AMRPA
AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

January 12, 2017

Francis J. Crosson, M.D., Chairman
Medicare Payment Advisory Commission
425 Eye Street, NW
Suite 701
Washington, DC 20001

Re: ***American Medical Rehabilitation Providers Association's Comments on Chairman's Draft Recommendation for Inpatient Rehabilitation Facilities***

Dear Chairman Crosson and MedPAC Commissioners:

This letter is submitted on behalf of the American Medical Rehabilitation Providers Association (AMRPA) to provide our comments on the Chairman's draft recommendation relating to Medicare payments for inpatient rehabilitation hospitals and units (IRFs) and specifically to urge its rejection.

AMRPA is the national voluntary trade association representing more than 500 freestanding rehabilitation hospitals, rehabilitation units of general hospitals, and outpatient rehabilitation service providers. Our members provide medical rehabilitation services in a vast array of health care settings working with patients to maximize their health, functional skills, independence, and participation in society so they are able to live as independently as possible by returning home, returning to work or, in many instances, pursuing an active retirement. On average Medicare Part A payments represent more than 60 percent of IRFs' revenues.[1]

The Commission's findings indicate that Medicare margins among inpatient rehabilitation providers remain adequate. Scratching below the surface, however, the aggregate margin is not indicative of the range of margins among IRFs. In actuality, MedPAC's analysis reveals that *most* IRFs do not have significant margins. The vast majority of IRFs are hospital-based rehabilitation units (78 percent) with aggregate margins of 2 percent. A substantial majority of IRFs are also nonprofit (57 percent) with aggregate margins of 3.6 percent.

The Chairman's draft recommendation of a 5 percent reduction to the IRF Prospective Payment System (IRF PPS) base rate runs the risk of severe adverse effects for a number of providers and their patients. A cut of this magnitude would result in sharply negative average margins for many segments of the IRF sector, including hospital-based units, which represent

[1] MEDPAC, REPORT TO CONGRESS 240 (Mar. 2015).

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four out of every five IRFs. Based on MedPAC's data, this suggests that half of those units would have margins of less than negative 3 percent per case. This lack of profitability is not sustainable and would likely lead to rehabilitation unit closures as well as further market consolidation, thereby compromising patients' access to care.

In addition to the Medicare data relied on by the Commission, the IRF PPS 2017 rate setting files reveal additional pertinent findings about the adequacy of Medicare payments to IRFs. Our analysis found that in FY 2015:

- 473 IRFs, or 42 percent of IRFs with available data, had negative Medicare margins (below 0 percent);
- 50 percent of IRFs had margins below 5.0 percent;
- 58 percent of rural IRFs had margins below 5.0 percent;
- 65 percent of IRFs had margins below 13.9 percent, MedPAC's *aggregate* Medicare margin for all IRFs in FY 2015; and
- The *median* margin for all IRFs was 4.9 percent.[2]

In analyzing payment versus cost as a definition of margins, it is clear that a 5 percent payment cut would have dramatic consequences for the majority of IRFs. Given that the median margin for IRFs is 4.9 percent, an aggregate 5 percent cut to the payment system is unduly harmful to more vulnerable providers due to the wide variations in margins at the individual provider level.

The root causes of variability in Medicare margins among IRFs are not well understood. Surely, economies of scale and other cost efficiencies contribute to the disparity given the lower margins of units, which typically have fewer patients and lower occupancy rates. Nonprofit IRFs tend to have narrower margins irrespective of size, which MedPAC staff has inferred for several years is attributable to relatively less focus on cost control. There may also be poorly understood links between cost ratios and staffing, patient mix, and the use of different therapy modalities. Based on the literature we have seen, we do not believe there is evidence that differentials in patient coding (i.e., upcoding) meaningfully contributes to the variability. Still, AMRPA shares MedPAC's desire to better understand the factors underlying the significant variation in Medicare margins. While we appreciate the Commission's concerns, we know that a 5 percent reduction is not the solution and, to the contrary, is likely to further exacerbate underlying financial disparities and hence potentially patient access.

Additionally, AMRPA does not believe that expanding the outlier pool is the solution to margin variability or otherwise adequate to offset the tremendous harm that a 5 percent reduction would inflict. We note CMS has determined that the current level of outlier payments at 3 percent is most appropriate. There may be multiple reasons for outlier cases: complex patents known at admission, patients who developed unforeseen costly problems, higher cost structures and other factors. All of these factors suggest that expanding the outlier pool would not be an appropriate response to the intended objective of adequately compensating for the treatment of highly complex patients and avoiding financial disincentives to care for them. As we have previously cautioned, outlier payments are not a general policy that should be used to arbitrarily redistribute funds within the IRF sector, nor could they be reliably employed in this way.

[2] This data is derived from AMPRA's analysis of CMS Final Rule Inpatient Rehabilitation Facility Prospective Payment System rate setting files for FY 2017

As MedPAC is aware, the outlier payment policy is a budget-neutral program, such that increasing total outlier payments would further decrease the PPS base rate in addition to the reduction the Commission is considering. Moreover, given the prospective nature of the outlier payment methodology, outlier payments have consistently resulted in a net loss that has taken money out of the IRF PPS system in recent years. This is certainly the case for individual IRFs that, despite their high costs, have fewer than average outlier cases. For these reasons, expanding the amount of the outlier pool further risks reducing reimbursement for those IRFs that can ill-afford it. While AMRPA is more than willing to discuss with CMS and MedPAC potential ways to improve the effectiveness of the outlier pool policy in its own right, we simply do not feel this is a viable approach to mitigate the harm of an excessive payment reduction.

It is apparent to AMRPA from the discussion at recent MedPAC meetings that most Commissioners recognize the important and unique role of inpatient rehabilitation providers in the post-acute continuum of care. A number of important observations were offered during the December meeting, including concerns about the blunt impact of using the market basket update to address Medicare margins, which range from ample to inadequate. Therefore, AMRPA is disappointed that the Commissioners would consider supporting a recommendation that is likely to jeopardize the financial wellbeing and viability of so many providers in the inpatient rehabilitation sector. MedPAC's prior recommendation regarding medical review is another option.

As the data in MedPAC's report consistently make clear, IRFs are not part of the problem of unsustainable Medicare spending or even the growth in post-acute care. The total number of discharges as a function of the Medicare population has remained flat for many years and is lower than a decade ago. At the same time that patient cases and spending have held steady, the quality of inpatient rehabilitation care has continually improved. While these trends are not meant to suggest that there isn't room for improvement in both IRF quality and Medicare payment policies, AMRPA believes the focus should be on sound reforms to modernize the program and link it to quality rather than the blunt instrument of an across-the-board cut that has no nexus to improving quality. For example, we believe that there are a range of alternative payment models, such as the Continuing Care Hospital (CCH) model required by law, that have the potential to both enhance quality and efficiency, and thereby reduce cost. In addition, AMRPA would be happy to meet with MedPAC staff to discuss and understand the true scope of Medicare margins, the apparent variability therein and ways by which to examine potential contributing factors.

AMRPA Recommendation: For all of the foregoing reasons, we recommend that the Commissioners reject the Chairman's draft recommendation and not propose a 5 percent reduction to IRF payments.

Once again, AMRPA appreciates the opportunity to provide the Commissioners with our comments on the important work you do. We welcome the opportunity to provide additional input throughout the process and to clarify any comments in this letter. If you have questions, please do not hesitate to contact Carolyn Zollar, AMRPA's Executive Vice President of

Government Relations and Policy Development at (202) 223-1920 or czollar@amrpa.org, or Martha Kendrick, AMRPA's Washington Counsel at (202) 887-4215 or mkendrick@akingump.com.

Sincerely,



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cc: Mark Miller, Ph.D., Executive Director