January 8, 2018

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

Re: ***American Medical Rehabilitation Providers Association's Comments on Chairman's Draft Recommendation Regarding Inpatient Rehabilitation Facilities for Fiscal Year 2019***

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) and specifically to urge its rejection.

AMRPA is the national voluntary trade association representing more than 600 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. On average Medicare Part A payments represent more than 60 percent of IRFs' revenues.[1]

Proposals to Stack Recommendations

Of primary concern to AMRPA is MedPAC's apparent decision to stack additional post-acute care recommendations on top of prior Commission recommendations, whose problems were previously flagged but ultimately ignored by MedPAC. The unintended consequences from the concurrent application of problematic policy recommendations jeopardize both patient access to care and the financial viability of inpatient rehabilitation providers.

PAC PPS Blended Rates

While we support post-acute care (PAC) payment system reform, this proposal would prematurely expedite provider transition towards a unified PAC PPS. To generate payments that

[1] MEDPAC, REPORT TO CONGRESS 261 (Mar. 2017).

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reflect the current cost of providing PAC services, the model's underlying cost data must align with the actual cost of care. Yet the MedPAC prototype relies on cost data from 2008-2010 Medicare claims data, and used a provider sample from 2013 that neither reflects the national PAC provider distribution nor captures the full array of PAC patients. Therefore, the data used in MedPAC's PAC PPS prototype contains foundational problems making it unworkable as an actual payment model.

Moreover, this proposal circumvents what Congress envisioned in passing the Improving Medicare Post-Acute Care Transformation (IMPACT) Act. The Act was enacted to standardize patient assessment, outcomes and resource use data across different PAC providers to obtain a more complete understanding of quality as a precursor to evidence-based payment reforms. AMRPA remains committed to seeing the IMPACT Act fully implemented so that reforms are built on top of the evidentiary base it was designed to create.

AMRPA is troubled by MedPAC's lack of transparency in considering a draft recommendation to base Post-Acute Care (PAC) payments on a blend of setting-specific relative weights and the unified PAC Prospective Payment System (PPS) relative weights beginning in 2019. Key details regarding the methodology and underlying data for this proposal have not been made available to the public. Specifically, the public has not been informed of what the actual relative weights would be, how these rates would be set, or how they would differ from the setting-specific weights under current PPSs. Without access to the same information available to the Commissioners, MedPAC is effectively precluding stakeholders from providing meaningful feedback to properly assess the merits and implications of this proposal before a final determination is made.

Medicare Margins

The Commission's findings indicate that aggregate Medicare margins among inpatient rehabilitation providers remain adequate. Yet as we have previously noted, MedPAC's overreliance on aggregate margins obfuscates the range of margins among IRFs. MedPAC's analysis reveals that *most* IRFs do not have significant margins. The clear majority of IRFs are hospital-based rehabilitation units (77 percent) that have an aggregate margin of 1.2 percent. Additionally, a substantial majority of IRFs are also nonprofit (57 percent) with aggregate margins of 2.0 percent.

The Chairman's draft recommendation of a 5 percent payment reduction to the IRF Prospective Payment System (PPS) base rate runs the risk of severe adverse effects for many providers and their patients.

AMRPA is particularly concerned that MedPAC has not revised its rationale or impact analysis of a 5 percent cut in light of its inaccurate forecast of the 2016 aggregate IRF margin. MedPAC's projected 2016 aggregate IRF margin (13.9 percent) overestimated the actual 2016

margin by nearly a full percentage point.[2] Despite having projected 2016 margins to increase, MedPAC's recent data indicate that Medicare margins declined for all IRF types in 2016.[3]

Provider Type	Percent of IRFs	Percent of cases	Aggregate margin, 2016 (percent)	Change from 2015 (percentage points)	Percent Change from 2015
All IRFs	100	100	13.0	-0.8	-5.8%
Freestanding	23	50	25.5	-1.2	-4.5%
Hospital-based	77	50	1.2	-0.8	-40.0%
Nonprofit	57	41	2	-1.6	-44.4%
For-profit	31	52	23.9	-1.1	-4.4%

In addition to the Medicare data relied on by the Commission, the IRF PPS FY 2018 rate setting files reveal additional pertinent findings about the adequacy of Medicare payments to IRFs. Our analysis found that for FY 2018:[4]

- 43 percent of IRFs will have negative Medicare margins (below 0 percent), and 65 percent of all rural IRFs will have negative Medicare margins;
- 52 percent of all IRFs will have margins below 5.0 percent;
- More than two-thirds of IRFs (64 percent) will have Medicare margins below 11.9 percent, MedPAC's aggregate Medicare margin for all IRFs in FY 2019; and The *median* Medicare margin for all IRFs will be 3.3 percent.

In analyzing payment versus cost as a definition of margins, it is clear that a 5 percent payment cut would have dramatic consequences for the majority of IRFs. Given that the median margin for IRFs is 3.3 percent, an aggregate 5 percent cut to the payment system is unduly harmful to more vulnerable providers due to the wide variations in margins at the individual provider level.

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[2] MEDPAC, REPORT TO CONGRESS 238 (Mar. 2016) (MedPAC projected IRFs' aggregate Medicare margin would be 13.9 percent in 2016).
[3] Data presentation from MedPAC's December 6, 2016 and December 7, 2017 public meetings; the titles of both meetings is "Assessing payment adequacy and updating payments: Inpatient rehabilitation facility services."
[4] This data is derived from AMPRA's analysis of CMS Final Rule Inpatient Rehabilitation Facility Prospective Payment System rate setting files for FY 2018.

harmful to more vulnerable providers due to the wide variations in margins at the individual provider level.

Focused Medical Record Reviews

MedPAC recommends that the Secretary conduct focused medical reviews to assess inter-rater reliability across IRFs variability in IRF assessment practices. However, the Commission seems decidedly focused on penalizing the more profitable subset of the provider community rather than identifying ways to facilitate greater efficiencies among less profitable providers while preserving access for the most medically complex patients.

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 coding or patient selection. For example, MedPAC seems to presume that more profitable IRFs are selecting more patients with specific conditions like stroke without paralysis. Selecting IRFs to review based on profitability, as opposed to payment and costs, inherently scrutinizes providers that have found ways to be efficient in resource utilization. As structured, such reviews risk mistaking correlation for causation and assume a unidirectional relationship despite the lack of support for that assumption.

AMRPA appreciates that MedPAC staff seek to gain a better understanding of Functional Independence Measure (FIM™) scoring at the clinical level. However, any medical record review conducted by CMS should only be used to assess inter-rater reliability for qualitative research purposes and not linked to payment denials or recoupments. Piling onto the completely overwhelmed audit program that IRFs already face threatens to add additional cost burdens on providers and the system at large without corresponding and potentially beneficial changes to practices or policies. Further, without evidence that MedPAC's IRF margin quintiles remain constant from year-to-year, the analysis should not trigger policy responses to what may be fleeting and otherwise arbitrary categories.

IRF Outlier Pool Expansion

AMRPA does not believe that expanding the outlier pool is the solution to margin variability or otherwise adequate to offset the tremendous harm that a 5 percent reduction in Medicare payments would inflict. There may be multiple reasons for outlier cases: complex patents known at admission, patients who developed 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. As we have previously cautioned, outlier payments are not a general policy that should be used to arbitrarily redistribute funds within the IRF sector, nor could they be reliably employed in this way.

Moreover, as MedPAC is aware, the outlier payment policy is a budget-neutral program, such that increasing total outlier payments would further decrease the PPS base rate in addition to 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, expanding the amount of 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 simply do not feel this is a viable approach to mitigate the harm of an excessive payment reduction.

Conclusion

MedPAC asserts that its proposed 5 percent cut would be mitigated by combining it with additional proposals to expand the high-cost outlier pool and incorporate blended rates derived from the PAC PPS. Unfortunately, these mitigating factors are more likely to become a series of compounding calamities. Simply stacking unproven and problematic recommendations on top of an inherently flawed across-the-board payment cut will not accomplish our shared goal of establishing meaningful reforms to Medicare payment policies for post-acute care.

Once again, 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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