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June 14, 2019

Seema Verma, MPH  
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-1710-P**

Dear Ms. Verma:

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 (IRF) Prospective Payment System for Federal Fiscal Year 2020 and Updates to the IRF Quality Reporting Program; Proposed Rule,” *Federal Register* 84, no. 79, 17244–17335 (April 24, 2019). 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.

This rule proposes a payment update and other revisions to Medicare payment policies for IRFs in fiscal year (FY) 2020 and proposes refinements to the case-mix classification system. The rule also proposes revisions and updates to the IRF quality reporting program (QRP).

**Proposed FY 2020 update to the Medicare payment rate for IRFs**

CMS proposes a 2.5 percent increase to the IRF payment rate. CMS obtained this result by following the statutory formula of starting with the applicable market basket increase (estimated to be 3.0 percent) and subtracting a productivity estimate of 0.5 percentage points, as required by the Patient Protection and Affordable Care Act (PPACA) of 2010. CMS also proposes an increase to the high-cost outlier threshold amount to maintain estimated outlier payments at 3 percent of total estimated aggregate IRF payments for FY 2020.

*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 aggregate IRF Medicare margins, which have been above 11 percent since 2012—the Commission determined that Medicare’s current payment rates for IRFs appear to be more than adequate and therefore recommended that the Congress reduce the IRF payment rate by 5 percent for FY 2020. We appreciate that CMS cited our recommendation, even while noting that the Secretary does not have the authority to deviate from statutorily mandated updates.

### **IRF wage index**

Historically, CMS has calculated the IRF wage index values using unadjusted wage index values (pre-reclassification, unadjusted for occupational mix and the rural floor) from acute care hospitals. In response to stakeholder comments on certain aspects of the wage index values and their impact on payments, the FY 2020 proposed rule requested feedback regarding the wage index used to adjust IRF payments and suggestions for possible updates and improvements to the geographic adjustment of IRF payments.

#### *Comment*

In response to this request for comments, the Commission reiterates our recommendations on wage index reform included in our 2007 report to the Congress.<sup>1</sup> We recommended that the Congress repeal the existing hospital wage index and instead implement a market-level wage index for use across other prospective payment systems, including certain post-acute care providers. Specifically, our recommended wage index would:

- use wage index data from all employers and industry-specific occupational weights,
- adjust for geographical differences in the ratio of benefits to wages,
- adjust at the county level and smooth large differences between counties, and
- include a transition period to mitigate large changes in wage index values.

Two significant research evaluations commissioned by the Secretary concluded that MedPAC’s proposed wage index would be an improvement over Medicare’s current hospital wage index.<sup>2,3</sup> Compared with the current wage index, the Commission’s proposed wage index would more fully reflect input prices, automatically adjust for occupational mix, reduce circularity, and reduce large differences between adjoining areas.

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<sup>1</sup> Medicare Payment Advisory Commission. 2007. *Report to the Congress: Promoting greater efficiency in Medicare*. Washington, DC: MedPAC.

<sup>2</sup> Institute of Medicine. 2011. *Geographic adjustment in Medicare payment, phase I: Improving accuracy. Second edition*. Washington, DC: The National Academies Press.

<sup>3</sup> MaCurdy, T, T. DeLeire, K. Lopez de Nava. et al. 2009. Revision of Medicare Wage Index. Final Report, Part I; and MaCurdy, T, T. DeLeire, K. Lopez de Nava. et al. 2010. Revision of Medicare Wage Index. Final Report, Part II. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files-Items/CMS1237065.html>

### **Proposed revisions to the case-mix groups (CMGs) and proposed updates to the CMG relative weights and average length of stay values beginning with FY 2020**

Under current law, the Secretary can require IRFs to submit such data as he deems necessary to establish and administer the IRF prospective payment system (PPS). Under the IRF PPS, for purposes of payment, patients are assigned to rehabilitation impairment categories (RICs) based on the principal diagnosis or primary reason for inpatient rehabilitation. Within each RIC, patients are sorted into case-mix groups (CMGs) based on the level of motor and cognitive function at admission and then further categorized into one of four tiers based on the presence of specific comorbidities that have been found to increase the cost of care. Each CMG and tier has a designated weight that reflects the average costliness of cases in the group compared with that of the average Medicare IRF case.

To determine the appropriate CMG, IRFs assess and score each patient's motor and cognitive function using the IRF–Patient Assessment Instrument (IRF–PAI). Historically, the IRF–PAI has been based on a modified version of the Uniform Data System for Medical Rehabilitation patient assessment instrument, commonly referred to as the FIM™. The IRF–PAI's 18 FIM data elements and associated modifiers, along with the FIM measurement scale, are used to measure a patient's level of disability and the burden of care for a patient's caregivers. (All else equal, greater level of disability generally results in higher payment.)

Beginning in FY 2020, CMS will remove the FIM data elements and associated modifiers from the IRF–PAI and instead measure a patient's level of disability using data items located in the "Quality Indicators" section of the IRF–PAI. These items are very similar to the FIM elements and associated modifiers but are used across PAC settings. The similarity and overlap in the FIM and quality indicator items mean that CMS can replace FIM elements with quality indicator items without materially changing the case-mix classification system. However, because the quality indicator items are defined somewhat differently from the FIM elements and use a different scale of measurement, the incorporation of these items into the case-mix classification system does necessitate some revisions to the CMGs to ensure that IRF payments are calculated accurately. In the FY 2019 final rule, CMS stated that, in future rulemaking, the agency would update the CMG relative weights and average length of stay values associated with these revisions.

CMS contracted with RTI International to develop proposed revisions for FY 2020 based on two years of data (FY 2017 and FY 2018). RTI International replicated the approach used to develop the current IRF classification system, substituting the quality indicator data items for the FIM elements. All other aspects of the classification system remain the same, including the RIC structure, the assignment of comorbidity tiers, and the methodology for calculating the payment weights. The CMG classification system will continue to have 21 RICs (plus two for patients who have very short stays or who die in the IRF). However, the revisions proposed by CMS would increase the number of CMGs from 92 to 97, change the number of CMGs in some RICs, and revise the relative weights of the CMGs and tiers. CMS proposes to implement these revisions in a budget-neutral manner; however, RTI International's analyses suggest that there would be some redistributive effect of payments across providers, resulting in increased aggregate payments for hospital-based and nonprofit IRFs.

*Comment*

The Commission supports these empirically based revisions to the case-mix classification system. Going forward, it will be important for CMS to continually evaluate the accuracy of the CMGs and to revise them as necessary. Ideally, provider-reported patient functional assessment information would increase the accuracy of the CMG-based payments. However, the Commission remains concerned about the integrity of such data. We expect that the scoring of patients' functional status on the quality indicator items will change once the items become a factor in payment. Some providers will quickly respond to the CMG revisions by devoting resources to improving the coding of the quality indicator items, by altering their quality indicator scoring practices, or both. Thus, we continue to caution CMS about the use of provider-reported functional assessment information and urge the agency to carefully evaluate its integrity and its contribution to the accuracy of payment.

**Proposed use of a weighted motor score beginning with FY 2020**

As noted above, the IRF case-mix classification system sorts patients into CMGs based on the level of motor and cognitive function at admission, as measured using FIM items. When the IRF PPS was first implemented, an overall motor score index for each patient was calculated by adding the unweighted scores of individual FIM items. However, beginning in FY 2006, CMS has used a motor score index that weights some FIM items more heavily than others. For example, a patient's ability to transfer from a bed to a chair is weighted more heavily in the current motor index than the patient's ability to bathe themselves.

When CMS finalized the use, beginning in FY 2020, of quality indicator items in place of FIM items, the agency also finalized the incorporation of an unweighted additive motor score derived from the quality indicator items. In the proposed rule for FY 2020, CMS states that the agency did not opt for a weighted motor index because it believed that the unweighted index would be easier for providers to understand. However, in response to comments on the FY 2019 proposed rule, CMS contracted with RTI International to examine the potential impact of weighting the quality indicator items in the motor score index. Based on that analysis, CMS is now proposing to replace the previously finalized unweighted motor score index with a weighted index beginning in FY 2020. Based on RTI's analysis, CMS has proposed a weighted motor score index for FY 2020 that would weight quality indicator items differently from the way similar FIM items are weighted in the weighted motor score index that is currently in use.

*Comment*

The Commission generally supports empirically based revisions to the IRF PPS, including the motor score index. However, as noted above, we expect that the scoring of patients' functional status on the quality indicator elements will change once those elements become a factor in payment. Further, weighting the quality indicator items differently will heighten the importance of some items (such as the patient's ability to feed themselves) over others (such as the patient's ability to transfer from a bed to a chair) in determining payment. It will thus be important for CMS

to monitor changes in scoring over time and to reevaluate and revise the motor score index as new data become available.

### **Form, manner, and timing of data submission under the IRF quality reporting program (QRP)**

CMS proposes to expand the reporting of IRF–PAI data used for the IRF QRP to include data on all patients, regardless of their payer, beginning with patients discharged on or after October 1, 2020, for the FY 2022 IRF QRP and the IRF–PAI V4.0. This proposal would ensure that the IRF QRP makes publicly available information regarding the quality of the services furnished to the entire IRF population, rather than just those patients who have Medicare. CMS sought input on this policy idea in the IRF proposed rule for FY 2018.

#### *Comment*

The Commission supports this proposal. As we noted in our comment letter on the FY 2018 proposed rule, the Commission supports efforts to ensure quality care for all patients, regardless of payer source. However, we caution CMS that any future Medicare payment adjustments related to performance should be based only on outcomes for Medicare beneficiaries.

### **Revisions to the discharge-to-community quality measure**

As part of the IRF QRP, CMS calculates a risk-adjusted rate of fee-for-service beneficiaries discharged to the community from an IRF stay who do not have a subsequent hospital readmission and remain alive during the following 31 days. CMS proposes to exclude patients who were nursing facility residents before an IRF stay from the measure calculation because they are not expected to return to the community following their stay.

#### *Comment*

The Commission maintains that Medicare quality measures should be patient oriented, encourage coordination across providers and time, and promote improvement in the delivery system. Medicare quality programs should include population-based outcome measures that are not unduly burdensome for providers. For example, measures that can be calculated by CMS using claims data represent a low level of provider burden. In principle, therefore, the Commission supports the inclusion of a discharge-to-community measure in the QRP. However, the Commission does not support CMS’s proposal to remove nursing home residents from the measure sample. Rather, the Commission supports expanding the definition of “return to the community” to include nursing home residents returning to their residence—that is, the nursing home where they live. The home of a nursing home resident is the nursing home; thus, a nursing home resident who returns to the nursing home following discharge from an IRF is returning to their community. Further, providers should be held accountable for the quality of care they provide for as much of their Medicare patient population as feasible.

Seema Verma  
Administrator  
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## **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 James E. Mathews, MedPAC's Executive Director, at 202-220-3700.

Sincerely,

A handwritten signature in cursive script that reads "Francis J. Crosson M.D.".

Francis J. Crosson, M.D.  
Chairman

FJC/dkk