AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

December 18, 2025

Submitted Electronically

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

Re: American Medical Rehabilitation Providers Association's Comments on MedPAC's FY 2026 IRF Payment Recommendation & Other Post-Acute Care Commentary

Dear Dr. Chernew, MedPAC Commissioners, and Staff:

On behalf of the American Medical Rehabilitation Providers Association (AMRPA) and our 800+ members, we appreciate the opportunity to provide our response to the Medicare Payment Advisory Commission's (MedPAC) December 2025 meeting session related to inpatient rehabilitation facility (IRF) payment adequacy, as well as a broader assessment of post-acute care trends and potential policy reforms. We were disappointed that MedPAC's most recent analysis of - and ultimate recommendation for - the IRF prospective payment system (PPS) was largely unchanged from last year despite AMRPA's extensive regulatory correspondence and engagement with Commission staff. **We therefore reiterate our serious concerns with MedPAC's proposal to reduce the IRF market basket by 7% for FY 2027 and urge the Commission to meaningfully consider our comments and address these issues during the January 2026 public meeting**. Despite the simplistic suggestion that a sector-wide cut of this magnitude would not impact patient care or IRF operations, discussions with our members paint a markedly different picture of how this payment change would impact the sector – particularly for smaller IRFs and those providers in rural and underserved areas. We therefore urge the Commission to carefully consider the following points before taking any further action on the draft recommendation.

First and most importantly, AMRPA believes this recommendation is driven by misunderstandings of the IRF patient population, the complex process by which a patient is deemed medically necessary for the IRF level of care, and the capital-intensive environment in which our hospitals operate. As fully licensed hospitals or units of hospitals, our members employ the staffing, medical equipment, and other technologies needed to provide significant medical management and oversight of patients' underlying and co-existing conditions, in addition to the rehabilitation therapy services provided in these facilities. Despite our past discussions with the MedPAC team about the unique costs borne by IRF providers, these costs remain unacknowledged when IRF payments are compared to non-hospital providers, such as skilled nursing facilities (SNFs). We therefore are reattaching a comparison chart in our appendix that highlights the key differentiating factors across all the post-acute care settings and how such factors drive very different outcomes for patients; we believe these differences fully counter past MedPAC commentary that patients in areas without IRF are able to access "substitutable" care at SNFs in the same marketplace and any other presumptions of "interchangeability" across two entirely different provider types. We urge MedPAC to incorporate this

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information into future analyses and public meeting commentary and reconsider the Chairman's draft with these setting-specific data in mind.

Furthermore, there continues to be perceived "overlap" of patients across the IRF and SNF setting, which was cited by numerous Commissioners in support for the recommended IRF payment reduction. AMRPA believes that MedPAC's underlying analysis has never provided sufficient detail about this "overlap" population despite these statements being recycled across meeting cycles and in MedPAC material.[1] It is also disappointing that MedPAC has not examined the IRF Review Choice Demonstration (RCD) in the context of this analysis, as this program – which requires impacted IRFs to demonstrate medical necessity for every traditional Medicare beneficiary – has yielded exemplary results[2] and firmly rebuts any notion that IRFs use inappropriate admission practices. In addition, we believe that some staff and Commissioners misinterpret patients with the same primary diagnosis as having the same post-acute care needs. We applaud one Commissioner's point that even patients with similar clinical profiles can have significantly different potential and capacity for medical rehabilitation. With these points in mind, we continue to urge the Commission to address these overly simplistic references to a "shared" or "overlapping" population, particularly given the distortions on payment adequacy discussions.

AMRPA members also report continued concern over the reported margins and their likely impact on MedPAC's overall recommendations. Several member hospitals – representing both distinct part rehabilitation units of acute care hospitals and freestanding rehabilitation hospitals - believe that the Medicare cost report data does not provide an accurate representation of the actual costs of IRF care. Due to these disparities, the margins derived from this data vary significantly from the actual margins at these hospitals. Other AMRPA members have suggested that MedPAC use national valuation agencies to ensure that cost allocations and other factors attributable to the total cost of care are factored into the margin analyses. Additionally, MedPAC should be mindful of the fact that Medicare cost report guidelines prevent certain hospital costs from being reported, and AMRPA therefore recommends that MedPAC should consider an assessment of the accuracy of cost-reporting mechanisms as part of its payment recommendation efforts. Until all costs incurred by IRFs are included and reported in an accurate manner, we believe MedPAC should caveat its analysis that the recommendations are based upon values that are not representative of the actual financial status of all IRFs. Indeed, MedPAC staff comments during the December meeting explicitly acknowledged that cost-allocation in particular may distort the picture on IRF relative margin analyses. Relatedly, AMRPA believes that the IRF field could provide more substantive commentary on MedPAC's margin and related payment analysis if the draft chapter and related materials were publicly shared prior to the annual meeting.

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[1] For example, despite numerous AMRPA outreaches, MedPAC's "Payment Basics" Report for IRFs continues to state that that "intensive inpatient rehabilitation services" are "frequently provided in skilled nursing facilities (SNFs)." This is categorically untrue, as skilled nursing facilities do not provide "inpatient" services in the first place, and there are significant and regulatorily-required differences in the frequency and intensity of services provided between IRFs and SNFs. We do not know why this incorrect statement remains unchanged in MedPAC's yearly reports. See: https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_25_IRF_FINAL_SEC.pdf

[2] While CMS has not released comprehensive, timely data on the program's entirety to date, based on AMRPA's analysis of the information released thus far, approximately 93% of the total cases submitted for review across both Alabama and Pennsylvania through Cycles 1 and 2 in each state have been affirmed. This reflects the information on Alabama Cycles 1-2 and Pennsylvania Cycle 1 released by CMS on the home page for the IRF RCD, as well as Pennsylvania Cycle 2 statistics released by Novitas, the contractor overseeing the demonstration in Pennsylvania.

In addition, AMRPA also urges MedPAC to more carefully consider the impact of a 7% payment reduction across the field and by type of IRF. As MedPAC staff and Commissioners both acknowledged, there are several critical unknowns about the differences in margins across types of IRFs, including units and freestanding providers. We appreciated a Commissioner's remarks that the current analysis may not get into the "harm" that such a payment cut would produce for certain IRFs, and the importance of avoiding the same adverse care and delivery outcomes tied to payment changes in other sectors -such as maternal and child health services. For this reason, we strongly encourage MedPAC to more carefully consider (and provide data on) how its recommended cuts would impact IRFs across the sector before concluding that a 7% cut would have no impact on access to care or IRFs' ability to treat Medicare patients, especially for rural IRF providers. Without more nuanced consideration, MedPAC's recommendation risks creating the disproportionately negative impacts on rural IRFs that other nationwide Medicare policies often have on rural providers. Numerous AMRPA members stand ready to discuss the impact of MedPAC's recommendation on their specific hospital if the Commission would be interested in conducting field interviews or related engagements.

Finally, AMRPA believes there are number of areas where MedPAC could work proactively with AMRPA to develop more nuanced recommendations, which would share the goals of protecting patients' access to care while offering more palatable policy change for both providers and policymakers. For example, AMRPA would appreciate the opportunity to further explore regulatory reforms and other efforts to modernize the IRF coverage and payment systems. As arguably the most regulated entity in the Medicare program, AMRPA believes that MedPAC could meaningfully address several outdated and overly burdensome rules that drive up costs for IRF providers with no corresponding patient benefit. Examples include reexamining the 60% rule (used for hospital classification purposes but often perceived as signaling the core conditions treated by IRFs) and the IRF quality reporting program. In addition, AMRPA strongly supports Commissioner interest in identifying and developing ways to show the long-term value of PAC placement determinations. We believe that this effort could facilitate more nuanced analysis of each PAC setting and the patients treated by each type of provider, as well as demonstrate the correlation between IRF utilization and improved outcomes for certain patients. Relatedly, MedPAC staff and numerous Commissioners noted that this type of data would be prerequisite to any new or future cross-sector PAC payment reform, and AMRPA strongly supports this notion as MedPAC plans its future analytical work.

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In closing, we believe many of our concerns with MedPAC's analysis and recommendations would be addressed with a better understanding of how our hospitals operate and the distinct role that IRFs play in the care and recovery of patients who have experienced catastrophic illness or injury. We also believe that the December session highlighted important ways to improve and add necessary nuance to the Commission's analysis, including consideration of regulatory reform to complement payment recommendations and exploring ways to capture the long-term value of each post-acute care setting.

As always, AMRPA would welcome the opportunity to host MedPAC staff and Commissioners on IRF tours or facilitate interviews with AMRPA hospital leaders to better illustrate our hospitals' value and corresponding impact on patients' long-term recovery and quality of life. In the meantime, we stand ready to further engage with the commission and consider improved methods for evaluating IRF payment adequacy prior to your January 2026 public meeting.

Should you have any questions related to our concerns or recommendations, please contact Kate Beller, AMRPA President, at KBeller@amrpa.org, or Troy Hillman, AMRPA Director of Quality and Health Policy, at THillman@amrpa.org.

Sincerely,

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Chair, AMRPA Board of Directors
Vice President and Chief Operations Officer, Madonna Rehabilitation Hospitals

Appendix: Comparisons Across Post-Acute Care Settings (IRF, SNF, LTCH, HH)
Initially Shared with MedPAC in December 2024

	INPATIENT REHABILITATION FACILITY (IRF)	SKILLED NURSING FACILITY (SNF)	LONG-TERM ACUTE CARE HOSPITAL	HOME HEALTH CARE
HOSPITAL-LEVEL CARE	**YES**	**NO**	**YES**	**NO**
INTENSITY OF CARE	Intensive, 24-hour-a-day, interdisciplinary rehabilitation care that is provided under the direct supervision of a physician	Daily skilled nursing or rehabilitation services	Extended medical and rehabilitative care for patients with complex medical needs resulting from a combination of acute and chronic conditions	Skilled nursing care and rehabilitation therapy, as well as some limited assistance with daily tasks designed to assist the patient in living in his or her own home
PHYSICIAN INVOLVEMENT & REHABILITATION EXPERIENCE REQUIREMENTS	• Rehabilitation physician required (specialized training & experience) • Responsible for overall plan of care and lead weekly interdisciplinary team meetings • Three face-to-face visits by physician required every week[3] • 24/7 physician coverage with daily visits typical	• No requirement for physician to have rehabilitation experience • Physician determines whether patient needs therapy • Physician visit required only once every 30 days for first 90 days, then every 60 days after	• No requirement for physician to have rehabilitation experience • Physician focus is primarily on medical management • Physician visits at least once a day • 24/7 physician coverage with daily rounding typical	• No requirement for physician involvement • A doctor or other health care provider must have a face-to-face visit before certifying need for home health services. • A doctor or other health care provider must order the care to be provided

[3] Beginning with the second week of admission to the IRF, a non-physician practitioner may conduct 1 of the 3 required face-to-face visits per week.

	INPATIENT REHABILITATION FACILITY (IRF)	SKILLED NURSING FACILITY (SNF)	LONG-TERM ACUTE CARE HOSPITAL (LTCH)	HOME HEALTH CARE
INTENSITY & TYPES OF THERAPEUTIC INTERVENTIONS	• General requirement for 3 hours/day, 5 days a week intensive interdisciplinary therapy (OT, PT, SLP, O&P). • Expectation that patient actively participates and benefits from therapies throughout IRF stay.	• Therapy provided based upon physician determination. • No requirement for specific number of hours per day. • No requirement for interdisciplinary therapy to be provided.	• Therapy is provided but primary focus is medical management of complex medical needs. • No requirement for specific number of hours per day. • No requirement for interdisciplinary therapy to be provided.	• Therapy is provided based upon orders from doctor or other health care provider after any needed consultation with a qualified therapist. • Duration and course of treatment is based upon qualified therapist's assessment of the beneficiary's function.
NURSING INVOLVEMENT & EXPERIENCE REQUIREMENTS	Registered nurses are present on a continuous basis and commonly have specialty certification in rehabilitation nursing.	Rehabilitation nurses are required to on site for a minimum of 8 hours per day. Skilled nursing care provided daily.	Nursing provided consistent with hospital-level of care for medical management of complex medical needs.	Part-time or intermittent skilled nursing care from a registered nurse or LPN (supervised by RN). Fewer than 8 hours a day and 28 hours per week.

	INPATIENT REHABILITATION FACILITY (IRF)	SKILLED NURSING FACILITY (SNF)	LONG-TERM ACUTE CARE HOSPITAL (LTCH)	HOME HEALTH CARE
SUCCESSFUL RETURN TO COMMUNITY PERCENTAGE	**66.95%**	50.57%*	18.05%	Not Reported
RATE OF POTENTIALLY PREVENTABLE HOSPITAL READMISSIONS 30 DAYS AFTER DISCHARGE	**8.90%**	10.72%*	20.09%	4.1%
RATE OF POTENTIALLY PREVENTABLE HOSPITAL READMISSIONS DURING STAY	**4.75%**	23.7%*†	Not Reported	10.8%
PERCENTAGE OF STAYS WHERE CURRENT MEDICATION LIST IS PROVIDED TO THE RESIDENT, FAMILY, AND/OR CAREGIVER AT FINAL DISCHARGE	**98.41%**	96.15%*	89.26%	91.13%

Values above represent national average performance for all Medicare cases as displayed in provider data files available via https://www.medicare.gov/care-compare/ for the September 2025 publications.

**Only the Short-Stay SNF measure values included as these represent the closest comparison to other post-acute care providers.*

†Short Stay SNF measure is not specific to "Potentially Preventable Readmissions" as it is labelled as "Percentage of short-stay residents who were re-hospitalized after a nursing home admission".