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June 22, 2018

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

RE: File code CMS-1694-P

Dear Ms. Verma:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Medicare 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 2019 Rates; Proposed Quality Reporting Requirements for Specific Providers; Proposed Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (Promoting Interoperability Programs) Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Medicare Cost Reporting Requirements; and Physician Certification and Recertification of Claims; Proposed Rule* published in the *Federal Register* on May 7, 2018. The rules revise the hospital inpatient prospective payment system, the long-term care hospital (LTCH) payment system, and quality reporting requirements for specific providers. In view of the competing demands on their time, we especially appreciate your staff's efforts to improve these hospital payment systems.

In this letter we comment on:

- Payment rates for services using chimeric antigen receptor T-cell therapy (CAR-T)
- Measuring uncompensated care on the hospital cost report's S-10 worksheet
- Hospital wage index
- Changes in hospital quality and value payment programs
- The LTCH prospective payment system (PPS)

Payment rates for services using CAR-T therapy

The FY 2019 proposed rule discusses proposals for Medicare payments to inpatient hospitals for chimeric antigen receptor T-cell therapy (CAR-T). CAR-T is a type of immunotherapy used to treat certain types of cancer that involves collecting and genetically modifying the patient's own T-cells. Patients receiving CAR-T therapy may be hospitalized during and after the treatment, as the treatment is associated with severe reactions in some patients.

Currently, two CAR-T products have been approved—Kymriah and Yescarta—and both are expensive. Both products are approved for adult patients with certain advanced lymphomas who have already tried two other kinds of treatment. Kymriah is also approved for young patients (up to age 25) with certain acute lymphocytic leukemias. CAR-T products have an extremely high list price. Yescarta has a list price of \$373,000. Kymriah's list price is \$475,000 for leukemia and press reports suggest that the manufacturer of Kymriah has matched Yescarta's list price of \$373,000 when used for lymphoma patients.¹

For FY 2019, CMS proposes to assign patients treated with CAR-T products to an existing MS-DRG (MS-DRG 016) that currently includes certain bone marrow transplants. CMS requests comments on its proposal to assign CAR-T therapy to this MS-DRG. In addition, CMS requests comments on whether CAR-T therapy meets the criteria for its own MS-DRG, and if so, how such a payment should be determined in the absence of Medicare claims and cost report data for the therapy.

The manufacturers of the two CAR-T products have applied for Medicare's new technology add-on payments (NTAP). CMS has indicated that the agency considers these products substantially similar and will consider their NTAP application jointly. CMS seeks comment on whether these products meet the criteria for an NTAP.

Given the extraordinarily high cost of CAR-T products, CMS also seeks comment on alternate methodologies it could use to establish payment for CAR-T therapy. As one alternative, CMS suggests it could use a cost-to-charge ratio (CCR) of 1.0 in estimating the costs of the CAR-T product for the potential NTAP and outlier payment calculations, and for the inpatient prospective payment system (IPPS)-exempt cancer hospitals' payment formula. This would presume that hospitals charged their actual costs for the CAR-T product. As a rationale, CMS indicates that it has received a number of public comments suggesting that hospitals would not inflate their charges for the CAR-T product given its high price and that consequently a CCR of 1.0 could be warranted.

¹ Beasley, D. 2018. U.S. approves Novartis cell therapy for lymphoma. *Reuters*. May 1. <https://www.reuters.com/article/us-novartis-pharmaceuticals/u-s-approves-novartis-cell-therapy-for-lymphoma-idUSKBN1I24GP>

Comment

We support CMS's proposal to pay for inpatients receiving CAR-T therapy in FY 2019 through an existing MS-DRG, with a potential new technology add-on payment (if CMS determines CAR-T meets the criteria) and outlier payments. Over the years, this approach has provided a mechanism for CMS to incorporate payment for new technologies into the IPPS while creating incentives for efficiency and for sharing risk between providers and the Medicare program. This approach would cover most (but not all) of any losses hospitals realized on inpatients receiving CAR-T therapy.

The Commission contends it is important to maintain the structure of the IPPS and not create policies that would unbundle services covered under the IPPS or create incentives that encourage high launch prices of new technologies. The IPPS has an established process for incorporating payment for new technologies, including drugs and devices, into the payment system. New technologies are paid through existing MS-DRGs. Since the cost of a new technology may not be reflected in the data that is used to establish the MS-DRG payment rates, a manufacturer can apply for a new technology add-on payment (NTAP) for the first three years a product is on the market. To qualify for an NTAP, a technology must meet three criteria that include being different from existing technologies, being high cost relative to the MS-DRG payment amount, and representing a substantial clinical improvement. The NTAP is capped at 50 percent of the estimated cost of the new technology. Cases that receive an NTAP may also receive an outlier payment if the cost of the case exceeds the MS-DRG payment plus the NTAP by more than the fixed loss amount. In the case of outlier payments, the IPPS pays 80 percent of a hospital's costs above the fixed loss amount.

We contend CMS should work through its established process to determine initial payment for CAR-T therapy. We support CMS paying for CAR-T in FY 2019 through an existing MS-DRG, a potential NTAP (if CMS determines CAR-T meets the three criteria for an NTAP), and outlier payments. We do not support creating a new MS-DRG for CAR-T for FY 2019 without claims data for patients receiving this therapy and cost report data for hospitals providing it. Once claims and cost report data for CAR-T therapy become available, CMS could consider establishing a new MS-DRG, consistent with its established process for doing so under the IPPS.

We agree that efforts should be made to accurately estimate the costs of the CAR-T product for the purposes of calculating a potential NTAP, outlier payments, and cancer hospital cost calculations, but we are concerned about a policy that would set the CCR for CAR-T equal to 1.0. Generally, hospitals inflate charges for services above their incurred costs. The Commission recently estimated that, on average, hospitals' charges are more than three times their actual costs.² A CCR of 1.0 for CAR-T would presume hospitals charged their actual costs, despite the financial incentive to increase charges. While it is possible that some hospitals may not inflate charges for the CAR-T product, it is not possible to know how common a practice that would be among

² Medicare Payment Advisory Commission. 2017. *A Data Book: Health care spending and the Medicare program*, Washington, DC: MedPAC.

hospitals. Furthermore, we are concerned that presuming charges equal costs could set a precedent for other items or services going forward.

Rather than using a CCR of 1.0 in the NTAP, outlier payment, and cancer hospital cost calculations, we support using the average sales price (ASP) with a two-quarter lag as an estimate of the cost of CAR-T products. ASP reflects the average manufacturer price to all purchasers net of rebates and discounts, with certain exceptions. The two-quarter lag in ASP could create incentives for price reductions. If the price of CAR-T declined, that decline would not be immediately reflected in ASP, and thus hospitals would benefit from the use of the higher ASP in the cost calculations for two quarters (even if the hospital received the price reduction). The ASP for the two CAR-T products could be averaged to permit use of a single average ASP for the cost of CAR-T in these calculations. Such averaging would put the products on a level playing field and could create incentives for price reductions. It is important to note that hospitals will incur other costs in treating patients receiving CAR-T therapy besides the cost of the CAR-T product itself. We are advocating that CMS use ASP to estimate the cost of the CAR-T product and use the standard charges-reduced-to-cost methodology to estimate the other costs associated with treating inpatients receiving CAR-T therapy.³

In future years, if CMS does consider creating a unique MS-DRG for an extraordinarily high-cost product like CAR-T therapy, it should be cognizant of issues related to the standard wage adjustment approach under the IPPS. Because the prices of drugs and biologics do not generally vary geographically, it would be inequitable to apply the standard wage adjustment to the payment for a MS-DRG that included CAR-T. (Initially assigning CAR-T to an existing MS-DRG with a potential NTAP and outlier payments would mitigate this concern in the short-run because NTAP and outlier payments are not wage adjusted.) We would request the agency to consider whether a different labor/non-labor share should be used for wage adjustment of any new MS-DRG for CAR-T therapy as well as for other MS-DRGs that may include unusually high-cost technologies.

In the longer run, with respect to Medicare payment policy for drugs more broadly, if manufacturers continue to launch drugs at extraordinarily high prices, there may be merit in considering whether new approaches for handling payment for these services are warranted. The Commission's June 2017 recommendation for the establishment of a Part B Drug Value Program (DVP) is an example of a potential new approach to Medicare payment for drugs. The voluntary DVP program would use a third-party vendor to negotiate Part B drug prices with manufacturers on behalf of providers and would permit the vendor to use tools such as formularies to enhance negotiating leverage. The Commission's DVP model also included binding arbitration as a tool that could be used to facilitate vendor and manufacturer negotiations for high-priced drugs without

³This suggestion to use ASP as the estimated cost of the CAR-T product in the potential NTAP, outlier, and cancer hospital cost calculations would apply to situations where the hospital had to pay the manufacturer for the CAR-T product administered to its patient. If there were contractual arrangements between manufacturers and hospitals where a hospital does not pay for the CAR-T product if the patient does not achieve a certain outcome, it would be important that CMS have processes in place to ensure that the Medicare program does not pay for the CAR-T product in that situation.

close substitutes. Although the Commission did not consider the DVP with respect to Part A–covered drugs, there may be merit in considering whether such a model could accommodate certain high-priced products regardless of the setting in which they are administered.

More generally, as policymakers consider alternative approaches to address payment for high-cost drugs, it is important to recognize that the establishment of special payment methods for high-cost products could create incentives for manufacturers to set high prices as a way to circumvent the normal payment systems. Care would need to be taken in devising any special approaches to ensure that they incorporate strong incentives to constrain drug prices.

Measuring uncompensated care on the hospital cost report’s S-10 worksheet

Medicare adjusts inpatient payment rates to increase payments to hospitals with a “disproportionate share” (DSH) of low-income patients, as measured by the disproportionate patient percentage (DPP). The DPP is computed as the sum of two fractions: the “Medicare SSI fraction” and the “Medicaid fraction.” The “Medicare SSI fraction” is the hospital’s share of Medicare patients that are low-income; it is computed as the share of Medicare inpatient days attributable to patients entitled to supplemental security income (SSI). The Medicaid fraction is the hospital’s share of total inpatient days attributable to Medicaid patients. The policy pays higher inpatient rates for hospitals with a high DPP.

In 2010, Congress enacted several changes to DSH payment policy in the Patient Protection and Affordable Care Act (PPACA). Under the updated DSH policy, CMS determines the amount of Medicare dollars that are potentially available for distribution as DSH and uncompensated care payments using the traditional DSH formula that is based on the DPP. However, rather than distribute the whole pool as traditional DSH payments, a portion of the pool is made available to hospitals as uncompensated care payments, and a portion is returned to the Medicare Part A trust fund as savings, assuming the rate of uninsurance remains below the rate of uninsurance in 2013 (presumably reducing the need for uncompensated care payments below the 2013 level). For fiscal year (FY) 2019, CMS calculated the size of the pool of potential DSH and uncompensated care dollars to be \$16.3 billion. CMS proposed to allocate this pool of dollars as follows:

- 1) CMS will pay 25 percent of the pool (\$4.1 billion) based on the traditional **DSH** formula.
- 2) The remaining 75 percent of the pool (\$12.2 billion) will be further divided into two parts:
 - a) For every 1 percent decline in the rate of uninsurance, the share of the remaining pool allocated to trust fund savings increases by 1 percentage point. CMS estimates that the rate of uninsurance in FY 2019 will be 32 percent lower than in 2013. This means that 32 percent of the \$12.2 billion (\$3.9 billion) will be **savings for the Medicare Part A trust fund**.

- b) The remaining \$8.3 billion (68 percent of \$12.2 billion) will be distributed to partially pay for **uncompensated care** costs at hospitals in 2019. The distribution of these payments depends on each hospital's estimated share of uncompensated care.
- 3) On net, hospitals will receive a total of **\$12.4 billion in combined Medicare DSH and uncompensated care dollars**.

Each DSH hospital's share of the \$8.3 billion will equal its estimated share of historical uncompensated care costs over the most recent three years of data available.

Comment: Computing uncompensated care on worksheet S-10

In FY 2018, CMS started to use the worksheet S-10 from the Medicare hospital cost reports to estimate hospitals' share of uncompensated care costs. While not perfect, using the S-10 computation is an improvement over the prior policy of using Medicaid days as a proxy for uncompensated care costs. However, the Commission is concerned that worksheet S-10 was changed for fiscal year 2017 in a way that created an incentive for hospitals to inflate charges. Prior to the 2017 change to worksheet S-10, uncompensated charity care costs were computed as the cost of care minus any payments received. These costs were derived by multiplying charges by the hospital's cost-to-charge (CCR). The prior formula was:

$$\text{Estimated uncompensated care cost} = (\text{Charges} \times \text{CCR}) - \text{Payments}.$$

For fiscal year 2017, CMS changed the computation of charity care costs. The difference is that payments are first subtracted from charges, then as a second step the reduced charges are multiplied by the CCR. The new formula is:

$$\text{Estimated uncompensated care cost} = (\text{Charges} - \text{Payments}) \times \text{CCR}.$$

The change does not affect the computation of uncompensated care costs in cases where 100 percent of charges are forgiven and payments are zero. However, for cases where a patient is given a partial discount, this change in the computation has two effects. First, it increases the estimated cost of uncompensated care on average. Second, the largest increase in uncompensated care payments will be for the hospitals with the largest markups of charges relative to costs. Because the pool of uncompensated care dollars is fixed and allocated based on each hospital's share of all uncompensated care costs, this second effect causes a shift in the allocation of uncompensated care dollars toward hospitals with larger markups. This in turn creates an additional incentive (on top of existing incentives) for hospitals to increase their markups.

To illustrate the problem, we created an example comparing a low-markup hospital and a high-markup hospital. It shows that, under current S-10 rules, the estimated cost of uncompensated care will be higher at the high-markup hospital even if the two had equal costs and gave an equal discount off the true costs of care. The illustrative example below is for a CT scan provided to an uninsured patient

who qualified for a discount from full charges under the hospital’s financial assistance policy. In this example, the hospital with higher charges for a CT scan (\$2,100) and a higher discount off charges (\$1,700) billed the patient \$400 for a service that cost \$500. Given the new S-10 computation, the hospital appears to provide \$405 of uncompensated care. In contrast, the low-markup hospital (which, like the high-markup hospital, also lost \$100 on the case) would appear to be providing less charity care (\$167 compared with than \$405) and thus would get less of the fixed pool of uncompensated care dollars. As a point of reference, under the prior formula, the uncompensated cost of the charity care discount would have been estimated to be \$100 for both hospitals.

Table 1: High markups lead to higher uncompensated care payments

	20% mark up	320% mark up
Charge for a CT scan	\$600	\$2,100
Cost	\$500	\$500
Uninsured discount	\$200	\$1,700
Amount billed and paid	\$400	\$400
Profit (loss)	(\$100)	(\$100)
Cost-to-charge ratio	0.833	0.238
Computed charity care costs under new formula (CCR x discount)	\$167	\$405
Computed charity care costs under the prior formula (cost-payments)	\$100	\$100

In sum, the new S-10 computation of uncompensated care reasonably estimates bad debt costs and charity care costs for cases where 100 percent of charges are forgiven as charity care; however, it creates an issue for cases where a person receiving financial assistance is given a partial charity-care discount. The Commission urges CMS to revert to measuring the cost of uncompensated care by first estimating costs and then subtracting payments. This would remove one of the incentives hospitals currently have to inflate charges and would prevent a misallocation of the fixed pool of uncompensated care dollars toward high-markup hospitals.

Hospital wage index

The FY 2019 proposed rule discusses several technical changes to the current hospital wage index system and invites comment on reforming this system more broadly. Three of the proposed technical changes to the current wage index system are of particular interest to the Commission.

- *Reclassification policy:* For FY 2019, CMS proposes changes that would permit nearly one-third of IPPS hospitals (1,043 hospitals) to receive either a reclassification to a different geographic area with a higher wage index or a specific exception to their original FY 2019 geographic wage index. To maintain budget neutrality, payments to all other hospitals will decline.
- *Rural floor policy:* The rural floor policy ensures urban hospitals do not have wage indexes lower than the wage index of the rural hospitals in their state. For FY 2019, CMS proposes to increase inpatient payments to 255 hospitals by roughly \$205 million as the result of the rural floor policy. These increases are also budget neutral, meaning payments to all other hospitals will be reduced.
- *Imputed rural floor policy:* Since 2005, the temporary three-year imputed rural floor policy has been used to estimate a rural floor wage index in states without rural areas, such as New Jersey. For FY 2019, CMS proposes to allow the imputed rural floor policy to expire.

Comment

The FY 2019 proposed rule's technical changes to the current hospital wage index system raise questions regarding whether this system equitably adjusts payments for local input costs. The exceptions built into the current wage index system erode the accuracy of the IPPS. That nearly 30 percent of PPS hospitals would receive a wage index reclassification in 2019 is evidence of a broken system. Similarly, the negative attributes of the rural floor policy have been well documented since 2012. Annually, the rural floor policy redistributes approximately \$200 million to \$400 million to roughly 250 hospitals in a handful of states. This policy is funded by reducing payments to all other hospitals nationally, rather than by reducing payments to other hospitals within the states to which this policy applies. In addition, while the Commission supports the proposed expiration of the imputed rural floor policy, this policy (like the others discussed above) has for several years been a part of the array of exceptions that erode the integrity of the IPPS. Therefore, the imputed rural floor policy should be permitted to expire in FY 2019, but reforming of the wage index system is required on a broader scale.

Responding in part to the array of policy exceptions built into the current hospital wage index system, the Commission's original perspective on this system was established in 2007 when we published our Congressionally mandated report on this subject.⁴ Each year since 2007 the Commission has consistently highlighted the existing system's inaccuracy, the circularity of hospital-reported data, the large volume of permitted exceptions, and administrative complexity. Because these concerns are still germane today, we reiterate our 2007 recommendation that the Congress repeal the current wage index system and give the Secretary the authority to create a new wage index system that:

⁴ Medicare Payment Advisory Commission. 2007. *Report to the Congress: Promoting greater efficiency in Medicare*. Washington, DC: MedPAC.

- Uses compensation data from all employers together with hospital industry-specific occupational weights;
- Adjusts for geographic differences in the ratio of benefits to wages;
- Adjusts at the county level and smooths large differences between counties; and
- Is implemented so that large changes in wage index values are phased in over a transition period.

As summarized in the FY 2019 IPPS proposed rule, two significant research evaluations commissioned by the Secretary and performed by Acumen and the Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine (formerly the Institute of Medicine) concluded that MedPAC's proposed wage index system would be an improvement over Medicare's current hospital wage index system. These two evaluations also concluded that employment and wage data should originate from the Bureau of Labor Statistics and should be smoothed to account for differences in wage indexes across adjacent payment areas.⁵ We hope this invitation for additional feedback in the FY 2019 proposed rule initiates action on this critical element of Medicare's hospital payment system.

Changes in hospital quality and value payment programs

In October 2017, CMS launched the Meaningful Measures Initiative aimed at improving patient outcomes and reducing burden by using a reduced set of the measures for patients, clinicians, and providers in quality programs. As a part of the initiative, CMS identified 19 high-priority areas for quality measurement with a focus on improving patient outcomes (e.g., admissions and readmissions to hospitals, patient's experience of care, transfer of health information, preventive care).

Under the hospital Value-Based Purchasing (VBP) program, CMS makes incentive payments to hospitals meeting performance standards on a set of quality measures. As a part of the Meaningful Measures Initiative, CMS proposes to remove a total of 10 measures from the VBP program. All of these measures would continue to be used in other hospital quality payment programs (e.g., the Hospital-Acquired Condition Reduction Program). This de-duplication would eliminate the patient safety domain of the VBP, and as a result, CMS is proposing to adjust the weights of the VBP measure domains: Clinical Outcomes domain—50 percent; Person and Community Engagement domain—25 percent; and Efficiency and Cost Reduction domain—25 percent. CMS also proposes to remove 39 measures from the Inpatient Quality Reporting (IQR) program, which reduces a hospital's annual market basket update if the hospital does not report quality measure data. CMS

⁵ Institute of Medicine. 2011. *Geographic adjustment in Medicare payment, Phase I: Improving accuracy. Second edition*. Washington, DC: The National Academies Press.

asserts that these measures are either duplicative of measures in the other hospital quality payment programs or do not meet CMS's meaningful measure factors.

CMS has been reviewing public comments on the issue of accounting for social risk factors in the VBP and IQR programs and reports prepared by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the National Academies of Sciences, Engineering, and Medicine. CMS continues to consider options to address equity and disparities in value-based purchasing programs. Based on these sources and a mandate contained in the 21st Century Cures Act of 2016, CMS plans to divide hospitals into quintiles based on the share of their Medicare patients (FFS and MA patients) that are fully dual-eligible beneficiaries. Hospitals that have readmission rates above the median of their quintile would receive a readmission penalty.

Comment

The Commission is concerned that there is too much overlap among the measures of the various hospital quality payment and reporting programs. This overlap creates unneeded complexity in the Medicare program. The Commission also asserts that the existing programs include process measures that are burdensome to report and not tied to outcomes.

The Commission has recently formalized a set of principles for measuring quality in the Medicare program. Overall, quality measurement should be patient oriented, encourage coordination, and promote delivery system change. The Commission asserts that Medicare quality incentive programs should use a small set of outcomes, patient experience, and value measures that are not unduly burdensome to assess the quality of care across different populations, such as beneficiaries enrolled in Medicare Advantage (MA) plans, accountable care organizations (ACOs), and fee-for-service (FFS) in defined market areas, as well as those cared for by specified hospitals, groups of clinicians, and other providers. The goals of CMS's Meaningful Measures Initiative—to improve patient outcomes and reduce burden—align with the Commission's principles. As CMS continues to revise Medicare quality programs with a focus on meaningful measures, we encourage CMS to use a uniform set of population-based outcome measures across settings and populations.

As described in our June 2018 report to the Congress, the Commission has examined the potential to create a single quality-based payment program for hospitals to replace Medicare's four hospital payment incentive programs. Under our redesign, the multiple hospital quality payment programs would be streamlined and consolidated under a single hospital value incentive program (HVIP) that scores a small set of population-based outcome, patient experience, and value (e.g., Medicare spending per beneficiary) measures. Over the next year, the Commission plans to continue to refine a design for an HVIP that conforms with our principles for quality measurement. Some topics the Commission will further explore include weighting of measures, payment withhold amounts, patient experience measures, and patient safety measures.

Legislation would be required for CMS to implement a redesigned hospital quality payment program, such as MedPAC's HVIP. In the interim, CMS should continue to improve the existing systems consistent with our principles. Therefore, we support CMS's proposal to remove

duplicative process measures from both the VBP program and IQRP. The Commission also generally supports the greater weighting of the clinical outcomes VBP domain, and the Commission will be evaluating weighting of the HVIP domains this fall. The Commission also supports the proposal to remove chart-abstracted, process measures from the IQRP that are unduly burdensome and not tied to outcomes.

The Commission supports CMS's continued consideration of how to account for social risk factors in Medicare quality program. The Commission asserts that the Medicare program should incorporate differences in providers' patient populations—which affect providers' performance on quality measures, including social risk factors—and that Medicare should account for social risk factors in quality programs by adjusting payment through peer grouping.

As we stated in last year's comment letter, we suggest two adjustments to CMS's implementation of peer grouping in the HRRP. These adjustments align with the Commission's design of the potential HVIP. First, CMS should base the peer group only on the share of FFS patients that are fully dual eligible, not on the share of all (FFS and MA) patients. The penalty does not apply to readmissions of MA patients, and we assert that their risk characteristics could distort the risk profiles of hospitals because the income characteristics of FFS and MA patients may differ for particular hospitals. Second, in our own readmission work we found that hospitals in the highest decile of low-income shares have much higher excess readmissions than those in the ninth decile. Therefore, the Commission contends that deciles, rather than quintiles, more completely capture the challenges of hospitals with the highest share of low-income patients.

The LTCH PPS

CMS proposes several changes to LTCH payment policy, including updating the LTCH PPS standard federal payment rate by 1.15 percent, permanently eliminating or providing a one-year delay in implementing the 25-percent threshold policy, and removing three quality measures collected as part of the LTCH quality reporting program.

Update to the proposed rates under the LTCH PPS

CMS proposes to increase the LTCH PPS standard federal payment rate by 1.15 percent based on an estimated market basket increase of 2.7 percent less the estimated adjustment for multi-factor productivity (0.8 percentage point) and an additional factor of 0.75 percentage point as required by PPACA. Providers that fail to submit data required for the LTCH quality reporting program (QRP) will have their payments reduced by an additional two percentage points, resulting in a 0.85 percent decrease to their payments under the LTCH PPS for fiscal year 2019.

Comment

In its March 2018 report to the Congress, after reviewing many factors—including indicators of beneficiary access, the volume of services, the supply of providers, and access to capital—the

Commission recommended that the LTCH market basket update be eliminated for 2019. The Commission concluded that LTCHs could continue to provide Medicare beneficiaries with access to safe and effective care without an update to the LTCH PPS payment rates in FY 2019. We reiterate our recommendation that the Secretary to eliminate the LTCH payment update for FY 2019.

In 2017, the Commission recommended to the Congress that all post-acute care providers be paid under a unified post-acute care (PAC) PPS. A PAC PPS would pay for services based on the characteristics of the patient, rather than the setting in which the care was provided. In 2018, the Commission recommended to the Congress that, prior to the implementation of a PAC PPS, setting-specific payments be blended with payments established under a unified PAC PPS beginning in fiscal year 2019. Such blending would begin to redistribute payments within the LTCH setting by increasing payments for medically complex patients and lowering payment for patients with less complex conditions.

Eliminating or delaying the implementation of the 25-percent threshold

In FY 2005, CMS established the 25-percent threshold policy. The goal of this policy was to prevent LTCHs from functioning as units of ACHs. Under the 25-percent threshold policy, payments to LTCHs that admit a large share of their patients from a single ACH are reduced. The 25-percent threshold policy initially applied only to LTCH hospitals-within-hospitals (HWHs) and LTCH satellites, with a less restrictive threshold specified for LTCHs located in rural areas or in areas with an MSA-dominant IPPS hospital. In July 2007, CMS extended the rule to freestanding LTCHs. However, the Congress subsequently delayed full implementation of the 25-percent threshold so that most HWHs and satellites continue to be paid standard LTCH rates for eligible patients admitted from their host hospitals as long as the percentage of Medicare admissions from the host hospital does not exceed a 50 percent threshold. In addition, the Secretary was prohibited from applying the 25-percent threshold to freestanding LTCHs before July 1, 2016 and was permanently prohibited from applying the 25-percent threshold policy to certain co-located facilities. Subsequently, CMS or the Congress delayed fully implementing the 25-percent threshold policy through September 30, 2018. In its FY 2019 proposed rule, CMS proposes to either delay implementing the 25-percent threshold policy for an additional year or to permanently eliminate the policy.

Comment

Since 2008, the Commission has supported the intent of the 25-percent threshold policy to help ensure that long-term care hospitals do not function as step-down units of acute care hospitals and that decisions about admission, treatment, and discharge in both acute care hospitals and LTCHs are made for clinical rather than financial reasons. Some have argued that with the implementation of the Pathway for SGR Reform Act's provisions reforming the LTCH PPS, the 25-percent threshold policy is no longer necessary. However, the Commission notes that the Pathway for SGR Reform Act of 2013 uses a broad definition of cases eligible for the LTCH standard payment rate. Under the current policy, over 20 percent of IPPS cases are potentially eligible to receive the LTCH standard payment rate, if admitted to an LTCH. By contrast, in our 2014 report to the

Congress, the Commission recommended a policy that would result in only 6 percent of IPPS cases eligible for the LTCH standard payment, if subsequently admitted to an LTCH.⁶ Therefore, the Commission concludes that there are still cases that could be treated in a lower-cost setting that would receive the LTCH standard payment rate under current law.

The Pathway for SGR Reform Act of 2013 mandates the Commission to evaluate the impact of changes associated with the LTCH dual-payment structure as it applies to the quality of patient care, hospice and other post-acute care, different types of LTCHs, and the growth in Medicare spending for services before June 30, 2019. This mandate also requires us to examine the continued need for the 25-percent threshold policy. We, therefore, request that CMS does not permanently eliminate the 25-percent threshold policy at this time.

LTCH quality reporting program

As with the hospital quality payment programs, CMS applied the Meaningful Measures Initiative to the LTCH Quality Reporting Program measures with the aim of improving patient outcomes and reducing burden by using a reduced set of measures for patients, clinicians, and providers in quality programs. Based on the evaluation, CMS proposes to remove two measures beginning in FY 2020 (i.e., facility-wide hospital-onset methicillin-resistant *Staphylococcus aureus* (MRSA) bacteremia outcome, ventilator associated event outcome), and one measure beginning in FY 2021 (i.e., percent of patients who were assessed and appropriately given the seasonal influenza vaccine).

Comment

The Commission supports the removal of the three quality measures that are either topped-out (e.g., performance across LTCHs is high) or for which the costs of measuring outweigh the benefits. As CMS continues to revise Medicare quality programs with a focus on meaningful measures, we encourage CMS to use a uniform set of population-based outcome measures across settings and populations.

If you have questions about any of the issues raised in our comments, please contact James E. Mathews, MedPAC's Executive Director, at (202) 220-3700.

Sincerely,



Francis J. Crosson, M.D.
Chairman

⁶ Medicare Payment Advisory Commission. 2014. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.