American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

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Michael Chernew, Ph.D.
Chairman
Medicare Payment Advisory Commission
425 I Street, NW, Suite 701
Washington, DC 20001

Dear Dr. Chernew:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations; our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to share our comments on two topics that were discussed during the October 2023 public meeting – "site-neutral" payments to inpatient rehabilitation facilities (IRF) and skilled-nursing facilities (SNFs), and nurse staffing requirements. Specifically, we:

- **urge the commission to reconsider its pursuit of IRF-SNF site-neutral payment policies; and**
- **recommend the commission focus any further study of nurse staffing requirements on their impact on long-term care facility capacity and subsequent access to care.**

Our detailed comments on these issues follow.

INPATIENT REHABILITATION FACILITY PAYMENTS

At the October 2023 meeting, the commissioners discussed a potential "site-neutral' policy for certain conditions treated in IRFs, specifically considering whether conditions that fall outside the 13 that must account for 60% of IRF patients should be paid at the skilled-nursing facility (SNF) rate. **The AHA appreciates that MedPAC continues to pursue proposals that could potentially improve the alignment of cost and payment under the IRF prospective payment system (PPS). However, we have numerous concerns about the commission's analysis; AHA believes a site-neutral policy would ultimately be harmful to seriously afflicted Medicare beneficiaries.** Chief among our concerns is that the manner of which MedPAC uses the 60% Rule in payment policy, which represents

a fundamental misunderstanding of the IRF exclusion criteria. **We urge MedPAC to reconsider its pursuit of IRF-SNF site-neutral payment policies.**

To begin, and as MedPAC has recognized, any IRF-SNF site-neutral payment policy is rife with potential complications. This is due to the vastly different regulatory environments that IRFs (hospitals) and SNFs (subacute facilities) operate under. The difficulties in aligning payment incentives and other important factors between these and other sites of care became apparent during MedPAC's work on the Unified Post-Acute Care (UPAC) payment system. As AHA pointed out from the beginning of that work, each post-acute site has its own unique payment and regulatory structure. In addition, and as was noted during the Commission's discussion, IRFs provide a vastly more intensive course of treatment than SNFs. Further, the Medicare cost sharing, lifetime coverage, and several other factors vary greatly between the two types of facilities. Although perhaps not entirely insurmountable, these factors make any attempt to align payment between the two sites of care a very complex task, which may not be worthy of the Commission's or Congress' efforts.

We also have serious concerns about the manner in which MedPAC's site-neutral policy would be tied to the IRF 60% Rule. **By applying the 60% Rule to a payment policy, the analysis presented during the Commission's session fundamentally misconstrued the rule's utility and purpose**.

By way of background, the 13 conditions listed as part of the exclusion criteria trace back almost 50 years to 1975, when the initial 10 conditions were selected; they in no way provide a modern-day representation of the typical conditions requiring inpatient rehabilitation.[1] The 60% Rule is intended only to serve as a tool that broadly distinguishes IRFs from acute-care hospitals based on patient mix. It is intended to serve neither as an adjunct to determine the appropriateness of IRF level of care, nor in determining whether individual patients are appropriate for IRF care. Since its inception, the rule was updated to account for medical advancements just once – in 2005 – with the addition of 3 more conditions. Yet, in the intervening years, there have been drastic shifts in the types of patients who require and benefit from IRF services.

As just a few examples, due to advancement in certain orthopedic procedures, certain post-surgical patients that once frequently required IRF services now rarely do. Conversely, certain oncology patients, once faced with grim survival rates, are now recovering and utilizing IRFs to regain function under close medical supervision in ways not possible in prior decades.

Even at the genesis of the IRF 60% Rule, it was recognized that it was a drastic over-generalization that only had utility as a facility classification tool; as such, it has never been used as a coverage or payment rule by Medicare. **Indeed, to the contrary, Medicare coverage regulations require that 100% of all Medicare beneficiaries treated in IRFs require intensive rehabilitation – they do not require patients to have any specific**

[1] Medicare Program; Prospective Payment for Medicare Inpatient Hospital Services, 49 Fed. Reg. 239 (Jan. 3, 1984).

conditions.[2] In other words, Medicare's medical necessity rules apply regardless of whether the patient's condition is one of those included in the 60% Rule or not. This means that even those conditions that MedPAC described as "nonqualifying" actually must, and do, meet the IRF medical necessity criteria. Indeed, these patients are only "nonqualifying" as far as the 60% Rule is concerned – they are actually valid IRF admissions.

However, MedPAC is considering a proposal that would utilize the 60% Rule for payment purposes, broadly grouping IRF patients into two categories – "qualifying" and "nonqualifying" – and modifying payment accordingly.

Two specific statements made during this session's presentation stood out as highlighting the fundamental misapplication of the 60% Rule to payment policy. The first was that "the alternative payment method to pay for stays that *do not require intensive rehabilitation* would rely on Medicare's definition of qualifying and nonqualifying conditions" (italics added). As stated earlier, CMS is already prohibited by its own medical necessity criteria from paying for any stays that do not require intensive rehabilitation. While it may be true that some conditions do not *typically* require inpatient rehabilitation, beneficiaries admitted to IRFs are those that do in fact require such a level of care, as demonstrated by meeting the stated medical necessity requirements. Therefore, the main premise of MedPAC's proposal, that some patients currently admitted to IRFs do not require intensive rehabilitation, is false.

The aforementioned misunderstanding led to the second comment that stood out to AHA, which was the main prompt of this policy discussion: "Nonqualifying conditions typically do not require the intensive rehabilitation care that is unique to IRFs. This raises the question: What is Medicare buying for the higher payment rates?" The answer to this question lies in the patient-centric nature of the IRF admissions process.

IRFs are required by regulation to undergo a rigorous preadmission screening process for every patient, which includes an evaluation overseen by a specialized physician to determine whether the patient is appropriate for intensive rehabilitation.[3] This is why, consistent with the perception that nonqualifying conditions do not *typically* require intensive rehabilitation, IRFs accept a relative low percentage of referrals with nonqualifying conditions.

The differences in patients who can benefit from IRF care and those who are better treated in a SNF are often very nuanced and difficult to capture on standardized patient assessment

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[2] The other medical necessity requirements, found at 42. C.F.R. 42 § 412.622, These medical necessity includes requiring at least 15 hours of therapy per week, a multiple disciplinary approach to care, close physician supervision, rehabilitation nursing, and several others.

[3] The preadmission screening requirement at 42 C.F.R. § 412.622(a)(4)(i) must be conducted by a licensed clinician within 48 hours of admission, include a detailed review of the patient's condition, history, prior and expected level of function, expected level of improvement, expected duration of treatment, evaluation of patient's risk for complications, conditions causing the need for rehabilitation, the detailed therapies needed by the patient, and the discharged expectations for the patient. The rehabilitation physician at the IRF must review and concur with the findings of this screening.

data. To be clear, while it may appear on paper that many patients are the same or similar, every single patient is unique. This is why it is left to the experience and training of the clinicians and case managers who must account for numerous medical, functional and social factors to determine the optimal placement for patients. These clinicians and experts must account for all of these factors and offer recommendations as to an appropriate placement for post-acute care. Maximizing outcomes for Medicare patients on the road to recovery after a serious injury or illness is far from a precise science, but instead requires the input of multiple clinical disciplines, input from patients and their families, and knowledge of the capabilities of the available sites of post-acute care.

The preadmission screening process utilized by IRFs is a patient-centric approach to post-acute placement that is precisely what Medicare beneficiaries should expect. By closely evaluating the specifics of each patient's medical, functional and social factors, it ensures that those patients who do not require IRF services are placed elsewhere, while those in need of intensive rehabilitation are able to benefit from those services, receiving the best possible care.

Yet, the approach that MedPAC is suggesting would substitute this patient-centric approach for a one-size-fits-all categorization that would broadly group all patients outside the 13 conditions into a "nonqualifying" class, despite their widely varying needs. Further, IRFs would be deeply disincentivized from taking these nonqualifying cases, which would restrict patients from accessing needed IRF care while recovering from serious ailments related to cardiac events, cancer and even COVID-19.

In addition to a lack of patient-centric analysis, the discussion failed to appreciate the current dynamics of the IRF PPS and how it already captures variation in resource use among different types of conditions. Under the current payment system, as is the case with all of the PPSs, CMS analyzes the relative resource use of each diagnosis group (referred to as case-mix groups, or CMGs under the IRF PPS) and assigns a relative weight. Through this design, the agency is already accounting for those types of patients that require varying intensities of care; payments are adjusted accordingly. The approach that MedPAC is suggesting – grouping 40% of IRF patients into a "nonqualifying group," based upon an erroneous criteria – would be a far less precise and accurate system than the one that currently exists.

To return to the primary discussion question for this session ("What is Medicare paying for?"), we encourage MedPAC to keep in mind the hundreds of thousands of seriously afflicted Medicare beneficiaries that benefit from IRF services every year. As the MedPAC analysis pointed out, the length of stay in IRFs is less than half that in SNFs, with well more than twice as much therapy, all while in a closely medically supervised, hospital setting. These patients are often facing more serious functional deficits, have more complex medical needs, or face other factors that make treatment in a less intensive setting suboptimal. Therefore, what Medicare is paying for includes: functional and medical outcomes that could not be achieved elsewhere; fewer complications and readmissions than would be the case if these patients were treated in SNFs; and a quicker return to home.

All of this results in savings to the Medicare program. As discussed before, disincentivizing the use of IRFs for a broad range of patient types based on the IRF classification criteria would be a grave disservice to both these beneficiaries and the Medicare program; such a policy would not advance the mission of delivering high quality, efficient care to beneficiaries.

Therefore, the AHA strongly urges MedPAC to reconsider its pursuit of an IRF-SNF site neutral payment policy. We appreciate the commission's efforts to ensure that payment is properly aligned with costs. We would be happy to work with your staff to discuss our concerns.

EXAMINING STAFFING RATIOS AND TURNOVER IN NURSING FACILITIES

Also at the October 2023 meeting, commissioners received an overview of the literature available on the relationship between nursing facility staffing and quality of care, as well as the wide variation in federal and state staffing requirements. Staff also reviewed key provisions of CMS' recent proposed rule that would impose minimum staffing standards on long-term care (LTC) facilities. Staff noted that they plan to analyze staffing data in the SNF payment adequacy chapter in the March 2024 report and include an informational chapter with updated staffing analysis in the June 2024 report; commissioners discussed what additional work staff should take on regarding minimum staffing requirements and other policy options to improve staffing.

The AHA and its members are committed to safe staffing to ensure high quality, safe, equitable and patient-centered care in all health care settings, including LTC facilities. However, we echo the concerns of several MedPAC commissioners that CMS' proposal to implement mandatory nurse staffing levels is an overly simplistic approach to a complex issue that, if implemented, would have serious negative unintended consequences for not only nursing home patients and facilities, but the entire health care continuum. Substantial evidence exists demonstrating the conceptual weakness of numerical nurse staffing thresholds to promote high-quality care; other data shows that these types of requirements would have detrimental effects on the nurse workforce throughout the care continuum. **We encourage MedPAC to focus its analyses on staffing on the effects minimum staffing requirements have had on facility capacity and, subsequently, patient access to care, including likely effects on discharge delays from general acute care hospitals.**

Prior to the COVID-19 pandemic, health care providers were already facing significant challenges making it difficult to sustain, build and retain the health care workforce. In 2017, the majority of the nursing workforce was close to retirement, with more than half aged 50 and older, and almost 30% aged 60 and older. These shortages only accelerated due to the profound disruptive impacts of the COVID-19 pandemic. Indeed, according to a 2022 study in *Health Affairs*, the total supply of RNs decreased by more than 100,000 from 2020 to 2021 — the largest drop observed over the past four decades.[4] An even more

[4] Auerbach, David, et al. "A Worrisome Drop in the Number of Young Nurses," *Health Affairs Forefront*, April 13, 2022. https://www.healthaffairs.org/content/forefront/worrisome-drop-number-young-nurses

comprehensive analysis from a large-scale biennial survey conducted by the National Council of State Boards of Nursing (NCSBN) and National Forum of State Nursing Workforce Centers (NFSNWC) found a similar number of registered nurses had left the workforce. It also showed that nearly 900,000 — or one-fifth of the 4.5 million total registered nurses — expressed an intention to leave the workforce due to stress, burnout and retirement. The NCSBN and NFSNWC study also noted that over 33,800 licensed practical nurses (LPNs) and vocational nurses left the field since 2020, disproportionately impacted nursing homes and LTC facilities.[5]

Unfortunately, our nation's ability to replace those nurses choosing to exit the field is also severely constrained. Indeed, the American Association of Colleges of Nursing notes that nursing schools have struggled for more than a decade to increase enrollments due primarily to an insufficient number of faculty and available clinical placement opportunities for students.[6] In fact, in 2022 the number of students in entry-level baccalaureate nursing programs decreased by 1.4%, the first time in 20 years in which schools have been unable to increase enrollment.[7]

In its proposed rule, CMS estimates that 75% of LTC facilities would have to increase staffing to meet the proposed standards, including the new standard requiring 24/7 RN staffing. Another study from the Kaiser Family Foundation estimated that 81% would need to hire more RNs or NAs.[8] **We suggest that MedPAC investigate the direct and indirect costs on not only LTC facilities, but the entire health care continuum as a result of this increased staffing.** For example, a 2022 study estimated that staffing shortages will potentially cost nursing and rehabilitation facilities, as well as home-health agencies, $19.5 billion per year.[9] Considering the finite availability of the nursing workforce, these costs will certainly be felt beyond nursing and rehabilitation facilities, and MedPAC can look further into these costs and the consequences of increased spending on staffing without clear ties to improved patient outcomes.

Further, faced with required staffing levels, we anticipate skilled nursing facilities and other LTC facilities may be forced to reduce their capacity or even close their doors when they are unable to meet these mandates. Organizations considering opening new LTC facilities would likely be discouraged from doing so knowing they may not be able to recruit enough staff to meet CMS' thresholds. This would have a ripple effect across the entire continuum

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[5] https://www.journalofnursingregulation.com/article/S2155-8256(23)00047-9/fulltext
[6] American Association of Colleges of Nursing, Fact Sheet: Nursing Shortage. October, 2022 https://www.aacnnursing.org/Portals/0/PDFs/Fact-Sheets/Nursing-Shortage-Factsheet.pdf
[7] https://www.aacnnursing.org/news-data/all-news/new-data-show-enrollment-declines-in-schools-of-nursing-raising-concerns-about-the-nations-nursing-workforce
[8] Burns, Alice, et al. "What Share of Nursing Facilities Might Meet Proposed New Requirements for Nursing Staff Hours?" Kaiser Family Foundation, September 18, 2023. https://www.kff.org/medicaid/issue-brief/what-share-of-nursing-facilities-might-meet-proposed-new-requirements-for-nursing-staff-hours/#:~:text=Finally%2C%20the%20rule%20was%20announced,improve%20enforcement%20of%20existing%20standards
[9] "Staffing shortages to cost U.S. care facilities $19.5 billion this year, study finds." Bloomberg, June 2, 2022. https://fortune.com/well/2022/06/02/staffing-shortages-to-cost-us-care-facilities-19-5-billion-this-year-study-finds/

of care, as general acute care hospitals, inpatient rehabilitation facilities and other health care facilities already struggle to find appropriate placement for their patients.

Indeed, hospitals and health systems already are experiencing significant challenges in moving patients through the health care continuum generally, and into skilled nursing facility care specifically. The average length-of-stay (ALOS) in hospitals for all patients increased 19.2% in 2022 compared to 2019 levels; for patient being discharged to post-acute care providers, the ALOS increased nearly 24% in the same period. Case-mix index-adjusted ALOS increased for patients being discharged from acute care hospitals to skilled nursing facilities by 20.2%.[10] These longer stays in hospitals are not a mere inconvenience. They result in delays in patients receiving the next level of medically necessary care. They also lead to longer wait times in hospital emergency departments because hospitals are unable to move current patients out of inpatient beds. In other words, constrained access to LTCs is a quality-of-care issue affecting all types of patients across the care continuum.

In part, the above trends reflect the significant shortages of health care workers experienced in skilled nursing and other long-term care facilities. But they also reflect an alarming increase in LTC facility closures across the country, a trend that could be accelerated if CMS' proposed rule is adopted. Since the beginning of 2020, at least 600 LTC facilities have closed while only three have opened so far in 2023 (compared to an average of 64 opening each year from 2020 to 2022).[11] **We suggest that MedPAC include metrics like closures, wait times, ALOS, and discharge delays in their future analyses of the effects of minimum staffing requirements.**

We thank you for your consideration of our comments. Please contact me if you have questions or feel free to have a member of your team contact Shannon Wu, AHA's senior associate director of policy, at swu@aha.org or 202-626-2963.

Sincerely,

/s/

Ashley B. Thompson
Senior Vice President
Public Policy Analysis and Development

Cc: Paul Masi, M.P.P.
MedPAC Commissioners

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[10] AHA Issue Brief, December 2022.
[11] "The Upheaval at America's Disappearing Nursing Homes, in Charts," *Wall Street Journal,* August 23, 2023. https://www.wsj.com/health/healthcare/the-upheaval-at-americas-disappearing-nursing-homes-in-charts-9aa8d2f9