AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

Statement for the Record of the

American Medical Rehabilitation Providers Association (AMRPA)

for the

Committee on Ways and Means
Subcommittee on Health

of the
U.S. House of Representatives

Hearing on: **After the Hospital: Ensuring Access to Quality Post-Acute Care**

March 25, 2025

Chris Lee · Chair, AMRPA Board of Directors
Vice President & Chief Operations Officer, Madonna Rehabilitation Hospitals
529 14th Street NW, Suite 1280, Washington, DC 20045 · Phone: 202-591-2469 · Fax: 202-591-2445

On behalf of the American Medical Rehabilitation Providers Association (AMRPA), we appreciate the opportunity to provide a written statement for the record of the Subcommittee's recent hearing, "After the Hospital: Ensuring Access to Quality Post-Acute Care." We thank the Subcommittee for its attention to these important issues, particularly as Congress works to ensure that the Medicare program is equipped to meet the demands of an aging population and uptick in the need for post-acute care. We share your members' stated goal of ensuring that individuals with severe injuries, illnesses, disabilities, and chronic conditions are able to access high-quality, medically necessary post-acute care at the right place and right time, without facing undue delays or other barriers.

AMRPA is the national trade association representing more than 800 freestanding inpatient rehabilitation hospitals and units, referred to in the Medicare program as "inpatient rehabilitation facilities" (IRFs). Our hospitals focus on the care and functional recovery of some of the most vulnerable patients – such as traumatic brain injury, stroke, and spinal cord injury patients. Our members help patients maximize their health, functional ability, independence, and participation in their communities, so they are able to return to home, work, or an active retirement. We appreciate that numerous members and witnesses recognized the critical – and distinct – role that IRFs play in the post-acute care continuum and the importance of policies that protect patient access. With these goals in mind, we offer the following feedback on issues raised during the hearing (Part I of our statement), as well as AMRPA's own recommendations for improving quality and reducing burdens (Part II of our statement).

I. AMRPA Response to Select Issues Raised During the Hearing

Unified Post-Acute Care Payment System Feasibility and Readiness

Following the IMPACT Act's passage in 2014, AMRPA has been highly engaged with this Subcommittee, as well as the Centers for Medicare and Medicaid Services (CMS), the Medicare Payment Advisory Commission (MedPAC), and other relevant policymakers to carry out the Act's implementation. Through these efforts, AMRPA has been part of numerous Technical Expert Panels (TEPs) and provided extensive feedback to help facilitate the complex cross-setting data collection required by the Act. AMRPA, along with the other post-acute care stakeholders subject to the Act's requirements, believe that these collaborative efforts have led to successful standardized patient assessment data reporting and, correspondingly, more coordinated care and informed decision-making in the discharge planning process. While there may be potential ways to alleviate some of the underlying reporting burden, we believe the IMPACT Act's primary goals related to quality improvement, interoperability and improved discharge planning have been achieved on a cross-sector basis.

Through these same efforts, the IMPACT Act also sought to explore whether this cross-sector data reporting could be used to establish a "unified" post-acute care payment system. AMRPA was equally involved in this component of the Act, including through dedicated TEPs and stakeholder feedback on numerous prototype reports. Through the multi-year effort to assess and evaluate the merits of a UPAC payment system, AMRPA and our allied PAC organizations became increasingly concerned as to whether the nuances involved in every PAC referral and the distinct role of each PAC setting could be appropriately incorporated into a unified PAC model.

Our collective and growing concerns ultimately prompted nine national organizations (representing all PAC sectors) to send a 2021 letter calling for policymakers to reconsider UPAC efforts, both due to the COVID-19 public health emergency and (most importantly) the projected impacts of the UPAC prototype on patient care. The groups collectively asserted their "growing concerns that continuing down the pathway of blurring PAC clinical settings in an attempt to best serve the specific needs of the patient by adopting a unified payment model will result in higher costs and diminished clinical outcomes for patients," and urged policymakers to make clear that the UPAC prototype was "not in any way suitable for adoption for payment purposes."[1] We believe these concerns were validated by both CMS and MedPAC in their final UPAC prototype assessments, as neither entity saw fit to recommend UPAC adoption in their respective analyses. MedPAC specifically noted that while designing a prototype report is "relatively straightforward," the companion policy reforms required to implement such a system could "take many years" and could prove to be "complex and possibly controversial."[2]

With this background in mind, AMRPA was highly concerned by one witness's assertions that the UPAC prototype was "ready" for implementation during the Subcommittee's hearing. Such an assertion is misrepresentative of the multi-year UPAC prototype development effort, and ignores the serious concerns raised by CMS and MedPAC with respect to both timing and feasibility. PAC stakeholders' collective concerns about a UPAC model's impact on patient care and outcomes remain just as strong in the current policy climate, evidenced by our joint statement for the record to the March 11th hearing.[3] In fact, the Subcommittee hearing itself emphasized the clear and distinct value of each PAC setting for the Medicare population and the importance of certain sector-specific reforms – rather than a "one-size-fits-all" model that could result in significant care delays and disruptions.

Given the important objectives that have already been accomplished by the IMPACT Act and the fact that PAC payment reform has already been largely achieved by regulatory action, AMRPA strongly urges the Subcommittee to focus on other ways to improve the PAC landscape. We support and applaud the Subcommittee's interest in finding ways to ensure access to quality post-acute care, and suggest numerous ways of accomplishing such goals in the IRF field in Section II of our statement.

[1] September 14, 2021 Stakeholder Letter from AAPM&R, AHCA, AMRPA, CPR Coalition, Federation of American Hospitals, LeadingAge, NALTH, the National Association of Home Care & Hospice, and Partnership for Quality Home Healthcare to RTI International; available here: https://amrpa.org/wp-content/uploads/2024/09/Stakeholder-Joint-Response-to-RTI-9.14.2021_Final.pdf.

[2] MedPAC June 2023 Report to Congress, Mandated report: Evaluation of a Prototype Design for a Post-Acute Care Prospective Payment System (pg. 418); available here: https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_MedPAC_Report_To_Congress_SEC.pdf.

[3] March 25, 2025 Statement from AHCA, AMRPA, Coalition to Preserve Rehabilitation Steering Committee, FAH, LeadingAge, National Alliance for Care at Home, and NALTH; available here: https://amrpa.org/wp-content/uploads/2025/03/Joint-Stakeholder-Statement-for-WM-PAC-Hearing-Record-3.25.pdf.

Office of Inspector General Reports on Prior Authorization in IRFs

We greatly appreciate the attention paid by both Subcommittee members and witnesses to concerns with the use of prior authorization in the Medicare Advantage system. As referenced in the written testimony from the Subcommittee's witnesses and in discussions during the hearing, the Department of Health and Human Services Office of Inspector General (HHS OIG) has released two important reports in recent years addressing the overuse and misuse of prior authorization, particularly with regards to post-acute care. We would like to offer additional details and context on the findings of these reports, which underscore just how serious the problem of prior authorization is for timely access to medically necessary post-acute care.

In 2018, the OIG found that approximately 75% of appeals submitted by Medicare Advantage beneficiaries or providers were fully or partially successful from 2014-2016, suggesting that three in four denials by MA plans were potentially inappropriate.[4] The same report also flagged that "CMS audits found widespread and persistent problems related to denials of care and payment in Medicare Advantage," with the agency citing more than half of audited MA contracts for inappropriately denying requests for services or payment.[5] The OIG further noted that despite the high likelihood of a successful outcome on appeal, only about 1% of denials were appealed, citing the lengthy, burdensome, and potentially overwhelming appeals process, especially for beneficiaries with critical conditions, like many of the patients treated in IRFs.[6]

In 2022, the OIG conducted a follow-up report specifically focused on denials that should have been initially approved by an MA plan; that is, denials by MA plans where OIG reviewers found that the claims met Medicare coverage and billing requirements, yet the plans still denied authorization inappropriately.[7] As part of this review, the OIG identified types of claims that were most prominently or frequently denied, which included claims for admission to IRFs and skilled nursing facilities (SNFs) as noted during the hearing. It is important to recognize that the OIG did not simply find that IRF claims are frequently subjected to prior authorization by MA plans (nearly all MA plans require prior authorization for IRF admissions), but that IRF claims were frequently denied *despite* meeting Medicare coverage and billing rules.

During the hearing, it was stated that 75% of audited IRF stays were not overturned on appeal; this is a misleading reference to the study's actual findings. In fact, the report highlighted four specific IRF claims, each of which were denied by the MA plan, but where the OIG found that the admission was medically necessary and the request should have been approved. At the time of the report, only one of those denials had been reversed *by the MA plan*, indicating that even when denials are challenged, the initial appeal level (which involves the plan reviewing its own decision itself) may be insufficient and further reforms are needed in order to ensure beneficiary

[4] U.S. Department of Health and Human Services Office of Inspector General (HHS OIG), *Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials*, OEI-09-16-00410 (Sept. 2018), available at https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf.
[5] *Id*. at 11.
[6] *Id*. at 10.
[7] HHS OIG, *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care*, OEI-09-18-00260 (April 2022), available at https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf.

access to the care to which they are entitled under the Medicare program. We offer some of our policy recommendations to do so in Part II of this statement below.

Clarifying the Record on IRF Margin Analysis

As a final response to the hearing itself, AMRPA would like to counter some of the mischaracterizations of PAC margins offered in written and verbal testimony. AMRPA is concerned that the significant difference between "marginal profit" and "aggregate margin" was insufficiently explained to Subcommittee members. Marginal profit is significantly different from a standard aggregate margin. As a result of the conflation of the two, we believe that a misrepresentative portrayal of aggregate margins was offered to the Subcommittee, producing inaccurate statements that there are "excessive" Medicare margins. AMRPA also believes that it is important to correct the record by providing the Subcommittee with Fee-for-Service (FFS) Medicare aggregate margins in addition to marginal profit values.

MedPAC – the commission charged with assessing Medicare payment issues for Congress – created the marginal profit metric and its description of the concept is illustrative on this point about differentiating it from aggregate margin. Specifically, in the March 2024 MedPAC Report to Congress, the Commission provided additional information regarding both marginal profit and aggregate margin, and how these distinct values are interpreted or used as part of the MedPAC analyses of payment adequacy. The report specifically states:

> *"We use multiple measures of margins in our payment adequacy analysis for different purposes.* ***We define "FFS Medicare marginal profit" as ((FFS Medicare payment – costs that vary with volume) / FFS Medicare payment). This marginal profit is an indicator of beneficiary access to care.*** *The "all-payer total margin," defined as ((payments from all payers and sources – cost of providing services) / payments from all payers and sources), is a measure of a sector's access to capital.* ***"FFS Medicare aggregate margin," defined as ((FFS Medicare payments for service – cost of providing service) / FFS Medicare payment for the service), is a sector-wide measure of the relationship between FFS Medicare's payments and providers' costs for services."***[8]

Additional information regarding marginal profit was provided throughout the report, indicating that these values are representative of access to care and not an indicator of payment adequacy.[9]

[8] MedPAC March 2025 Report to the Congress: Medicare Payment Policy, 52.

[9] Specifically, MedPAC explains that "[a]nother factor we consider when evaluating access to care is whether providers have a financial incentive to expand the number of FFS Medicare beneficiaries they serve. In considering whether to treat a patient, a provider with excess capacity compares the marginal revenue it will receive (e.g., the FFS Medicare payment) with its marginal costs. That is to say, the FFS Medicare marginal profit reflects the costs to treat Medicare beneficiaries that vary with volume in the short term. If FFS Medicare payments are larger than the marginal costs of treating an additional beneficiary, a provider with excess capacity has a financial incentive to increase its volume of FFS Medicare patients. In contrast, if payments do not cover the marginal costs, the provider may have a disincentive to care for FFS Medicare beneficiaries." *Id*. at 53.

This point is further clarified in the endnotes for each of the various settings, which sets forth the specific calculation of marginal profit.[10]

These issues have been raised by MedPAC Commissioners in the context of IRF payment adequacy assessments, including during the December 2024 public session.[11] Indeed, MedPAC stated in its recent March 2025 MedPAC Report to Congress that it is considering disbanding the marginal profit metric anytime the Medicare aggregate margin is positive:

> *"**When FFS Medicare payments exceed providers' total costs for providing those services, examining the FFS Medicare marginal profit does not yield any additional information about the adequacy of FFS Medicare payment rates. Moreover, it is difficult to use cost reports to precisely estimate IRFs' variable costs.** However, when using our estimates from prior work— that about 80 percent of IRFs' costs were variable—in 2023, IRFs' FFS Medicare marginal profit was 31 percent in aggregate, 18 percent among hospital-based IRFs, and 40 percent for freestanding IRFs. If we had instead used the 85 percent upper-bound estimate from our hospital analysis of the share of costs that was variable, IRFs' FFS Medicare marginal profit would still have been substantially positive at 28 percent. Both estimates of marginal profit suggest that IRFs with available beds have a strong financial incentive to admit FFS Medicare patients. **Therefore, in future years, the Commission may consider whether to continue to report the marginal profit when Medicare total payments more than cover providers' total costs.**"*[12]

Based on these analyses and methodologies, we believe the more appropriate measure of Medicare margins for PAC settings is the FFS Medicare aggregate margin, which yields figures that differ significantly from what was presented during the hearing across the SNF, HHA, and IRF settings. We further note that the current fiscal pressures facing IRFs were not referenced during the hearing. In fact, AMRPA analysis of IRF FFS Medicare margins (utilizing information from the CMS Rate Setting File) indicates that nearly 40% of all IRFs have projected negative Medicare FFS margins for FY 2025, including:

- 53% of all IRF units within acute care hospitals;
- 52.4% of non-profit IRFs; and
- 47% of rural IRFs.

Further, more than half the IRFs in 14 of 52 U.S. states and territories have projected negative FY 2025 IRF margins under the current payment system, which would be seriously exacerbated under a potential unified PAC payment system. In all, any further reduction or changes in

---

[10] Per MedPAC, if the Commission approximates marginal cost as total Medicare costs minus fixed building and equipment costs, then marginal profit can be calculated as follows: Marginal profit = (payments for Medicare services – (total Medicare costs – fixed building and equipment costs)) / Medicare payments. This comparison is a lower bound on the marginal profit because [MedPAC does] not consider any potential labor costs that are fixed." *Id. a*t 191, 221, and 255.

[11] For example, in the December 2024 meeting, MedPAC Commissioner Brian Miller questioned the methodology for determining variable costs and inconsistency in methodology between inpatient rehab facilities and general acute care hospitals. The December 2024 meeting transcript is available: https://www.medpac.gov/wp-content/uploads/2023/10/December2024_MedPAC_public_meeting_transcript_SEC.pdf.

[12] MedPAC March 2025 Report to the Congress: Medicare Payment Policy, 254.

Medicare FFS payment could negatively impact Medicare beneficiary access to appropriate and necessary care, especially in situations where negative margins already exist. **We urge the Subcommittee to carefully consider these data when considering any large-scale or setting-specific PAC payment reform efforts.**

II. AMRPA Recommendations to Reduce Burden and Improve Access to Care

As noted throughout the hearing, AMRPA is cognizant that concerns about access to quality and timely post-acute care also live within a context of increasing fiscal pressures, not only on providers, but on the Medicare program as a whole. Therefore, we appreciate the opportunity to provide policy recommendations for the Subcommittee's consideration that we believe would increase access to care and reduce unnecessary burden on providers while minimizing costs to Medicare's bottom line.

IRF Review Choice Demonstration

In 2023, the previous Administration implemented a new "Review Choice Demonstration" (RCD) program for inpatient rehabilitation hospitals and units located in Alabama, which has now expanded to Pennsylvania and is planned to expand next to Texas, California, and eventually, 17 states and Washington, DC.[13] The IRF RCD allows Medicare contractors broad discretion to make medical necessity decisions for every FFS beneficiary in demonstration states, and potentially to overturn the judgement of the rehabilitation physicians and care teams that treat patients on a daily basis. AMRPA and our members have long expressed serious concerns about the potential for this demonstration to restrict access to care for FFS beneficiaries. Further, this program has already imposed significant additional burdens on hospitals currently subject to the program, with many of our members reporting they have dedicated full-time staff to manage the RCD. This burden also falls on physicians, who are forced to spend significant time re-justifying care decisions for patients who have already gone through the rigorous pre-admission screening mandated for all Medicare IRF patients, taking away from time that could be spent providing care to beneficiaries.

Despite this program being in place for over a year and a half, only in January 2025 did CMS issue any publicly reported, program-wide data on the RCD.[14] Unfortunately, this data provided limited opportunity for participating hospitals and other stakeholders to identify any meaningful trends, as data was aggregated across states and multiple review cycles. Nevertheless, the most recent available data on the RCD shows that more than 90% of IRF claims are being affirmed, calling into question the return on investment for this program.

AMRPA recently called on the current Administration to reconsider this program, given reports of inconsistent and inaccurate guidance being distributed by program contractors, serious

[13] https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/prior-authorization-and-pre-claim-review-initiatives/review-choice-demonstration-inpatient-rehabilitation-facility-services.
[14] CMS, Review Choice Demonstration for Inpatient Rehabilitation Facility Services Quarterly Updates, Oct. 2023 – Sept. 2024, https://www.cms.gov/files/document/irf-rcd-stats-fy-2024.pdf.

confusion among providers about what standards are being used, and concerns that contractors may be functionally changing the Medicare coverage requirements that are clearly laid out in statute and regulation, without following proper regulatory procedures such as public notice and comment. Further, given the increased focus on meaningful transparency and accountability in government programs from the current Administration, we believe it is critical that CMS commit to a regular schedule for the release of more detailed and timely program data, so that all stakeholders, including those on this Subcommittee, can fully analyze the impact of the program. **We urge the Subcommittee to carefully consider whether the RCD is consistent with Congress' goals for the Medicare IRF benefit and access to post-acute care more generally**.

Prior Authorization in Medicare Advantage

As discussed by all witnesses throughout the hearing, one of the most pressing issues limiting access to medically necessary post-acute care is the overuse and misuse of prior authorization by Medicare Advantage plans. For years, AMRPA members have reported that MA plans routinely and consistently divert beneficiaries away from IRFs to less intensive settings of care through the abuse of prior authorization and other utilization management techniques. As the Subcommittee heard from the hearing witnesses, inappropriate delays and denials of IRF admissions have a direct negative impact on beneficiaries' long-term health, function, and their ability to maximize their recovery.

In addition to the findings of the OIG reports described above, AMRPA has collected its own data on the outcomes of MA plan prior authorization requests specifically for IRF admissions.[15] In July and August of 2024, a total of 367 IRFs from 48 states and Puerto Rico submitted data on the outcomes of more than 27,000 prior authorization requests. Overall, the data confirmed the observations of AMRPA members regarding prior authorization practices, with plans denying more than 57% of all initial requests for an IRF admission, resulting in nearly 70,000 days spent waiting in the acute care hospital in just those two months. If similar trends were extrapolated to the approximately 1,200 IRFs nationwide for the 2024 calendar year, this would represent as many as 1.2 million waiting days due to prior authorization, all before an initial decision was even rendered.

Clearly, prior authorization represents a serious issue in the post-acute care space, delaying and denying access to care for MA beneficiaries and contributing to backlogs in the acute care system. In fact, AMRPA's analysis of MA per beneficiary admission rates across the program indicates that access to IRF care is nearly three times lower in MA than in Traditional Medicare.[16] In order to mitigate some of these concerns, AMRPA provides the following recommendations for the Subcommittee's consideration:

---

[15] American Medical Rehabilitation Providers Association (AMRPA), *Access to Inpatient Rehabilitation for Medicare Advantage Beneficiaries: An Examination of Prior Authorization Practices in 2024*, https://amrpa.org/wp-content/uploads/2025/03/2024-Prior-Auth-Survey-Full-Results_FINAL.pdf.

[16] MA admissions data sourced from eRehabData, AMRPA's outcomes and policy modeling system, and Netsmart Technologies, Inc. – UDSMR® database, indicate that MA admissions to IRF per 1,000 beneficiaries have a monthly value of between 0.35 and 0.42. According to data reported by MedPAC, monthly Traditional Medicare admissions per 1,000 beneficiaries hovers around 1.0.

- ***Improving Seniors' Timely Access to Care Act***: AMRPA has long supported this bipartisan, bicameral legislation in prior Congresses as a critical first step in protecting MA beneficiaries' access to care. Enacting this legislation would meaningfully advance transparency into MA plan practices beyond what is currently available to CMS and the public and would codify into law important bipartisan regulatory reforms finalized by CMS. When the legislation is reintroduced in the 119th Congress, we urge Subcommittee members to support its passage this year.
- ***Decision Timeframe for Expedited Requests***: AMRPA has also called on Congress and the Administration to implement a mandatory 24-hour turnaround time for MA plan determinations on expedited prior authorization requests. Currently, MA regulations only require that plans make such expedited determinations within 72 hours of a request, a significant contributor to unnecessary delays in either beginning care that is eventually authorized or beginning an appeals process when beneficiaries or providers believe that care has been inappropriately denied.
- ***Network Adequacy***: As noted by one member of the Subcommittee during the hearing, AMRPA supports modifications to CMS' existing network adequacy standards for MA organizations to require plans to specifically offer adequate coverage of inpatient rehabilitation facilities within their network, similar to other provider types that are included in the mandatory standards (such as SNFs). Despite a bipartisan congressional letter endorsing such a change, signed by more than 20 members of the Ways & Means Committee, CMS has thus far failed to act on this recommendation.[17]
- ***Enforcement of Existing Regulatory Requirements***: In 2024, new regulatory requirements constraining MA plans' use of prior authorization went into effect, changes which AMRPA strongly supported.[18] However, since these rules went into effect, our members have reported no beneficial changes in their experiences with prior authorization, and many have reported that plans appear to be flouting these requirements. We believe it is critical that MA organizations, like providers in the MA program, are held accountable if and when they fail to comply with the program "rules of the road." We encourage both the new Administration and Congress, as appropriate, to ensure robust oversight of MA plan compliance, including through the agency audit process, and enforce the program rules as they exist today so that beneficiaries in MA can receive care on a level playing field with their counterparts in the Traditional Medicare program.

Streamlining the IRF Quality Reporting Program (QRP)

Finally, as the Subcommittee considers ways to reduce burdens across PAC providers and ensure that resources are maximally devoted to care and innovation, we urge the Subcommittee to consider potential changes to the quality reporting program. Specific to IRFs, the IRF-PAI (Patient Assessment Instrument for Payment and Quality) has expanded from 3 to 31 pages in the last 10 years, adding nearly 350 new or modified data elements to be collected and reported

[17] Letter dated Sept. 30, 2024 is available here: https://amrpams.informz.net/AMRPAMS/data/images/MA Network Adequacy - Final Letter with Signatures 9.30.24.pdf.
[18] Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly, 88 Fed. Reg. 22,120 (April 12, 2023).

for every single patient. Failure to timely report these data elements may result in a 2% payment penalty on all Medicare payments for a full fiscal year, even though only 134 of these are used for publicly reported IRF QRP measures. CMS also recently expanded the data collection of IRF-PAI data to require reporting on non-Medicare patients, even though this information will not be included in public reporting of quality, and the assessments have not been tested and approved for use for patients under the age of 18, including pediatric and adolescent patients. AMRPA also notes that of the 17 IRF QRP measures that are publicly reported:

- 4 measures are "topped out," meaning that performance is so high and unvarying that meaningful distinctions and improvement in performance can no longer be made; and
- 10 measures have never obtained endorsement from a Consensus-Based Entity, indicating that they have not received a full review of reliability, validity, or scientific acceptability.

Should Congress consider opportunities for regulatory relief or reducing the administrative burdens placed upon post-acute care providers, we encourage review and oversight of the implementation of the IMPACT Act's data reporting requirements. Specifically, we encourage this Subcommittee's review of the extent to which CMS has implemented Standardized Patient Assessment Data Elements (SPADEs) and QRP measures that are inappropriate, untested, or provide minimal value to the Medicare program, Medicare beneficiaries, and providers. Furthermore, we urge Congress to ensure that penalties levied under the QRP program are only issued for intentional or egregious instances of non-compliance, rather than inadvertent, minor errors caused by such a sizeable reporting instrument.

***

We thank you for your careful consideration of our comments and post-acute care issues. AMRPA looks forward to working with you and your colleagues to advance policies that ensure patients are able to access the care they need. If you have any questions, please contact Kate Beller, JD, AMRPA President, at kbeller@amrpa.org.

Sincerely,

Chris Lee, MSPT, FACHE
Chair, AMRPA Board of Directors
Vice President and Chief Operations Officer – Madonna Rehabilitation Hospitals