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May 24, 2024  
Ms. Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1806-P  
P.O. Box 8013  
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***Re: Medicare Program; FY 2025 Inpatient Psychiatric Facilities Prospective Payment System—Rate Update, CMS-1806-P***

Dear Administrator Brooks-LaSure:

The Association of American Medical Colleges (AAMC or the Association) welcomes this opportunity to comment on the proposed rule entitled “Medicare Program; FY 2025 Inpatient Psychiatric Facilities Prospective Payment System—Rate Update,” 89 *Fed. Reg.* 23146 (April 3, 2024), issued by the *Centers for Medicare & Medicaid Services* (CMS or the Agency).

The AAMC (Association of American Medical Colleges) is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. Its members are all 158 U.S. medical schools accredited by the Liaison Committee on Medical Education; 13 accredited Canadian medical schools; approximately 400 academic health systems and teaching hospitals, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America’s medical schools, academic health systems and teaching hospitals, and the millions of individuals across academic medicine, including more than 193,000 full-time faculty members, 96,000 medical students, 153,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Following a 2022 merger, the Alliance of Academic Health Centers and the Alliance of Academic Health Centers International broadened participation in the AAMC by U.S. and international academic health centers.

The Consolidated Appropriations Act (CAA) 2023 requires CMS to revise the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) methodology for determining payments, and CMS has requested feedback on potential changes to certain facility-level payments.<sup>1</sup> CMS seeks comment through three requests for information (RFIs) for the rural and teaching status adjustments along with a new payment adjustment for inpatient psychiatric facilities (IPFs) based on the Medicare Payment Advisory Commission (MedPAC) Medicare Safety Net Index (MSNI). The AAMC appreciates CMS’s commitment to refining the IPF PPS, as the long-term stability of these critical clinical sites ensures patients’ access to care.

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<sup>1</sup> Pub. L. 117-328.

The RFIs for rural and teaching status adjustments use CMS' analysis of prior year payments for IPFs to model prospective changes to the regression modeling for these facility-level adjustments. As part of the required review of payment adequacy, CMS has provided an analysis of these facility-level adjustments utilizing a different mix of variables than earlier regression analysis. In the third RFI, CMS seeks comment on the MedPAC-developed MSNI as applied to IPFs to create a payment adjustment similar in purpose to the disproportionate share hospital (DSH) payment.

Overall, the AAMC supports the RFIs' proposed revisions to facility-level adjustments for rural location and teaching status. The MSNI payment adjustment, as proposed, would be introduced to IPF PPS in a budget-neutral manner that would redistribute IPF payments instead of allocating additional funds to the IPF PPS. Through CMS's modeling, the addition of a safety net-specific payment adjustment could address some additional costs at certain IPFs, but the AAMC urges CMS to look for ways to incorporate such an adjustment that minimally impacts the IPF base rate payment. Because the total funding for IPFs may not increase due to the addition of an MSNI payment adjustment, it appears to affect the distribution of payments to IPFs significantly. While the MSNI payment adjustment would benefit some safety net IPFs, the AAMC fears the addition of the adjustment would also severely destabilize other safety net IPFs that do not fare as well under the MSNI methodology for reasons such as having a lower share of Medicare patients or incomplete uncompensated care data.

#### **RFI UPDATES TO THE RURAL LOCATION AND TEACHING STATUS ADJUSTMENTS**

The rural location adjustment has been part of the IPF payments from the inception of the IPF Prospective Payment System, with the intent of reimbursing rural IPFs for higher costs of care. (P. 23187). Since 2005, the rural adjustment has been set at 17 percent, based on regression analysis indicating that rural facilities' per diem costs were 17 percent higher than urban IPFs'. CMS performed an analysis on a MedPAR data set from CY 2019 through CY 2021 based on a new adjustment regression model that excludes occupancy rate variables. Through this analysis, CMS determined that holding all other variables constant, rural IPF costs are 19 percent higher than nonrural IPFs.

CMS should adopt policies that ensure the long-term stability of rural IPFs and to that end, the AAMC believes that the updated regression model for analyzing IPF costs more accurately reflects the reality rural IPFs face. The AAMC would note that the timeline for the data set used to analyze the new regression model overlapped with the start of the public health emergency caused by COVID-19. Before proposing future policies for facility payment adjustments, CMS could find value in looking at more current data sets to ensure that the updated regression model will have similar outcomes. Rural communities face unique access to care issues and changes to reimbursement should not harm rural IPFs. The updated regression analysis would increase the rural adjustment factor from 1.17 to 1.19, a welcomed update to account for the higher patient care costs in rural areas. (P. 23195).

Like the rural location adjustment, the teaching status adjustment has been part of the IPF PPS since 2005. Similar to the indirect medical education adjustment for Inpatient Prospective Payment System (IPPS) hospitals, the teaching status adjustment is meant to compensate teaching IPFs for higher patient care costs. The initial IPF PPS teaching adjustment was based on regression modeling that determined teaching status can account for higher patient care costs at teaching IPFs. The regression modeling informed the development of a "teaching variable" which is incorporated into the teaching status adjustment. The adjustment is calculated as one plus the ratio of residents to the average daily census,

raised to the “teaching variable” of 0.5150. When all other variables are held constant, an increase in the teaching variable will increase the teaching status adjustment payment.

Like the facility payment for rural locations, CMS modeled an updated teaching status adjustment based on regression modeling using the same set of MedPAR data from 2019 to 2021. CMS asks for comment on an RFI that models an updated teaching status variable after performing a regression analysis of the aforementioned data set. As modeled, the updated regression analysis would increase the teaching status adjustment factor from 0.5150 to 0.7286. (P. 23195-6). The AAMC believes the updated teaching adjustment factor more accurately reflects the additional patient care costs at teaching IPFs.

### **REQUEST FOR INFORMATION MSNI**

Unlike other prospective payment systems, the IPF PPS does not have an adjustment to the IPF base rate for a DSH payment. Medicare DSH payments assist acute care hospitals (subsection (d) hospitals) that serve a significantly disproportionate number of low-income patients. MSNI is an index developed by MedPAC as an alternative to the traditional DSH calculation, and MedPAC has recommended CMS consider the applicability of the MSNI to the IPF PPS. In response to a request from MedPAC, CMS has modeled an updated MSNI policy for the IPF PPS.

To analyze how an MSNI payment adjustment could impact the IPF PPS, CMS proposes a modified policy based on the MSNI RFI in the fiscal year (FY) 2024 Inpatient Prospective Payment System (IPPS) proposed rule.<sup>2</sup> Under the IPF PPS model, the MSNI is calculated as the sum of three ratios: the low-income subsidy (LIS) volume ratio, the proportion of revenue spent on uncompensated care costs (UCC), and the Medicare Dependency Ratio.<sup>3</sup> By statute, any changes in payment to IPF hospitals or facilities must be made in a budget-neutral manner.<sup>4</sup> Under the MedPAC proposal a pool of additional funding (\$4 billion) is part of the model and would be made available to help offset recent decreases in aggregate DSH payments to IPPS hospitals as well as the anticipated negative impacts of the MSNI to certain hospitals with lower relative shares of Medicare patients. The additional pool of funding is not available for, nor in the RFI for the IPF PPS. This means that funding for the addition of the MSNI payment adjustment would be funded entirely by cuts to IPF PPS payments for IPFs with lower MSNI values. As CMS modeling shows, proposing these changes without additional funds in a budget-neutral system will create wild swings in payments for many hospitals.

The AAMC highlighted reservations regarding the previous MSNI proposal in a comment letter to CMS for the FY 2024 IPPS proposed [rule](#). Specifically, redistributing payments based on the MSNI model would shift payments to hospitals that have a higher Medicare patient population and could reduce payments to many safety net providers with already low or negative margins. The AAMC believes the same issues are present in this proposal for the IPF PPS, but because IPFs do not receive DSH payments currently, nor are there any additional funds being offered to offset the cost of implementing the MSNI, the impacts could be greater for certain safety net IPF providers. CMS’s analysis shows that implementing the MSNI as proposed would have “significant distributional impacts,” which would reduce payments to IPFs with lower MSNIs. (P. 23197). Implementing MSNI payments along with the

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<sup>2</sup> 88 FR 58640.

<sup>3</sup> The proposed formula would be LIS + UCC + (0.5 \* Medicare Dependency Ratio) 89 FR 23196.

<sup>4</sup> 1886(s)(5)(D)(iii).

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needed modifications to the rural and teaching adjustment would require CMS to reduce the IPF base rate payment by approximately \$245, whereas implementing the new regression modeling for rural and teaching adjustments alone would reduce base rate payments by approximately \$6.

Additionally, some unique issues for IPFs likely impact the accurate modeling of an MSNI adjustment for IPF facilities and units. Specific to IPF units, UCC, and total revenue amounts are found in the hospital cost reports, meaning there is no unit-level data for UCC and total revenue. As such, the IPF unit UCC ratio is calculated using the hospital's UCC and revenue information. (P. 23197). CMS also highlights that some data is not available or that IPF cost report information is not as robust as IPPS cost report information. It is possible that a hospital and unit's patient mix is substantially different, which could impact the development of accurate estimations for unit costs.

Also troubling is CMS's finding that urban and rural IPF facilities are not reporting uncompensated care. This could be explained, in part, by the lack of a DSH payment for IPFs, but these facilities undoubtedly provide UCC. (P. 23197). Further understanding of this anomaly should inform MSNI regression modeling incorporating a UCC variable. Because IPF unit's UCC data is derived from a percentage of the hospital's cost report, and no UCC data is available for IPF facilities, the MSNI UCC factors are likely not representative of the true amount of uncompensated care at IPFs.

Further, CMS estimates that adding a new factor for MSNI will reduce the updated rural adjustment factor from 1.19 to 1.16 and reduce updates to the teaching status adjustment factor by 0.0331. The adoption of a safety-net payment adjustment should not be proposed in a manner that will make financially vulnerable IPF facilities less stable. For these reasons, while the AAMC supports the concept of adjusting payments for safety-net providers, CMS must ensure that any metric used to support these providers is developed with accurate, complete data and does not disadvantage other IPFs.

## CONCLUSION

Thank you for the opportunity to comment on this proposed rule. The AAMC supports the methodology for updating the regression models used to determine the rural and teaching status adjustments. CMS should further refine a safety-net payment that has a lower impact on IPF PPS base rate payments and ensure that adopting new payments increases IPF's financial stability. If you have questions regarding our comments, please feel free to contact Brad Cunningham at [bcunningham@aamc.org](mailto:bcunningham@aamc.org).

Sincerely,



Jonathan Jaffery, M.D., M.S., M.M.M., F.A.C.P.  
Chief Health Care Officer

cc: David Skorton, M.D., AAMC President and Chief Executive Officer