December 22, 2023

SUBMITTED ELECTRONICALLY

Michael E. Chernew, Ph.D.
Chair
Medicare Payment Advisory Commission

Paul B. Masi, M.P.P.
Executive Director
Medicare Payment Advisory Commission

Re: American Medical Rehabilitation Providers Association's Comments on MedPAC's Inpatient Rehabilitation Facility Recommendation for Fiscal Year 2025

On behalf of the American Medical Rehabilitation Providers Association (AMRPA) and our 700+ inpatient rehabilitation hospital members, we appreciate the opportunity to provide our response to the Chairman's December 2023 draft recommendation for Medicare payments for inpatient rehabilitation hospitals and units. AMRPA is the national, voluntary trade association representing more than 700 inpatient rehabilitation hospitals and rehabilitation units located within acute-care hospitals (referred to by policymakers as inpatient rehabilitation facilities, or "IRFs"). Our members treat a distinct patient population who require and demonstrably benefit from the intensive rehabilitation program uniquely provided in the IRF setting, which include patients with conditions such as stroke, traumatic brain injury and traumatic spinal cord injury. As MedPAC is aware, AMRPA is dedicated to protecting patient access and payment adequacy for our members in the Medicare program, and we have appreciated our longstanding engagement with MedPAC on a range of IRF payment and coverage issues that advance our goals.

As an initial matter, we strongly urge the Commission to oppose the Chairman's draft recommendation to reduce IRF payments by 5% in the fiscal year (FY) 2025 IRF Prospective Payment System (IRF PPS). Consistent with our past comments, we believe this recommendation fails to account for the true costs of hospital operations and care delivery. We believe this is a particularly concerning issue going into FY 2025 given the challenges tied to nursing and other key healthcare personnel shortages (this is illustrated by MedPAC's own data showing a considerable decrease in aggregate margins). Just as importantly, however, AMRPA is greatly concerned about comments offered by Commissioners during the meeting indicating that such a cut may be appropriate due to the perceived similarity of the IRF and skilled nursing facility (SNF) setting, including the acuity of patients treated and the intensity of therapy provided. We hope our comments spur the Commission to consider a more nuanced approach to its payment recommendation analysis and ensure that its work is driven by comprehensive and accurate understanding of the IRF benefit. We look forward to discussing our comments in greater depth.

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I. The Draft Recommendation Fails to Reflect the Current Fiscal Climate Facing IRFs & All Hospital Providers

Consistent with our prior comments, AMRPA is strongly concerned about the impact of an across-the-board payment reduction if the draft recommendation is ultimately implemented. In recent years, there has been an increase in the number of IRFs that were focused to close due to financial hardships and pandemic-related challenges. Implementing an across-the-board 5% payment reduction would only increase the likelihood of additional closures – particularly among smaller and rural IRFs that serve vulnerable communities. With an aging population and the expansion of the patients who can benefit from intensive rehabilitation (such as oncology patients and, most recently, long COVID patients), we believe it is critical that MedPAC focus on maintaining access to IRF care and ensure that its recommendations are aligned with that goal.

We also believe that the FY 2025 recommendation fails to fully or accurately account for the fiscal pressures currently facing IRFs. Last year, we thought that the Commission was more accurately forecasting the true impacts of the IRF fiscal climate (impacted by inflation and labor costs) when it reduced its overall payment cut recommendation from 5% to 3%. However, we now fail to understand why MedPAC is increasing its recommendation back to a 5% cut when the aggregate FFS Medicare margin for IRFs decreased from 17.0% to 13.7%. In other words, we question why MedPAC would *increase* its proposed payment reduction when the financial environment has grown more challenging.

We also note that, regardless of the financial challenges, IRFs improved outcomes as shown by the increase in the discharge to community percentage from 64.9% in 2018-2019 to 67.3% in 2021-2022. IRFs distinguish themselves among post-acute care providers by their high rates of returning patients to the community at a higher level of function, which in turn represents significant long-term savings to the Medicare program. We urge the Commission to find ways to incorporate this type of long-term value proposition into its payment analysis.

Finally, AMRPA observes that while the aggregate FFS Medicare margin for IRFs is less than the aggregate FFS Medicare margin for SNFs (18.4%), MedPAC's draft recommendation for the SNF sector is a 3% reduction in payment. Given MedPAC's focus on margins during the IRF session, we fail to understand why a setting with a higher aggregate Medicare margin would face a lower proposed cut. AMRPA therefore strongly urges MedPAC to reevaluate its payment recommendation and ensure that any payment recommendation does not inadvertently reduce patient access to IRF care in their communities.

II. MedPAC Must Appropriately Distinguish IRFs from other Settings in its Payment Analysis & Broader Commentary

While not directly related to MedPAC's payment adequacy analysis for IRFs, AMRPA is increasingly concerned about comments offered by both staff and Commissioners in recent meetings about the similarity of IRFs and SNFs and the patients treated by each provider type. Given the importance of MedPAC's recommendations to Congress and regulatory policymakers, we believe it is imperative that the Commission fully understands the key differences between

these settings. Some of the commentary offered – for example, the fact that IRF and SNF patients generally receive the same number of therapy minutes during their stay – is simply misrepresentative of IRF care delivery. IRF patients generally receive three hours of specialized, multi-disciplinary therapy per day with an average length of stay (ALOS) of 13 days, allowing patients recovering from serious illness or injury to return home at a higher level of function and mobility. In comparison, and by MedPAC's own data, the SNF ALOS for Medicare beneficiaries is between 30 and 35 days, with less than half (43.5%) of patients being successfully discharged to the community after their stay. Furthermore, while all patients receive a multi-disciplinary therapy program in an IRF, there is no corresponding requirement for multiple therapies to be furnished to SNF patients during their stay. While the overall amount of therapy provided across a 13-day stay and a 30-day stay may be comparable in terms of total minutes, the intensity and multi-disciplined nature of such therapy furnished during the stay are the much more important differentiating factors, and these differences evidenced by the improved functional recoveries, discharge to community rates, and other key metrics. This is just one of several comments offered during recent meetings that AMRPA urges MedPAC to rectify moving forward.

We applauded several Commissioners for countering these assertions of interchangeability during the discussion and pointing out that clinical guidelines specifically call for one of the most important patient populations - stroke patients – to be treated in an IRF. We therefore urge MedPAC to be more nuanced when discussing IRFs and SNFs, and ensure that the differences between the two settings are appropriately communicated to the Commission and accounted for in MedPAC's analysis.

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AMRPA appreciates the collaborative relationship we have with MedPAC and offers these comments with that in mind. We would welcome the opportunity to further engage with the commission and consider improved methods for evaluating IRF payment adequacy and patient outcomes within the Medicare program. If you have any questions related to our concerns or recommendations, please contact Kate Beller, AMRPA Executive Vice President for Policy Development and Government Relations, at KBeller@amrpa.org, or Troy Hillman, AMRPA Director of Quality and Health Policy, at THillman@amrpa.org.

Sincerely,

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