AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

December 6, 2022

SUBMITTED ELECTRONICALLY

Michael Chernew, Ph.D.
Chairman
Medicare Payment Advisory Commission

Jim Mathews, Ph.D.
Executive Director

Re: MedPAC November 2022 Unified Post-Acute Care Payment Prototype Discussion & Patient Impact Concerns

Dear MedPAC Commissioners and Staff:

On behalf of the American Medical Rehabilitation Providers Association (AMRPA) and our 700+ inpatient rehabilitation hospital and unit members, we submit the following comments regarding MedPAC's most recent commentary on its approach to developing a unified post-acute care prospective payment system (UPAC PPS), as required by the Improving Medicare Post-Acute Care Transformation (IMPACT) Act.

AMRPA recognizes the significant task before MedPAC and the work the Commission has already undertaken in developing a prototype UPAC PPS model, especially as it prepares for the prototype's inclusion in the June 2023 Report to Congress. We have also appreciated the opportunity to provide the Commission and staff with our initial concerns and recommendations on MedPAC's UPAC PPS model and its related policy recommendations for the future PAC landscape since the Commission first began its analysis. We will provide much more extensive commentary on MedPAC's prototype work in the coming months as the Commission offers more precise detail on its payment model and the specific impacts on providers and, most importantly, patients in need of post-acute care services. **However, we had grave concerns with some of the comments made at the November 2022 public meeting, and we would like to see these points retracted or otherwise addressed as the Commission proceeds in its work.**

Since the beginning of its UPAC analysis, MedPAC has been almost singularly focused on how this type of model could result in savings for the Medicare program. While AMRPA recognizes that this is an important *component* of any PAC payment reform analysis, we believe recent Commissioner statements prioritize short-term cost reduction at the expense of care quality, timely recovery, and long-term outcomes. The Commission's assertions about high rates of "similar" patients being treated by different types of PAC providers and the "interchangeability" of services being delivered across PAC settings represent a serious and alarming misunderstanding of each segment of the PAC continuum, particularly for inpatient rehabilitation

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hospitals and units. We are concerned with the overall lack of discussion and acknowledgment of the direct impacts a UPAC could create for patient care quality, especially for some of the most vulnerable and high-intensity patients.

In past sessions, AMRPA appreciated MedPAC's recognition of the critical role that IRFs played during early COVID-19 surges, and had hoped that this recognition correspondingly reflected an understanding of IRFs' distinct characteristics among PAC providers – offering hospital-level, physician-led care coupled with diagnostic and therapeutic equipment and services, emergency response/preparedness capabilities, and high ratios of nurses, therapists and other key clinical personnel. The repeated recent assertions that complex patients currently treated by inpatient rehabilitation hospitals and units could and *should* be seen in lower cost settings without these characteristics raises vital questions of how these vulnerable populations would fare under MedPAC's PAC prototype.

These concerns were perhaps best illustrated by assertions during the November meeting that MedPAC's long-term goal is "directing patients to lower-cost settings when there's overlap," and that "if you have stroke patients being treated in multiple settings, you really want to direct them to the lower-cost setting." AMRPA is alarmed that this implies that stroke patients would be redirected from IRFs to skilled nursing facilities (SNF) under MedPAC's model, which **stands in direct conflict with the clinical guidelines for stroke patients endorsed by the American Stroke Association and American Heart Association (ASA/AHA).**[1] The ASA/AHA white paper accompanying the guidelines specifically notes that dedicated, inter-professional stroke care – services that are distinctively delivered by IRFs—has "been shown to not only reduce mortality rates and the likelihood of institutional care and long-term disability, but also to enhance recovery and increase independence in activities of daily living." Basing a stroke patient's placement entirely on setting cost creates immediate risks to the patient and their family, and significantly decreases the likelihood of a timely return to the community and full clinical recovery (all of which would certainly offset any short-term savings tied to the initial placement decision). On account of the specialized stroke recovery services that patients can only receive at inpatient rehabilitation hospitals and units, the AHA/ASA guidelines "recommend that, *whenever possible*, initial rehabilitation should take place in an inpatient rehabilitation facility rather than a nursing home." AMRPA and our ally provider organizations strongly believe that PAC coverage and payment models must prioritize patient's clinical needs above financial incentives, and the disconnect between these recognized clinical guidelines and Commissioners' commentary shows the need for a largescale reexamination of MedPAC's work to date.

AMRPA notes that stroke patients are far from the only group that could face serious coverage restrictions and receive inappropriate levels of care under this sort of prototype. MedPAC's preference for ultimately retiring setting-specific payment adjustments creates enormous risks for those PAC patients that require hospital-level PAC services following their illness or injury. In

[1] Carolee J. Winstein, et al., "Guidelines for Adult Stroke Rehabilitation and Recovery; A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association," Stroke (May 2016), http://stroke.ahajournals.org/content/early/2016/05/04/STR.0000000000000098.full.pdf+html. An Abstract of the Guidelines is available at http://stroke.ahajournals.org/content/early/2016/05/04/STR.0000000000000098.

fact, the same ASA/AHA guidelines white paper makes reference to the need for intensive rehabilitation services required by patients with spinal cord injury, brain injury, and amputation, among other conditions.

While MedPAC has spent considerable time focused on the financial aspects of a UPAC prototype, it is now imperative that MedPAC focus on the *care delivery* aspect of this prototype and how any future model would protect patients' access to the level of care they need – which is particularly critical for those suffering from severe injury and/or disability. Focusing only on cost-savings tied to the initial post-acute care placement will result in tremendous rates of avoidable spending on complications and readmissions, and most importantly, delay or impede patients' ultimate recovery.

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AMRPA appreciates the opportunity to provide our recommendations and concerns as MedPAC proceeds with its UPAC payment analysis. We look forward to additional engagement during the drafting and editing of the June 2023 Report to Congress. If you have any questions, please do not hesitate to reach out to Kate Beller, AMRPA Executive Vice President for Policy Development and Government Relations, at kbeller@amrpa.org.

Sincerely,

Anthony Cuzzola,
Chair, AMRPA Board of Directors
VP/Administrator – JFK Johnson Rehabilitation Institute