February 7, 2025

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 2026

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) January 2025 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. As stated in our comments following the December 2024 meeting (which we have included as Attachment A), **we have serious concerns with MedPAC's recommendation to reduce the IRF market basket by 7% for FY 2026**. As MedPAC itself acknowledged, there are wide variations in margins and hospital-specific fiscal pressures facing IRFs based on their location, patient population, and structure (i.e., unit or freestanding IRF). We cannot understand MedPAC's conclusion, therefore, that such policy change would result in "no adverse effect on access to care." In fact, AMRPA believes that patient access to medically necessary IRF care would be immediately and significantly hindered by this cut, especially in those instances where low to negative margin IRFs can no longer afford to provide services and must close. In addition to the policy itself, AMRPA has a number of procedural and analytical concerns related to this recommendation. For all these reasons, we urge the Commission to carefully consider the following issues before finalizing its Report to Congress.

I. AMRPA Concerns with the Commission's Assessment & Discussion of Stakeholder Feedback

First, we are concerned that the IRF payment recommendation received limited time for review and discussion among Commissioners and failed to recognize or address timely comments submitted in response to the December 2024 meeting. During the January 16th session, MedPAC considered its final payment recommendation for five different Medicare services (skilled nursing facility services; home health agency services; inpatient rehabilitation facility services; outpatient dialysis services; and hospice services) in the same 35 minutes, affording only 7 minutes for each of the different settings/services. Within those 7 minutes, MedPAC Staff provided a brief summary of the analysis and Chairman's recommendation, and commissioner discussion was limited to any time remaining following the staff summary. We do not believe this allowed for meaningful discussion (and potential debate) on five major Medicare recommendations that will ultimately be considered by Congress.

During the staff presentation of IRF services, for example, there was no mention of comments received following the December 2024 meeting, nor were any of the issues noted in the comments from AMRPA and American Hospital Association (AHA) addressed by MedPAC Staff or Commissioners. Public comment is an essential part of producing and refining congressional reports that helps assure the voices of stakeholders are heard and considered. AMRPA consistently works to submit timely and comprehensive feedback to the Commission on the assumption that such input is taken into account when payment recommendations (or any MedPAC line of work) is finalized. While AMRPA appreciates that MedPAC is now publicly displaying comments submitted in response to meetings, we remain concerned that these comments do not receive an adequate amount of consideration by the Staff or Commissioners when developing and finalizing the Chairman's recommendation. We urge the Commission to include, meaningfully review and publicly discuss, stakeholder comments before finalizing the recommendations and the Report to Congress. Otherwise, the careful review and input provided by sophisticated public stakeholders does not appear to receive any visibility from the Commission.

II. MedPAC's Post-Acute Care Analyses Should Be Consistent Across Settings and, to the Greatest Extent Practical, Use Transparent Criteria to Inform Recommendations

Consistent with our prior comments, AMRPA is highly concerned at the lack of consistency between analyses, presentations and recommendations across MedPAC's post-acute care assessments. For example, the SNF services were reported during the January meeting as totaling $25 billion, with a footnote indicating that this excluded $5 billion in beneficiary copayments. Alternatively, IRF FFS payments for services were stated as $9.6 Billion with a footnote indicating the inclusion of beneficiary copayments. If MedPAC had included SNF beneficiary cost-sharing, the total FFS spending number would be 20% higher than what MedPAC is reporting. The IRF total FFS spending figure should be treated the same; that is, without inclusion of the beneficiary cost-sharing amounts. We also note that AMRPA flagged this discrepancy for MedPAC staff, and our inquiry remains unanswered as of the drafting of this letter. AMRPA is concerned that MedPAC is not standardizing the reporting of payments made to all post-acute care settings, and whether consideration of payment recommendations is influenced by variations in the reporting of this information. In addition, policymakers stand to receive inconsistent and misrepresentative data on spending totals across settings when determining whether to act on the Commission's recommendations.

Furthermore, AMRPA is concerned that MedPAC's recommendations are not being informed solely on Medicare fee-for-service (FFS) payment adequacy, despite MedPAC's numerous assertions that the Commission is limited to using FFS data in its work. Based on MedPAC's methodology, AMRPA assumes that settings with similar margins should receive similar payment adequacy findings and, consequently, similar recommended changes to their respective market baskets. However, during the December and January sessions, MedPAC commissioners and staff often cited Medicare Advantage, Medicaid, and All-Payer margins in support of the chair's recommendation. This appears inconsistent with MedPAC's stated charge (assessing only FFS payment adequacy) and appears to be facilitating inconsistent recommendations across post-acute care settings with similar FFS payment performance.

Lastly, AMRPA urges MedPAC to be more transparent with the way in which it determines the payment recommendation for IRFs and all other Medicare providers. As MedPAC is likely aware, the difference between a 5% market basket reduction (the 2024 recommendation) and 7% market basket reduction (this year's recommendation) would have serious and disparate impacts across the IRF field if implemented. Despite the magnitude of this change in MedPAC's recommendation, it did not appear that this change was backed by any type of methodology. In fact, during the Commissioner discussion, it was confirmed that the post-acute care recommendations were not driven by any specific calculation, and the Commission is instead simply "signaling to Congress" that IRFs and other providers that may be considered for cuts. AMRPA is highly concerned that, without any standardized methodology or mathematical reasoning for the recommendations, MedPAC is not providing Congress with the sophisticated analysis necessary to prevent significant disruptions in patient access to care and provide Medicare beneficiaries with high-quality health care.

In sum, AMRPA urges MedPAC to standardize and provide consistency in the analyses, presentations and recommendations for all post-acute care settings to avoid any unintended consequences impacting Medicare beneficiary access to any of these services.

III. MedPAC's Recommendation Does Not Fully or Accurately Reflect Fiscal Pressures Facing IRF Providers

As a final point, our member hospitals continue to be concerned about the overgeneralization and use of margin analyses that do not accurately represent the current financial state of IRFs. Not only has the inflationary environment created financial challenges among IRFs, but staffing shortages and increased labor costs are major concerns reported by AMRPA members. Utilizing cost report data that is at least two years old does not accurately reflect on the current financial state of IRFs, where the costs of maintaining staffing and mitigating turnover have increased significantly. One of the largest impacts to staffing is burnout and fatigue, which has increased significantly due to the COVID-19 Public Health Emergency and the continued expansion of administrative burden to maintain compliance with payment, quality, and other regulatory requirements.

AMRPA's position is supported by numerous recent analyses on hospital costs. As indicated in the comments[1] provided by the AHA following the December 2024 MedPAC meeting, there has been a sharp rise in operating costs, driven by a workforce crisis and considerable increases in the costs of care. In analysis[2] provided by Syntellis and AHA, it was stated that "[c]ompared to before the COVID-19 pandemic, hospital total expense per patient, as measured by median Total Expense per Adjusted Discharge, rose 22.5% — due largely to a 24.8% increase in Labor Expense per Adjusted Discharge from 2019 to 2022. Total Expense rose 17.5% and Total Labor Expense jumped 20.8% over the same period.". The report notes that a major factor in increased labor expense was a reliance on contract labor to fill gaps in workforce shortages; specifically, the analysis states that:

[1] Microsoft Word - 2025-01-10_MedPAC Letter v7.docx
[2] AHA Q2_Feb 2023.pdf

> "Total Contract Labor Expense skyrocketed 257.9% from 2019 to 2022 as a result. Contract Labor full-time equivalents (FTEs) jumped 138.5% over the three-year period, and the median wage rate paid to contract staffing firms rose 56.8% as organizations competed for a limited pool of qualified healthcare professionals. In specific departments such as nursing and emergency services, Contract FTEs increased more than 180% per unit of service from 2019 to 2022."

AMRPA is concerned that the cost report information included in the analysis supporting the IRF payment recommendation does not adequately account for these increases in costs resulting from significant shortages of qualified healthcare professionals.

In addition to incorporating more "real time" data on operating costs, AMRPA also supports the comments made by MedPAC Commissioner Dr. Brian Miller[3] that MedPAC "should quantify the costs of regulatory compliance, whether it's Medicare conditions of participation, …requirements for participation, or quality regulation." We think that this type of analysis would be particularly insightful given the intensive regulatory and oversight environment in which IRFs operate. As just a few examples:

- Per a 2024 report, administrative costs attributable to dealing with insurer prior authorizations and appealing denials have expanded to just under $30 billion.[4]
- IRFs subject to the IRF Review Choice Demonstration (RCD) are facing significant compliance-related costs as they oversee the submission and review of all fee-for-service admissions.
- Annual updates to the IRF PPS and IRF QRP have required a significant amount of administrative burden and technology investments, with the IRF-PAI now a 30-page form, requiring the assessment, data collection, and submission of nearly 500 unique data elements, 267 of which are required for the IRF QRP compliance determination to avoid a 2% payment penalty.
- From a technology investment standpoint, AMRPA also notes increased costs attributable to cybersecurity. In the aforementioned May 2024 AHA analysis, the AHA found that hospitals spent nearly $30 billion on property and medical liability insurance, according to data from Lightcast.

AMRPA urges MedPAC to take a closer look at all of these various operating and compliance-related costs for IRFs and revise their margin analyses accordingly to create a payment recommendation that more accurately represents the current financial situation of all IRFs.

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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

[3] https://www.medpac.gov/wp-content/uploads/2024/08/January-2025-public-meeting-transcript-SEC.pdf
[4] "America's Hospitals and Health Systems Continue to Face Escalating Operational Costs and Economic Pressures as They Care for Patients and Communities" (May 2024) (*do you have a hyperlink?*)[4],

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 the March meeting or March Report to Congress.

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

Attachment A

December 26, 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

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.

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
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.

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
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.