Medicare Payment Advisory Commission

425 I Street, NW • Suite 701
Washington, DC 20001
202-220-3700 • www.medpac.gov

Michael E. Chernew, Ph.D., Chair
Amol Navathe, M.D., Ph.D., Vice Chair
Paul B. Masi, M.P.P., Executive Director

May 23, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Attention: CMS-1806-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; Fiscal Year (FY) 2025 Inpatient Psychiatric Facilities (IPFs) Prospective Payment System – Rate Update; Proposed Rule," *Federal Register* 89, no. 65, 23146–23224 (April 3, 2024). 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.

Our comments relate to the following topics:

- Update to the patient-level case-mix adjustment
- Wage index updates
- Request for information on the updates to the facility adjustments
- Clarification of the eligibility criteria for filing as an all-inclusive-rate hospital
- Request for information on the development of a patient assessment instrument
- Adoption of a 30-day risk-standardized all-cause emergency department visit following an IPF discharge

Update to the patient-level case-mix adjustment

CMS implemented the IPF prospective payment system (PPS) in 2005, setting the base payment rate and patient and facility adjustments using the latest available data at the time. Since then, each year CMS has updated the payment rate based on market basket price growth and other statutory adjustments; however, the patient- and facility-level adjustments have remained the same. In the proposed FY 2023 rule, CMS presented analyses that used more recent data to calculate IPF PPS patient and facility adjustments and requested comments on methods and findings. In this year's proposed rule, CMS refined the methods and used the latest data to propose updates to the patient-level

adjustments and electroconvulsive therapy payment rate for stays in FY 2025. These updates include updated diagnosis related group (DRG) payment weights; removing and adding certain DRGs; updates to the comorbidity adjustments; and updates to the age, length of stay, and emergency department adjustments. CMS does not propose updates to the facility-level adjustments and instead requested comments on analyses conducted (discussed further below).

Comment

We support CMS's proposal to update the IPF PPS patient-level payment adjusters in FY 2025. In our comment letter on the FY 2023 IPF PPS proposed rule, MedPAC supported CMS's pursuit of improvements to the PPS, but we were concerned about CMS's methodology, which excluded a large number of IPF stays because there were no ancillary charges associated with them.[1] We feared that excluding those stays could bias the results, since such stays composed a large share of the total number of cases and tended to be concentrated among freestanding for-profit IPFs. Therefore, we are pleased that CMS proposes to include these stays (as well as including multiple years of data) in the calculation of the updated patient-level adjustments for FY 2025. Going forward, we encourage CMS to continue to monitor and update the weights as needed using the most recent data available. As we stated in our comment letter on the FY 2024 proposed rule, given the substantial changes in payment weights for some types of cases when more recent data were applied, it is important to update the payment weights even as CMS considers other critical refinements to the IPF PPS.[2] Better aligning payment weights to costs so that some types of cases are not more profitable than others is important in promoting equitable access to care.

Wage index updates

Since the start of the IPF PPS, CMS has used general acute care hospital wage data to develop the IPF PPS wage index. For FY 2025, CMS proposes to continue to use the unadjusted inpatient prospective payment systems' (IPPSs') wage index (referred to as the "pre-floor, pre-reclassification hospital inpatient wage index").

CMS also proposes to:

- update the wage index with newer wage data and Office of Management and Budget (OMB) labor market area delineations

---

[1] Medicare Payment Advisory Commission. 2022a. MedPAC letter commenting on CMS's proposed rule entitled: "Medicare Program; FY 2023 Inpatient Psychiatric Facilities (IPF) Prospective Payment System (PPS)– Rate Update; Proposed Rule." April 4. (https://www.medpac.gov/wp-content/uploads/2022/05/05272022_FY2023_IPF_PPS_MedPAC_COMMENT_v2_SEC.pdf.)
[2] Medicare Payment Advisory Commission. 2023a. MedPAC letter commenting on CMS's proposed rule entitled: "Medicare Program; FY 2024 Inpatient Psychiatric Facilities Prospective Payment System – Rate Update; Proposed Rule." April 4. https://www.medpac.gov/wp-content/uploads/2023/06/06022023_IPF_FY2024_MedPAC_comment_SEC.pdf.)

- continue its policy of capping the wage index decrease a provider can experience in a given year at 5 percent
- Phase in the loss of the 17 percent rural adjustment for IRFs moving from a rural to urban classification under the new OMB delineations

Comment

The Commission supports CMS's annual process to update the IPF PPS wage index with newer wage data and OMB delineations. The Commission also supports having a policy to cap and phase in the wage index changes that a provider can experience in a given year (though we have previously stated that the maximum change should apply to annual increases as well as decreases).

However, the Commission has long been concerned with flaws in the wage index system that CMS uses to adjust IPF payments to reflect geographic differences in labor costs.[3] To improve the accuracy and equity of Medicare's wage index systems for IPPS hospitals and other providers (such as, but not limited to IPFs), Medicare needs wage indexes that are less manipulable, more accurately and precisely 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. 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 new wage index systems for hospitals and other types of providers that:

- use all-employer, occupation-level wage data with different occupation weights for the wage index of each provider type,
- reflect local area level differences in wages between and within metropolitan statistical areas and statewide rural areas, and
- smooth wage index differences across adjacent local areas.[4]

We urge the Secretary to use existing authority to adopt the Commission's recommended approach for IPFs.

Clarification of the eligibility criteria for filing as all-inclusive-rate IPFs

For years, CMS has stated its concern that IPFs were not submitting complete information on ancillary services. As noted above, a large share of IPF claims submitted to CMS have no ancillary charges associated with them, even though the IPF base rate is intended to cover the costs of ancillary services such as prescription drugs and laboratory services, and one

[3] Medicare Payment Advisory Commission. 2007. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.
[4] Medicare Payment Advisory Commission. 2023b. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

would expect that almost all beneficiaries needing inpatient psychiatric care would require such services. In 2017 and 2018, CMS issued several transmittals indicating that cost reports without any ancillary service charges would be rejected except for IPFs that designate as having an "all-inclusive" rate structure. All-inclusive-rate IPFs are those that do not have a charge structure in which to report ancillary services separately; historically all-inclusive-rate facilities have been government- or tribally-owned. However, as noted in this proposed rule, the number of IPFs filing all-inclusive cost reports has grown since CMS issued these transmittals and the growth has been concentrated among freestanding for-profit IPFs. In this proposed rule, CMS clarifies that only government-owned or tribally-owned IPFs are eligible to file a cost report using an all-inclusive rate structure (though they are encouraged to report ancillary charges if they can). CMS proposes to issue instructions to Medicare administrative contractors (MACs) to put in edits to reject cost reports from IPFs filing as all-inclusive unless they are government- or tribally- owned starting on October 1, 2024.

Comment

The lack of IPF data on drug costs, laboratory services, and other ancillary costs undermines CMS's ability to measure patient costs accurately. The Commission strongly supports CMS's proposal to clarify and enforce the requirements surrounding all-inclusive-rate filing status. This clarification, combined with earlier CMS transmittals on this topic, appear to indicate that IPFs that are not government- or tribally-owned must submit information on ancillary charges in their cost reports or otherwise be rejected by the MACs (i.e., these IPFs cannot file as all-inclusive and cannot report zero ancillary charges). We encourage CMS to continue to monitor the accuracy of these data as well as monitor the submission of ancillary charges on claims. As we noted in our comment letter on the FY 2024 IPF PPS proposed rule, another way to enforce this requirement would be to reject individual claims that do not contain ancillary charges (as we believe is done by some state Medicaid programs).[5]

Request for information on updates to the facility adjustments

Under the IPF PPS, payments to IPFs are adjusted based on the providers' teaching status and location. Teaching IPFs receive higher payment to cover their additional patient care costs, with the amount depending on the IPF's ratio of residents to its average daily census. IPFs located in rural areas receive a 17 percent increase in payments and those located in Hawaii and Alaska receive a cost-of-living adjustment. These adjustments were determined when the IPF PPS was first implemented (2005) and have not been refined since then. In the FY 2023 proposed rule, CMS presented analyses showing substantial changes in facility-level adjustments when using more recent data. At that time, CMS also examined the impact of adding a low-income adjustment using the same definition that Medicare uses to identify disproportionate share (DSH) hospitals. In our comment letter on

[5] Medicare Payment Advisory Commission. 2023a, *op cit.* As we noted in the letter, to ensure that facilities are paid for the small number of cases in which no ancillary services were provided, the agency could consider adding a modifier option to the claim.

the FY 2023 proposed rule, the Commission referred CMS to our work showing a better way to target Medicare funds to "safety-net" providers for acute care hospitals, referred to as the Medicare Safety-Net Index (MSNI).[6] In this year's proposed rule, CMS presents and seeks comment on analyses conducted to add the MSNI to the IPF PPS as well as update other facility-level adjustments.

Comment

We commend CMS for undertaking this important work to improve the IPF PPS. We support CMS's efforts to include an adjustment in the payment system for IPFs that serve a more vulnerable patient population that may be more costly and less profitable to serve. We also reiterate the Commission's prior findings that the DSH patient percentage is not the best way to identify safety-net providers and allocate limited Medicare dollars because the metric does not incorporate the share of uninsured and Medicare patients, which can result in hospitals serving high proportions of these patients being disadvantaged in the formula.[7]

For this proposed rule, CMS modeled an MSNI based on the version MedPAC developed for acute care hospitals.[8] It is the sum of the share of an IPF's patients who are dually eligible or receive the low-income subsidy for Part D drugs, the proportion of total revenues spent on uncompensated care, and half of the Medicare dependency ratio (defined as Medicare covered days divided by total patient days). CMS included the MSNI in a logged per diem cost regression with other patient and facility factors. CMS found the model fit (R^2) to improve with the addition of the MSNI and found the coefficient on MSNI to be positive (higher MSNI was associated with higher per diem costs) and statistically significant at the 0.001 level.

In the Commission's June 2022 chapter on a framework for identifying and supporting safety-net providers for acute care hospitals and physician practices, we noted that the MSNI adjustment may differ across different sectors.[9] That is, factors that are important for identifying safety-net acute care hospitals may not be exactly the same for IPFs. Depending on the sector, different factors and weighting may be more appropriate. Below, we discuss each of the components of the CMS-constructed MSNI for IPFs:

- **Low-income share**: Based on CMS's findings and our own analyses, many IPFs serve fairly high shares of low-income beneficiaries. CMS should analyze whether those IPFs that serve the highest shares of low-income beneficiaries tend to have higher per diem case-mix-adjusted costs, lower revenues (e.g., due to lower cost-

[6] Medicare Payment Advisory Commission. 2022a, *op cit.*
[7] Medicare Payment Advisory Commission. 2022b. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.
[8] Medicare Payment Advisory Commission. 2022b, *op cit*; Medicare Payment Advisory Commission. 2024. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.
[9] Medicare Payment Advisory Commission. 2022b, *op cit*.

sharing revenues), or lower profit margins. If this is not the case, it may not be appropriate to include IPFs' share of low-income patients in an IPF MSNI.

- **Uncompensated care:** Given Medicare's 190-day limit on covering care in freestanding IPFs and the Institutes for Mental Disease (IMD) exclusion limiting Medicaid coverage, it is likely that IPFs do provide uncompensated care; those that do may need greater support. Currently, however, an IPF's level of uncompensated care can only be measured for IPF units by allocating it from the parent hospital; there is no accurate information on uncompensated care for freestanding IPFs, since they are not required to submit such information on their cost reports. CMS should require all IPFs (freestanding and IPF units) to report uncompensated care. Once this information is more fully collected, it can be included in the IPF MSNI.

- **Medicare share of days**: As discussed in our June 2023 report, we learned from interviews with IPFs that Medicare patients were viewed as higher risk (and costlier) than other patients because they tend to be older, have more comorbidities, and generally require more resources to treat safely.[10] Moreover, not all beds at IPFs may be appropriate and available for Medicare patients (for example, Medicare patients with more comorbidities may require a specialized hospital bed instead of lay-flat bed).[11] Thus, Medicare share of days is likely an important component for identifying safety-net IPFs and may even warrant higher weight in the MSNI formula. To further assess this, CMS could examine the relationship between Medicare share of days and IPFs' adjusted costs and profitability. This could be done in aggregate for all IPFs and for types of IPFs (since hospital-based IPFs tend to have greater Medicare share of days and higher costs).

In the Commission's application of the MSNI for acute care hospitals, we capped changes to minimize disruption to hospitals and avoid extreme add-ons for outlier hospitals. The MSNI was capped at roughly the 95th percentile, which was roughly a 30 percent add-on.[12] CMS should explore applying a similar cap. One way to do this may be to normalize the MSNI and base each IPF's adjustment on the difference between the IPF's MSNI and the national MSNI.

Request for information on the development of a patient assessment instrument

Per the Consolidated Appropriations Act, 2023, CMS must develop and implement a standardized patient assessment instrument for the purposes of improving quality of care, payment accuracy, and health equity. The tool should assess patients on: functional status; cognitive function and mental status; special services, treatments, and interventions;

---

[10] Medicare Payment Advisory Commission. 2023b, *op cit*. Medicare Payment Advisory Commission. 2023c. *Interviews with inpatient psychiatric facilities*. Report prepared for MedPAC by L&M Policy Research. https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Interviews_with_IPFs_MedPAC_CONTRACTOR_SEC.pdf
[11] Medicare Payment Advisory Commission. 2023c, *op cit*.
[12] Medicare Payment Advisory Commission. 2022b, *op cit*; Medicare Payment Advisory Commission. 2023d. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

medical conditions and comorbidities; impairments; and other categories as determined appropriate by the Secretary. CMS solicits comments on:

- The framework for IPF–PAI development,
- Approaches to develop items on IPF–PAI, and
- Approaches to collect IPF–PAI data.

Comment

In our June 2023 report to the Congress, the Commission examined the provision of IPF services to Medicare FFS beneficiaries.[13] Our analyses of the IPF PPS showed that the current adjusters in the payment system are not sufficient for differentiating the costs associated with patients with different diagnoses. Misalignment of payments and costs creates incentives for providers to admit certain types of patients and avoid others. The Commission contends that more information is needed to understand the drivers of IPFs' costs in caring for Medicare beneficiaries and to ensure that payments are aligned with those costs. Information from a patient assessment tool could serve a critical role in determining patient characteristics and needs not obtainable through other administrative data such as claims and cost reports.

In designing this tool, CMS should draw from past experience with using provider-completed patient assessment instruments for the dual purpose of assessing quality of care and determining payment. In the post-acute care settings, information from patient assessment instruments determines aspects of how providers are paid (e.g., functional ability at admission is a component of provider payment for Medicare FFS patients using SNF, IRF, and home health care services). The Commission has previously reported on evidence of some providers coding patients as more impaired upon admission into post-acute care than they appeared upon discharge from the prior acute care setting. Greater impairment results in greater payments for the post-acute care stay (all else equal), and we questioned whether functional ability, a critical metric for patients using post-acute care, can be accurately measured by provider-completed patient assessment instruments given the financial incentives in place.[14] In developing items for this assessment tool, CMS should consider the following:

- Select and test items with **high inter-rater reliability** that are less subject to differential coding practices. CMS should include items in which clear guidance can be provided, decreasing ambiguity to IPFs. Inter-rater reliability should be periodically assessed, even after the tool is implemented;

- Select items that have **evidence of differential resource use and outcomes**. For example, CMS's 2005 comprehensive study on IPF costs found several factors that

---

[13] Medicare Payment Advisory Commission. 2023b, *op cit*.
[14] Medicare Payment Advisory Commission. 2019. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.
Medicare Payment Advisory Commission. 2016. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC

affect resource use, including activities of daily living deficits, danger to self/others, and cognitive impairment.[15] CMS may need to commission a new study (examining these items and potentially others such as instrumental ADLs) to ensure that items are selected only if they meaningfully contribute to patient outcomes or resource use;

- Implement a **strong audit plan** to ensure sufficient and continual monitoring of the data as it is collected. The Commission has previously stated that under such audits, meaningful penalties, such as civil monetary penalties, could be imposed on providers whose data submissions are either inaccurate or not supported by adequate documentation.[16] In addition, conditions of participation could be expanded to require sufficient documentation in the medical record to support the data from the assessment tool.

Collect information on staffing

Lastly, we encourage CMS to consider collecting information on staffing. Labor is the primary component of IPFs' costs: CMS calculated the labor share of costs to be 78.8 percent for FY 2025 (78.7 percent for FY 2024). This is higher than most other institutional settings (e.g., labor costs comprise less than 70 percent of IPPS hospital costs, 74 percent of inpatient rehabilitation facility costs, and 71 percent of skilled nursing facility (SNF) costs). However, there is little available information on the mix (and amount) of staff employed by IPFs and how staff spend their time across various IPF tasks (such as inpatient assessment, counseling, drug management, nursing care, and behavioral monitoring). IPF staffing data would provide essential insights into the variation in costs and quality of care across providers, enabling CMS (and Medicare beneficiaries, if data were publicly available) to better understand the services they are purchasing and using. There is a precedent in Medicare for regularly collecting staffing information: SNFs are required to submit detailed staffing data through the Payroll Based Journal. Payroll data are considered the gold standard for measuring staffing; the data are submitted electronically and can be audited by other data sources.[17] Researchers have found the SNF payroll data to be consistent and accurate; the data serve as an important tool for policymakers to monitor staffing and assess its relationship to patient outcomes.[18]

---

[15] RTI International, Department of Health and Human Services. 2005. *Psychiatric inpatient routine cost analysis: Final report.* Report prepared for the Centers for Medicare & Medicaid Services. Waltham, MA: RTI International. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-andReports/Reports/downloads/cromwell_2005_3.pdf.
[16] Medicare Payment Advisory Commission. 2019, *op cit*.
[17] Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2023. Medicare program; prospective payment system and consolidated billing for skilled nursing facilities; updates to the quality reporting program and value-based purchasing program for federal fiscal year 2024. Proposed rule. *Federal Register* 88, no. 68 (April 2023): 21316–21422.
[18] Zheng, Q., C. S. Williams, E. T. Shulman, and A. J. White. 2022. Association between staff turnover and nursing home quality—Evidence from Payroll-Based Journal data. *Journal of the American Geriatrics Society* 70, vol. 9: 2508–251.
Geng, F., D. Stevenson, and D. Grabowski. 2019. Daily nursing home staffing levels highly variable, often below CMS expectations. *Health Affairs* 38, vol. 7: 1095–1100.

Monitoring IPF staffing and its relationship to outcomes for beneficiaries who use these services may help improve quality of care for this vulnerable patient population.

Adoption of a 30-day risk-standardized all-cause emergency department visit following an IPF discharge

CMS proposes to add the measure *30-day risk-standardized all-cause emergency department (ED) visit following an IPF discharge* to the IPF quality reporting program (QRP).

Comment

The Commission supports the addition of this claims-based measure to the IPF QRP. Our prior work found substantial (unadjusted) ED use following an IPF discharge.[19] Identifying IPFs with higher or lower rates of standardized ED visits following discharge may serve as an important tool for beneficiaries, policymakers, and other stakeholders to assess IPF quality of care. Moreover, the current readmission measure does not capture ED visits.

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 Paul Masi, MedPAC's Executive Director, at 202-220-3700.

Sincerely,

Michael E. Chernew, Ph.D.
Chair

[19] Medicare Payment Advisory Commission. 2023b, *op cit*.