



June 28, 2013

Chairman Kevin Brady (R-TX)
House Ways and Means Committee
Health Subcommittee
1102 Longworth House Office Building
Washington D.C. 20515

VIA ELECTRONIC SUBMISSION

RE: Comment Letter on Health Subcommittee Hearing on Proposals to Reform Medicare Post-Acute Care Payments

Dear Chairman Brady:

This “statement for the record” is being submitted on behalf of HealthSouth Corporation (“HealthSouth”) in connection with the House Ways and Means Health Subcommittee’s Hearing on June 14, “Proposals to Reform Medicare Post-Acute Care (“PAC”) Payments,” that included testimony from Jonathan Blum, Deputy Administrator and Director, Center of Medicare, Centers for Medicare and Medicaid Services (“CMS”) and Mark Miller, Executive Director, Medicare Payment Advisory Commission (“MedPAC”). HealthSouth operates 103 freestanding rehabilitation hospitals (also known as inpatient rehabilitation facilities, or “IRFs”) in 28 states and Puerto Rico and employs approximately 23,000 people. As the largest provider of rehabilitation hospital care and services in the United States, we welcome the opportunity to work closely with Congress to find appropriate PAC reforms that can both improve care for our patients and extend the viability of the Medicare program.

In the coming weeks, HealthSouth plans to submit a more comprehensive and detailed letter on a number of PAC issues in response to the House Ways and Means and Senate Finance Committees’ request for stakeholder input on PAC reform, pursuant to the “Dear Stakeholder” letter dated June 19, 2013. However, we wanted to take the opportunity to briefly address and provide additional clarification on several specific issues that arose out of the Subcommittee’s June 14 hearing relating to the following issues: **I)** the 60% Rule; **II)** differences between IRFs and SNFs; **III)** IRF spending; and, **IV)** Medicare payments for IRF services compared to SNF services. These issues are discussed in more detail below.

I. 60% Rule

(A) “60 Percent Rule” Is a “Clunky” and “Crude” Policy, According to CMS and MedPAC

As the Subcommittee is aware, President Obama has included a proposal to revisit the so-called “60% Rule” by elevating the compliance threshold percentage from its current level of 60%, to 75%. HealthSouth agrees with Mr. Blum when he testified that “over the long term we need to move away from these more crude and clunky measures like...[the] 75-percent [Rule].” We also agree with Mr. Miller’s testimony indicating that this policy appears to have little analytical or clinical rationale behind it, when he said that “...whether it’s 60 percent or 75 percent, I don’t think there’s a lot of science in that.”¹

The 60% Rule was established in the mid-1980’s to distinguish IRFs from general acute care hospitals; the original threshold percentage was 75%. The Rule stated that to be considered an IRF for Medicare reimbursement purposes, 75% of an IRF’s patients would have to have one of 10 medical conditions (the Rule is now comprised of 13 conditions, often referred to as “CMS 13” or “qualifying conditions”). Like general acute care hospitals, rehabilitation hospitals previously were paid on a “cost-plus” basis. When Congress established prospective payment for general acute care hospitals in the early 1980’s it recognized that the diagnosis related group, or “DRG”-based system would not be appropriate for IRFs, due to different cost structures associated with IRFs’ clinical, rehabilitation, medical, and nursing programs as well as longer length of stays for IRF patients. Thus, Congress authorized the Secretary to define IRFs to distinguish them from acute hospitals and allow them to continue to be paid on a “cost-plus” reimbursement system. The 75% Rule was developed by the Secretary for this purpose. When IRFs moved to prospective payment (“IRF-PPS”) in 2002, the Rule was still maintained despite the fact that cost-based reimbursement ceased.

The Rule’s “qualifying conditions” have been identified as those that “typically require” the care and services of a rehabilitation hospital.² The Rule has nothing to do, per se, with Medicare’s “reasonable and necessary” standard for coverage³—each case

¹ In an appearance before the Health Subcommittee earlier this year, MedPAC Chairman Glenn Hackbarth similarly characterized the 60% Rule as “arbitrary.”

² See generally, CMS’s Final Rule implementing the 75% Rule, “Medicare Program; Changes to the Criteria for Being Classified as an Inpatient Rehabilitation Facility,” 69 Fed. Reg. 25,752 (May 7, 2004); see also, 48 Fed. Reg. 39,752, 39,756 (Sept. 1, 1983).

³ See generally, 74 Fed. Reg. 39,762, 39,789 (August 7, 2009) (CMS acknowledging substantive differences between Medicare’s coverage principles and facility classification policies such as the 60% Rule).

treated in an IRF is subject to rigorous admission and coverage criteria that Medicare contractors use for probe audits, RAC reviews, and various other medical review-related activities that are intended to determine the “medical necessity” of claims submitted for Medicare reimbursement. We agree that the Rule’s effect and impact is “arbitrary,” “crude,” and that it does not appear to have “a lot of science” behind it. In light of these characterizations, it would seem highly illogical to elevate the compliance threshold to 75%—thereby effectively intensifying and worsening the Rule’s arbitrariness, crudeness and general lack of science.

(B) The 60% Rule’s Impact and Congress’s Response to It

The Rule’s impact is straightforward: it imposes restrictions on the number and types of patients IRFs can admit—irrespective of what patients’ physicians determine is in their best interest when considering their post-acute care rehabilitation needs—and because it forces IRFs to “manage to a number” it can have arbitrary results on patients’ access to IRF services. It is not uncommon for an IRF to admit a “non-CMS 13” patient at a given point in time while being unable to admit the identical type of patient a relatively short period of time later, by virtue of the “manage to the number, stay-within-the-quota”-type mentality that the Rule imposes. Oftentimes when an IRF is unable to admit a patient due to the effects of the 60% Rule, he or she instead will be re-directed to a nursing home. Consequently, elevating the 60% Rule to a 75% Rule would impede patients’ access to IRF services and force more of them into nursing homes. And, as we outline below, there are significant differences between the level of care offered in an inpatient rehabilitation hospital and those offered in a nursing home.

As the Subcommittee is aware, concerns with Rule’s effects and its impact on Medicare beneficiary’s access to rehabilitation hospital care led Congress in 2007 to specify in the Medicare, Medicaid, and SCHIP Extension Act of 2007 (“MMSEA”) that the compliance threshold would be permanently set at a level not to exceed 60 percent, in contrast to the 75 percent threshold slated to be imposed by CMS under a Final Rule it issued on May 7, 2004. Congress’s decision to establish a permanent 60% Rule undoubtedly was influenced by bi-partisan, bi-cameral legislation introduced in 2007 that sought to establish such a Rule and that enjoyed 240 House co-sponsors (H.R.1459) and 61 Senate co-sponsors (S.543). 7 current Members of the Health Subcommittee co-sponsored that legislation, as did 7 other current members of the full Ways and Means Committee. The legislation was introduced by 2 former members of the Ways and Means Committee, Representatives Kenny Hulshof (R-MO) and John Tanner (D-TN).

Establishing a “permanent” 60% Rule was a policy choice that involved a “cost.” The 60% Rule was “paid for” by the elimination of IRFs’ market basket update for a year-and-a-half (from April 1, 2008 through September 30, 2009), which produced a budgetary savings to Medicare of \$4 billion for the 2008-2017 budget window.

Ironically, were Congress to reinstate the 75% Rule it would be an effective “double-whammy” for IRFs and patients requiring our services, as there surely would not be a restoration of the cuts imposed that were used both to offset the costs of the permanent 60% Rule and help pay for 2008’s “doc fix.”

(C) Revisiting The 60% Rule Is Not Reform—But Changing The Way Medicare Pays for “Outliers” Under the IRF PPS Would Be

Reducing patients’ access to IRF services by re-directing them into nursing homes is not “reform.” Concerns with how Medicare pays nursing homes for therapy and rehabilitation services have been well-documented by CMS, MedPAC⁴, and HHS-OIG.⁵ CMS has acknowledged that “shifting patients from the IRF setting to a SNF setting is not necessarily more beneficial to the patient or the Medicare Trust Fund.”⁶ We are aware of nothing which would suggest that shifting more Medicare beneficiaries out of IRFs and into nursing homes would result in better care and outcomes for them notwithstanding that that is, effectively, the ultimate upshot of elevating the 60% Rule to 75%. We believe, respectfully, that there are better, more thoughtful and sound ways to achieve \$1 billion in savings.

We wish to reiterate and emphasize with the Subcommittee that in expressing our respectful objections to the prospect of re-visiting the 60% Rule, we do not do so without acknowledging our understanding of the very real challenges facing Congress in its quest to ensure that Medicare is paying providers more accurately and with an eye toward encouraging efficient, cost-effective care that achieves high-quality outcomes for patients and to put the Medicare Trust Fund in a more stable fiscal position. It is with this understanding that we have put forth what we believe is a credible policy alternative instead of a more restrictive 60% Rule, that if adopted could potentially achieve a comparable range of budgetary savings that we believe merits this Subcommittee’s and Congress’s careful attention and consideration—reforming the so-called “outlier payment” policy under the IRF PPS.

⁴ See, e.g., MedPAC, “Report to the Congress: Medicare Payment Policy,” Chap. 7, pg. 193 (March 2012) (MedPAC recommending that SNF PPS be rebased in 2013 to “redistribute payments away from intensive therapy care that is unrelated to patient care needs...”).

⁵ See, e.g., HHS-OIG Podcast describing report #OEI-02-09-002000 (relating to therapy payments under the SNF PPS having a “huge vulnerability” because providers have incentives to “bill for more therapy than the patient may need”), accessible on-line at: <https://oig.hhs.gov/newsroom/podcasts/reports.asp#snf>

⁶ 76 Fed. Reg. 48,486, 48,499 (August 11, 2011).

Our analysis of the most recent outlier data available from CMS's IRF PPS Rate – Setting file for the FY 2014 Proposed Rule⁷ reveals that the IRF-PPS made “outlier” payments totaling just under \$214 million. Approximately 55% of these \$214 million in outlier payments (\$117.28 million) went to 113 of the 1,132 IRFs listed on the Rate-Setting file. Moreover, 226 IRFs received “outlier” payments under the IRF-PPS ranging from 8% to 57% of their *total Medicare payments*, with such payments representing over 60% (nearly \$132 million) of all “outlier” payments. We believe that many of these payments are not going toward the intended policy purpose of providing additional payments to cover the unanticipated costs of random draws of particularly complex or ill patients but are instead attributable to inadequate cost management that leads to inefficient care.

To the extent Congress may determine this year that the IRF-PPS will be impacted as part of the “doc fix” or other similar measures, we believe rather than pursuing a policy that would place a burden on beneficiaries—which in the case of ratcheting the 60% Rule up to a 75% Rule would diminish their access to IRF services—that it should instead challenge IRFs to provide care and services more efficiently by more effective cost management, both of which could be accomplished through reducing the amount of “outlier” payments made under the IRF-PPS. This reduction could be achieved through several potential policy options, such as lowering CMS's withhold percentage under the IRF-PPS outlier policy below the current 3% rate, or placing a limitation on the amount of outlier payments that an IRF can receive as a percentage of its total Medicare payments. We believe that “reform” within the IRF-PPS should not focus on shifting more patients to nursing homes and diminishing their access to IRF services. Instead, the focus should be on the IRF-PPS outlier payment policy to encourage more effective cost management and more cost-efficient care. We respectfully urge the Subcommittee to continue examining this area of IRF payment policy in lieu of re-visiting the 60% Rule as it continues its deliberations on PAC reform and “doc fix” offset options throughout the year.

II. IRFs and SNFs Perform Fundamentally Different Services

There is a common misperception, highlighted by several comments and exchanges of dialogue and discussion during the hearing, as well as in the written testimony of the witnesses, suggesting that IRFs receive higher payments than skilled nursing facilities (“SNFs”) for providing essentially the same care. With all due respect to the proponents of these types of statements, they are simply not accurate.

⁷ Accessible by scrolling down to “FY 2014 Data Files” at the following link on the CMS Website: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Data-Files.html>

Rehabilitation services provided in an IRF differ substantially from rehabilitation care provided in SNFs in several meaningful ways. Such differences include:

- **Medical Leadership by/from Rehabilitation Physicians:** All IRF patients are required to be managed by medical directors with specialized training in medical management of inpatients requiring rehabilitation. IRF patients must be approved for admission by rehabilitation physicians prior to admission, and within 24 hours of being admitted a rehabilitation physician must conduct a post-admission evaluation documenting the patient's admission status. These process and documentation-specific steps must be accompanied by ample clinical and medical detail of the patient's history, condition, and medical and rehabilitation needs in the medical record justifying why he/she needs to be seen "in person" at least 3 times per week by a rehabilitation physician (and of course, those "in person" visits must actually occur). In addition to having a documented need for requiring physician supervision by a rehabilitation physician, IRF patients must also have an overall plan of care developed by a rehabilitation physician documented in his/her medical record. SNFs have no similar requirements for the medical management and oversight of their patients, including medical rehabilitation led by a rehabilitation physician; it is entirely possible for SNF patients to go many days if not weeks without ever seeing a physician—much less a physician with specialized skill and training in rehabilitative medicine.
- **Intensive Therapy Requirements; Specified Admission Criteria:** With few exceptions, all IRF patients must have a well-documented need for, and actually receive, therapy that is provided on a multi-disciplinary basis (which must include either physical therapy or occupational therapy) for at least 3 hours per day, 5 days per week (or otherwise receive 15 hours of therapy per week). Nursing homes have no similar requirement.
- **24 Hour/7 Day a Week Nursing Care:** IRFs are licensed as hospitals and are required to provide patients with around-the-clock nursing care provided by Registered Nurses. Many of these Registered Nurses have special certification as a Certified Rehabilitation Registered Nurse. Nursing homes have no such requirement.

IRFs provide a distinct, physician-driven level of care and are required to meet hospital conditions of participation and other policies and regulations developed and implemented specifically for an IRF level of care and the intensity of services we provide. These policies and regulations involve rigorous admission and coverage criteria that require IRFs to carefully evaluate whether a patient needs IRF services. That evaluation is based at its core on the judgment and expertise of physicians skilled and

trained in rehabilitation medicine, and their judgment should not be subordinated to payment policies that make no distinctions between the services and quality of care outcomes achieved in IRFs and SNFs. There are significant differences between IRFs and SNFs, and Medicare’s payment policies should recognize them.

III. IRF Spending is Not the Growth Problem in Medicare PAC Spending

Many of the IRF-specific proposals discussed at the hearing are based on the inaccurate premise that Medicare spending for IRF services is growing rapidly. Indeed there was a certain “tone” to the hearing to the effect that Medicare expenditures for PAC services are growing at a rapid clip and such growth is occurring across the board in all PAC payment systems. Despite significant Medicare spending increases for other PAC providers (particularly SNFs and Home Health), Medicare’s IRF expenditures have been relatively stable since 2004 and, since 2007 have consistently represented less than 1.5% of overall Medicare expenditures. Expenditure growth for SNF and Home Health accounted for 88% of total PAC expenditure growth between 2007 and 2011 while IRF spending growth during that period accounted for only 5% of total PAC expenditure growth, as demonstrated in the following table:

	2007	2011	Change	% of Spending Increase
IRF	\$5,264,800,000	\$5,884,064,000	\$619,264,000	5%
LTACH	\$4,332,000,000	\$5,229,000,000	\$897,000,000	7%
HH	\$15,362,000,000	\$18,437,000,000	\$3,075,000,000	25%
SNF	\$21,953,000,000	\$29,751,000,000	\$7,798,000,000	63%
Total PAC⁸	\$46,911,800,000	\$59,301,064,000	\$12,389,264,000	100%

According to CMS’s most current data, higher PAC costs, on a per capita basis, essentially point to seven states where PAC spending is significantly higher than the national average: Louisiana, Texas, Mississippi, Florida, Oklahoma, Massachusetts, and Illinois.⁹ Yet, higher per capita PAC expenditures in each of these states are driven by non-IRF PAC sectors. In Texas, for instance, high PAC expenditures are almost solely associated with high utilization of Long-Term Acute Care Hospitals, high utilization of

⁸ All data in table are “standardized.”

⁹ Data derived from Medicare’s “Geographic Public Use File” (accessible on CMS website at: <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Geographic-Variation/index.html>).

Home Health, and high per-user Home Health expenditures.¹⁰ In Florida, higher PAC expenditures are driven by high utilization and costs for both Home Health and SNF services.¹¹ Despite claims made by proponents of certain IRF-reform proposals, although growth in Medicare PAC expenditures has occurred, it has not been fueled by significant IRF expenditure growth.

IV. Cost Differences Between IRFs and SNFs are Not “Quite Significant”

Several comments during the hearing suggested that cost differences between IRFs and SNFs are “quite significant”—however, based on CMS data this is not necessarily the case. The cost difference between IRFs and SNFs when evaluating the national average cost per case (standardized) in 2011 was somewhat comparable: \$16,794 for SNFs and \$18,131 for IRFs; and, that year nearly 28 percent of Medicare SNF users had an average cost per case *that was more than* Medicare’s national average cost per case for IRF services. Thus, basing any PAC reform proposal on the assumption that cost differences between IRFs and SNF are “quite significant” would not be accurate.

HealthSouth appreciates the opportunity to share this statement for the record with the Subcommittee. We appreciate the Subcommittee’s leadership and look forward to working with your staff and you in the months and years ahead to develop sensible and sound policies that can improve our PAC payment systems. We look forward to submitting a more comprehensive comment letter on PAC reform in the coming weeks. Please do not hesitate to contact me on (202) 239-3466 or via email at justin.hunter@healthsouth.com if you have any questions about this statement for the record.

Sincerely yours,

Justin R. Hunter
Senior Vice President
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¹⁰ *Id.*

¹¹ *Id.*

Supplemental Contact Sheet

This supplemental contact sheet is being submitted in connection with a “statement for the record” submitted to the Ways and Means Health Subcommittee on June 28, 2013 in connection with the hearing entitled, “Proposals to Reform Medicare Post-Acute Care Payments,” held on June 14, 2013.

The statement is being submitted by Justin Hunter on behalf of HealthSouth Corporation (based in Birmingham, Alabama). Mr. Hunter is HealthSouth’s senior vice president of public policy, legislation, and regulations, and he is based in Washington, D.C. His contact information is as follows:

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