



Medicare Payment  
Advisory Commission

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Acting 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-1771-P**

Dear Ms. Brooks-LaSure:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS's) proposed rule entitled "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2023 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Costs Incurred for Qualified and Non-qualified Deferred Compensation Plans; and Changes to Hospital and Critical Access Hospital Conditions of Participation," *Federal Register* 87, no. 90, pp. 28108–28746 (May 10, 2022). We appreciate CMS's ongoing efforts to administer and improve Medicare's payment systems for hospitals, particularly given the many competing demands on the agency's staff.

In this letter we comment on CMS's proposals to:

- Use 2021 data—with some modifications—for rate setting in both the hospital inpatient prospective payment systems (IPPS) and long-term care hospital (LTCH) PPS;
- Promote stability in various aspects of the IPPS and LTCH PPS;
- Create a permanent supplemental payment for Puerto Rico and Indian Health Service (IHS) hospitals;
- Establish a payment adjustment for domestic N95 respirators;
- Add new measures to the LTCH quality reporting program; and
- Establish overarching principles for measuring equity and health care quality disparities across CMS quality programs

**Using 2021 data, with modifications, for FY 2023 IPPS and LTCH PPS rate setting**

For IPPS and LTCH PPS rate setting, CMS's goal is to use the best available data, which is generally Medicare Provider Analysis and Review (MedPAR) data that spans the fiscal year two years prior to the upcoming payment year and Healthcare Cost Report Information System (HCRIS) data that begins during the fiscal year three years prior to the payment year. Consistent with this approach, for FY 2023 rate setting, CMS proposes to use the FY 2021 MedPAR file and the FY 2020 HCRIS data set (collectively referred to as FY 2021 data). However, to reflect its anticipation that Medicare inpatient hospitalizations for COVID-19 will continue into FY 2023 but at a lower level than in FY 2021 data, CMS proposes to apply two main modifications in its FY 2023 rate setting:

- Set Medicare severity–diagnosis related group (MS–DRG) and Medicare severity–long-term care diagnosis related group (MS–LTC–DRG) relative weights based on the average of the weights as calculated with and without COVID-19 stays; and
- Estimate the outlier fixed-loss amounts using charge and cost-to-charge ratio inflation factors based on data prior to the COVID-19 public health emergency (PHE).

As it is not possible to precisely know how COVID-19 hospitalizations and charges in FY 2023 will compare to FY 2021, CMS contends that these approaches will reflect a more reasonable estimation than unmodified 2021 data, and therefore will more accurately estimate relative resource use and outlier fixed-loss amounts in FY 2023.

*Comment*

The Commission continues to appreciate the current challenge CMS faces in rate setting, particularly in determining which data are most likely to approximate FY 2023. Last year we supported CMS's decision to set IPPS and LTCH PPS rates for FY 2022 using pre-PHE data, agreeing that the widespread availability of COVID-19 vaccinations would likely lead to a dramatic decline in cases in FY 2022 such that utilization would more closely resemble that in 2019 than in 2020. However, COVID-19 cases spiked at points in FY 2022, and the CDC now expects new variants will continue to emerge. We therefore concur with CMS that COVID-19 cases will continue into FY 2023 but likely will be fewer than in 2021, and we support CMS's proposal to set FY 2023 IPPS and LTCH PPS rates using FY 2021 data with some modifications to account for the PHE. In addition to the two main modifications CMS proposed, in estimating the outlier fixed-loss amount, CMS could also consider a modified approach to account for the expectation that the number of extremely costly COVID-19 cases in FY 2023 will be lower than in FY 2021. For example, just as CMS calculated relative weights for FY 2023 by averaging the results from FY 2021 claims with and without COVID-19 cases, the agency could similarly consider calculating the outlier threshold using the average of the estimate with and without COVID-19 cases.

### **Promoting stability in various aspects of the IPPS and LTCH PPS**

For FY 2023 and subsequent years, CMS proposes several changes to promote predictability and stability in IPPS and LTCH PPS payments and mitigate the financial impacts of significant fluctuations on hospitals. The three main proposals—each of which would be implemented in a budget-neutral manner—are:

- A 5 percent cap on any decrease to a hospital’s wage index from its wage index in the prior year (regardless of the reason for the decrease);
- A 10 percent cap on any decrease in a MS–DRG or MS–LTCH–DRG relative weight;
- Moving toward setting an IPPS hospital’s share of uncompensated care payments based on three years of audited S-10 data (starting with two years in FY 2023—audited 2018 and 2019 data—and increasing to three years starting in FY 2024).

#### *Comment*

The Commission supports CMS’s goal of promoting predictability and stability in IPPS and LTCH PPS payments, including its budget-neutral proposals to cap the amount by which certain components can change in a given year and to average multiple years of data in calculating hospitals’ share of uncompensated care payments. However, we contend that any caps on the maximum annual change to wage indexes or MS–DRG weights should apply not just to decreases but to increases as well.

### **Permanent supplemental payments for Puerto Rico and Indian Health Service (IHS) hospitals**

For FY 2023 and subsequent years, CMS:

- Proposes to discontinue a temporary exception for how uncompensated care payments are calculated for Puerto Rico and Indian Health Service (IHS) hospitals. This exception had increased Puerto Rico hospitals’ uncompensated care payments by about \$88 million and IHS hospital payments by about \$14 million in 2022.
- Proposes to use its exceptions authority to provide \$79 million of supplemental payments to Puerto Rico hospitals and \$13 million to Indian Health Service (IHS) hospitals. The payments would be made as add-on payments to inpatient payment rates. The goal of the add-on is to limit the decline in uncompensated care payments to Puerto Rico and IHS hospitals as CMS discontinues the temporary exception and starts to use cost report data to estimate Puerto Rico and IHS hospitals’ uncompensated care costs.

Both the temporary exception to how uncompensated care payments are calculated and the proposed \$79 million in supplemental payments to Puerto Rico hospitals dramatically increase inpatient payment rates to Puerto Rico hospitals and create high Medicare profit margins. In

aggregate, Puerto Rico hospitals reported a 32.5 percent Medicare margin in 2019. More importantly, the large distortions in inpatient payment rates dramatically increase payments to Medicare Advantage (MA) plans in Puerto Rico. We estimate that the supplemental payments to Puerto Rico hospitals boost payments to MA plans by almost \$1 billion per year. This large distortion to Medicare inpatient payment rates and to payments to MA plans will grow as fewer and fewer Puerto Rico Medicare beneficiaries remain in fee-for-service (FFS) Medicare. The share of Puerto Rico Medicare beneficiaries in FFS Medicare has already declined from 13 percent in 2013 to less than 6 percent in 2022.

## Background

Beginning in 2014, Congress introduced uncompensated care payments to IPPS hospitals designated as disproportionate share (DSH) hospitals. Each year, CMS calculates a fixed pool of dollars referred to as the uncompensated care pool.<sup>1</sup> CMS distributes this uncompensated care pool to DSH hospitals based on estimates of each hospital's share of acute care hospitals' aggregate uncompensated care costs. CMS determined that using Worksheet S-10 of the Medicare cost report would provide the best estimate of uncompensated care costs because it was developed specifically to collect information on uncompensated care. However, because the worksheet was new and had not yet been audited, for FY 2014 CMS assumed the best available proxy for uncompensated care costs was low-income insured days, defined as the sum of inpatient days for two groups of patients: (1) days where Medicaid is the primary payer and (2) days attributable to Medicare patients receiving Supplemental Security Income (SSI). The initial effect was to pay each hospital a flat amount (approximately \$200) from the uncompensated care pool for every Medicaid day and Medicare day attributable to patients receiving SSI.

In 2017, CMS made an adjustment to the uncompensated care cost proxy for Puerto Rico hospitals. Puerto Rico's Medicare beneficiaries are not eligible for SSI. Therefore, to compensate for this, CMS created a synthetic SSI day count equal to an additional 14 percent of each hospital's Medicaid day count. The net result is that, from 2017 onward, Puerto Rico DSH hospitals receive uncompensated care payments equal to 114 percent of their Medicaid days multiplied by a fixed payment amount (e.g., \$194 in 2022). For example, if a Puerto Rico hospital had 1,000 Medicaid days, it would receive an uncompensated care payment in 2022 equal to  $1,000 \times 1.14 \times \$194$  or \$221,160.

Beginning in 2018, CMS began using audited uncompensated care costs from Worksheet S-10, stating it could no longer assume that alternative data were a better proxy. However, CMS acknowledged concerns raised by some commenters regarding Puerto Rico and IHS/Tribal hospitals' inability to fill out the S-10 accurately, which one commentator said could take "years to address."<sup>2</sup> However, the vast majority of Puerto Rico hospitals have filled out the S-10 in recent years. Following these comments, CMS decided to continue to use 2013 Medicaid days as the

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<sup>1</sup> The uncompensated care pool is the product of two factors: (1) 75 percent of estimated aggregate operating DSH payments under the formulas in effect prior to 2014; and (2) the national uninsured rate as a percentage of the uninsured rate in 2013.

<sup>2</sup> [Federalregister.gov/d/2022-08268](https://www.federalregister.gov/d/2022-08268).

proxy for Puerto Rico and IHS/Tribal hospitals' uncompensated care costs through fiscal year 2022.

### **CMS proposal**

Beginning in FY 2023, CMS proposes to discontinue the exception for Puerto Rico and IHS hospitals' share of uncompensated care, such that all hospitals' uncompensated care costs would be based on Worksheet S-10. However, CMS estimates that this methodological change would drastically reduce these hospitals' uncompensated care payments. To mitigate these payment reductions, CMS proposes new, permanent supplemental payments for Puerto Rico and IHS hospitals affected by this change. In FY 2023, these non-budget-neutral supplemental payments would total \$92 million: \$79 million to Puerto Rico hospitals and \$13 million to IHS hospitals. As with current uncompensated care payments, the new supplemental payment would be an add-on to IPPS payment rates and be included when calculating MA benchmarks. This dramatically increases payments to MA plans.

### *Comment*

The Commission supports discontinuing the use of 2013 Medicaid days as a proxy for uncompensated care costs. However, we do not support paying \$79 million of supplemental payments as an add-on to Puerto Rico inpatient payment rates. Distributing the proposed supplemental payments to Puerto Rico hospitals as an add-on payment to IPPS payment rates would create tremendous distortions in Medicare payment rates for Puerto Rico hospitals under the IPPS, and the benchmarks used to calculate payments to Puerto Rico MA plans. CMS should reduce the size of the supplemental payments to Puerto Rico to an empirically justified level and distribute the supplemental payments as separate payments outside of inpatient payment rates.

The proposal would also direct \$13 million in supplemental uncompensated care payments to IHS hospitals. The IHS payments differ from Puerto Rico payments in two important ways. First, IHS hospitals are all government hospitals receiving federal budgets from the Indian Health Service, while Puerto Rico hospitals are primarily for-profit hospitals. Second, because MA penetration is low in IHS areas, the potential for distorting MA benchmarks is much lower with the IHS supplemental payments. Given the lower risk of distorted MA benchmarks, it is appropriate for CMS to continue the supplemental payments to IHS hospitals until there is a better estimate of the appropriate level of uncompensated care payments. We will limit our comments in this letter to the Puerto Rico add-on payments.

### **Using Medicaid days as a proxy for uncompensated care costs is inappropriate; we concur that it should be discontinued**

Medicaid days have always been a particularly poor proxy for uncompensated care costs in Puerto Rico for two reasons. First, the per day payment amount (initially about \$200) was estimated by dividing the full uncompensated care pool by the total number of Medicaid and SSI days at general acute care hospitals. Puerto Rico hospitals received the same fixed-dollar amount per Medicaid day as other hospitals, despite having labor costs that are significantly lower than

the rest of the nation. For example, Puerto Rico hospitals recently reported an average wage for registered nurses of about \$18 per hour compared to \$44 for the nation as a whole.<sup>3</sup> Second, using Medicaid days as a proxy for uncompensated care assumes the ratio of Medicaid days to uncompensated care volume is similar across the nation. This is a poor assumption because Medicaid covers about 50 percent of the population in Puerto Rico compared to about a quarter of the population, on average in the 50 states.<sup>4</sup>

The Medicaid day proxy resulted in a dramatic increase in payments for Puerto Rico hospitals. As CMS noted in its 2014 IPPS final rule, the new uncompensated care policies (containing the distorted proxies for uncompensated care) were expected to increase 2014 DSH and uncompensated care payments to Puerto Rico hospitals from \$8 million (under the 2013 DSH-only policy) to \$82 million.<sup>5</sup> The aggregate Medicare margin for Puerto Rico hospitals increased as a result from -0.7 percent in 2013 to 18.6 percent in 2015. In contrast, most hospitals in the 50 states saw their net DSH and uncompensated care payments decline, and their aggregate Medicare margin declined from -5.1 percent to -7.6 percent.

### **Continuing high add-on payments for Puerto Rico hospitals distorts Medicare Advantage (MA) benchmarks**

Because less than 6 percent of Puerto Rico beneficiaries are in FFS Medicare (fewer than 40,000 FFS beneficiaries), the current add-on uncompensated care payments are spread over relatively few discharges, and thus distort FFS spending and MA benchmarks.<sup>6</sup> We estimate that uncompensated care add-on payments based on the flawed proxy inflated FFS spending per beneficiary in Puerto Rico by almost \$2,000 per beneficiary in 2019. This distortion in FFS spending has resulted in inflated MA benchmarks in Puerto Rico. The high MA benchmarks have allowed Puerto Rico MA plans to generate high profit margins (of over 10 percent) and offer a large amount of extra benefits.<sup>7</sup>

Similarly, we estimate the proposed \$79 million in supplemental payments would increase FFS spending in Puerto Rico by more than 25 percent above what it would have been if Puerto Rico hospitals received uncompensated care payments based only on their reported uncompensated

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<sup>3</sup> Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2022. FY 2022 wage index home page. <https://www.cms.gov/medicare/medicare-fee-service-payment/acuteinpatientpps/wage-index-files/fy-2022-wage-index-home-page>.

<sup>4</sup> Medicaid.gov. 2022. Quality of care in Puerto Rico. <https://www.medicare.gov/state-overviews/puerto-rico.html>.

<sup>5</sup> Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2013. Medicare program; hospital inpatient prospective payment systems for acute care hospitals and the long term care hospital prospective payment system and fiscal year 2014 rates; quality reporting requirements for specific providers; hospital conditions of participation; payment policies related to patient status. Final rule. *Federal Register* 78, no. 60 (August 13): 50496–51040.

<sup>6</sup> Among beneficiaries with both Part A and Part B coverage in Puerto Rico, less than 94 percent are enrolled in a Medicare Advantage (MA) plan. MA payment benchmarks in Puerto Rico are based on Medicare FFS spending for beneficiaries with both Part A and Part B coverage.

<sup>7</sup> MedPAC analysis found that Puerto Rico MA plans generated profit margins of over 10 percent every year from 2017 to 2020. These margins do not account for potential remittances sent to CMS for any revenues equivalent to the difference between a plan's medical loss ratio (MLR) and an MLR of 85 percent. There are a large number of MA plans in Puerto Rico with drug coverage, zero premiums, and no deductibles.

care costs. If these increases are fully transferred to MA benchmarks, this could result in about \$1 billion of additional Medicare program payments to MA plans in Puerto Rico. It would also create a self-reinforcing cycle of increasing MA benchmarks causing declines in the number of Puerto Rico beneficiaries enrolled in FFS Medicare, which in turn will cause even greater increases in MA benchmarks as the supplemental payments are spread over fewer beneficiaries.

### ***Recommended actions***

The uncompensated care payments to Puerto Rico hospitals are built on a flawed proxy and should be reduced to an empirically justified level. If CMS is concerned that—at least in the short term—the reported uncompensated care costs on Puerto Rico’s cost reports do not accurately reflect these hospitals’ uncompensated care costs, there are better alternatives to extending the excessive levels based on the flawed proxy. For example, CMS could set supplemental payments for Puerto Rico hospitals such that supplemental payments as a share of Medicare revenues equaled the national average. We estimate that such an approach would result in Puerto Rico hospitals receiving about \$10 million in payments for uncompensated care. If policymakers conclude that more than \$10 million is needed to maintain quality of or access to hospital care in Puerto Rico, those funds should be directed to providers in ways that do not cause large distortions in inpatient payment rates and MA benchmarks. The decline in FFS enrollment in Puerto Rico from 13 percent of Medicare beneficiaries in 2013 to less than 6 percent of Medicare beneficiaries in 2022 makes paying for uncompensated care as an add-on to FFS inpatient claims untenable. If the decline in FFS enrollment continues, the distortions in payment rates and benchmarks will grow exponentially.

Over the longer term—and across all regions of the nation—CMS should make two changes to how uncompensated care payments are made:

- The uncompensated care payments should not be made as an add-on to the IPPS payment rate. The add-on can more than double IPPS payment rates. As Medicare Advantage penetration grows, these distortions grow.
- The uncompensated care payments should not be factored into MA benchmarks. In the case of Puerto Rico, putting the supplemental uncompensated care payments into the benchmark would increase benchmarks by over 25 percent in 2023.

CMS could avoid the payment rate distortions and the MA benchmark distortions by directly paying hospitals for a portion of uncompensated care costs, as suggested by the Commission in our 2015 IPPS comment letter.<sup>8</sup> The MA plans’ portion of uncompensated care costs would also be paid directly by the Medicare program in a way that is similar to how it is done for indirect medical education (IME) payments. This would prevent uncompensated care payments from

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<sup>8</sup> Medicare Payment Advisory Commission. 2015. Comment letter to CMS on the IPPS and LTCH payment update. <http://medpac.gov/docs/default-source/comment-letters/medpac-comment-on-cms-s-proposed-rule-on-the-hospital-inpatient-prospective-payment-system-and-long-.pdf?sfvrsn=0>.

entering the benchmarks. The objective would be to not distort hospital pricing and not distort MA benchmarks.

### **Establishing a payment adjustment for domestic N95 respirators**

CMS maintains that it is important to support domestic manufacturing of N95 respirators to help prepare for future biological and pandemic threats. CMS therefore proposes increased payments to hospitals to compensate them for the higher costs of purchasing domestically manufactured N95 respirators rather than those imported from other countries. CMS seeks feedback on two options that would increase payments to hospitals under the OPSS and IPPS beginning in 2023:

- A biweekly lump sum payment that would be reconciled at cost report resettlement, when each hospital would report the aggregate cost and total quantity of N95 respirators it purchased that were domestically made and those that were not; or
- A per discharge add-on payment for hospitals that meet or exceed a “domestic sourcing threshold” of 50 percent for domestically sourced N95 respirators.

#### *Comment*

Although we agree with CMS that ensuring a robust supply chain of N95 respirators is vitally important for hospitals and the nation, we oppose both options. Instead, the best way to ensure a robust domestic supply of personal protective equipment likely involves solutions beyond the Medicare program (e.g., direct purchases and stockpiling of masks by the federal government).

Either of the options proposed by CMS would undermine the prospective, bundled nature of Medicare’s hospital payments by paying hospitals more as their costs increase. In addition, while N95 respirators are an essential supply, other items, such as surgical gloves or pharmaceuticals, might be equally important to combat future biological and pandemic threats. Similarly, hospitals are not the only type of providers to acquire N95s. Making higher Medicare hospital payments for domestically sourced N95 respirators would create a precedent, opening opportunities to establish separate cost-based payments for other domestically sourced supplies and other providers. The proposed options also would increase administrative costs for hospitals (e.g., hospitals would have to identify domestically made products and track their use), could be susceptible to misreporting of costs (e.g., hospitals’ costs for N95 respirators could be artificially inflated to increase reimbursement), and are likely to have a minor effect on most hospitals’ finances (e.g., the add-on of a few dollars to payment for a discharge for which Medicare now pays \$15,000).

Medicare payment policy is not the most appropriate mechanism to support domestic manufacturing of medical supplies. However, if CMS concludes that a change to Medicare payment policy is required for this purpose—a conclusion with which we strongly disagree—it should be done in way that minimizes administrative burden and effects on the integrity of the Medicare’s prospective payment systems. For example, setting the per respirator extra payment for purchasing a domestically made product at a national level (rather than on a hospital-by-



hospital basis) would reduce the administrative burden on hospitals of tracking their expenditures on such products, encourage hospitals to purchase the most economical domestically made product, and reduce the ability of hospitals to increase their payments by artificially inflating reported N95 costs (such as by getting discounts on other products in exchange for paying high prices on N95 masks).

### **New measures in the LTCH quality reporting program (QRP)**

CMS is seeking comment on future measure concepts for the LTCH QRP.

#### *Comment*

As CMS considers other measures for inclusion in the LTCH QRP, we note that we do not at this time support the inclusion of measures based on provider-reported assessment data, such as measures of change in or attainment of mobility. The Commission has found that the consistency of facilities' recording of functional assessment information, such as change in mobility, raised questions about using such information for quality reporting or payment.<sup>9</sup> Still, maintaining and improving these outcomes are critically important to patients, so it is desirable to improve the reporting of assessment data so that these outcomes can be adequately assessed. If a process to validate assessment data is put in place, and if the accuracy of the provider-reported assessment data improves, then CMS should consider including them in the LTCH QRP program.

### **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 their 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 is requesting information on principles and approaches that could be used in the Hospital Inpatient Quality Reporting Program 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.

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<sup>9</sup> Medicare Payment Advisory Commission. 2019. *Report to the Congress: Medicare and the Health Care Delivery System*. Washington, DC: MedPAC.

### **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. The Commission recognizes that optimal health outcomes can be adversely affected by social risk factors. MedPAC 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>10</sup> Rather than adjusting performance measures for patients' social risk factors, 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>11</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>12</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 *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

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<sup>10</sup> Medicare Payment Advisory Commission. 2021. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

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>11</sup> Medicare Payment Advisory Commission. 2022. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

<sup>12</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.

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>13</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 low-income subsidy (LIS). 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. Collectively, we referred to this population as "LIS beneficiaries" because those who receive full or partial Medicaid benefits automatically receive the LIS. Compared to the non-LIS population, LIS beneficiaries have relatively low incomes and differ in other regards, including being twice as likely to be Black and three times as likely to be disabled. In addition, expanding the definition of "low-income" to include all LIS beneficiaries helped to reduce impact of variation in state Medicaid policies. 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>14</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 not be attributable to random variation. Key decisions 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.

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<sup>13</sup> Medicare Payment Advisory Commission. 2022. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

<sup>14</sup> Medicare Payment Advisory Commission. 2022. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

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>15</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 and that providers can be differentiated.<sup>16</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 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 payment 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>17</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.

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<sup>15</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>16</sup> Medicare Payment Advisory Commission. 2021. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

<sup>17</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.

**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 contact James E. Mathews, MedPAC's Executive Director, at 202-220-3700.

Sincerely,

A handwritten signature in black ink, appearing to read "m. chernew", with a horizontal line extending to the right from the end of the signature.

Michael E. Chernew, Ph.D.  
Chair