MEDPAC Medicare Payment Advisory Commission

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June 21, 2017

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

RE: File Code CMS-1671-P

Dear Ms. Verma:

The Medicare Payment Advisory Commission (MedPAC) appreciates the opportunity to submit comments on the Centers for Medicare & Medicaid Services (CMS) proposed rule entitled Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2018; Proposed Rule, *Federal Register* 82, no. 84, 20690-20747 (May 3, 2017). We appreciate your staff's continuous efforts to administer and improve the Medicare payment system for inpatient rehabilitation facilities (IRFs), particularly given the competing demands on the agency.

This rule proposes a payment update and other revisions to Medicare payment policies for IRFs in fiscal year (FY) 2018 and proposes revisions and updates to the IRF quality reporting program (QRP).

Proposed FY 2018 update to the Medicare payment rate for IRFs

As required by the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, CMS intends to apply a 1.0 percent increase to the IRF payment rate. CMS also proposes an update to the high-cost outlier threshold amount to maintain estimated outlier payments at 3 percent of total estimated aggregate IRF payments for FY 2018.

Comment

We understand that CMS is required to implement this statutory update. However, we note that after reviewing many factors—including indicators of beneficiary access to rehabilitative services, the supply of providers, and aggregate IRF Medicare margins, which have been above 10 percent since 2011—the Commission determined that Medicare's current payment rates for IRFs appear to be more than adequate and therefore recommended that the Congress reduce the IRF payment rate

by 5 percent for FY 2018. We appreciate that CMS cited our recommendation, even while noting that the Secretary does not have the authority to deviate from statutorily mandated updates.

In conjunction with our recommendation to reduce the IRF payment rate by 5 percent, we reiterated our March 2016 recommendation that the IRF PPS outlier pool be expanded to redistribute payments within the IRF PPS and reduce the impact of potential misalignments between IRF payments and costs. This action is within the Secretary's authority. The recommendation was in response to Commission research suggesting that the IRF case-mix groups (CMGs) may not be adequately capturing differences in patient acuity and costs across cases and providers. We found that the mix of case types in IRFs is correlated with profitability. More costly cases, such as strokes, are disproportionately admitted by IRFs with lower margins, which could indicate that high-cost cases are less profitable than other cases. Expanding the outlier pool from the current level of 3 percent to 5 percent of aggregate IRF payments would ameliorate the financial burden for IRFs that have a relatively high share of costly cases. We recognize that, by increasing payments for the most costly cases, Medicare may increase payments for providers who are less efficient as well as for providers who care for patients whose acuity is not well captured by the case-mix system. Nevertheless, because of our concerns about the accuracy of Medicare's payments for resource-intensive cases, the Commission continues to believe that an expanded outlier pool is warranted in the near term. Over the longer term, CMS must assess variation in costs within the IRF CMGs and differences in relative profitability across CMGs.

We note that our research also found that patients cared for by high-margin IRFs, compared with those in low-margin IRFs, were less severely ill during the preceding acute care hospitalization but appeared to be more functionally disabled upon assessment in the IRF. This finding suggests the possibility that differences in assessment and coding practices across IRFs may contribute to wide variation in IRF margins. To help ensure payment accuracy and improve program integrity, we recommended in March 2016 that the Secretary analyze patterns of coding across IRFs and reassess the inter-rater reliability of the IRF Patient Assessment Instrument (IRF-PAI).

Other proposed revisions to Medicare payment policies for IRFs

The IRF compliance threshold requires that no less than 60 percent of all patients (Medicare and other) admitted to an IRF has as a primary diagnosis or comorbidity at least 1 of 13 conditions specified by CMS. Compliance is evaluated by Medicare's administrative contractors either through review of a random sample of medical records or, more commonly, through the less resource-intensive "presumptive" method. The presumptive method uses a computerized algorithm to compare a facility's IRF-PAI assessments for all Medicare patients for the year with a list of eligible codes. The diagnosis codes on the list are ones that CMS believes demonstrate either that the patient meets criteria for the medical conditions that may be counted toward an IRF's compliance percentage or that the patient has a comorbidity that could cause significant decline in function such that the patient would require intensive rehabilitation.

For FY 2018, CMS proposes to remove G72.89 ("Other Specified Myopathies") from the presumptive compliance list. CMS initially included the code in the presumptive compliance list because the agency believed that the code is intended to represent a relatively narrow set of

myopathies confirmed by the results of specific medical testing and identified as such in the medical record. However, CMS analyses have found that a disproportionate number of claims from certain IRFs include code G72.89. The agency is concerned that some IRFs are using the code more broadly than was intended, including to represent patients with generalized weakness who do not meet the compliance criteria.

In the proposed rule, CMS also solicits comments on additional refinements the agency should consider making to the criteria used to classify facilities for IRF payment.

Comment

The Commission supports this refinement, as it has supported CMS's previous efforts to tighten the requirements for compliance. Given the high IRF payment rate, the Commission believes it is important to ensure that IRF payments are made only to providers that furnish IRF-level services to beneficiaries who need and can tolerate that level of care.

We note that CMS was alerted to the possibility of a problem with the way some IRFs were using code G72.89 by observing anomalous coding patterns across IRFs. The Commission has previously recommended that CMS conduct focused medical record review of IRFs that have an atypical mix of patients and anomalous patterns of coding. The Commission has voiced its concern that providers may differ in their assessment of patients' motor and cognitive function, resulting in payments for some IRFs that are too high relative to the costs incurred in treating their patients. But, as CMS has observed, other anomalies in IRF coding practices can affect Medicare payment and compliance as well. To improve the accuracy of payments and protect program integrity, we urge CMS to continue to focus on the coding practices of providers.

We encourage CMS to continue to refine the criteria that determine the need for intensive inpatient rehabilitation. We support efforts to expand the use of specific patient-based criteria in the IRF payment system and move away from the simple diagnosis-based criteria used for most of the 13 conditions that qualify for the 60 percent rule. The criteria for hip and knee replacement and for arthritis conditions detail specific clinical factors that indicate whether a patient's condition is severe enough to warrant treatment in an IRF and whether the patient can tolerate the advanced regimen of therapy that IRFs provide. CMS should consider the need for similar detailed clinical criteria for the other conditions used to evaluate compliance. Continued consideration of anomalous coding and utilization patterns may identify conditions that might need additional scrutiny. For example, the Commission has found that patients with neurological conditions, particularly neuromuscular disorders, are concentrated in certain IRFs.

Proposed revisions and updates to the IRF Quality Reporting Program

The Patient Protection and Affordable Care Act (PPACA) of 2010 required the Secretary to establish the IRF Quality Reporting Program (QRP). Beginning in FY 2014, the Secretary is required to reduce any annual update to the standard federal rate by 2 percentage points for any IRF that does not comply with the requirements established by the Secretary. The IRF QRP currently includes 18 measures. Data for three measures are currently displayed on the IRF

Compare website, with more measures to be added. The IRF QRP is intended to allow comparisons of patient outcomes across providers.

Accounting for social risk factors

CMS has previously noted its concerns about the impact of social risk factors—such as income, education, race and ethnicity, employment, disability, community resources, and social support—on the measurement of outcomes. The agency wants to ensure that all beneficiaries using IRFs, including those with social risk factors, receive high quality care. At the same time, the agency seeks to ensure that the quality of care furnished by IRFs is assessed as fairly as possible. To those ends, CMS has been reviewing reports prepared by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the National Academies of Sciences, Engineering, and Medicine on the issue of accounting for social risk factors in CMS's value-based purchasing and quality reporting programs, including the IRF QRP. CMS has also been monitoring and awaiting results from the National Quality Forum's (NQF) 2-year trial period in which quality measures seeking endorsement are assessed to determine whether risk adjustment for selected social risk factors is appropriate. At the end of the trial, NQF will issue recommendations on the future inclusion of social risk factors in risk adjustment for these quality measures. As CMS continues to consider the analyses from these reports and awaits the results of the NQF trial on risk adjustment for quality measures, the agency is seeking public comment on whether and how to incorporate social risk factors in Medicare QRPs.

Comment

ASPE's report to the Congress, *Social Risk Factors and Performance Under Medicare's Value-based Purchasing Programs*," released in December 2016, provides empirical analysis of the effects of six social risk factors (dual enrollment, residence in low-income areas, Black race, Hispanic ethnicity, rural residence, disability) on the nine Medicare quality payment programs including the Hospital Readmission Reduction (HRR) program. ASPE found that beneficiaries with social risk factors had worse outcomes on quality measures, regardless of the providers they used. At the same time, ASPE found that providers that disproportionately served beneficiaries with social risk factors tended to have worse performance on quality measures, even after accounting for their beneficiary mix.

ASPE simulated the effect of three different approaches to account for social risk factors in each of the Medicare programs:

- Adjusting quality and resource use measures for differences in the social risk of patients;
- Stratifying providers into groups by the proportion of at-risk patients served; and
- Creating separate payment adjustments for providers based on the share of at-risk patients.

The Commission recognizes that social risk factors can play a role in outcomes. But the Commission does not support adjusting quality and resource use measures for these factors, because doing so would hide actual disparities in care and could reduce pressure on providers to improve care for at-risk populations. MedPAC has generally supported a solution similar to

ASPE's stratification approach, which uses peer grouping to report outcomes. This approach would allow for the full effect of social risk factors, like Medicaid status, to be considered in comparing IRF outcomes and (in the future) adjusting payment, because the effect would not be dampened by other patient-level variables (such as clinical severity) in the risk-adjustment model. This approach also would provide "unmasked" results that would allow providers to compare themselves to their peers and identify opportunities for improvement. In addition, this approach has the advantage of being straightforward to implement, since no new risk-adjustment models would need to be developed.

Defining standardized patient assessment data

The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 requires the Secretary to implement quality and resource use measures that are standardized and interoperable across PAC settings. The required quality measures include measures of function and cognition, skin integrity, medication reconciliation, incidence of major falls, the transfer of health information and care preferences, readmissions, and discharge to community. In the proposed rule, CMS proposes that "standardized" patient assessment data should be defined as patient assessment questions and response options that are identical across PAC providers (including skilled nursing facilities, home health agencies, and long-term care hospitals, as well as IRFs) and to which identical standards and definitions are applied.

Comment

The Commission supports this change in the definition of "standardized." Because the goal of cross-cutting measures is to gauge and compare care provided across PAC settings, it is critical that each measure use uniform definitions, specifications (such as inclusions and exclusions), and risk-adjustment methods. Otherwise, differences in rates across settings could reflect differences in the way the rates were constructed rather than underlying differences in the quality of care. Our work on the design of a unified PAC payment system and the work of others suggest considerable overlap in where beneficiaries are treated for similar PAC needs. These results indicate it is imperative that quality and resource use measures are directly comparable across settings so that Medicare can evaluate the value of its purchases and beneficiaries can make informed choices about where to seek care.

Removal of the all-cause unplanned readmission measure

CMS proposes to remove the all-cause unplanned 30-day post-discharge readmission measure from the IRF QRP. CMS has previously adopted a measure of potentially preventable 30-day post-discharge readmission and a measure of potentially preventable within-stay readmission for IRFs.

Comment

The Commission supports the removal of this measure. Measuring potentially preventable readmissions holds providers accountable only for conditions that generally could have been

managed by the IRF. By contrast, the all-cause readmissions measure captures readmissions for any condition, including those that generally are not considered preventable.

Standardized patient assessment data reporting

CMS proposes the addition of several elements to the IRF-PAI beginning in FY2019. These elements relate to special services, treatments, and interventions that may be provided to IRF patients, including IV medications, dialysis, oxygen, and nutritional approaches (such as parenteral feeding and mechanically altered diets). Other elements relate to hearing and vision. The elements would be standardized (as defined above) to align with those collected in other PAC settings.

Comment

The Commission supports the addition of elements to the PAC assessment tools that are standardized across the PAC settings. However, CMS needs to be mindful that measures, when used for risk-adjustment, may be susceptible to provider manipulation. Of the items included in the proposed rule, the Commission is concerned about those that may induce service use, such as oxygen therapy, intravenous medications, and nutritional approaches. The Commission supports the inclusion of these care items when they are tied to medical necessity. For example, in prior Commission work developing a reformed payment system for SNFs, we required that patients be counted as using oxygen services only if they have diagnoses that typically require the use of oxygen. We encourage CMS to take a similar approach in measuring use of services that are especially discretionary. For some elements, CMS may want to consider requiring a physician signature to attest that the reported service was reasonable and necessary and including a statement adjacent to the signature line warning that filing a false claim is subject to treble damages under the False Claims Act.

Items that were not proposed but which may warrant consideration include high-cost services such as cardiac monitoring and specialty bed/surfaces. Because patient assessment items are sometimes used for risk-adjustment, CMS may want to consider whether high-cost services such as these would be included in future collection efforts.

Expanding quality measures to include all patients regardless of payer status

In the proposed rule, CMS solicits comments on whether the agency should require quality data reporting on all IRF patients, regardless of payer, where feasible. The agency has received input suggesting that it expand the quality measures to include all patients, so as to provide an appraisal of the quality of services a facility provides to all its patients.

Comment

The Commission supports efforts to ensure quality care for all patients, regardless of payer source. But we are sensitive to the increased burden this may present to providers. Since it has long been common practice for providers to collect IRF-PAI data on all patients, expanding IRF quality measures to include all patients may not be particularly onerous and may even relieve burden, to

the extent that providers must now separate out assessment data for Medicare patients from that of all patients. However, we caution CMS that any future payment adjustments related to performance should be based only on outcomes for Medicare beneficiaries.

Conclusion

MedPAC appreciates your consideration of these issues. The Commission values the ongoing collaboration between CMS and MedPAC staff on IRF policy, and we look forward to continuing this relationship.

If you have any questions regarding our comments, please do not hesitate to contact Mark Miller, MedPAC's Executive Director, at 202-220-3700.

Sincerely,

Francis J. Crosson, M.D.
Chairman

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