



Medicare Payment
Advisory Commission

425 I Street, NW · Suite 701
Washington, DC 20001
202-220-3700 · www.medpac.gov

Michael E. Chernew, Ph.D., Chair
Paul B. Ginsburg, Ph.D., Vice Chair
James E. Mathews, Ph.D., Executive Director

May 27, 2022

Chiquita Brooks-LaSure
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-1767-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) 2023 and Updates to the IRF Quality Reporting Program (QRP); Proposed Rule," *Federal Register* 87, no. 66, 20218–20266 (April 6, 2022). 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.

We focus our comments on CMS's proposed payment update, the cap on wage index decreases, the facility-level adjustment factor methodology, the IRF transfer payment policy, and changes to the IRF QRP.

Proposed FY 2023 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 recommendation that indicated that, after reviewing many factors—including indicators of beneficiary access to inpatient rehabilitation services, the supply of providers, and aggregate IRF Medicare margins (which have been above 13 percent since 2015)—the Commission determined that Medicare's current payment rates for IRFs appear to be more than adequate. We therefore recommended in March of this year that the Congress reduce the IRF

payment rate by 5 percent for FY 2023.¹ In making this recommendation, we were cognizant of recent public health emergency (PHE)–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 2023. To the extent that PHE-related costs do continue, any additional financial support should be targeted to providers that are essential for ensuring beneficiary access to the level of care IRFs provide.

Proposed cap on wage index decreases

For FY 2023 and subsequent years, CMS proposes applying a 5 percent cap on any decrease to an IRF provider’s wage index from its wage index in the prior year, regardless of the reason for the decrease. CMS contends that applying a 5 percent cap will help mitigate instability in IRF PPS payments from year to year. New IRFs would be paid the wage index for the area in which they are geographically located for their first full or partial fiscal year, with no cap applied.

Comment

The Commission supports the proposed 5 percent cap on wage index decreases. However, we contend that the cap should apply not just to wage index decreases but to increases as well, such that no provider would have its wage index value increase or decrease by more than 5 percent in any given year. Consistent with CMS’s proposed approach, implementation of MedPAC’s approach to the revised relative wage index values (where changes are limited to plus or minus 5 percent) should be implemented in a budget-neutral manner.

Solicitation for comments regarding the facility-level adjustment factor methodology

CMS currently adjusts IRF PPS payments to account for facility-level characteristics such as a facility’s percentage of low-income patients, teaching status, and location in a rural area, if applicable. The facility-level adjustments are intended to account for differences in costs attributable to the characteristics of different types of IRF providers. Historically, there have been large fluctuations in the values of these factors from year to year. In response, CMS has implemented several refinements to the methodology used to calculate the adjustment factors, including:

- 1) a 3-year moving average approach to calculate the facility-level adjustment factors, beginning in FY 2010.
- 2) the addition of a variable for a facility’s freestanding or hospital-based status to the facility-level adjustment regression analysis to control for differences in cost structure between hospital-based and freestanding IRFs, beginning in FY 2014. CMS added this variable so that these differences would not inappropriately influence the adjustment factor estimates.
- 3) freezing the facility-level adjustment factors for FY 2015 and all subsequent years at the FY 2014 levels.

¹ Medicare Payment Advisory Commission. 2022. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

Given the relatively large fluctuation in these factors and, in particular, the magnitude of the changes in the teaching and rural adjustments over the years, CMS is soliciting comments from stakeholders on the methodology used to determine the facility-level adjustment factors and suggestions for possible updates and further refinements to this methodology.

Comment

The Commission is concerned about the year-to-year volatility in the facility-level adjustments and therefore supports additional research on the facility-level adjustment factors to determine the cause of the volatility and to evaluate the accuracy and reliability of the adjustments. The accuracy of each adjustment is important, especially since these adjustments are implemented in a budget-neutral manner, which shifts payments across different IRF provider types. There are a range of items to consider and options that CMS could pursue to refine the methodology for each adjustment. Given the relatively large fluctuation in the teaching adjustment and rural adjustment estimates over the years, we focus our comments on these two adjustments.

IRF teaching adjustment: It is surprising that the additional patient care costs associated with IRFs' teaching programs appear to fluctuate substantially year over year. We highlight the approximately 95 percent increase in the teaching adjustment factor from FY 2014 (1.0163) to FY 2015 (1.9791), as cited in the proposed rule. The volatility in the teaching adjustment suggests that it may be measuring something other than the additional patient care costs associated with a teaching program. The instability of the adjustment raises questions about whether outliers, methodological issues, or data quality issues could be biasing the adjustment.

Rural adjustment: We encourage CMS's further investigation into the rural adjustment and support refinement to the methodology used to determine the accuracy of the adjustment.

On average, rural IRFs tend to have fewer cases, longer lengths of stay, and higher average cost per case. The differences in cost per case become even more evident when cost per IRF discharge is standardized for wage index, case-mix index, and outliers.² For example, when we analyzed data for FY 2020, we found that standardized costs were about 15 percent higher for rural IRFs compared to urban IRFs. However, it is important to note that about 90 percent of rural IRFs are hospital-based providers that also tend to have higher costs and fewer cases compared to freestanding IRF providers. Due to this sizeable overlap between rural-based and hospital-based providers and the large volatility in the calculated year-to-year rural adjustment, we urge CMS to conduct analyses on whether the rural adjustment is truly reflecting the additional costs faced by IRFs located in rural settings in order to ensure that these costs are not more appropriately captured by other factors.

Generally, the Commission has been concerned that the rural adjustments in many of Medicare's payment systems are not well targeted, and this concern applies to the rural adjustment under the IRF PPS as well. The Commission contends that additional payments for rural providers should be

² Medicare Payment Advisory Commission. 2021. *A data book: Health care spending and the Medicare program*. Section 8: Post-acute care. Washington, DC: MedPAC.

directed to those that are necessary for access to care. Rural status is currently defined as areas outside of the core-based statistical areas. This definition can include areas with a single provider that is essential to access, but it can also include relatively suburban areas with multiple competing providers. The Commission encourages CMS to consider a more targeted rural payment adjustment policy such as the home health rural payment add-on policy implemented between calendar years 2019 and 2022.³ Specifically, this policy established three categories of rural counties and ties the duration and size of the payment add-on for each category to the population density and utilization levels of rural counties. Payments are then targeted to areas with lower population density and limits payments to rural areas with higher utilization. This policy is consistent with the principles for rationalizing special payments to rural providers that we laid out in our June 2012 report to the Congress—that Medicare should target payment adjustments to isolated areas that may have access challenges.⁴

Solicitation for comments regarding the IRF transfer payment policy

Under the IRF transfer payment policy implemented in January 2002, CMS pays IRFs based on a per diem amount for each case-mix group (CMG) when a discharge occurs earlier than the average length of stay for the CMG. In the absence of this policy, an IRF would receive the full CMG payment rate for patients that are discharged early. When this policy was implemented, early discharges to home health (HH) were excluded from the transfer policy because the HH PPS had just been developed and HH claims were not available for CMS to analyze. As a result, IRFs continue to receive the full CMG payment rate even when patients are discharged early to HH care. CMS now states that the HH PPS is well established with an adequate supply of claims data, and the agency does not think the same analytical challenges would present as issues. CMS also cites a recent Office of Inspector General (OIG) report, which found that Medicare could realize significant savings by expanding its IRF transfer payment policy to include early discharges to HH.⁵ Given the availability of HH claims data and the findings of the recent OIG report, CMS plans to analyze HH claims data to determine if including HH in the IRF transfer payment policy is appropriate and is soliciting comments regarding the IRF transfer payment policy.

Comment

The Commission supports further consideration of including HH in the IRF transfer payment policy. When IRFs discharge patients to another care setting, some of the care furnished in the other setting may substitute for services that otherwise would have been provided during the IRF

³ Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2018. Medicare and Medicaid Programs; CY 2019 Home Health Prospective Payment System Rate Update and CY 2020 Case-Mix Adjustment Methodology Refinements; Home Health Value-Based Purchasing Model; Home Health Quality Reporting Requirements; Home Infusion Therapy Requirements; and Training Requirements for Surveyors of National Accrediting Organizations. Final rule. *Federal Register* 83, no.219 (November 13): 56406–56638.

⁴ Medicare Payment Advisory Commission. 2012. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

⁵ Office of Inspector General, Department of Health and Human Services. 2021. *Early discharges from inpatient rehabilitation facilities to home health services*. Report no. A-01-20-00501. Washington, DC: OIG.

stay; thus, the IRF may be furnishing a product that does not include the full course of care implied by the CMG payment. When this happens, Medicare may be paying twice for the same services. We therefore encourage CMS's further investigation into the issue and support the agency's initial plan to analyze HH claims to determine the appropriateness of including HH in the IRF transfer payment policy.

The goal of Medicare payment policy is to ensure that beneficiaries have access to high-quality services while encouraging efficient use of resources. An expanded transfer policy could accomplish this goal by eliminating full payments for IRF discharges to HH that occurred earlier than the average length of stay for the respective CMG, thereby diminishing the influence of financial considerations on IRFs' clinical decision-making. An expanded transfer policy would also target payment reductions to providers with short stays, recognizing that some IRFs—such as those that have financial relationships with HH care providers—may have an increased incentive to discharge patients early to HH care.

Overarching principles for measuring equity and health care quality disparities across CMS quality programs

CMS is working to advance health equity by designing and implementing policies and programs that support health for all beneficiaries. Accounting for health care disparities in quality measures is a cornerstone of their approach to advancing health care equity. CMS has proposed quality measure stratification (measuring performance differences among subgroups of beneficiaries) as a tool to address health care disparities and advance health equity. In this proposed rule, CMS is requesting information on principles and approaches that could be used in the IRF Quality Reporting Program (QRP) and other quality programs to stratify measure results.

Approaches for measures stratification

CMS identifies two approaches for reporting stratified measures: 1) “within-provider disparity method,” which would compare measure performance results for a single measure between subgroups of patients with and without a given factor (e.g., dual-eligible beneficiaries and others), and 2) “between-provider disparity methodology,” which would report performance on measures for only the subgroup of patients with a particular social risk factor, allowing providers to compare their performance for the subgroup to state and national benchmarks.

Prioritizing measures for disparity reporting

CMS proposes a set of principles to prioritize measures for disparity reporting in quality reporting programs. These principles include prioritizing measures that: 1) meet industry standards for measure reliability and validity, 2) have evidence that the outcome being measured is affected by underlying health care disparities, 3) meet statistical reliability and representation standards, and 4) show differences in performance across subgroups.

Selecting social risk factors to use in stratification

Social risk factors are the wide array of non-clinical drivers of health known to negatively impact patient outcomes. These include factors such as socioeconomic status, housing availability, and nutrition (among others). CMS recognizes the limited availability of social risk data to use in stratification as a challenge. The agency names different sources of data that can be used to identify social risk, including patient-reported data, CMS administrative claims, area-based indicators of social risk, and imputed data sources.

Identifying meaningful performance differences

CMS proposes different approaches to identify differences in performance for stratified results. One potential approach is ordering health care providers in a ranked system based on their performance on disparity measures to quickly allow comparison of performance with that of similar health care providers. Another potential approach is benchmarking or comparing individual results to state or national averages.

Reporting disparity measures

CMS discusses different approaches by which stratified measure results can be reported. The agency cites that confidential reporting, or reporting results privately to health care providers, is generally used for new programs or new measures to give providers an opportunity to become more familiar with calculation methods and to improve before wider reporting is implemented. Measure results can also be publicly reported to provide all stakeholders with important information on provider quality. Public reporting also relies on market forces to incentivize providers to improve and become more competitive in their markets without directly influencing payment from Medicare.

Comment

The Commission supports CMS's overall efforts to measure and report health care disparities by stratifying quality measure results for different subgroups of beneficiaries. The Commission recognizes that optimal health outcomes can be adversely affected by social risk factors. MedPAC has traditionally focused on modifying payment systems to incentivize health care providers and payers (e.g., Medicare Advantage plans) to deliver high-quality care in the most efficient manner. While strong incentives for achieving value-based care objectives are critical, it is also important to apply such incentives fairly—that is, to recognize when these incentives can undermine access to care for beneficiaries. The Commission's recent work to account for differences in patients' social risk factors in quality payment programs and revisit payment for safety-net providers aims to improve incentives to deliver high-quality and efficient care. In the past we have highlighted some disparities in care when we have identified them in our payment adequacy analysis. Moving forward, the Commission plans to more deliberately incorporate analysis by social risk factors, in particular income and race/ethnicity, into our payment adequacy and other analyses.

Over the past several years, the Commission has recommended redesigned value incentive programs that incorporate peer grouping for hospitals, Medicare Advantage plans, and skilled nursing facilities.⁶ Rather than adjusting performance measures for patients' social risk factors, which can mask disparities in performance, these programs would make adjustments to payments based on a provider's performance compared with its peers. With peer grouping, each provider's performance is compared with providers with similar mixes of patients (that is, its "peers") to determine rewards or penalties based on performance. A provider would earn points based on its performance relative to national performance scales, but how those points are converted to incentive payments would vary by peer group, with larger multipliers (i.e., the payment adjustment per point) for peer groups with higher shares of beneficiaries at high social risk.

Selecting social risk factors to use in stratification

In our modeling of value incentive programs, we concluded that there is a need for better measures of patient social risk than are currently available.⁷ The National Academies of Sciences, Engineering, and Medicine (NASEM) outlined considerations to determine whether a social risk factor (measure) should be accounted for in a Medicare quality payment program.⁸ The social risk factor should have a *conceptual* relationship with the outcome of interest (that is, there should be a reasonable hypothesis positing how the social risk factors could affect a Medicare beneficiary's health outcome) and *empirical* association with outcome measures (that is, there should be verifiable evidence of an association between the social risk factor and the outcome of interest).

Medicare beneficiaries who are disabled or low income are eligible to concurrently enroll in Medicaid. In our various value incentive program models, we tested a share of a provider's patients who were fully dual eligible for Medicare and Medicaid as a measure of social risk because there is a conceptual relationship between dual eligibility and our outcomes of interest. There is a clear and established relationship between poverty, socioeconomic status, and health outcomes—including increased risk for disease and premature death.

Although there are many reasons to use dual eligibility as a proxy for beneficiary social risk, we recognize it is an imperfect measure. One drawback is that Medicaid eligibility requirements and benefits vary across states. Also, dual eligibility may be too narrow because it reflects a

⁶ Medicare Payment Advisory Commission. 2021. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2020. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2019. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

⁷ Medicare Payment Advisory Commission. 2022. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

⁸ National Academies of Sciences, Engineering, and Medicine. 2016. *Accounting for social risk factors in Medicare payment: Identifying social risk factors*. Washington, DC: The National Academies Press.

beneficiary's income but does not directly reflect other social risks, like food insecurity and limited access to transportation.

In the Commission's recent work to identify safety-net hospitals, we expanded our definition of "low-income" as a proxy for beneficiary social risk.⁹ In this work, we defined "low-income" beneficiaries as those who are eligible for full or partial Medicaid benefits or receive the Part D low-income subsidy (LIS). This expanded definition includes beneficiaries who do not qualify for Medicaid benefits in their states but who do qualify for the LIS based on having limited assets and an income below 150 percent of the federal poverty level. Collectively, we referred to this population as "LIS beneficiaries" because those who receive full or partial Medicaid benefits automatically receive the LIS. Compared to the non-LIS Medicare population, LIS beneficiaries have relatively low incomes and differ in other regards, including being twice as likely to be Black and three times as likely to be disabled. In addition, expanding the definition of "low-income" to include all LIS beneficiaries helped to reduce the impact of variation in state Medicaid policies. The Commission intends to continue to explore improvements to our definition of "low-income" as a proxy for beneficiary social risk.

The Commission also recognizes that another approach to capture beneficiary social risk would be to use area-level measures of social risk.¹⁰ We encourage CMS to test various area-level measures for their potential to account for differences accurately across providers in the social risk of their patient populations. More research is needed to understand the accuracy of any area-level measure for Medicare beneficiaries compared with the gold standard of person-reported information.

Identifying meaningful performance differences

The Commission encourages CMS to report stratified quality measure results that are reliable, meaning that they reflect true differences in performance and not be attributable to random variation. Key decisions for CMS include defining the reliability standard for measure results and selecting the strategies to ensure reliable measure results for as many providers as possible.

A high reliability standard should be used to determine the minimum number of observations required for a provider's performance to be stratified and reported. For providers with low patient volume, establishing reliable measure results is problematic because they do not have enough observations to ensure that the measure detects signal (actual performance) rather than noise (random variation). Unreliable measure results can lead to erroneous conclusions about a provider's performance; a low-volume provider can appear to have unusually good or poor performance when in fact its performance is not statistically different from the average.¹¹ In our

⁹ Medicare Payment Advisory Commission. 2022. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC. (To be published June 2022)

¹⁰ Medicare Payment Advisory Commission. 2022. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

¹¹ Garrett, B., C. Carter, and D. Wissoker. 2021. Evaluation of the reliability of Medicare spending per beneficiary for post-acute care. *Medical Care* 59, no. 8 (August 1): 721–726.

illustrative modeling of a value incentive program for skilled nursing facilities, we used a reliability standard of 0.7, meaning that 70 percent of the variance in a measure's results was attributable to actual performance differences and that providers can be differentiated.¹²

Setting a minimum case count to ensure reliability inevitably means excluding some providers from the quality measurement program. One way to include as many providers as possible is to pool data across years, allowing a performance measure to be calculated for many small providers that would otherwise be excluded. Such pooling is consistent with other quality payment program designs and measures. For example, Medicare's Hospital Readmissions Reduction Program uses three years of performance data to calculate readmission results. Blending performance across years also encourages sustained high quality. However, pooling data across years could dampen a provider's drive to improve if their recent better results are blended with older, poorer performance. In such a case, the provider's improved performance would not be fully recognized in its payment incentive payment for several years. To counter this disincentive, CMS could consider weighting the more recent years more heavily. CMS could also pool data across years only for low-volume providers, while reporting just the most recent year's performance for providers that meet a minimum count in a single year.

Reporting disparity measures

The Commission supports moving to publicly reporting stratified measure results. Publicly reporting Medicare quality information has two main objectives. The first is to increase the accountability of health care providers by offering patients, payers, and purchasers a more informed basis on which to hold providers accountable (e.g., directly through purchasing and treatment decisions). The second objective is to maintain standards and stimulate improvements in the quality of care through economic competition (reputation and increased market share) and by appeals to health care professionals' desire to do a good job.¹³ The Commission also contends that public reporting should enable comparisons of individual providers with state and national averages to give consumers meaningful reference points.

Expanding IRF QRP 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 beginning in FY 2025. 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. Since it has long been common practice for providers to collect IRF-PAI data on all patients,

¹² Medicare Payment Advisory Commission. 2021. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

¹³ Marshall, M. N., P. G. Shekelle, H. T. Davies, et al. 2003. Public reporting on quality in the United States and the United Kingdom. *Health Affairs* 22, no. 3 (May–June): 134–148.

Chiquita Brooks-LaSure

Administrator

Page 10

expanding IRF quality measures to include all patients should 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 advise CMS that any future payment adjustments related to performance should be based only on outcomes for Medicare beneficiaries.

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

Sincerely,

A handwritten signature in black ink, appearing to read "m. chernew", with a long horizontal line extending to the right from the end of the signature.

Michael E. Chernew, Ph.D.
Chairman

MC/JMT