January 16, 2019

Francis J. Crosson, M.D.
Chairman
Medicare Payment Advisory Commission
425 Eye Street, N.W.
Suite 701
Washington, DC 20001

Re: American Medical Rehabilitation Providers Association’s Comments on Chairman’s Draft Recommendations for Inpatient Rehabilitation Facilities for Fiscal Year 2020

Dear Chairman Crosson and MedPAC Commissioners:

This letter is submitted on behalf of the American Medical Rehabilitation Providers Association (AMRPA) to provide our comments on the Chairman’s draft recommendations relating to Medicare payments for inpatient rehabilitation facilities (IRFs). In summary, we respectfully urge the Commissioners to reject the Chairman’s draft recommendation to reduce the Fiscal Year (FY) 2020 IRF Prospective Payment System (IRF PPS) payment rate by five percent.

AMRPA is the national voluntary trade association representing more than 625 freestanding rehabilitation hospitals, rehabilitation units of general hospitals, and outpatient rehabilitation service providers. Our members provide medical rehabilitation services in a vast array of health care settings working with patients to maximize their health, functional skills, independence, and participation in society so they are able to live as independently as possible by returning home, returning to work or, in many instances, pursuing an active retirement. In 2017, Medicare accounted for approximately 58 percent of IRF discharges.¹

Medicare Margins

During its December meeting, the Commission’s analysis of IRF payment adequacy focused on overall Medicare margins for all IRFs; however, as we have previously noted, this approach fails to recognize that margins vary substantially. MedPAC’s analysis found that most IRFs have nominal Medicare margins. The majority of IRFs are hospital-based rehabilitation units (76 percent) that have an aggregate margin of 1.5 percent. A majority of IRFs are nonprofit

(56 percent) and have aggregate margins of 2.2 percent. The Chairman’s draft recommendation of a five percent payment reduction to the IRF PPS base rate could have a significant and adverse effect for many IRFs and the patients served in these hospitals.

We continue to be concerned that MedPAC has not revised its analysis to account for differences in the Commission’s projected 2017 aggregate IRF margin (14.3 percent) and the actual 2017 margin (13.8 percent). The 2017 actual margin is more than the 2016 aggregate IRF margin, but less than the 2015 margin.

While AMRPA shares MedPAC’s desire to better understand the factors underlying variation in Medicare margins, we remain troubled by the continued suggestion that strong margins are due to patient selection or coding. For example, MedPAC seems to presume that more profitable IRFs are selecting more patients with specific conditions like stroke without paralysis. Based on the literature we have seen, we do not believe there is evidence that differentials in patient coding meaningfully contributes to the variability. While we appreciate the Commission’s concerns regarding variation in Medicare margins, a five percent reduction is not the solution and, to the contrary, is likely to further exacerbate underlying financial disparities and potentially negatively affect patient access.

In addition to the Medicare cost report data from the Centers for Medicare and Medicaid Services (CMS) that MedPAC used to complete its analysis, the IRS PPS Fiscal Year (FY) 2019 rate setting files provide additional information about the adequacy of Medicare payments to IRFs. Our analysis found that for FY 2019:

- 44 percent of IRFs have negative Medicare margins (below 0 percent), and half of all rural IRFs have negative Medicare margins;
- 54 percent of all IRFs have margins below 5.0 percent;
- More than two-thirds of IRFs (64 percent) will have Medicare margins below 11.6 percent, MedPAC’s aggregate Medicare margin for all IRFs in FY 2020; and
- Across all IRFs, the average Medicare margin per facility will be 3.4 percent.

Several important observations were offered during MedPAC’s December 2018 meeting, including the suggestion from one of the Commissioners that the Commission consider whether a more appropriate recommendation is to improve the uniformity of patient assessments rather than to reduce the payment rate. Additionally, the Commissioners discussed the discrepancies in payment recommendations between post-acute care providers with similar projected Medicare margins.

Outlier Pool Expansion

We continue to have concerns with the Commission’s standing recommendation to increase the outlier pool from three percent to five percent. MedPAC explains that the recommendation is intended to reduce misalignment between IRF payments and costs by

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2 This data is derived from AMRPA’s analysis of CMS’ FY 2019 Final Rule Inpatient Rehabilitation Facility Prospective Payment System rate setting files.
redistributing payments. However, AMRPA opposes using outlier payment policy to arbitrarily redistribute funds among IRFs.

There may be multiple reasons for outlier cases: complex patents known at admission, patients who develop unforeseen costly problems, higher cost structures and other factors. These factors suggest that expanding the outlier pool would not achieve MedPAC’s intended policy objectives of increasing outlier payments for the costliest cases while easing the burden for IRFs with a relatively large number of such cases nor truly help any providers negatively affected by the payment decrease.

The outlier payment policy is a budget-neutral program. Increasing total outlier payments would further decrease the PPS base rate beyond the reduction the Commission is considering. Moreover, given the prospective nature of the outlier payment methodology, outlier payments have consistently resulted in a net loss that has taken money out of the IRF PPS system in recent years. This is certainly the case for individual IRFs that, despite their high costs, have fewer than average outlier cases. For these reasons, increasing the outlier pool further risks reducing reimbursement for those IRFs that can least afford it. While AMRPA is eager to discuss with CMS and MedPAC potential ways to improve the effectiveness of the outlier pool policy, we oppose making changes to the outlier payment policy as a short-term solution to addressing variation in case-mix groups (CMGs).

Additional Concerns

During its December 2018 meeting, MedPAC outlined two concerns regarding IRF payments. Namely, IRFs with high margins have a different case mix than other IRFs, and IRFs may not be assessing patients’ functional ability in a uniform manner. As outlined above, the recommendation to implement an across-the-board five percent payment cut will not properly align IRF payments and costs. Instead, for a majority of IRFs, the draft recommendation would result in a negative Medicare margins. The recommendation fails to appropriately address MedPAC’s stated concerns regarding the IRF PPS.

In light of MedPAC staff’s expressed concerns regarding the accuracy of provider-reported data, AMRPA affirms its support for the Improving Medicare Post-Acute Care Transformation (IMPACT) Act’s (P.L. 113-185) requirement for post-acute care providers to report on a standardized functional status quality measure. The law establishes the foundation for meaningful comparisons in quality and resource use by post-acute care providers. Functional status data is a key consideration for qualitative assessments, a determinate of the clinical appropriateness of care in the different settings, and a key predictor of resource use in post-acute care. Furthermore, as Commissioners observed at the November 2018 meeting, improving functional outcomes is the ultimate objective of post-acute care. AMRPA views function as the most critical substantive quality measure under development and thinks functional status data should be a fundamental component of any unified post-acute care payment system.
Conclusion

AMRPA appreciates the opportunity to provide the Commissioners with our comments on the important work you do. We welcome the opportunity to provide additional input throughout the process and to clarify any comments in this letter. If you have questions, please do not hesitate to contact Carolyn Zollar, AMRPA’s Executive Vice President of Government Relations and Policy Development, at (202) 223-1920 or czollar@amrpa.org, or Martha Kendrick, AMRPA’s Washington Counsel, at (202) 887-4215 or mkendrick@akingump.com.

Sincerely,

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