MEDPAC Medicare Payment Advisory Commission

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June 25, 2013

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: File code CMS-1599-P

Dear Ms. Tavenner:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) acute and long-term care hospitals proposed rule, published in the *Federal Register* on May 10, 2013. The proposed rule addresses the hospital inpatient prospective payment system for acute care hospitals, the long-term care hospital prospective payment system, and quality reporting requirements for specific providers. In view of their competing demands and limited resources, we especially appreciate your staff's efforts to improve hospital payment systems.

In this letter we have eight comments:

- The proposed adjustments for documentation and coding changes are reasonable. However, we suggest that the proposed 0.8 percent adjustment in 2014 be explicitly parsed as a prospective adjustment of 0.55 percent and a retrospective adjustment of 0.25. This would prevent overpayments from continuing into 2014. The remaining recoveries of past overpayments could occur in future years.

- With respect to disproportionate share (DSH) and uncompensated care payments, we agree with most of the steps CMS is taking to implement the new uncompensated care program mandated by the Patient Protection and Affordable Care Act of 2010 (PPACA). However,

we are concerned about the proposal to allocate uncompensated care dollars among hospitals based only on the number of Medicaid and supplemental security income (SSI) days at a hospital. This will essentially defer implementation of uncompensated care payments by one year. Our 2007 report to the Congress showed the current DSH system—which is also based on Medicaid and SSI days—does a poor job of directing funds toward hospitals with high shares of uncompensated care. We believe that the S-10 form is a better source of data and should eventually be used as the source of uncompensated care data. However, CMS raised concerns that the S-10 data may be flawed because they are reported on a new form in the cost report and suggested that reporting will improve over time. Balancing these two concerns, we suggest CMS distribute uncompensated care payments based on a blend of uncompensated care data from cost reports (form S-10) along with the Medicaid and SSI days as CMS proposes. We believe a four-year transition (2014 to 2017) to fully using S-10 data would accomplish the goal of the legislation without causing a financial shock to hospitals. We also support CMS' proposal to make interim payments to hospitals to help them avoid cash flow difficulties.

- CMS' proposed rules governing the readmissions policy conforms with requirements under current law, but adjustments to the law may be needed over the longer term as we discuss in our June 2013 report to Congress.
- With respect to quality measurement and incentives, we support the movement toward placing a greater weight on outcomes measures. However, with respect to the policy on hospital acquired infections, we suggest that CMS only use CDC hospital-acquired infections measures. These are more robust than the claims-based indicators of infections.
- In 2014, the low-volume adjustment will revert back to a prior low-volume policy that does a better job of targeting isolated low-volume hospitals that lack economies of scale. However, CMS should reconsider whether there is empirical support for expanding the policy to increase payments for hospitals with up to 500 total discharges.
- The law governing the wage index system needs to be changed. Current exceptions initiated in law or in regulation need to cease, and a new wage index system needs to be put in place.

- With respect to CMS's discussion of possible policy changes to the long-term care hospital (LTCH) PPS that would encourage the LTCH industry to refocus its admitting practices on serving chronically critically ill and medically complex (CCI/MC) patients, we believe the policy potentially represents a first real step towards criteria for LTCH patients that would appropriately limit high LTCH payment rates to the most medically complex patients who may be most likely to benefit from an LTCH program of care. This approach has the potential for significant Medicare savings, at least in the short run. The approach also may expand the concept of site neutrality by limiting payments for other cases admitted to LTCHs to IPPS payment rates for the same MS-DRGs. The Commission remains concerned, however, about the level of payments for medically complex patients in both LTCHs and ACHs. While the Commission continues to support the use of criteria to justify higher LTCH payments, we urge CMS to continue to strive toward site-neutral payments so that Medicare pays the same, subject to risk differentials, for the same services, regardless of where the services are provided.
- With respect to the proposed new quality measures for inpatient psychiatric facilities, we have concerns about all three proposed measures. We are concerned about balancing the benefits of quality measurement with the burden associated with data collection efforts. Before adding these or any new process measures to the IPFQR program, CMS should critically evaluate the extent to which the measures contribute to meaningful differences in health outcomes among IPFs and over time. Where possible, CMS should focus on quality measures that are outcomes based rather than process based.

Adjusting payments for documentation and coding changes

Congress mandated that CMS recover $11 billion in past overpayments that resulted from documentation and coding changes that occurred following implementation of MS-DRGs in 2008. The recoveries must be completed by 2017. We concur with CMS' proposal to not take the full $11 billion in 2014, but rather to stretch recoveries out over four years (2014 to 2017). This allows Medicare payments rates in 2014 to increase at a rate close to the 1.0 percent increase we recommended in our March 2013 report.

CMS proposes to reduce hospitals' 1.8 percent base payment update by 0.8 percent in 2014 to recover roughly $1 billion of the $11 billion in overpayments. CMS also states that a prospective 0.55 percent reduction is needed to prevent further overpayments, but does not propose taking that adjustment in 2014. In the past, the Commission has stated that stopping overpayments should be a priority.[1] Therefore, we suggest taking the 0.55 percent prospective adjustment in 2014 along with a 0.25 percent retrospective adjustment.[2] The total adjustment in 2014 would still be 0.8 percent. The remaining retrospective adjustments would be made in future years.

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[1] Medicare Payment Advisory Commission. 2011. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

[2] The law governing recovery of the $11 billion in overpayments states that the recoveries will only come from the base rate and not affect hospitals that are paid a hospital specific rate (e.g., Sole Community Hospitals). Therefore, under our suggestion, the 0.25 percent reduction that funds the recovery of past overpayments would only apply to the base rate and not affect hospitals paid a hospital-specific rate. However, the 0.55 percent adjustment would apply to all hospitals. All IPPS hospitals are receiving higher payments in 2013 due to the industry's documentation changes; therefore, all IPPS hospitals should have their payments reduced to prevent further overpayments in 2014.

Disproportionate share and uncompensated care payments

Historically Medicare has paid higher inpatient payment rates to hospitals with a high share 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 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 share of total inpatient days attributable to Medicaid patients. This net effect of the policy is to pay higher inpatient rates for low-income Medicare patients and indirectly subsidize Medicaid patients with Medicare inpatient dollars.

The original justification for Medicare DSH payments was that poor Medicare patients were thought to be more expensive in ways that were not accounted for by the original DRG system. By 2011, both the Commission and other researchers concluded that, at most, 25 percent of the DSH payments were empirically justified by the higher costs at hospitals treating low-income *Medicare* patients.[3] Therefore, hospitals that served high shares of Medicaid patients were given higher payments than justified by the costs of their Medicare patients.

Some have argued that DSH payments should remain to assist hospitals that serve poor patients with their higher *non-Medicare* uncompensated care burdens. However, in 2007 the Commission found that the DPP was a poor predictor of uncompensated care costs.[4] In other words, the DSH formula failed to direct significantly higher payments to hospitals with high amounts of uncompensated care costs.

In 2010, Congress enacted several changes in the DSH payments pursuant to the Patient Protection and Affordable Care Act (PPACA). The key changes scheduled to take place in fiscal year 2014

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[3] Nguyen, N. X., and S. H. Sheingold. 2011. Indirect medical education and disproportionate share adjustments to Medicare inpatient payment rates. *Medicare & Medicaid Research Review* 1, no. 4: E1-E19.
[4] Medicare Payment Advisory Commission. 2007. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC

are:

- DSH payments will be reduced to 25 percent of what they would have been under prior DSH formulas.
- The remaining 75 percent of prior DSH dollars will be divided into two parts.
    - One part will be used to create a pool of dollars to pay for uncompensated care at hospitals. The size of the pool depends on the change in the number of uninsured individuals in the country. The distribution of the residual pool depends on each hospital's share of uncompensated care.
    - As the numbers of uninsured individuals falls, the Medicare funds allocated to helping hospitals pay for uncompensated care will decrease. The remainder not allocated to uncompensated care will be allocated to trust-fund savings. For every 1 percent decline in the rate of uninsurance, the share of the DSH pool allocated to uncompensated care payments will decline by 1 percentage point and the share allocated to trust fund savings will increase by 1 percentage point.
    - In 2014, we expect the total pool of dollars distributed as either DSH or uncompensated care payments will remain roughly at 2013 levels due to two offsetting effects. Medicaid expansions will increase the size of the DSH pool, but that will be offset by the share of the DSH pool retained by the treasury due to declining rates of uninsured individuals.

The net result of these changes in DSH and uncompensated care payment policy is to:

- Bring DSH payments down toward an empirically justified level (25 percent of the current level).
- Shift Medicare from implicitly subsidizing Medicaid to explicitly subsidizing uncompensated care. This is a major change in the use of trust fund dollars.
- Lower the amount of Medicare dollars spent on uncompensated care as rates of uninsurance decline.

CMS has been given the challenging task of implementing this law. We agree with several steps

CMS is taking, but have reservations regarding the proposal to use the Medicaid and SSI days as the sole measure of uncompensated care costs of the uninsured in 2014. Instead, CMS should use a blend of data on uncompensated care costs from the form S-10 along with Medicaid and SSI days. Eventually CMS should transition to only using the S-10.

The proposed method for computing the size of the uncompensated care pool is reasonable. The total dollars available for DSH and uncompensated care payments will depend on Medicare discharge volumes, the share of Medicare days that are SSI days, and the Medicaid share of days. We agree that it is reasonable for the Office of the Actuary to estimate Medicaid and SSI shares and to prospectively compute the dollars available in the combined DSH/uncompensated care pool. The Office of the Actuary projected that the 2014 combined payment pool would be $12.338 billion in fiscal year 2014 and proposes to fix the size of the combined pool prospectively for the purpose of computing uncompensated care payments at this amount. The Actuary's fiscal year estimate of $12.338 billion is roughly $500 million less than our calendar year estimate (almost $13 billion) that was published in our March 2013 report to Congress. We projected spending on a calendar year basis to better match most hospital's cost reporting cycle which we use to compute hospital margins. The difference between the fiscal year and the calendar year estimates could be explained by the fact that the Medicaid expansion will not start until 3 months into the fiscal year. It will only be in effect for three fourths of the fiscal year, but will be in effect for the full 2014 calendar year. Therefore, we would expect less growth in Medicaid over the fiscal year and expect the Office of the Actuary estimate to be roughly $500 million lower than our estimate. While the $12.338 billion estimate appears reasonable, it would be helpful if CMS provided some information on how the $12.338 billion estimate was computed. This estimate of $12.338 billion is referred to as factor 1 in the proposed rule.

The proposed method for computing the share of the pool going to uncompensated care is reasonable. The share of the pool going to uncompensated care and the share remaining with the Treasury depends on the share of individuals that are uninsured. This is referred to as factor 2. We agree that using the most recent CBO estimates of the uninsured for all individuals is reasonable.

Therefore, the amount of dollars CMS proposes to distribute to hospitals appears reasonable.

The proposed interim payments are appropriate. The proposal to distribute interim payments throughout the year rather than making hospitals wait until the end of the year for one large payment will prevent unnecessary cash-flow problems for hospitals.

We agree that Medicaid shortfalls should not be considered uncompensated care. Medicaid shortfalls should not be deemed uncompensated care for three reasons. First, this would encourage states to reduce Medicaid funding and shift the costs to the Medicare program. Second, Medicaid shortfalls are likely to be the most unreliable data from the cost report. Medicaid payments come in many forms and in some cases hospitals return a portion of their Medicaid payment as a provider tax. Given special Medicaid payments and provider taxes, accurate computation is almost impossible. Third, because Medicaid payments can be manipulated via provider taxes, hospitals and states would waste internal resources trying to maximize their share of the uncompensated care pool. Individual states efforts to increase their share of the pool will disadvantage hospitals in other states and is a pure loss to the healthcare system because the national size of the uncompensated care pool is fixed. For all of these reasons, uncompensated care should not include Medicaid shortfalls.

We have concerns regarding how payments are being distributed among hospitals. The remaining question is how to allocate the fixed pool of uncompensated care dollars among hospitals. The proposed rule raises questions about the quality of data from the hospital cost report form S-10. Rather than use the S-10 data, the rule states that "data on utilization for insured low-income patients can be a reasonable proxy for the treatment costs of uninsured patients." This is administratively simple, as it basically continues to distribute money based on a hospitals relative share of SSI and Medicaid patients. Each DSH hospital in the country would receive a fixed dollar amount (roughly $200) from the Medicare trust fund for each Medicaid day and each SSI day. The proposal to use Medicaid and SSI days is based on the assumption that hospitals with higher shares of Medicare and SSI days will also have higher uncompensated care costs associated with the

uninsured. However, our 2007 analysis of data from the GAO and data from the American Hospital Association (AHA) suggests that this is not a valid assumption.[5] Given our prior findings that the Medicaid and SSI shares were poor predictors of uncompensated care costs, it is clear that there is a need to transition to new measures.

The S-10 provides two alternative measures of uncompensated care burdens that could begin to replace the reliance on Medicaid and SSI shares. First, charity care for the uninsured is reported on the form S-10 (line 23 column 1) and would be a reasonable proxy for the costs of treating the uninsured. The law explicitly gives the Secretary the authority to use data which is the best proxy for the "costs of subsection (d) hospitals treating the uninsured." Line 23 column 1 would fit this aspect of the law. Alternatively, CMS could transition to using an all uncompensated care measure that includes bad debts for insured patients (line 30 column 1). Either option would be consistent with the law.

A key question involves the quality of the data reported on the cost report Form S-10. We have examined both the 12/31/2012 version of this data set and the more recent 3/31/2013 version of this data set. While some hospitals did not initially fully fill out the S-10, it appears that the S-10 data is getting better and is now a viable source of data. We note the following:

- Charity care is a clear concept for hospitals. To complete line 23 column 1 of the Form S-10 a hospital only needs to know which patients it approved for charity care, the charges for those patients, the payments from those patients (which are often zero), and the hospital's cost-to-charge ratio. This is the cleanest available measure of uncompensated care for the uninsured.

- The cost of bad debts is more difficult to accurately compute, but the S-10 provides a reasonable proxy. The difficulty with bad debt computations on the S-10 is that the bad

[5] Medicare Payment Advisory Commission. 2007. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC

debt expenses on provider financial statements are measured after contractual discounts are applied. For example, assume an uninsured patient was given a CT scan with a charge of $1,000 and given a discounted price of $500. If the patient paid none of this bill, the bad debt expense would be $500. If the hospital entered the $500 of bad debts on Form S-10, the S-10 would compute the cost of this expense as $500 times the cost-to-charge ratio of (e.g., 0.30) or $150. However, the true loss would be the $300 cost of care, which is the full charges ($1,000) times the cost-to-charge ratio of 0.3. In this case, the S-10 would underestimate the loss on bad debts by $150 ($300-$150). In contrast, assume a patient received the same CT scan but was insured. The negotiated price was $500 and the cost to the hospital was $300 ($1,000 charge times 0.3). The insurer paid 80 percent of the negotiated price or $400. The patient failed to pay their coinsurance of $100. The profit on the case is $100 ($400-$300). However, the S-10 would estimate the loss as the unpaid coinsurance of $100 times the cost-to-charge ratio of 0.3 or $30. Hence, in this case, the S-10 would overestimate the loss on the case by $130 (assuming a $30 loss rather than a $100 profit). This method of computing the bad debt component of uncompensated care may on balance be roughly correct due to underestimating losses on the uninsured that do not pay their debts and overestimating losses unpaid coinsurance. While the computation of losses from bad debts is not as clean as the estimates of charity care losses, we believe that the S-10 data is still better than the poor assumption that a hospital's share of inpatient days attributable to Medicaid and SSI patients reflects its share of uncompensated care.

- While the Medicare Administrative Contractors (MACs) should still screen the S-10 data for accuracy, on average the most recent data in the S-10 appears reasonable. Among the 2,700 hospitals that were eligible for DSH and uncompensated care payments (3/31/2013 cost report and impact files), 94 percent reported providing uncompensated care (line 30, column 1) and 87 percent reported providing charity care for the uninsured (line 23, column 1). A comparison of 12/31/2012 and 3/31/2013 cost report shows significant improvement in reporting, and to improve reporting further CMS could convene a panel of industry representatives to clarify the instructions for filling out the S-10. Among those that filled out the section of the S-10 on charity care on the 3/31/2013 file and also reported

> their total expenses on Schedule G, charity care for the uninsured equaled an average of 2.6 percent of total expenses. This 2.6 percent does not include bad debts. Among the 2,152 of the 2,700 hospitals that report having both bad debt and charity data on the S-10 and that fill out data on total expenses on cost report Schedule G, the total uncompensated care was an average of 5.3 percent of total expenses. This is similar to data from the AHA. The AHA reports that from 1980 through 2011 the aggregate amount of uncompensated care has always ranged from between 5.1 percent and 6.1 percent of total expenses.[6] The S-10 data is within this range.

Given our analysis of the S-10 data, we do not see major problems in the way the Form S-10 computes charity care and manageable problems in the way the form computes bad debts. The main problem with the form is that some hospitals initially did not provide data on their non-Medicare bad debts. This improved significantly from the 12/31/2012 release of the data to the 3/31/2013 release of the data. To give hospitals a motivation to further improve S-10 reporting and to improve estimates of uncompensated care burdens, we suggest phasing in the use of S-10 data over four years. During this four-year phase in CMS could use a blend of the S-10 data along with Medicaid and Medicare days (using the proposed rule methodology) to allocate uncompensated care payments. This would acknowledge that both data sets are imperfect and give hospitals an incentive to improve S-10 reporting.

An added benefit of phasing in the use of S-10 data is that it will smooth the changes in Medicare payments. If there were no transition, hospitals that serve large shares of Medicaid and Medicare SSI patients but provide little uncompensated care will face significant reductions in payments. In contrast, hospitals with high levels of uncompensated care but few Medicaid and Medicare patients would see large increases in payments. A four-year transition would give hospitals time to adjust to these changes in Medicare payments. One option is to base 25 percent of 2014 payments on uncompensated care data from the S-10 and 75 percent on the Medicaid and SSI days as is

[6] American Hospital Association. 2013. Uncompensated hospital care cost fact sheet. January. http://www.aha.org/content/13/1-2013-uncompensated-care-fs.pdf.

outlined in the proposed rule. This could then move to 50 percent each in 2015, 75 percent S-10 in 2016, and 100 percent S-10 data in 2017. The phase in will accomplish three goals: It will gradually move payments to hospitals facing the largest burdens of caring for the uninsured, give hospitals a financial incentive to improve their S-10 reporting, and prevent a financial shock to hospitals.

The hospital readmissions reduction program may need statutory changes

The proposed rule asks for comments on CMS' proposed implementation of section 1886 (q) of PPACA, the hospital readmissions reduction program. CMS' proposed implementation of current law is reasonable; however, eventually we see a need for changes in the law.

The program is designed to reduce payments to hospitals that have excess readmissions and encourage them to reduce their readmission rates. Doing so requires a measure of readmissions, a method for determining excess readmissions, and a formula for computing penalties for hospitals with excess readmissions. Current law is highly prescriptive in how the readmission policy is implemented. We concur that the implementation proposed is aligned with current law.

However, as we explain in on our June 2013 report to Congress, we have some concerns with the law governing readmissions. Specifically, there may be a need to eventually refine the law to address four issues with the current policy:

- The readmission penalty formula is flawed. Aggregate penalties would remain constant even if national readmission rates decline. In addition, the condition specific penalty per excess readmission is higher for conditions with low readmission rates. This issue becomes more important in 2015 when elective total hip arthroplasty and elective total knee arthroplasty are added to the readmission policy. The method prescribed in law for computing penalties will result in relatively large penalties for readmissions of hip and knee replacements due to the cases relatively low readmission rate for these cases. This highlights the need to revise the penalty formula by 2015 as we discuss in our June 2013 report to Congress.

- Single-condition readmission rates face significant random variation due to small numbers of observations.
- Heart failure readmission rates are inversely related to heart failure mortality rates.
- Hospitals' readmission rates and penalties are positively correlated with their low-income patient share.

To address the first three concerns we discussed using an all-condition readmission measure with a fixed target in our June 2013 report. The readmission measure should focus on readmissions that are not planned and could potentially be prevented. Given a fixed target, penalties would decline if hospitals' collective performance improves. In addition, to address the issue of readmission rates and penalties being correlated with patient income, we discuss evaluating hospital readmission rates against a group of peer hospitals with a similar share of low-income Medicare beneficiaries as a way to adjust readmission penalties for socioeconomic status. These actions would require legislative changes because the current formula used to compute the readmission penalty is set in law.

Hospital quality incentives and reporting

We suggest using only CDC HAI measures for the Hospital-Acquired Condition (HAC) Reduction program

Section 3008 of PPACA (which added section 1886(p) to the Social Security Act) requires the Secretary to make a negative 1 percentage point payment adjustment, effective October 1, 2014 and after, to IPPS and Maryland waiver hospitals that rank in the worst quartile of all IPPS hospitals, relative to the national average, in the risk-adjusted rate of "hospital-acquired conditions" (HACs), as defined by the Secretary. CMS calls this the HAC Reduction Program. In the proposed rule, CMS proposes the "general framework for implementation of the HAC Reduction Program for the FY 2015 implementation."

For the initial set of quality metrics in the FY 2015 HAC Reduction program, CMS proposes to use a set of Patient Safety Indicators (PSIs) developed by the Agency for Healthcare Research and Quality (AHRQ) and two healthcare-associated infection (HAI) measures developed by the Centers for Disease Control and Prevention (CDC)[7]. The two types of measures (PSI and HAI) would be grouped into two separate measure domains. Within each domain, a rate for each measure would be calculated for each hospital, and then those rates would be combined into a single composite rate for each domain. Those PSI and HAI domain values would be weighted equally and combined into one "Total HAC Score" for each hospital. Any hospital with a Total HAC Score in the highest quartile relative to the national average would have a one percent reduction applied to its base DRG payments. This reduction would be applied after the application of all other payment adjustments, such as from the readmissions reduction program.

The Commission remains concerned that rates of preventable patient safety incidents remain unnecessarily high and that progress in improving patient safety in hospitals has been too slow.[8] The HAC Reduction program will sharpen every hospital's focus on taking steps to reduce or eliminate the rate of HACs, and they will need to devote significant clinical and administrative resources to those efforts. Therefore, success on each measure selected for the program must be clinically achievable—that is, the condition being measured must be preventable if a hospital uses evidence-based care processes, and the metric itself must be technically rigorous—that is, the measurement method must be statistically reliable and use a data source that is collected as consistently as possible across hospitals. We suggest that only the CDC HAI measures meet both of these criteria and therefore CMS should use only those measures for the HAC Reduction Program.

[7] CMS proposes to add one more HAI measure in FY 2016 and two more in FY 2017.

[8] Eber, M. R., R. Laxminarayan, E. N. Perencevich, and A. Malani. 2010. Clinical and economic outcomes attributable to health care-associated sepsis and pneumonia. *Archives of Internal Medicine* 170, no. 4 (February 22): 347–353. Landrigan, C. P., G. J. Parry, C. B. Bones, et al. 2010. Temporal trends in rates of patient harm resulting from medical care. *New England Journal of Medicine* 363, no. 22 (November 25): 2124-2134.
Office of Inspector General. 2010. *Adverse events in hospitals: National incidence among Medicare beneficiaries*. Report no. OEI-06-09-00090. Washington, DC: OIG.

Both of the HAI measures that CMS proposes for the first year of the HAC Reduction Program have evidence-based clinical processes available to prevent them. Prevention of Central-line associated bloodstream infections (CLABSI) was the subject of a successful national clinical initiative that eventually involved more than 1,000 hospitals.[9] The CDC has issued a clinical guideline for the prevention of catheter-associated urinary tract infections.[10]

The proposed HAI measures also are more statistically reliable than PSIs for measurement of rates at the hospital level. Research has shown that the CDC's standardized system for hospital reporting of nosocomial infections, the National Healthcare Safety Network, is superior to claims-based measures such as the AHRQ PSIs for hospital-level measurement.[11] Evidence also indicates that some hospitals may respond to the use of claims-based quality measures such as the PSIs by changing administrative billing and coding practices rather than increasing clinical resources for infection control and other patient safety activities.[12]

Our final comment concerns a statutory, not regulatory, issue in the HAC reduction program. As currently designed, the program will penalize 25 percent of hospitals every year even if the industry overall significantly reduces rates of hospital-acquired conditions. As we have discussed elsewhere with respect to the current readmissions penalty policy, it may be more appropriate for the HAC reduction program to use a fixed performance target, so that if the industry significantly lowers the overall rates of hospital-acquired conditions, total payment penalties would be reduced.

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[9] Heath Research and Educational Trust, et al. 2012. *Eliminating CLABSI, a national patient safety imperative: Final report on the national* On the CUSP: Stop BSI *project* (October).
[10] Healthcare Infection Control Practices Advisory Committee, Centers for Disease Control and Prevention. 2009. *Guideline for prevention of catheter-associated urinary tract infections.*
[11] Stevenson K.B., Y. Khan, J. Dickman, et al. 2008. Administrative coding data, compared with CDC/NHSN criteria, are poor indicators of health care-associated infections. *American Journal of Infection Control* 36, no. 3 (April): 155-164.
[12] Lee, G.M., K. Kleinman, S.B. Soumerai, et al. 2012. Effect of nonpayment for preventable infections in U.S. hospitals. *The New England Journal of Medicine* 367, no. 15 (October 11): 1428-1437.

We support the proposal for placing greater weight on outcome and efficiency domains

For calculating a hospital's Total Performance Score in the VBP program, CMS proposes to decrease the weights for the process and patient experience measure domains, and increase the weights for the outcome and efficiency domains (Table 1):

Table 1. Proposed domain weights for calculation of hospital VBP performance scores

Domain	FY 2015	FY 2016	Change
Process of care	20%	10%	-10%
Patient experience	30%	25%	-5%
Outcome	30%	40%	+10%
Efficiency	20%	25%	+5%

The Commission has long urged that Medicare's quality measurement system should move toward the use of outcome measures and away from reliance on clinical process measures, and therefore we support CMS's proposal on changing the VBP program domain weights. An area for future consideration is to determine if the relative magnitude of the incentives across programs (i.e., VBP,HAI, readmissions) is appropriate relative to the importance of the measure.

We support the proposal to decrease process measures and increase outcome measures in the Inpatient Quality Reporting (IQR) program

CMS proposes to drop 7 process measures that require hospitals to extract data from medical records, while adding 5 outcome measures that would use Medicare claims data, including measures of 30-day readmission rates and mortality rates for COPD and stroke. The fifth proposed outcome measure would be a risk-standardized payment amount associated with a 30-day episode of care for acute myocardial infarction (AMI).

The Commission has long urged that Medicare's quality measurement system should move toward the use of outcome measures and away from reliance on clinical process measures, and therefore we support CMS's proposal to reduce the number of process measures using chart-abstracted data,

to refine the current readmission measures to exclude planned readmissions, and to add the 30-day mortality and readmission measures for COPD and stroke to the IQR program.

Low-volume adjustment

In fiscal year 2014 the low-volume adjustment reverts back to its original form which appropriately targets the higher costs at isolated low-volume hospitals and measures total admissions rather than just Medicare admissions when evaluating economies of scale. The original low-volume adjustment is limited to hospitals with fewer than 200 total discharges. In our March 2003 report we found some effect up to 500 total (all-payer) discharges.[13] CMS could revisit the economies of scale computation to determine if slightly larger **isolated** hospitals should be eligible for the low-volume adjustment.

Proposed changes to the hospital wage index for acute-care hospitals

The FY 2014 IPPS Proposed Rule requests comments on a variety of detailed hospital wage index issues. We wish to reiterate our recommendations on wage index reform, included in the Commission‘s 2007 Report to Congress, which were to repeal the existing hospital wage index statute and to replace it with a new wage index system described below. The repeal of the current system would include removing reclassifications stipulated in law and adjustments implemented through regulation (e.g., the imputed rural floor in FY 2014), and give the Secretary the authority to establish a new wage index system. Our 2007 recommendations stated that the law should be changed to establish a new hospital compensation index so that it:

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

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[13] Medicare Payment Advisory Commission. 2003. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

The system we proposed is similar to a recommendation by the Institute of Medicine and was intended to replace the system of geographic reclassification and exceptions that is currently in place.[14]

Research on the development of a patient criteria-based payment adjustment under the long-term care hospital (LTCH) prospective payment system (PPS)

The Commission has long been concerned about Medicare's payments for services furnished in long-term care hospitals (LTCHs). Studies have consistently shown that total Medicare payments are significantly higher, on average, for episodes that include LTCH stays than for similar episodes that do not, although the difference narrows considerably for the most medically complex episodes. Research also suggests that only the most medically complex patients may achieve better outcomes if their episode of care includes an LTCH stay. However, outcomes for less complex patients who use LTCHs have consistently been shown to be the same as or worse than those of similar patients who do not have an LTCH stay. It seems clear that LTCH care for less complex patients is not cost-effective for Medicare or for beneficiaries.

Yet CMS has lacked a mechanism to ensure that Medicare pays higher LTCH rates only for the most medically complex cases. Because there are almost no established criteria for admission to an LTCH, a provider can admit any patient needing hospital-level care—even if the patient could be cared for appropriately in a lower-cost setting—as long as the facility maintains an average length of stay greater than 25 days. In 2004, the Commission concluded that continued growth in the number of LTCHs and the financial incentives presented by multiple Medicare prospective payment systems (PPSs) made it imperative that the Congress and the Secretary of Health and Human Services develop criteria to ensure that LTCHs serve only the most medically complex patients. Efforts to develop such criteria were stymied, however, in part because the types of

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[14] Medicare Payment Advisory Commission. 2007. *Report to the Congress: Promoting greater efficiency in Medicare*. Washington, DC: MedPAC. Institute of Medicine. 2011. *Geographic adjustment in Medicare payment, Phase I: Improving accuracy. Second edition.* Washington, DC: The National Academies Press.

patients treated in LTCHs are also treated in both acute care hospitals (ACHs) and other post-acute care settings.

The May 10, 2013, proposed rule for the LTCH PPS includes a summary of several years of research that CMS believes can be used to empirically identify the medically complex cases for whom LTCH care may be cost effective. The research suggests that these patients have specific characteristics—such as the need for prolonged mechanical ventilation or the presence of severe wounds, sepsis, multiple organ failure, or stroke—combined with stays of 8 or more days in an intensive or critical care unit (ICU/CCU) at an ACH. These chronically critically ill and medically complex (CCI/MC) patients have intensive service needs and have a predictable and consistent need for extended hospital-level care after the ICU/CCU stay that can be met in a step-down unit in an ACH or in an LTCH (or in some specialized skilled nursing facilities). These patients are costly to care for and often generate financial losses when cared for in ACHs paid under the acute care hospital inpatient prospective payment system (IPPS).

CMS is considering policy changes to the LTCH PPS that would encourage the LTCH industry to refocus its admitting practices on serving patients meeting the CCI/MC profile. In the proposed rule, CMS discusses (but does not propose) a revised LTCH payment system that would limit full LTCH payment rates to LTCH patients who meet the CCI/MC profile at the point of transfer from an ACH. Payment for all other LTCH patients—including patients admitted directly to the LTCH without an immediately preceding stay at an ACH—would not exceed the amount paid for the same MS-DRG under the IPPS. Under CMS's framework, an LTCH could continue to admit any patients they thought could clinically benefit from their services. But because payment for non-CCI/MC cases would be sharply reduced, admitting these patients might not be financially advantageous, especially given the requirement that LTCHs maintain an average length of stay of more than 25 days. To maintain an acceptable profit margin while simultaneously achieving a long average length of stay, LTCHs likely would need to focus primarily on admitting CCI/MC cases.

The policy discussed by CMS has the potential for significant Medicare savings, at least in the short run. The Commission has also been exploring ways to define the types of cases that may warrant the higher LTCH payment rates. In a recent analysis, MedPAC staff matched LTCH claims data from 2011 with immediately preceding ACH discharges to identify LTCH cases that had ACH ICU/CCU stays of 8 or more days before being transferred to the LTCH. We found that a majority (59 percent) of LTCH cases were not heavy users of ICU/CCU services during their preceding ACH stays. Under the framework discussed by CMS, these cases likely would not qualify for full LTCH payments. However, it is important to note that, in both the policy discussed by CMS and the Commission's analyses, service use would determine the level of payments. In any payment system, such a feature often creates incentives to provide more services in order to increase payments. That incentive may be somewhat less direct in this case because the level of payment for the LTCH would depend on services furnished by a separate provider. Nevertheless, many LTCHs have close relationships with their referring ACHs. At the same time, though, competing demand for ICU beds may temper opportunities for gaming, at least in the short-term.

The policy change discussed by CMS potentially represents a first real step towards criteria for LTCH patients that would appropriately limit high LTCH payment rates to the most medically complex patients who may be most likely to benefit from an LTCH program of care. This approach also may expand the concept of site neutrality by limiting payments for other cases admitted to LTCHs to IPPS payment rates for the same MS-DRGs.

The Commission remains concerned, however, about the adequacy of payments for medically complex patients in both LTCHs and ACHs. The Commission has long held that payments to providers should be properly aligned with the resources needs of beneficiaries. Medicare's payments to LTCHs may not reflect this principle, because inflated costs were used to set the initial LTCH PPS rates, and patients may not need this level of care. CMS's efforts to slow the growth in LTCH spending through regulation likely have not altered the underlying inaccuracies in payments for LTCH care. MedPAC analyses suggest that payments for medically complex cases in ACHs also are not properly calibrated to the resource needs of patients. As CMS noted, CCI/MC

cases often generate large losses for ACHs. The fact that LTCHs are distributed unevenly—some areas have many LTCHs, others have none—has created inequities across ACHs in the relative profitability of medically complex cases. The fact that there are no LTCHs in many areas also indicates that medically complex cases can be appropriately treated in non-LTCH settings. While the Commission continues to support the use of criteria to justify higher LTCH payments, we urge CMS to continue to strive toward site-neutral payments so that Medicare pays the same, subject to risk differentials, for the same services, regardless of where the services are provided. The end result would be higher payments for the most difficult cases (including those that have long stays in PPS hospitals due to not being in an area with an LTCH), and lower payment rates for cases that do not need the most medically complex care.

In the proposed rule, CMS asked for comments regarding the necessity of continuing to impose the so-called "25-percent rule" on admissions to LTCHs if full LTCH payment were limited to patients that meet the CCI/MC criteria. The 25 percent rule, which is intended to help ensure that LTCHs do not function as units of acute care hospitals, reduces payments for an LTCH that admits more than 25 percent of its patients from a single acute care hospital. In the absence of LTCH admission criteria, the Commission has always viewed the 25-percent rule as a blunt but necessary instrument. Under the 25 percent rule, an LTCH's decision to admit a patient may be based not only on the patient's clinical condition but also on how close the facility is to exceeding the threshold. In addition, as the Commission has previously noted, some LTCHs may appropriately admit patients from only a small number of acute care hospitals because they are located in areas with a dominant acute care hospital, such as a trauma or transplant center.

At issue is whether it is problematic for LTCHs to serve as de facto step-down units of acute care hospitals. The concern has always been that, in such a scenario, Medicare makes two payments (one to the acute care hospital and one to the LTCH) for what should be one hospital-level stay (and likely *is* one stay in areas without LTCHs). However, Medicare may avoid IPPS outlier payments when an ACH transfers a costly CCI/MC case to an LTCH. Indeed, this phenomenon may explain why some studies have found LTCH care to be cost-effective for the most medically

complex patients. Further, the medically complex cases identified using CMS's CCI/MC framework are the very patients who have been identified as most likely to benefit from the type of specialized program that LTCHs can provide. In areas with LTCHs, then, both beneficiaries and the program may benefit when CCI/MC cases are transferred relatively quickly from ACHs and admitted to LTCHs.

Nevertheless, we cannot ignore the possibility of a new set of inappropriate provider responses to payment incentives under the CCI/MC framework. Therefore, if CMS moves forward with its CCI/MC criteria, we urge the agency to continue to apply the 25 percent rule during implementation until the robustness of the CCI/MC criteria can be assessed and unintended consequences can be observed and addressed.

Inpatient psychiatric facilities quality reporting (IPFQR)

CMS is required in fiscal year 2014 and each subsequent year to reduce the annual market basket update by 2 percentage points for any inpatient psychiatric facility (IPF) that fails to successfully report on a specified set of quality measures. Six chart-abstracted IPF quality measures will be used for the payment determination in FY 2014 and beyond: hours of physical restraint use; hours of seclusion use; patients discharged on multiple antipsychotic medications, with and without appropriate justification; post-discharge continuing care plan created; and post-discharge continuing care plan transmitted to the next level of care provider.

The May 10, 2013 rule proposes to add three new measures beginning in FY 2016. The measures are: (1) alcohol use screening, which assesses the share of patients 18 years and older who were screened during their stay for alcohol use using a validated screening questionnaire; (2) alcohol and drug use status after discharge, which assesses the share of discharged patients contacted within a month after discharge to assess alcohol and drug use; and (3) follow-up after hospitalization for mental illness, which assesses the share of discharges for patients age 6 and older who had an outpatient visit or intensive outpatient encounter with a mental health professional or received partial hospitalization services within 7 and within 30 days after

discharge. All three measures would be collected via chart abstraction and would be reported in aggregate for all specified patients, regardless of payer.

In our comment letter on the FY 2012 IPPS proposed rule, we expressed concern about the steadily increasing number of clinical process measures required for acute care hospitals under the IPPS Hospital IQR program, because such measures require hospitals to devote substantial resources to clinical record data abstraction. Given that a growing body of literature suggests that such measures may have little or no association with reducing ACH mortality or readmission rates, the Commission is concerned that the benefits from measuring hospitals' adherence to these processes might be outweighed by the costs of implementing the measures, and might deflect hospitals' attention and resources from productive quality improvement activities.

The Commission's concerns about balancing the benefits of quality measurement with the burden associated with data collection efforts extend to the quality reporting programs for other providers, including IPFs. In the current proposed rule, CMS does not make clear how the first two measures proposed for FY 2016, assessing IPF patients' use of alcohol or drugs at admission and after discharge, will by themselves appreciably improve outcomes for these patients. No outside group, such as the National Quality Forum (NQF), has endorsed alcohol or drug assessment measures such as those CMS proposes. The Commission believes that, before adding these or any new process measure to the IPFQR program, CMS should critically evaluate the extent to which the measures contribute to meaningful differences in health outcomes among IPFs and over time.

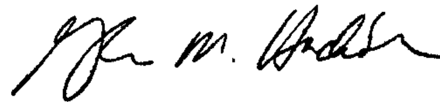
Regarding the third proposed measure, researchers have found that regular follow-up therapy after hospitalization for mental illness improves patient outcomes. Clinical practice guidelines recommend an outpatient visit with a mental health practitioner after discharge to support the patient's transition to the home or work environment and to ensure that gains made during hospitalization are not lost. In addition, follow-up therapy helps health care providers detect early post-hospitalization reactions or medication problems and provide continuing care. Recognizing this, CMS has proposed a post-discharge follow-up measure that would assess if patients had an

outpatient encounter after hospitalization for mental illness. The proposed measure appears to be similar to a HEDIS® measure that has been specified by NCQA for collection using administrative data, such as claims or health plan encounter data. CMS has proposed data collection via clinical chart abstraction. However, as currently specified, calculation of the HEDIS® measure requires the use of CPT or HCPCS codes to identify the type of outpatient visit received by the patient and the use of Provider of Service codes to identify mental health practitioners, information that is not usually available to an IPF provider (unless the IPF also furnishes outpatient care and the patient opts to receive care there). It is thus not clear to us how IPFs could accurately report this information to CMS. However, information about Medicare beneficiaries' post-discharge service use is readily available to CMS via claims data. Therefore, the agency already has the information it needs to track and report this measure (either publicly or privately to individual IPFs).

Two of the measures proposed by CMS would require IPFs to assess patient experiences following discharge. The Commission has long supported the use of quality measures that promote providers' clinical and financial accountability across care settings. Quality measures that create incentives for providers to improve transitions between care settings can reduce readmissions and may have other positive effects on patient outcomes. However, the Commission believes that measuring those outcomes—such as readmissions—can have a greater impact on provider behavior than process measures such as the ones being proposed by CMS. For example, if IPFs are assessed as to extent to which their patients have potentially avoidable readmissions within some period of time after an initial discharge from an IPF, then providers will have incentives to meaningfully assist patients as they make the transition to the community (or to other providers) following the IPF stay. IPFs seeking to prevent avoidable readmissions for their patients might take steps to identify patient populations that are most at risk for readmission, improve patient education and self-management training, schedule and assist patients with follow-up visits with outpatient providers, and communicate better with other providers in the community, as well as calling patients to see if they have completed follow-up visits. The outcome measure, therefore, is far more likely to elicit desirable changes in provider behavior. CMS, where possible, should focus on quality measures that are outcomes based rather than process based.

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

Sincerely,



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