AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

December 23, 2024

Submitted Electronically

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

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

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 2024 meeting session related to inpatient rehabilitation facility (IRF) payment adequacy and related issues. AMRPA is dedicated to protecting patient access to inpatient rehabilitation and positioning our hospitals to meet the demands of an aging and medically complex population. **We therefore have serious concerns with MedPAC's proposal to reduce the IRF market basket by 7% for FY 2026 and urge the Commission to revise this proposal prior to the January 2025 public meeting**. This proposal – which is not based on any sort of specified methodology - would create serious and immediate care disruptions if acted upon by Congress. Even more concerning, AMRPA believes this recommendation is driven by misunderstandings of the IRF patient population, the array of services provided by our hospitals, and the corresponding capital-intensive environment in which our hospitals operate. We therefore urge the Commission to carefully consider the following issues before taking any further action on the draft recommendation.

As we've previously discussed with MedPAC, our member hospitals serve a medically complex patient population who require, and demonstrably benefit from, the intensive rehabilitation program uniquely provided in the IRF setting. As 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. AMRPA was therefore concerned when both staff and Commissioners failed to recognize these features of our hospitals when discussing the relatively higher payments for IRFs versus non-hospital providers, such as skilled nursing facilities (SNFs). In fact, several comments offered during the meeting indicated that the proposed cut is appropriate due to the perceived similarity of the IRF and SNF settings. We believe this stems from a persistent misunderstanding of the factors that differentiate IRF and SNF settings, ranging from physician and nursing involvement to therapeutic interventions. We have therefore attached an 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

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

the same marketplace and any other presumptions of "interchangeability" across two entirely different provider types. We urge MedPAC to incorporate this data into future analyses and public meeting commentary and reconsider the draft Chairman's recommendation with this material in mind.

Relatedly, AMRPA asks MedPAC to correct the (unfortunately oft-repeated) misrepresentative commentary around the 60% rule. As we assume MedPAC is aware, the 60% rule is purely used to determine, in the aggregate, whether a freestanding rehabilitation hospital or acute rehabilitation unit can maintain its designation and payment under the IRF PPS. The 60% rule has never been used to determine whether individual patients qualify for admission to an IRF, as IRF admissions are and have always been a physician-led, patient-specific (rather than condition-based) process. As AMRPA discussed with MedPAC last cycle, advances in medicine and technology have made rehabilitation all the more critical for the full functional recovery of a broader patient population (this explains, for example, the increasing focus in transplant-related rehabilitation in recent years). We strongly support comments from one Commissioner that policies that promote access to medically appropriate IRF care (without consideration for a rule that is not germane to admission and has not been updated in decades) will have "positive downstream effects," such as greater rates of return to home and greater independence. Any insinuations that patients are inappropriate for IRF care or could receive "comparable" care at SNF based on the application of the 60% rule runs counter to these goals.

In addition to addressing the misrepresentations about the IRF and SNF benefit, AMRPA also urges MedPAC to more carefully consider the impact of a 7% payment reduction across the field. As MedPAC staff and Commissioners both acknowledged, there are a number of critical unknowns about the differences in margins across types of IRFs. While a MedPAC Commissioner acknowledged in a subsequent session that MedPAC looks to "avoid particularly large recommended cuts because of the potential disruption," the proposed 7% reduction would create exactly these types of operational disruptions for a significant sector of the IRF field (including IRF units) and create corresponding access issues for patients treated by those providers.

Finally, and consistent with our past comments, we believe the FY 2026 recommendation fails to account for the true costs of hospital operations and care delivery. We believe this is a particularly concerning issue in the current health care climate given the challenges tied to staffing shortages and labor costs. The staff presentation and discussion also failed to incorporate the high capital projects undertaken by IRFs as part of their role in advancing medical rehabilitation care, such as new gyms and investments in continually-evolving technologies that advance patient care and functional recovery. We ask that MedPAC take these factors into account when assessing payment adequacy for IRF providers and the full impact that such significant cuts will have on innovative care delivery, staffing, and operations.

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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. 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 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,

Chris Lee
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)

	INPATIENT REHABILITATION FACILITY (IRF)	SKILLED NURSING FACILITY (SNF)	LONG-TERM ACUTE CARE HOSPITAL (LTCH)	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[1] • 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

[1] 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
INTESNITY & 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 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%**	49.90%	18.05%	Not Applicable
RATE OF POTENTIALLY PREVENTABLE HOSPITAL READMISSIONS 30 DAYS AFTER DISCHARGE	**8.90%**	10.51%	20.09%	3.90%

Values above represent national performance for all Medicare cases as displayed in provider data files available via https://www.medicare.gov/care-compare/ for the December 2024 publications.