MEDPAC | Medicare Payment Advisory Commission

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May 23, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Attention: CMS-1804-P

Dear Ms. Brooks-LaSure:

The Medicare Payment Advisory Commission (MedPAC) appreciates the opportunity to submit comments on the Centers for Medicare & Medicaid Services' (CMS's) proposed rule entitled "Medicare Program; Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) for Federal Fiscal Year (FY) 2025 and Updates to the IRF Quality Reporting Program (QRP); Proposed Rule," *Federal Register* 89, no. 62, 22246–22292 (March 29, 2024). We appreciate your staff's continuous efforts to administer and improve the Medicare payment system for IRFs, particularly given the competing demands on the agency.

Our comments cover CMS's proposed payment rate update, update of the case-mix group relative weights, and the wage index adjustment and adoption of the revised Office of Management and Budget (OMB) market area delineations.

Proposed FY 2025 update to the Medicare payment rate for IRFs

CMS proposes a 2.8 percent increase to the IRF payment rate, reflecting the applicable market basket increase (currently projected to be 3.2 percent) less an estimated productivity adjustment of 0.4 percentage points, as required by statute.

Comment

We understand that the Secretary does not have the authority to deviate from statutorily mandated updates, and thus CMS is required to implement this statutory update. However, we appreciate that CMS cited our March 2024 recommendation to reduce the IRF payment rate by 5 percent for FY 2025.[1] We made this recommendation after reviewing many indicators of payment adequacy, including beneficiary access to inpatient rehabilitation services, the supply of providers, and aggregate IRF Medicare margins (which have been above 13 percent since 2015), the totality of which suggest that Medicare's current payment

[1] Medicare Payment Advisory Commission. 2024. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

rates for IRFs are more than adequate. In making this recommendation, we were cognizant of recent public health emergency–related changes that increased cost growth in IRFs, but we expect these costs to normalize in subsequent years and do not anticipate any long-term effects that warrant inclusion in the annual update to IRF payments in 2025.

Proposed FY 2025 update to the case-mix group relative payment weights

As in previous years, CMS proposes to update payment weights for each case-mix group (CMG) using the latest available Medicare cost reports and fee-for-service claims data. CMS calculates costs per IRF stay and sets payment weights to be proportional to differences in cost per stay such that cases in more resource intensive CMGs are assigned greater payment weights and cases in less resource intensive CMGs are assigned lower payment weights. Since the implementation of the IRF PPS, CMS has used a hospital-specific relative value (HSRV) method, which compares within-IRF relative cost variation across CMGs, to assign payment weights to CMGs.

Comment

In our March 2024 report to the Congress, we presented analyses that used an alternative method in place of HSRV to assign payment weights. We referred to this as an "average-cost" method. The average-cost method would set payment weights to be proportional to IRFs' costs per stay by calculating the average cost of cases within each CMG without regard to the types of IRFs providing care in each CMG. According to our analyses, the average-cost method would improve upon some of the concerning trends we observed with the current application of the HSRV method. Under the current method, we found a substantial declining relationship between average costs per stay and IRFs' average payment weights (also referred to as the "case-mix index" or CMI) over time. In other words, IRFs with higher CMIs were not associated with similarly high average costs per stay. This pattern differs from that seen in the earlier years of the IRF PPS when this relationship was more proportional. Additionally, we observed that highly profitable IRFs (generally, freestanding for-profit IRFs) tended to concentrate their cases in the most highly weighted CMGs. Using data from 2019, we found that, among stays in the most profitable condition category of "other neurological," over 30 percent admitted to freestanding for-profit IRFs indicated "other specified myopathies" as the condition for which the patient received rehabilitation compared with 6 percent of stays among hospital-based nonprofit hospitals.[2] Admission of these patients by some IRFs has come under scrutiny by the Department of Justice and CMS.[3]

In contrast, using an average-cost method to calculate weights substantially improved the relationship between average costs per stay and CMI and demonstrated greater uniformity

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[2] Medicare Payment Advisory Commission. 2024, *op cit.*

[3] Department of Justice. 2019. Encompass Health agrees to pay $48 million to resolve False Claims Act allegations relating to its inpatient rehabilitation facilities. Washington, DC: DOJ. https:// www.justice.gov/opa/pr/encompass-health-agrees-pay-48- million-resolve-false-claims-act-allegations-relating-its.
Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2017. Medicare program; inpatient rehabilitation facility prospective payment system for federal fiscal year 2018. Final rule. *Federal Register* 82, no. 148 (August 3): 36238–36305.

in IRF profitability across cases. The average-cost method may better promote access to IRF care by reducing the financial incentives to avoid patients who would be assigned to lower-weighted CMGs and reducing incentives to code patients into higher-weighted CMGs.

We urge CMS to re-examine the current HSRV method used to assign payment weights and consider replacing it with the average-cost weighting method. Making such a change would pose no additional administrative burden on providers. In our analysis, assuming no behavioral changes and budget neutrality, replacing HSRV weights with average-cost weights had the effect of slightly increasing payments to hospital-based IRF units as well as small and rural IRFs. Freestanding, large IRFs would have slight decreases in payments.

As discussed in MedPAC's report, this change would not eliminate financial incentives for IRFs to select profitable patients, nor would it eliminate issues of inter-rater reliability in patient assessment, as MedPAC has discussed in the past.[4] Therefore, regular monitoring and auditing of IRF service use and the accuracy of the provider-reported assessment data, which are used to determine payment, would be needed.

Wage index updates

Since the start of the IRF PPS, CMS has used general acute care hospital wage data to develop the IRF PPS wage index. For fiscal year 2025, CMS proposes to continue to use the unadjusted inpatient prospective payment systems (IPPS) wage index (referred to as the "pre-floor, pre-reclassification hospital inpatient wage index").

CMS also proposes to:

- update the wage index with newer wage data and OMB market area delineations
- continue its policy of capping the wage index decrease a provider can experience in a given year at 5 percent
- Phase in the loss of the 14.9 percent rural adjustment for IRFs moving from a rural to urban classification under the new OMB delineations

Comment

The Commission supports CMS's annual process to update the IRF PPS wage index with newer wage data and OMB delineations. The Commission also supports having a policy to cap and phase in the wage index changes that a provider can experience in a given year. We continue to urge CMS to apply a cap to the wage index increase that a provider can experience in a given year as well.

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[4] Medicare Payment Advisory Commission. 2024, *op cit.*

However, the Commission has long been concerned with flaws in the wage index system that CMS uses to adjust IRF payments to reflect geographic differences in labor costs.[5] To improve the accuracy and equity of Medicare's wage index systems for IPPS hospitals and other providers (such as, but not limited to, IRFs), Medicare needs wage indexes that are less manipulable, more accurately and precisely reflect geographic differences in market-wide labor costs, and limit how much wage index values can differ among providers that are competing for the same pool of labor. In the Commission's June 2023 report to the Congress, we recommended that the Congress repeal the existing Medicare wage index statutes, including current exceptions, and require the Secretary to phase in new wage index systems for hospitals and other types of providers that:

- use all-employer, occupation-level wage data with different occupation weights for the wage index of each provider type;
- reflect local area level differences in wages between and within metropolitan statistical areas and statewide rural areas; and
- smooth wage index differences across adjacent local areas.[6]

We urge the Secretary to use existing authority to adopt the Commission's recommended approach for IRFs.

Conclusion

We appreciate the opportunity to comment on these important policy proposals. The Commission values the ongoing collaboration between CMS and MedPAC staff on technical policy issues, and we look forward to continuing this relationship.

If you have any questions, or require clarification of our comments, please do not hesitate to contact Paul Masi, MedPAC's Executive Director, at 202-220-3700.

Sincerely,

Michael E. Chernew, Ph.D.
Chair

[5] Medicare Payment Advisory Commission. 2007. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.
[6] Medicare Payment Advisory Commission. 2023. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.