



Medicare Payment  
Advisory Commission

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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-1769-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; FY 2023 Inpatient Psychiatric Facilities (IPF) Prospective Payment System (PPS)—Rate Update and Quality Reporting—Request for Information; Proposed Rule," *Federal Register* 87, no. 64, 19415–19441 (April 4, 2022). We appreciate your staff's continuous efforts to administer and improve the Medicare payment system for IPFs, particularly given the competing demands on the agency.

We focus our comments on CMS's proposed cap on wage index decreases, update to the fiscal year (FY) 2023 fixed dollar loss threshold, and analyses of the IPF PPS adjustments conducted by CMS and its contractor, the Bizzell Group.

**Proposed cap on wage index decreases**

The labor share of the IPF PPS per diem base rate is adjusted annually for differences in geographic wage levels using the pre-reclassified and pre-floor IPPS wage index. The wage index is assigned to IPFs based on their geographic location, delimited by Core-Based Statistical Areas (CBSAs) established by the Office of Management and Budget (OMB). Changes to CBSAs are published in OMB bulletins and the IPF PPS may adopt these changes, in a budget-neutral manner, to ensure accurate representation of geographic variations in wage levels. In the past, when CBSA changes have been adopted, CMS has blended old and new wage indices to more smoothly transition wage index values and avoid large changes. In FY 2021, in updating the wage index for OMB bulletin changes, CMS proposed and finalized a limit to the reduction in any wage index value to 5 percent in one year, thus mitigating the impact on providers whose wage index values will decrease. CMS now proposes to permanently implement this strategy for FY 2023 and going forward. This proposal has also been made for other Medicare settings.

*Comment*

While the Commission supports the proposed cap on wage index decreases of no more than 5 percent from the prior year, we believe the limit should apply to increases from the prior year as well. That is, the Commission supports eliminating changes of more than 5 percent in the wage index in both directions in an effort to avoid large fluctuations and promote a smooth transition from year-to-year. Consistent with CMS's proposed approach, the implementation of the revised relative wage index values (where changes are limited to plus or minus 5 percent) should be done in a budget-neutral manner.

**Update to the FY 2023 outlier fixed dollar loss threshold amount and statistical trim of outlier providers in computing the threshold**

To accommodate extraordinarily high-cost cases, the IPF PPS established an outlier policy where cases exceeding a threshold amount (multiplied by the IPF's facility-level adjustments plus the per diem amount) in total costs receive a portion of the difference between the costs and threshold, with that portion decreasing for longer lengths of stay. To maintain budget neutrality, IPF PPS payments are adjusted to accommodate the outlier payments, and the outlier fixed dollar loss threshold is set annually to ensure that outlier payments do not exceed 2 percent of total aggregate IPF PPS payments. CMS generally uses the most recent data available to calculate the fixed dollar loss threshold. However, when calculating the threshold for FY 2022, CMS found that FY 2020 IPF claims indicated fewer covered days during the COVID-19 public health emergency (PHE) and an increase in the average cost of those covered days. In response to these findings and concerns about other potential effects of the PHE on IPF utilization, CMS opted to use 2019 claims data instead of 2020 data to calculate the FY 2022 threshold.

In the proposed rule for FY 2023, CMS notes that these trends have continued in FY 2021. In addition, some providers have significant increases in their charges resulting in higher-than-normal estimated costs per day. CMS proposes to use the FY 2021 claims data—the most recent available—to calculate the fixed dollar loss threshold, with a trim applied to exclude IPFs with extraordinarily high simulated costs per day (greater than 3 standard deviations from the mean). Using the trimmed FY 2021 data to simulate payments in FY 2023, CMS calculates that the threshold must be increased to adhere to the requirement that outlier payments not exceed 2 percent of aggregate payments. Therefore, the agency proposes to set the fixed dollar loss threshold for FY 2023 at \$24,270 (up from \$16,040 in FY 2022 and \$14,630 in FY 2021).

*Comment*

While we would expect the fixed dollar loss threshold to change more than prior years given the two-year gap in the underlying data, growth of over 50 percent (from \$16,040 in FY 2022 to \$24,270 in FY 2023) is substantially larger than the 10 percent prior change (from \$14,630 in FY 2021 to \$16,040 in FY 2022, which followed even smaller changes in prior years). The Commission supports CMS's aim to align payment system parameters to reflect the patients served by IPFs using the most recently available data. While there are negative implications of a fixed

dollar loss threshold set too low (i.e., risking the adequacy of payment for non-outlier cases), a threshold that is too high might risk underpaying some high-cost patients who fall under the threshold. While this is always the case for any set threshold, the Commission has found large variation in costs among IPFs and suggests additional analyses to determine the appropriateness and implications of the proposed increase. We encourage CMS to conduct, and report findings from, additional analyses to study the drivers and implications of the currently proposed fixed dollar loss threshold. We pose some questions below to support those additional analyses:

- Are outliers concentrated among certain types of IPFs?
- What are the characteristics of patients who have costs that were just under the fixed dollar loss threshold?
- Are there recent changes in the case mix of beneficiaries using IPFs contributing to the higher threshold?
- Is the reduction in IPF cases in recent years driving volatility in outliers and the fixed loss threshold?

### **Analyses of IPF PPS adjustments**

CMS and its contractor, the Bizzell Group, conducted a study to assess the IPF PPS adjustments (<https://www.cms.gov/medicare/medicare-fee-for-service-payment/inpatientpsychfacilpps>). The study recalculated all patient and facility adjustments used in the IPF PPS using 2018 data and explored areas where modifications or additions could improve payment accuracy. Since many of the adjustments used in the IPF PPS have not been updated since the payment system was implemented in 2005, the study found multiple areas where updates to adjustments and refinements would improve payment accuracy. CMS solicits comments on the study analyses and findings.

#### *Comment*

The Commission commends CMS for undertaking this study to improve IPF PPS payment accuracy. The study was comprehensive and found several areas for improvement in terms of updated adjustments, addition of codes, and changes in groupings. The findings aligned with those found by a study commissioned by MedPAC with the Urban Institute.<sup>1</sup> We have the following comments on specific aspects of the study.

***Improve payment accuracy:*** The Commission supports improving the accuracy of Medicare payments and thus supports using more recent data to update the IPF PPS adjustments. The Bizzell Group study found substantial changes to diagnosis related groups (DRGs) and comorbidity adjustments when using more recent data. For example, using 2018 data the regression coefficient on DRG 887 (other mental disorder diagnosis) increased by 33.7 percent compared to the current coefficient. That is, cases assigned to this DRG would receive a larger adjustment if more recent data were used to calculate IPF PPS adjustments. The Urban study commissioned by MedPAC

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<sup>1</sup> Medicare Payment Advisory Commission. 2021. *Medicare's prospective payment system for inpatient psychiatric facilities at 15 years*. Report prepared for MedPAC by the Urban Institute. [https://www.medpac.gov/wp-content/uploads/2022/04/Apr22\\_IPF\\_CONTRACTOR\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2022/04/Apr22_IPF_CONTRACTOR_SEC.pdf).

also found that the original payment weights differed substantially from those estimated with more recent data and advised that updates to payment adjustments be implemented as soon as feasible. We urge CMS to implement the updated adjustments even while the agency concurrently considers other refinements to the payment system.

***Update the rural adjustment:*** The rural adjustment under the IPF PPS has been set at 17 percent since start of the payment system. Using updated data, the Bizzell Group study found that rural location was associated with an 11 percent increase in IPF costs. The Commission supports decreasing the rural adjustment accordingly to improve payment accuracy for all IPFs and promote spending Medicare dollars efficiently.

***DSH adjustment:*** The Bizzell Group study analyzed the relationship between IPFs' costs and the share of low-income patients they treated, using the same definition that Medicare uses to identify disproportionate share (DSH) hospitals. The study found that a higher DSH percentage was associated with higher costs and simulated the impacts of including a DSH percentage adjustment in the IPF PPS. The Commission agrees with the need to identify and support providers that serve a more vulnerable and costly population. However, our recent work looking at acute care hospitals suggests that there is a better way to target Medicare funds to "safety-net providers."<sup>2</sup> We urge CMS to consider an alternative measure such as the one the Commission has developed in refining the IPF PPS to account for the added costs to providers disproportionately serving vulnerable populations.

***IPF ancillary charges:*** For years, CMS has been concerned with the reporting of certain ancillary costs and charges by IPFs. In particular, CMS has expressed concern regarding the number of providers and stays for which there are no or very low drug and laboratory costs. The expectation is that most patients requiring hospitalization for psychiatric treatment would need drugs and laboratory services and that the IPF base rate should include costs of all ancillary services. The lack of data on drug costs, laboratory services, and other ancillary costs negatively affects CMS's ability to accurately measure patient costs. Indeed, the Urban Institute study commissioned by MedPAC found compression in the payment weights due to the lack of variation in patient costs (i.e., the calculated payment weights could not adequately capture the range of patient case mix).<sup>3</sup>

CMS has issued multiple transmittals to improve the reporting of ancillary costs on the cost reports. However, our examination of ancillary charges on the IPF claims indicates that a substantial portion of providers continue to report no drug charges as of 2020. The most recent 2018 CMS transmittal on this topic clarified that IPFs that charged under an "all-inclusive" rate do not need to report separate ancillary charges, but those that do not report under an all-inclusive rate will have their cost reports rejected if no ancillary charges are reported.<sup>4</sup> Since that time, there has been a substantial increase in the number of IPFs that have converted to all-inclusive rate status. To mitigate the bias from the large portion of certain types of IPFs without ancillary costs, the

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<sup>2</sup> Medicare Payment Advisory Commission. 2022. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC. Forthcoming.

<sup>3</sup> Medicare Payment Advisory Commission. 2021. *Medicare's prospective payment system for inpatient psychiatric facilities at 15 years*. Report prepared for MedPAC by the Urban Institute. [https://www.medpac.gov/wp-content/uploads/2022/04/Apr22\\_IPF\\_CONTRACTOR\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2022/04/Apr22_IPF_CONTRACTOR_SEC.pdf).

<sup>4</sup> <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R15P240.pdf>.

Bizzell Group study reweights the data used. This reweighting presumes that ancillary charges were “missing” data and gives data from providers who do report greater weight to counterbalance the missing data. Whether treating nonreporting of ancillary costs as missing data is appropriate depends on why the data are missing. That is, it is not known whether IPFs fail to report ancillary charges separately because they were appropriately bundled with all other charges into an all-inclusive per diem rate; if no ancillary charges were incurred because the IPF cares for a patient mix with lower care needs or inappropriately stints on care; or if ancillary charges for services furnished during the IPF stay are inappropriately billed outside of the IPF base rate (unbundling). We urge CMS to conduct further investigation into the lack of certain ancillary costs and charges and whether IPFs are providing necessary care and appropriately billing for inpatient psychiatric services under the IPF PPS.

### **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 the agency’s 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 requests information on principles and approaches that could be used in the IPF 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. We recognize that optimal health outcomes can be adversely affected by social risk factors. The Commission 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.<sup>5</sup> Rather than adjusting performance measures for patients' social risk factors,

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<sup>5</sup> Medicare Payment Advisory Commission. 2021. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

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.<sup>6</sup> 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.<sup>7</sup> 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 an *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 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 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.<sup>8</sup> In this work, we defined "low-income" beneficiaries as those who are eligible for full or partial Medicaid benefits or receive the Part D

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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.

<sup>6</sup> Medicare Payment Advisory Commission. 2022. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

<sup>7</sup> 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.

<sup>8</sup> Medicare Payment Advisory Commission. 2022. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC. Forthcoming.

low-income subsidy (LIS). Expanding the definition of “low-income” to include all LIS beneficiaries helps to reduce the impact of variation in state Medicaid policies. 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. In our hospital safety-net work, we referred to this collective 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 or Hispanic and three times as likely to be disabled. 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.<sup>9</sup> 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 are not attributable to random variation. Key steps 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.<sup>10</sup> In our 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 such that providers can be differentiated.<sup>11</sup>

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

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<sup>9</sup> Medicare Payment Advisory Commission. 2022. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

<sup>10</sup> 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.

<sup>11</sup> Medicare Payment Advisory Commission. 2021. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.



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 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.<sup>12</sup> The Commission also contends that public reporting should enable comparisons of individual providers with state and national averages to give consumers meaningful reference points.

### **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 Chernew, Ph.D.  
Chair

MC/BTF

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<sup>12</sup> 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.