MEDPAC Medicare Payment Advisory Commission

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May 15, 2020

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

RE: File Code CMS-1729-P

Dear Ms. Verma:

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 for Federal Fiscal Year 2021; Proposed Rule," *Federal Register* 85, no. 77, 22065–22099 (April 21, 2020). 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.

This rule proposes a payment update and other revisions to Medicare payment policies for IRFs in fiscal year (FY) 2021. We focus our comments on CMS's proposed update, proposed revisions to the statistical area delineations used to construct the wage indexes, and proposal to allow non-physician practitioners to perform certain IRF coverage requirements that are currently required to be performed by a rehabilitation physician.

Proposed FY 2021 update to the Medicare payment rate for IRFs

CMS proposes a 2.5 percent increase to the IRF payment rate, reflecting the applicable market basket increase (estimated to be 2.9 percent) less an estimated productivity adjustment of 0.4 percentage points, as required by the Affordable Care Act (ACA) of 2010. CMS also proposes an increase (0.4 percent) to the high-cost outlier threshold amount to maintain estimated outlier payments at 3 percent of total estimated aggregate IRF payments for FY 2021.

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 12 percent since 2014—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 2021. 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 March 2020 recommendation to reduce the IRF payment rate for FY 2021 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. 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 costliest 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.

Adoption of the Office of Management and Budget's geographic area delineations to establish the wage indexes

The payment rates for each IRF are adjusted to reflect the relative differences in area wage levels using geographic areas (called core-based statistical areas, or CBSAs) delineated by the Office of Management and Budget (OMB). Periodically, OMB revises the delineations and CMS adopts them in establishing the wage index values. On September 14, 2018, OMB published an updated set of delineations that included the creation of new CBSAs, the splitting of some existing CBSAs, and changes in the designation of some areas from rural to urban and from urban to rural. In previous adoptions of OMB's revised delineations, CMS has included a one-year transition that blended old and new wage index values to avoid large changes to the wage index values.

Consistent with prior actions, this year (for FY 2021) CMS proposes to adopt the most recent delineations of geographic areas and include a one-year transition. This year, however, CMS proposes to take a different approach to the one-year transition. CMS proposes to limit the reduction to any wage index value to 5 percent in one year, thus mitigating the impact on IRFs whose wage index values will decrease. CMS proposes to allow IRFs whose relative index values would increase to receive the full benefit of the increased wage index value. The adoption of the new wage index values would be done in a budget-neutral manner.

Comment

The Commission supports the adoption of the new delineations of the geographic areas and the use of a one-year transition to mitigate the impact of changes to the wage index values. Regarding the limit on decreases to the wage index values, the Commission supports eliminating wage index changes of more than 5 percent in one year. However, the Commission believes the limit should

apply to both increases and decreases in the wage index, not just decreases. As a result, no provider would have its wage index value increase or decrease by more than 5 percent for FY 2021. Consistent with CMS's proposed approach, the implementation of the revised relative wage index values (where changes are limited to plus or minus 5 percent) should be done in a budget-neutral manner.

The Commission also reiterates its June 2007 recommendations on wage index reform.[1] We recommended that the Congress repeal the existing hospital wage index and instead implement a market-level wage index for use across the inpatient prospective payment system and other prospective payment systems, including certain post-acute care providers. Specifically, our recommended wage index system would:

- use wage data from all employers and industry-specific occupational weights,
- adjust for geographic differences in the ratio of benefits to wages,
- adjust at the county level and smooth large differences between counties, and
- include a transition period to mitigate large changes in wage index values.

The wage index system we proposed would more fully reflect input prices, automatically adjust for occupational mix, reduce circularity, and reduce large differences between adjoining areas compared with the current system. Two significant research evaluations commissioned by the Secretary concluded that MedPAC's proposed wage index system would be an improvement over Medicare's current hospital wage index system.[2] We understand that eliminating the current wage index system, and the associated apparatus (such as the rural floors and reclassifications), would require Congressional action, but we urge the agency to consider our recommendations and make adjustments to the current system where it has the discretionary authority to do so.

Proposal to allow non-physician practitioners to perform certain IRF coverage requirements

In the FY 2018 IRF proposed rule, CMS included a request for information (RFI) from stakeholders about ways in which the agency could reduce the burden for IRFs and physicians, improve quality of care, and decrease costs. Since the RFI, CMS has implemented several changes. First, in FY 2019, CMS allowed the post-admission evaluation to count as one of the three face-to-face visits with a rehabilitation physician required each week. Also, in FY 2019, CMS allowed rehabilitation physicians to lead weekly interdisciplinary meetings remotely (by video or telephone conferencing) without additional documentation requirements. Then, most recently in FY 2020, CMS finalized an amendment to the definition of a rehabilitation physician to clarify that the

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[1] Medicare Payment Advisory Commission. 2007. *Report to the Congress: Promoting greater efficiency in Medicare*. Washington, DC: MedPAC.

[2] Institute of Medicine. 2011. *Geographic adjustment in Medicare payment, Phase I: Improving accuracy. Second edition.* Washington, DC: The National Academies Press.
MaCurdy, T, T. DeLeire, K. Lopez de Nava. et al. 2009. Revision of Medicare wage index. Final report, Part I.
MaCurdy, T, T. DeLeire, K. Lopez de Nava. et al. 2010. Revision of Medicare wage index. Final report, Part II.
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files-Items/CMS1237065.html

determination as to whether a physician qualifies as a rehabilitation physician is made by the IRF. Additionally, based on responses to the RFI, CMS solicited comments in the FY 2019 IRF proposed rule on potentially allowing non-physician practitioners to fulfill some of the requirements that rehabilitation physicians are currently required to complete. The feedback from stakeholders was conflicting, but as noted in "Medicare Program; Inpatient Rehabilitation Facility (IRF) Prospective Payment System for Federal Fiscal Year 2021; Proposed Rule," CMS agreed with commenters that non-physician practitioners have the training and experience to perform certain IRF requirements and that utilizing non-physician practitioners would increase access to post-acute care services in areas with physician shortages.

Now, in the FY 2021 proposed rule, CMS proposes to remove the post-admission physician evaluation and to allow non-physician practitioners to perform IRF services and documentation requirements currently required to be performed by the rehabilitation physician, as outlined at § 412.622(a). Currently—among other requirements—for IRF care to be covered, the patient must need physician supervision, including:

- at least 3 face-to-face visits per week throughout the patient's stay in the IRF to assess the patient both medically and functionally;
- a comprehensive preadmission screening within the 48 hours immediately preceding the IRF admission;
- a post-admission physician evaluation conducted within 24 hours of admission (which, as noted above, can be counted as one of the required physician face-to-face visits during the first week of care);[3]
- an individualized overall plan of care for the patient that is developed by a rehabilitation physician with input from the interdisciplinary team within 4 days of the patient's admission to the IRF; and
- an interdisciplinary team approach, including weekly team meetings led by a rehabilitation physician.

Under CMS's proposal, a qualified non-physician practitioner could replace required physician involvement. CMS expects the IRF to determine whether the non-physician practitioner has specialized training and experience and therefore may perform any of the duties that are currently required to be performed by a rehabilitation physician.

Comment

Medicare's conditions of coverage and payment serve to distinguish the IRF level of care and payment from other settings. Currently, each IRF is required to have a medical director of rehabilitation with training or experience in rehabilitation who provides services in the facility on a full-time basis (or at least 20 hours per week for hospital-based IRF units). Given the costliness of

[3] In response to the COVID-19 pandemic, CMS has removed the post-admission physician evaluation requirement at §412.622(a)(4)(ii) for the duration of the public health emergency.

the IRF setting relative to other post-acute care (skilled nursing facilities or home health care), it is reasonable to expect that the beneficiary needs supervision by a rehabilitation physician, as reflected in three face-to-face visits with a physician each week, the development of an individualized plan of care with physician input, and in the involvement of a physician in weekly interdisciplinary team meetings. Beneficiaries whose conditions do not require close physician oversight can be cared for appropriately in other, less-intensive settings at a lower cost to the Medicare program.

Allowing non-physician practitioners to conduct certain IRF requirements (such as pre-screening documentation review and compliance, development of the patient's plan of care, and participation in an interdisciplinary team as cited in the proposed rule) suggests that such high levels of care may not be required by all beneficiaries who are cared for in an IRF, or that the level of resources needed to provide IRF-level care have fallen, or both. Relaxing conditions of coverage and payment that have been established in part to ensure that Medicare's higher payments are warranted calls into question the level of those payments and provides further evidence that they may be too high. It also underscores the need for Medicare to move away from setting-based payments for PAC and toward a unified payment system that pays for PAC based on the characteristics of the patient and not on the setting in which the care is provided.

IRF patients are presumed to need a higher level of care because they have conditions that are thought to require an intense level of therapy each week (generally consisting of at least three hours of therapy per day at least five days per week) as prerequisite for admission. The need for intense therapy and physician supervision is generally what separates IRF-level patients from patients who receive care provided in other post-acute settings. In the FY 2019 final rule, CMS noted that the purpose of the physician supervision requirement is to ensure that the patient's medical and functional statuses are being continuously monitored as the patient's overall plan of care is being carried out. The agency also stated that it should be the responsibility of the rehabilitation physician to use his or her best clinical judgement to determine whether the patient needs to be seen more than three times in the first week of the IRF admission—the most critical phase of the recovery process. On that premise, these statements raise concerns of whether further removing the rehabilitation physician from the overall treatment process is in the best interest of patient care. To the extent that the skills of a rehabilitation physician are warranted, relieving the physician of these responsibilities could impact health outcomes for Medicare beneficiaries in IRFs.

MedPAC understands CMS's goals of reducing physician burden and increasing beneficiary access to care. However, given the importance of physician oversight in this setting, we urge CMS not to proceed with its proposal to reduce the level of physician engagement in the care of IRF patients. Should CMS ultimately decide to implement this proposal in the final rule, the Commission strongly urges CMS to monitor differential patient outcomes. Specifically, we suggest comparing the cost, payments, and quality of care for Medicare beneficiaries before and after the implementation of this proposal.

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 James E. Mathews, MedPAC's Executive Director, at 202-220-3700.

Sincerely,

Paul B. Ginsburg, Ph.D.
Vice Chairman

PBG/jmt