported short stay quality measures for SFY 2017 rely on some data from the last three months of SFY 201.

Three new MDS-based quality measures were recently added to NHC and therefore included in the 2017 report:

- Long-stay residents who received an antianxiety or hypnotic medication
- Long-stay residents whose ability to move independently worsened
- Short-stay residents who made improvements in function

In addition, three new "claims-based" short stay measures were also recently added to NHC and appear in the 2017 report:

- Short-stay residents who hospitalized after admissions
- Short-stay residents who had an outpatient emergency department visit
- Short-stay residents who were successfully discharged back into the community

These measures are called "claims-based" because the measures calculated from MDS data are risk adjusted based on data reported to CMS from hospitals. This risk adjustment introduces a time lag into the NHC reporting, and so the data for these measures describe the 4-quarters that make up Oregon SFY 2016. Definitions for the claims-based measures can be found at: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/New-Measures-Technical-Specifications-DRAFT-04-05-16-.pdf>

²⁶ This is a change from the three-quarter average used in the SFY 2016 report.

Facilities that reported a measure for less than 20 short-stay residents or 30 long-stay residents during SFY 2017 are excluded from analyses for that measure. This report presents the average of values for all facilities for which NHC reports data for that measure.

Hospital Discharge Data (HDD)

Hospital Discharge Data (HDD) collected by the Oregon Association of Hospitals and Health Systems (OAHHS) capture diagnosis, payer, and demographic information on individuals who spend time in an inpatient hospital in Oregon. HDD data were linked to MDS in a 2-step process. First, using LinkKing software, OHA probabilistically matched persons who, per MDS, had entered or discharged from a nursing facility in SFY 2014 through SFY 2017 to persons who, per the HDD, were discharged from a hospital during calendar years 2013 through 2017. Matching was based on first name, last name, middle initial, date of birth, and sex. Second, we aligned these matched hospital discharges and nursing facility admissions by date; an alignment margin of plus or minus two days was used. At the end of these steps, 31,748 of the 41,029 nursing facility admissions in SFY 2017 were linked to hospital discharges. For 1,640 of the unlinked nursing facility admissions, MDS indicated that the resident had not entered from a hospital; these admissions were excluded from the denominator in calculating the linkage rate. Overall, therefore, we achieved an 82.9% linkage rate between HDD and MDS for SFY 2017. This compares to 83.4% and 80.5% linkage rates in SFY 2016 and 2015, respectively.

Rural Urban Commuting Areas (RUCAs)

Rurality was measured using the Rural-Urban Community Areas-B (RUCA-B) classification. RUCAs utilize distance to a city center and commuting flows to classify rurality and have been found to be very sensitive to demographic changes²⁷. To create the analytic file that assigned a rurality to each facility, Census tracts were matched to facility ZIP codes in our data using a ZIP-Tract crosswalk file from the US Census bureau. Because some ZIP codes map onto more than one Census tract and some Census tracts map onto more than one ZIP code, ZIP codes that fell into more than one Census tract were assigned to the largest area grouping.

The Census tract-based RUCA Version 2 codes are based on: a) 2000 Census work commuting information, and b) Census Bureau-defined Urbanized Areas and Urban Clusters.

RUCA-B classifications are as follows:

"Urban": An area with population $\geq 50,000$ or town of any size with high primary commuting flow (30-49%) to an Urban Core (UC) and/or $\geq 30\%$ secondary flow to an Urban Area (UA)

"Large Rural City/Town": An area with population of from 10,000-49,999 with $\geq 10\%$ primary commuting flow to an UC and/or $< 29\%$ secondary commuting flow to an UA.

"Small and Isolated Small Rural Town": A city/town core with a population size of 2,500-9,999 with $\geq 10\%$ primary commuting flow to a small UC and/or with 10-29% secondary commuting flow to a UA or a town with a population core $< 2,500$ with primary commuting flow to a tract outside a UA or UC and/or with $\geq 10\%$ secondary commuting flow to a UC or 10-29% secondary commuting flow to a UA.

RUCA Definitions:

"Urban Clusters": cities/towns of from 2,500 to 49,999 populations

"Urban Area": cities of 50,000 and greater population

"Primary Flow": the primary commuting destination; assigned by the first digit

"Secondary Flow": second largest share of commuting flow; assigned by the second digit

Commented [DW46]: A comment for footnote 27:

University of Washington School of Medicine. *RUCA Data: Travel Distance and Time, Remote, Isolated, and Frontier*. Available at: <http://depts.washington.edu/uwruca/>. Accessed September 1, 2016.

The citation states it was accessed on September 1, 2016. Might want to update the accessed date to 2019.

²⁷ Larson, EH., Hart, LG., Rural Health workforces methods and analysis. In: Larson, EH., Johnson, KE., Norris, TE., Lishner, DM., Rosenblatt, RA., & Hart, LG. eds. *State of the Health Workforce in Rural America: State Profiles and Comparisons*. Seattle, WA: WWAMI Rural Health Research Center, University of Washington; 2003: 15-22.
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Definitions Used in This Report

Admission: This occurs when a person enters a NF and is admitted as a resident. An admission may be:

- An entry into a nursing facility (if the resident has never been admitted to the specified facility before, or if the resident was in the specified facility previously and was discharged and not did not return within 30 days of the discharge); or
- A reentry, which occurs when an individual is discharged from a nursing facility and then returns to the same facility within 30 days of that discharge.

Discharge: A discharge occurs when an individual is released from a nursing facility whether they re-enter or not. This does not include a leave of absence or hospital observational stays of less than 24 hours unless the individual was admitted to the hospital.

Final discharge: A final discharge occurs when an individual is released from the nursing facility and does not return to the same facility within 30 days of that discharge date

Discharge followed by a reentry within 30 days: This occurs when an individual is released from a nursing facility and returns to the same facility within 30 days of the discharge date.

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