MEDPAC Medicare Payment Advisory Commission

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June 30, 2009

Charlene Frizzera, Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Blvd.
Baltimore, MD 21244-1850

Re: File code CMS-1495-NC

Dear Ms. Frizzera:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) notice entitled *Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System Payment Update for Rate Year Beginning July 1, 2009 (RY 2010); Notice*. We appreciate your staff's work on this prospective payment system (PPS), particularly given the competing demands on the agency.

Creation of a market basket for inpatient psychiatric facilities

In addition to establishing payment rates for RY 2010, the notice requests comments regarding the creation of a market basket specific to inpatient psychiatric facilities (IPFs) that could be used in place of the rehabilitation, psychiatric, and long-term care hospital (RPL) market basket. The RPL market basket was developed to measure the rate of inflation for the resources used in treating the specific types of patients served by these facilities. It is based on data from freestanding inpatient rehabilitation facilities, IPFs, and long-term care hospitals. Ideally, the market basket used to update payment rates for IPFs would be based on the best available data that accurately reflect the cost structures of IPFs only. Therefore, MedPAC supports study of this issue for IPFs, as well as for inpatient rehabilitation facilities and long-term care hospitals.

Creating a market basket specific to IPFs necessitates a better understanding of the differences in the underlying cost levels and structures of freestanding versus hospital-based IPFs. To date, research examining geographic variation, case mix, urban and rural status, length of stay, teaching status, and the presence of a qualifying emergency department has not yielded satisfactory explanations for these cost differences. Without an understanding of the reasons for the cost differences, it is impossible to know if Medicare should recognize them. For example, hospital-based IPF units may have higher costs because of the allocation of overhead to the unit; Medicare may not want to include these costs in an IPF market basket. On the other hand, hospital-based IPF units may have higher costs due to differences in case mix or patient severity that is not measurable using available administrative data. Additional research is needed to determine the source of these differences and to determine whether those differences should be recognized.

CMS has requested help from the public in the form of additional information or data to help the agency better understand differences in the cost level and structure across hospital-based and freestanding IPFs to inform the potential construction of a sector-specific market basket. While we believe that seeking outside input is appropriate, we advise the agency to proceed with caution in using outside data. It may be difficult for CMS to confirm that the methods used to collect outside data are sound and that the data are representative of the industry overall. For example, questions have been raised about whether some of the data used to determine the practice expense relative value units for the physician fee schedule were adequately representative of practice costs for certain specialties. This may have resulted in distorted physician payments. Therefore, as CMS reviews outside data, we urge the agency to evaluate (1) the soundness of any information submitted by providers to help explain observed cost differences between free-standing and hospital-based providers; and (2) whether the market basket should be based on the cost structure of both freestanding and hospital-based facilities, or of just one type of facility if higher costs in another type cannot be explained by differences in case mix and other patient characteristics.

Temporary increase in resident caps

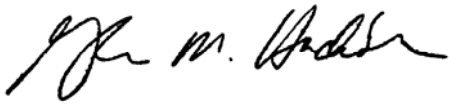
The notice also requests comments on whether CMS should permit an increase in an IPF's Medicare resident cap when residents transfer to an IPF because their original training facility closes (or closes its residence program). Such an increase is allowed on a temporary basis under the IPPS. If an acute care hospital closes, a temporary adjustment to the FTE caps of a hospital that trains displaced residents is allowed for as long as those residents are displaced (and as long as the original hospital remains closed). If a hospital closes just its residency program, the temporary adjustment is allowed for an "adopting" hospital if the original hospital agrees to temporarily reduce its FTE cap based on the FTE residents training in the program at the time of the program's closure. In both cases, the temporary adjustment to the FTE cap allows adopting hospitals to count the displaced FTE residents for Medicare payment purposes.

Although the extent of the problem of displaced psychiatry residents is not clear at this time, the number of inpatient psychiatric units is declining. We therefore agree that a temporary increase in the resident cap, such as that allowed for acute care hospitals, would provide an incentive for IPFs to accept those psychiatry residents who are displaced by the closure of residency training programs.

MedPAC appreciates the opportunity to comment on the important policy proposals crafted by the Secretary and CMS. The Commission also values the ongoing cooperation and collaboration between CMS and MedPAC staff on technical policy issues. We look forward to continuing this productive relationship.

If you have any questions, or require clarification of our comments, please feel free to contact Mark Miller, MedPAC's Executive Director, at (202) 220-3700.

Sincerely,



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Chairman