MEDPAC Medicare Payment Advisory Commission

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May 24, 2016

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

RE: File Code CMS-1647-P

Dear Mr. Slavitt:

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 2017; Proposed Rule, *Federal Register* 81, no. 79, 24178-24227 (April 25, 2016). 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 for IRFs in fiscal year (FY) 2017 and proposes revisions and updates to the IRF quality reporting program (QRP).

Proposed FY 2017 update to payment rates for IRFs

CMS proposes a 1.45 percent increase to the IRF payment rate. CMS obtained this result by following the statutory formula of starting with a 2.7 percent market basket increase and subtracting a productivity estimate of 0.5 percentage points and an additional deduction of 0.75 percentage points; both are required by the Patient Protection and Affordable Care Act (PPACA) of 2010. 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 2017.

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 Medicare margins—the Commission determined that Medicare's

current payment rates for IRFs appear to be adequate and therefore recommended no update to IRF payment rates for FY 2017. 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 March 2016, the Commission recommended that the Secretary expand the IRF PPS outlier pool to increase payments for the most costly cases and fund the expanded pool by reducing the base payment amount for all IRF cases. The recommendation was in response to Commission research that suggested that the IRF 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 raises concerns that high-cost cases might be 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. Expanding the outlier pool by a larger amount would increase the effect but would require Congressional action. 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. While this outcome is not desirable, the Commission's concern about the accuracy of Medicare's payments for resource-intensive cases warrants this approach in the near term.

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, 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).

Proposed revisions and updates to the IRF Quality Reporting Program

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. The IRF proposed rule discusses five measures for adoption in the IRF QRP in response to the IMPACT requirement: total estimated Medicare spending per beneficiary, discharge to community, potentially preventable 30-day post-discharge readmission, potentially preventable within stay readmission, and drug regimen review conducted with follow-up. Similar measures have been proposed for (or are already used in) other PAC settings.

Comment

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. Separate measures will continue to evaluate each PAC setting in isolation rather than support cross-setting comparisons of PAC providers. We emphasize this principle in our discussion of the MSPB measure, but note that the principle applies to all four of the IMPACT measures discussed here.

The Commission recognizes that socio-economic status (SES) factors can play a role in the outcomes for quality and resource use measures. One way to consider SES factors is to include them in the risk adjustment method. The Commission does not support this approach because it results in adjusted rates (or spending amounts) that hide actual disparities in care (and spending), and could reduce pressure on providers to improve care for the poor. The Commission believes that a better way to address any differences in outcomes is to compare rates (or spending amounts) that have not been adjusted for SES across providers that have similar shares of, for example, low-income, beneficiaries. This way, the outcome rates remain intact but the comparisons are "fair" because providers are compared with their peers.

To promote transparency for beneficiaries and competition across providers, the Commission supports the public reporting of the cross-cutting quality measures. CMS should move towards reporting the cross-cutting measures quality measures for all providers in each setting.

Medicare spending per beneficiary-PAC IRF—This measure would capture the average risk-adjusted total Medicare spending per beneficiary during the IRF stay and the 30 days after discharge from the IRF. As a measure of resource use, it is intended to provide information about a provider's efforts to coordinate care and improve the efficiency of services furnished during an episode of care. By holding IRFs accountable for resource use over episodes of care, the measure will increase providers' responsibility for care furnished during their own "watch," for a safe transition to the next setting or home, and for care during the next 30 days. CMS is developing separate MSPB measures for each of the four PAC settings.

Comment

The Commission supports the adoption of a resource use measure that promotes providers' responsibility for episodes of care. By reporting provider's performance regarding resource use during their patients' stays plus 30 days after discharge, the measure will ready providers for broader payment reforms—such as bundled payments—that extend providers' responsibility for episodes of care. However, the Commission does not support the development of setting-specific MSPB measures. We believe a uniformly defined resource use measure for all four PAC settings, rather than separate measures for each PAC setting, will better meet the intent of the IMPACT Act and enable comparisons across PAC settings. Under a single measure, the episode definitions,

service inclusions/exclusions, and risk adjustment methods would be the same across all PAC settings.

Until there is a uniform PAC PPS and payment differences between settings are eliminated, the Commission appreciates that a single measure would, without other adjustment, consistently advantage lower-cost settings and disadvantage higher-cost settings due to the large spending differences associated with the initial PAC stay across the settings. Therefore, to assess providers' performance in the near term, CMS should use a single measure and compare providers within each setting (i.e., an IRF's spending would be compared with other IRFs' spending). In the future, comparisons of the single measure could be made across all PAC settings.

Discharge to community—CMS proposes a risk-adjusted rate of FFS beneficiaries who are discharged to the community following a PAC stay and who do not have unplanned hospital readmissions during the 31 days following discharge to the community. CMS proposes to gather the discharge status from the PAC claim.

Comment

The Commission supports this measure and has used a similar measure to track the quality of IRFs and skilled nursing facilities (SNFs) for several years. However, the Commission urges CMS to confirm discharge status by matching claims of the discharging IRF with any subsequent institutional provider (a hospital, IRF, SNF, or long-term care hospital (LTCH)). CMS reports almost 99 percent agreement between the "discharge status" on the IRF claim and that coded on the IRF Patient Assessment Instrument, but reports about 90 percent agreement between the discharge status on the IRF claim and the presence of a subsequent acute hospital claim and does not report the extent of agreement between the discharge status on the IRF claim and the presence of subsequent claim for other institutional services (e.g., SNF care). To ensure that discharge to community rates reflect actual performance, such status should be confirmed by the absence of a subsequent claim to a hospital, another IRF, a SNF, or an LTCH.

Potentially preventable within stay readmission and potentially preventable 30-day post-discharge readmission—These measures assess a facility's risk-adjusted rate of unplanned, potentially preventable hospital readmissions for Medicare FFS beneficiaries during the IRF stay and in the 30 days after discharge from the IRF.

Comment

The Commission supports these measures, believing that IRFs should be held accountable for the care they provide to beneficiaries and for safe transitions to the next setting (including home). MedPAC has tracked post-discharge readmission measures over multiple years for IRFs and SNFs. As noted above, the measure definition and risk adjustment should be identical across the four PAC settings so the post-discharge rates can be meaningfully compared.

Drug regimen review conducted with follow-up for identified issues—CMS proposes to adopt a drug regimen review measure that would report the percentage of stays in which a drug regimen

review was conducted at the time of admission and timely follow-up with a physician each time potentially clinically significant medication issues were identified. The purpose of the measure is to encourage PAC providers to perform a review of all patients' medications to identify and resolve any potential adverse effects and drug reactions (including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy).

Comment

The Commission supports CMS's proposed medication reconciliation measure. The medication and reconciliation and follow-up process can help reduce medication errors that are especially common among patients who have multiple comorbidities and many health care providers. In addition to the proposed measure, MedPAC encourages CMS to assess whether PAC providers conduct medication reconciliation when discharging their patients. For example, CMS could also measure whether a PAC provider sends discharge medication lists to either the next PAC provider or, if being discharged home, to the patient's primary care provider.

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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