MEDPAC | Medicare Payment Advisory Commission

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June 9, 2025

Mehmet Oz, M.B.A., M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Attention: CMS-1829-P

Dear Dr. Oz:

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) 2026 and Updates to the IRF Quality Reporting Program (QRP); Proposed Rule," *Federal Register* 90, no. 82, pp. 18534–18565 (April 30, 2025). 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 and the method used to update the case-mix-group relative weights.

Proposed FY 2026 update to the Medicare payment rate for IRFs

CMS proposes a 2.6 percent increase to the IRF payment rate, reflecting the applicable market basket increase (currently projected to be 3.4 percent) decreased by an estimated productivity adjustment of 0.8 percentage points, as required by statute.

Comment

The Commission understands that the Secretary is required to update the IRF PPS rates by the market basket minus a productivity adjustment. We appreciate that CMS cited our March 2025 recommendation to reduce the IRF payment rate by 7 percent for FY 2026.[1] The Commission 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

[1] Medicare Payment Advisory Commission. 2025. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.

2015). Based on that review, the Commission concluded that Medicare's current payment rates for IRFs are more than adequate.

Proposed FY 2026 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]

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 in IRF profitability across cases. The average-cost method would better align payments to the costs of providing IRF care and would help to reduce the financial incentives to admit patients assigned to higher-weighted CMGs over those assigned to lower-weighted CMGs under the current HSRV method.

The Commission urges CMS to re-examine the current HSRV method used to assign payment weights and consider replacing it with the average-cost weighting method.

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

Making such a change would pose no additional administrative burden on providers. In our analysis, assuming budget neutrality and no behavioral changes, 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.

Conclusion

MedPAC appreciates your consideration of these issues. The Commission values the ongoing collaboration between CMS and MedPAC staff on Medicare policy, and we look forward to continuing this relationship. If you have any questions regarding our comments, please do not hesitate to contact Paul B. Masi, MedPAC's Executive Director, at 202-220-3700.

Sincerely,

Michael E. Chernew, Ph.D.
Chair