Medicare Payment Advisory Commission

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June 1, 2023

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-1781-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 2024 and Updates to the IRF Quality Reporting Program (QRP); Proposed Rule," *Federal Register* 88, no. 67, 20950–21014 (April 7, 2023). 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 for fiscal year (FY) 2024, as well as the wage index adjustment and the proposal to adopt the discharge function score measure in FY 2025.

Proposed FY 2024 update to the Medicare payment rate for IRFs

CMS proposes a 3.0 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 0.2 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 2023 recommendation to reduce the IRF payment rate by 3 percent for FY

2024.[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 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 2024.

Wage index adjustment

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 2024, CMS proposes to continue to use the unadjusted inpatient prospective payment systems wage index (referred to as the "pre-floor, pre-reclassification hospital inpatient wage index").

Comment

The Commission has long been concerned with flaws in the wage indexes Medicare uses to adjust provider payments to reflect geographic differences in labor costs.[2] To improve the accuracy and equity of Medicare's wage index systems for inpatient prospective payment system 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 forthcoming June 2023 report to the Congress, we recommend that the Congress repeal the existing Medicare wage index statues, including current exceptions, and require the Secretary to phase in new Medicare 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.

Section 1886(j)(6) of the Social Security Act requires the Secretary to adjust the proportion of IRFs' costs attributable to wages and wage-related costs by a factor reflecting the relative wage level in the geographic area of the IRF but does not specify the wage index to be used.[3] We

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[1] Medicare Payment Advisory Commission. 2023. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
[2] Medicare Payment Advisory Commission. 2007. *Report to the Congress: Promoting greater efficiency in Medicare.* Washington, DC: MedPAC
[3] Social Security Administration. Payment to hospitals for inpatient hospital services. https://www.ssa.gov/OP_Home/ssact/title18/1886.htm.

therefore urge the Secretary to adopt the Commission's recommended approach to wage-adjust payments under the IRF PPS.

Adoption of discharge function score measure beginning with the FY 2025 IRF QRP

CMS proposes to remove three function-related measures from the IRF QRP beginning in FY 2025. The first is a topped-out process measure about the application of a functional assessment and care plan. The second and third measures (change in self-care score and change in mobility score) are IRF specific and not specified across PAC settings. CMS proposes to add a cross-setting Discharge Function Score (DC Function) measure to the IRF QRP beginning in FY 2025. This outcome measure evaluates functional status by calculating the percentage of IRF patients who meet or exceed an expected discharge function score (for self-care and mobility activities) using the standardized patient assessment data from the IRF Patient Assessment Instrument (IRF–PAI).

The method to calculate the proposed DC Function Score measure uses an imputation approach to account for functional item responses that were coded as “activity not attempted” (ANA). Specifically, the proposed method uses a statistical imputation approach that recodes missing functional data to the most likely value had the status been assessed, rather than the lowest or near-lowest level of function.

Comment

Function is a key outcome for patients receiving post-acute care. It is a particularly important component in evaluating the quality of IRF care because, for IRF patients, the overall goal of inpatient rehabilitation is to maintain or improve function. However, we advise caution in the use of provider-reported patient function measures, such as the Discharge Function Score measure. As we discussed in our June 2019 report to the Congress, the inconsistency of PAC providers’ recording of functional assessment information, such as change in mobility, raises concerns about using such information for purposes of public reporting or payment.[4] In that report, the Commission noted that differential coding practices across different types of IRFs and differences in profitability by case type may contribute to variation in provider profitability. In addition, in our March 2023 report to the Congress, we noted that the current imputation method recodes any ANA code to the most dependent level (or second most dependent level) which, all else equal, would lead to a lower motor score and raise Medicare payment for the stay.[5] To the extent that some providers code patient function in response to payment incentives, it is possible that some of these practices will be manifested in functional improvement data submitted through the IRF QRP, even if there are no payment implications immediately at hand. Because maintaining and improving these outcomes are critically important to patients, we encourage CMS to seek ways to improve the reporting of assessment data.

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[4] Medicare Payment Advisory Commission. 2019. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.
[5] Medicare Payment Advisory Commission. 2023. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

That said, the Commission supports CMS's proposal to improve the quality of IRF–PAI data by using statistical imputation to recode missing functional status data to the most likely value had the status been assessed, but we also suggest that the agency provide clarity on its methodology. We note that, in its unified PAC PPS prototype design for CMS/Office of the Assistant Secretary for Planning and Evaluation, RTI International used a Rasch analysis to recode ANA codes to create a motor function score for PAC users.[6] We encourage CMS to more clearly explain its proposed approach to recoding, contrasting it with that used in the PAC PPS prototype, to ensure transparency, clarity, and clinical meaningfulness.

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,

Michael E. Chernew, Ph.D.
Chair

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[6] RTI International. 2022. *Report to Congress: Unified payment for Medicare-covered post-acute care.* Report prepared for the Centers for Medicare & Medicaid Services. Research Triangle Park, NC: RTI International. https://www.cms.gov/files/document/unified-pac-report-congress-july-2022.pdf.