MEDPAC | Medicare Payment Advisory Commission

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April 30, 2026

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

Attention: CMS-1845-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) 2027 and Updates to the IRF Quality Reporting Program (QRP); Proposed Rule," *Federal Register* 91, no. 65, pp. 17195–17230 (April 6, 2026). 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 requests for information about changes in source of data for the wage index and the potential options to modernize the IRF payment system.

Construction of an IRF-specific wage index

For FY 2027, CMS proposes to continue to use the unadjusted inpatient prospective payment systems (IPPS) wage index (referred to as the "pre-floor, pre-reclassification hospital inpatient wage index").

The proposed rule also solicits comments on whether CMS should consider using alternative data sources to construct an IRF-specific wage index for potential use in future years, citing MedPAC's 2023 recommendation for the Secretary to phase in new Medicare wage index systems. CMS seeks feedback to better understand the potential advantages and limitations of using alternative data sources, such as Bureau of Labor Statistics (BLS) data and IRF cost reports, as well as other methodologies that stakeholders believe could appropriately reflect the geographic variation in labor costs for IRFs.

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.[1] To improve the accuracy and equity of Medicare's wage index systems for IPPS hospitals and other providers (such as, but not limited to, IRFs), Medicare needs wage indexes that are less manipulable, more accurately 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 within a given market. In the Commission's June 2023 report to the Congress, we recommended that the Congress repeal the existing Medicare wage index statutes, including current exceptions, and require the Secretary to phase in a new Medicare wage index system for hospitals and other types of providers that:

- Uses all-employer, occupation-level wage data with different occupation weights for the wage index of each provider type;
- Reflects local area level differences in wages between and within metropolitan statistical areas and statewide rural areas; and
- Smooths wage index differences across adjacent local areas.[2]

The Commission supports CMS's initial steps toward constructing an IRF-specific wage index for potential use in future years. The use of BLS Occupational Employment and Wage Statistics (OEWS) data for core-based statistical area (CBSA)– and occupation-level wage estimates has numerous advantages: This data source is publicly available, recent, and includes all-employer mean wage data. These features would reduce CMS administrative burden, reflect more recent data than the current cost report data that is the basis of the unadjusted hospital wage index, acknowledge that employers in a market compete for similar types of workers, and decrease current circularity that causes deviation between the labor costs reported by hospitals and broader labor market wages. For IRF-specific occupation weights, either sector-specific cost reports (or surveys) or industry-specific BLS data would be reasonable and involve trade-offs between accuracy, completeness, and administrative burden. For IRFs, hospital cost reports do not currently include occupation-level wages (or full-time equivalents), but could be modified to do so, or CMS could conduct an episodic occupational mix survey (as is currently done for IPPS hospitals). Alternatively, industry-level BLS data could be used as a proxy for each sector. While the occupational mix at IRFs may differ from the closest existing North American Industry Classification System category, we continue to believe that using these data to calculate occupation weights and then applying these weights to all-employer occupation-level relative wages would yield a better approximation of IRFs' variation in labor costs across markets than the current approach of using aggregate wage data from hospital cost reports.

Regardless of the alternative wage index data sources used, we urge CMS also to consider the two other parts of our June 2023 wage index recommendation: to account for

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[1]Medicare Payment Advisory Commission. 2007. *Report to the Congress: Promoting greater efficiency in Medicare.* Washington, DC: MedPAC.
[2] Medicare Payment Advisory Commission. 2023. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

differences in wages within metropolitan statistical areas (for example, by using data from the Census Bureau's American Community Survey), and to smooth wage index differences across adjacent local areas (such as county lines). We also encourage the agency to estimate the magnitude of changes under an improved wage index and contemplate phasing in larger changes over a period of time.

Request for information regarding future IRF payment reform

Given changes in patient complexity and advances in rehabilitation care that have occurred since the IRF PPS was implemented in 2002, CMS is exploring opportunities to modernize the IRF payment system. CMS worked with a contractor to identify refinements that could better align payment with patient characteristics and resource use, strengthen the relationship between spending and value, and support CMS's broader goal of a more consistent and coordinated approach to post-acute care (PAC) payment and delivery.

CMS seeks comment on changes to IRF patient clinical classification, among other refinements. Since its implementation, the IRF PPS has relied on 17 major impairment group codes (IGCs), comprising 85 specific IGCs, to classify each IRF patient into one of 21 distinct Rehabilitation Impairment Categories (RICs). Under this framework, up to three International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) etiologic diagnosis codes are mapped through a multi-step process—from IGCs to RICs to the case-mix groups (CMGs) on which payment is determined. CMS states that, over time, the primary reason for IRF admission, the clinical care delivered, and the resulting payment have become misaligned, possibly due to changes in diagnostic coding practices and patient complexity. To address this misalignment, CMS is considering using the clinical categories recently implemented under the skilled nursing facility (SNF) Patient-Driven Payment Model (PDPM) to develop a new set of IRF-specific clinical categories. The current mapping of etiologic diagnoses to IGCs and RICs would then be replaced with a crosswalk from ICD-10-CM diagnosis codes directly to IRF PPS clinical categories. CMS's contractor report implied that age and motor scores would also be incorporated but did not specify how they would be defined or incorporated.

Comment

We appreciate that CMS referenced the Commission's work identifying persistent differences in profitability across IRF RICs, which could incentivize admission of certain types of patients over others as a motivation to pursue payment system improvements, and we support CMS's ongoing monitoring and improvements to the IRF PPS to better align payments with the costs of providing care.[3] We offer some comments on the material provided in the proposed rule and in an online technical report for CMS to consider as it moves forward with efforts to refine and improve the IRF PPS.

[3] Medicare Payment Advisory Commission. 2023. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC. Medicare Payment Advisory Commission. 2024. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.

Refinements to IRF patient clinical classification

In the technical report, CMS's contractor relies heavily on the SNF PDPM to construct clinical categories for classifying IRF stays. Although the Commission has found some overlap in the types of patients treated in SNFs and IRFs, prior work also shows meaningful differences in patient mix across the two settings, with many patients more appropriately treated in one setting than the other.[4] We therefore encourage CMS to ensure that clinical categories adapted from the SNF setting are appropriate for accurately classifying IRF patients. For example, CMS could examine the cost per stay distribution of IRF stays by clinical categories to better understand the variation for stays within the same category.

To determine the primary diagnosis for the IRF stay, CMS's contractor uses the principal diagnosis from the prior acute hospital stay when there is one (88 percent of IRF stays). However, it is not clear how closely these diagnoses align and whether this method would appropriately capture the reason for IRF admission. For example, differences between the two diagnosis codes may arise if a patient's condition evolves during the acute hospital stay, leading to a change in the most clinically relevant diagnosis at the time of IRF admission. To assess the validity of the contractor's approach, CMS should compare the principal diagnosis from the prior hospitalization with the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF–PAI) etiologic diagnosis for stays in which both codes are available. CMS should examine, with clinical input, how frequently changes in diagnosis occur and under what circumstances. In addition, CMS should assess whether IRF patients differ systematically based on whether they were admitted from an acute hospital or the community—examining differences in costs, diagnoses, and other patient and stay characteristics.

The contractor's report indicates that age and motor score bins will be components of the payment groups, but it does not describe how these bins will be constructed. Regarding patient motor scores, the Commission recognizes that patient function is an important determinant of resource use in post-acute care. However, our prior work suggests that consistent reporting of functional status across patients and providers may be challenging because providers have incentives to code functional status in ways that increase payment. In considering reforms to the IRF PPS, CMS should contemplate strategies to improve coding of patients' functional status, such as enhanced monitoring and auditing, requiring hospital discharge assessments, and gathering and incorporating patient-reported outcomes. The Commission discussed these strategies in our June 2019 report to the Congress.[5]

Other considerations

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

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[4] Medicare Payment Advisory Commission. 2026. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.
[5] Medicare Payment Advisory Commission. 2019. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

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 implemented refinements over the years in the methodology used to calculate the facility-level adjustment factors and, in the final rule for FY 2015, the agency froze the factors for that year and all subsequent years at the FY 2014 levels.

In the proposed rule for FY 2023, CMS solicited comments on possible updates and refinements to its facility-level adjustment methodology. In our comment letter on the FY 2023 proposed rule, we expressed particular concern about the year-to-year volatility in the teaching adjustment and rural adjustment.[6] Regarding the teaching adjustment, we noted that it was surprising that additional patient care costs associated with an IRF's teaching program would fluctuate so much and suggested that the instability raised questions about whether outliers, methodological issues, or data quality issues could be biasing the adjustment. Regarding the rural adjustment, we agreed that rural IRFs tended to have fewer cases, longer lengths of stay, and higher average costs per case than urban IRFs. However, we noted that most rural IRFs are hospital-based providers, which have fewer cases and higher costs relative to freestanding IRFs. We urged CMS to conduct analyses on whether the rural adjustment truly reflects the additional costs faced by IRFs in isolated locations. We also pointed out that the Commission generally is concerned that rural adjustments in many of Medicare's fee-for-service payment systems are not well targeted. As we discussed in our report on a unified PAC PPS, in the absence of other extenuating circumstances the Medicare program should not correct for the inefficiencies of low-volume providers or the higher costs of hospital-based providers. Instead, a rural adjustment should be targeted to providers that are isolated and necessary to ensure beneficiary access to care in addition to having consistently low volume.[7]

Therefore, we encourage CMS to reexamine the current facility adjustments for rural location, shares of low-income patients, and teaching to assess whether they are still appropriate.

We also urge CMS to consider alternate methods for constructing payment weights as refinements to the IRF PPS proceed. Specifically, the Commission has shown that using an average cost payment weight methodology could help to mitigate the differences in profitability by case-mix group that currently exists in the IRF PPS.[8]

Lastly, we note that the Commission recommended reducing the IRF payment rate by 7 percent for FY 2027 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 suggests that Medicare's current payment rates for IRFs are more than

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[6] Medicare Payment Advisory Commission. 2022. MedPAC letter commenting on 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." April 6. (https://www.medpac.gov/wp-content/uploads/2022/05/05272022_FY2023_IRF_MedPAC_COMMENT_SEC.pdf.)
[7] Medicare Payment Advisory Commission. 2023. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.
[8] Medicare Payment Advisory Commission. 2024. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

adequate.[9] We encourage CMS to be mindful of the overall level of payments in the IRF PPS as it considers implementing refinements.

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

[9] Medicare Payment Advisory Commission. 2026. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.