Charles N. Kahn III
President and CEO

December 17, 2014

Glenn Hackbarth
Chairman
Medicare Payment Advisory Commission
425 Eye Street, NW, Suite 701
Washington, DC 20001

Dear Chairman Hackbarth:

On behalf of the Federation of American Hospitals ("FAH"), we are writing with respect to the Medicare Payment Advisory Commission's ("MedPAC") consideration of potential site-neutral payment policy recommendations governing inpatient rehabilitation facilities ("IRFs") and skilled nursing facilities ("SNFs").

FAH is the national representative of more than 1,000 investor-owned or managed urban and rural community hospitals throughout the United States, including approximately one-half of all free-standing IRFs as well as many IRF units within hospitals.

The FAH supports MedPAC's goal of increasing the efficiency, effectiveness, quality and patient outcomes of post-acute care for Medicare beneficiaries and agrees that a more patient-centered focus that ensures the right care in the right setting is the right approach. While appropriate site neutral payment policies, among other delivery reforms, could help achieve this goal, they should be considered with extreme caution. Along those lines, reliable clinical evidence simply does not now exist to support the kinds of site neutral policy recommendations that MedPAC is considering regarding care provided in IRFs and SNFs, and we urge MedPAC to refrain from taking action at this time.

Recognizing the lack of clinical and quality data, earlier this year a bipartisan, bicameral Congress enacted the Improving Medicare Post-Acute Care Transformation (IMPACT) Act. Its central premise is the establishment of a meticulous process to develop the payment and quality data building blocks that could support policies, such as site neutral payments, which would reform post-acute care. The cornerstone of that framework for reform is a universal assessment tool that can measure health status, clinical severity, and functional impairment across all PAC

sites and standardize that data for comparative purposes. That tool should incorporate the Functional Independence Measure (FIM) used by IRFs, and also must measure improvement in a patient's condition over time in a comparable way across PAC settings. Universal assessment tools are necessary for providers to improve placement of patients to the most appropriate care settings. The implementation of a payment system based on assessment instruments that do not precisely capture these dimensions of patient care across PAC providers could lead to poorer outcomes for patients. Of course, physician judgment, recognizing the importance of patient preference, social supports, and other issues that can impact a patient's care is paramount.

Absent the data generated by the widespread use of that assessment instrument, there is too great a risk of implementing blunt site-neutral payment policies that undermine the goal of ensuring beneficiaries are placed in the most clinically appropriate care settings. There are important clinical and functional differences between patients treated at IRFs and SNFs. Site-neutral payment, without the appropriate recognition of the need for highly effective risk and case- mix adjustment and conforming regulatory changes, would significantly underestimate the clinical differences between patient populations served in these settings and would not recognize the differential costs incurred to comply with various CMS regulations. For example, IRFs are required to have higher staffing ratios with more frequent patient contact by physicians. In addition, IRFs must meet stringent Federal hospital conditions of participation among other strict federal and state hospital licensing and regulatory requirements. Blunt site neutral payment policies risk becoming site preference policies that would serve patients poorly by simply seeking the setting with the lowest payment, independent of clinical appropriateness or quality of care.

We are aware that others have brought to your attention serious data flaws and limitations associated with the Urban Institute study which some have relied on to support the immediate implementation of IRF/SNF site neutral payment policies. FAH shares those concerns. In addition, we have evaluated the recent study by Dobson Davanzo & Associates, LLC on the comparative effectiveness of IRFs and SNFs, and strongly agree with its findings that across many conditions, "IRF rehabilitated patients experience better long-term clinical outcomes than the SNF population."

For all of these reasons, it is premature for MedPAC to proceed with site neutral payment policy recommendations for IRFs and SNFs. To the extent that MedPAC does decide to move forward at this time, we strongly urge that such recommendation be limited in scope, tantamount to a demonstration or pilot program, and apply only to cases that are ineligible to comply with the 60 percent rule. In addition, the recommendation should explicitly include conforming regulatory revisions necessary to ensure that there is not only site neutral payment, but site neutral regulation.

Among the key conforming regulatory changes: Cases that qualify under the 60 percent rule should not be subject to a site neutral payment policy, and to the extent cases that do not qualify under the 60 percent rule are subject to a site-neutral policy, those cases should be excluded from determining compliance with the 60 percent rule. In addition, the so-called "3-hour Rule," as well as pre-admission and post-admission screening and physician evaluation, respectively, should not apply to cases subject to site neutral payment policies. These policies impose costs on

IRFs that are no longer relevant to cases whose payments are deemed to be site neutral between IRFs and SNFs.

Even with these conforming regulatory changes, however, inpatient rehabilitation hospitals, by their very nature, incur higher costs than SNFs, which should be recognized in IRF payment rates. In addition, the IRF payment system includes crucial supplemental payments intended to support their mission in rural areas, teaching, and providing care to indigent patients, all of which should be retained.

Thank you for the opportunity to submit our comments. If you have any questions, please do not hesitate to contact me or Steve Speil at (202) 624-1529.

Sincerely,

