



425 I Street, N.W. ◦ Suite 701
Washington, DC 20001
202-220-3700 ◦ Fax: 202-220-3759
www.medpac.gov

Francis J. Crosson, M.D., Chairman
Jon B. Christianson, Ph.D., Vice Chairman
Mark E. Miller, Ph.D., Executive Director

May 31, 2016

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

RE: File code CMS-1655-P

Dear Mr. Slavitt:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Medicare proposed rule entitled *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 2017 Rates; Quality Reporting Requirements for Specific Providers; Graduate Medical Education; Hospital Notification Procedures Applicable to Beneficiaries Receiving Observation Services; and Technical Changes Relating to costs to Organizations and Medicare costs Reports; Proposed rule published in the Federal Register on April 27, 2016 and the interim final rule with comment period entitled Medicare Program; Temporary Exception or Certain Severe Wound Discharges from Certain Long-Term Care Hospitals Required by the Consolidated Appropriations Act of 2016; Modification of Limitation on Redesignation by the Medicare Geographic Classification Review Board published in the Federal Register on April 21, 2016*. 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 their competing demands, we especially appreciate your staff's efforts to improve these hospital payment systems.

In this letter we comment on five key issues:

- Support for the proposed changes to uncompensated care payments
- Agree that adjustments for documentation and coding are necessary and required by law
- Suggest changes to the hospital wage index
- Suggest changes in IPPS quality metrics and incentives
- Suggest changes in the LTCH payment system

Uncompensated care payments

Historically Medicare has adjusted 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 effect of the policy is to pay higher inpatient rates for low-income Medicare patients and indirectly subsidize hospitals serving Medicaid patients with supplemental Medicare inpatient dollars.

In 2010, Congress enacted several changes to DSH payment policy in the Patient Protection and Affordable Care Act (PPACA). Under the new DSH policy, CMS will determine the amount of Medicare dollars that are potentially available to be distributed 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, part of the pool will go toward uncompensated care payments and part will go toward savings for the treasury as the rate of uninsurance declines (and presumably the need for uncompensated care payments declines). CMS determined that the size of the pool of potential DSH and uncompensated care dollars will be \$14.23 billion in FY 2017. CMS is proposing to allocate the potential pool of dollars as follows:

- CMS pays 25 percent of the pool (\$3.56 billion) based on the traditional **DSH** formula.

- The remaining 75 percent of the pool (\$10.67 billion) is further divided into two parts: savings for the treasury and payments for uncompensated care.
 - 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 estimated that the rate of uninsurance has declined by 43 percent since the passage of PPACA. This means that 43 percent of the \$10.67 billion (\$4.6 billion) will be **savings for the Medicare Part A trust fund**.
 - The remaining \$6 billion (\$10.67 billion x .57 percent) will be distributed to partially pay for **uncompensated care** costs at hospitals in 2017. The distribution of these payments depends on each hospital's estimated share of uncompensated care. We expect a similar amount will be available in future years.
- On net hospitals will receive a total of **\$9.6 billion in combined Medicare DSH and uncompensated care dollars**.

CMS has proposed to use Medicaid and SSI days as a proxy for a hospital's uncompensated care costs in FY 2017. Therefore, in FY 2017, each DSH hospital's share of the \$6 billion in uncompensated care payments will purely be a function of the hospital's number of Medicaid and SSI days. However, in FY 2018, CMS proposes to estimate each hospital's level of uncompensated care using hospital reported uncompensated care costs reported on worksheet S-10 of the Medicare cost report. This will allow the approximately \$6 billion in uncompensated care payments to be distributed using a direct measure of uncompensated care rather than using Medicaid days as a proxy for uncompensated care.

Comment: We support the proposal to start using worksheet S-10 to compute uncompensated care costs starting in 2018 with a three-year phase in. This is consistent with our March 2016 recommendation to phase in the use of S-10 data over three years. Using S-10 data coupled with selective auditing of cost reports submitted by hospitals reporting the highest levels of

uncompensated care, will lead to far better estimates of uncompensated care costs at DSH hospitals than using Medicaid and SSI days as a proxy for uncompensated care.

The use of the S-10 also will create more balance between Medicare support of Medicaid patients and Medicare support of the uninsured. The proposed rule shows that traditional Medicare DSH payments are estimated to be \$3.56 billion in 2017. Because the DPP is dominated by the Medicaid share of patient days, the \$3.56 billion will largely be distributed to hospitals with high Medicaid shares. In 2017, the \$6 billion in “uncompensated care” payments again will be distributed using Medicaid and SSI days as a proxy for uncompensated care costs. Because Medicaid days are much more common than SSI days, most of the dollars (over \$5 billion of the \$6 billion) will be distributed as a per diem payment of approximately \$160 for each Medicaid day. And the remaining \$1 billion will be distributed as a per diem for Medicare SSI days. The net result is the Medicare Part A trust fund will provide significant payments for Medicaid patients. In contrast, there will be no direct payments for uncompensated care costs in 2017 because Medicaid and SSI days will continue to be used as proxies for uncompensated care.

In 2018, distributing uncompensated care dollars (the \$6 billion) based on uncompensated care costs (not Medicaid days) coupled with distributing the \$3.56 billion in traditional DSH payments based on the DPP formula will make Medicare support more proportional to the financial burdens of serving the uninsured and Medicaid patients. In the longer run, there are more fundamental questions regarding whether the Medicare Part A Trust Fund should be the source of support for the uninsured.

Defining uncompensated care

CMS proposes to define uncompensated care as the sum of the cost of charity care and the cost of non-Medicare bad debts. We agree with this proposal. It is inappropriate for Medicare to include “Medicaid shortfalls” when estimating uncompensated care costs for two reasons. First, the level of “shortfall” will depend on a specific hospital’s cost structure and the Medicaid payments (including Medicaid DSH payments) it receives from state Medicaid programs. It would be

inappropriate for Medicare to signal to the states that it will increase Medicare payments to a hospital if the state reduces Medicaid payments to that hospital. Second, computing losses on Medicaid patients is operationally problematic for several reasons. One operational complexity stems from Medicaid paying hospitals a single DSH payment that in part covers costs of the uninsured and in part covers estimates of a hospital's Medicaid "shortfall." It is not clear how CMS would determine how much Medicaid "shortfall" is left after the Medicaid DSH payments are made. In addition, hospitals in some states return a portion of their Medicaid revenue to the state through provider taxes. It would be difficult for CMS to arrive at a net "shortfall" figure given the lack of reported data on the net value of Medicaid DSH payments less provider taxes. Finally, Medicare will still make \$3.56 billion in traditional DSH payments in 2017. In many cases, Medicaid patients in fact may be profitable after considering Medicaid DSH payments and increases in Medicare DSH payments that occur with each additional Medicaid day. Therefore, for reasons of principle and operational complexity, the Medicaid "shortfall" should not be included when Medicare computes uncompensated care costs.

The current method of distributing uncompensated care payments distorts DRG prices

In FY 2014, CMS proposed to make uncompensated care payments directly to hospitals without tying the payments to the DRG pricing system. However, many hospital representatives objected because their contracts with managed care companies were (and still are) based on the price computed by the Medicare FFS "pricer." Thus, hospitals were concerned that if the uncompensated care payments were not in the "pricer" program that CMS uses to compute the FFS price for each discharge, managed care companies would not pay their share of uncompensated care costs. Managed care companies were only obligated to pay the negotiated rate, which is often the rate specified by the FFS pricer.

Because the uncompensated care payments are included in the Medicare Advantage (MA) plans' benchmarks, the MA plans should be expected to pay an amount of uncompensated care costs that is proportional to the amount paid under the FFS program. To accomplish this, the FY 2014 final

IPPS rule adjusted the “pricer” program to put an amount into each hospital’s DRG payment rate that reflected its share of uncompensated care payments. In practice, this means that the rate MA plans paid hospitals was increased by a hospital-specific fixed add-on to reflect payments for uncompensated care. This method of putting a hospital-specific fixed add-on to the DRG payment rate was continued through 2016 and is proposed for 2017.

Comment: The problem is that the per discharge add-on payment varies widely from hospital to hospital. This distorts the basic DRG pricing system. Under the proposed system for 2017, one hospital may have an add-on of over \$2,000 per discharge in the Medicare pricer and a competing hospital may have \$0 add-on per discharge. Therefore, MA payment rates could differ by \$2,000 for the same service in the same city. MA plans have an incentive to steer patients away from the hospital providing more uncompensated care (and having a higher add-on per discharge). MA plans may try to negotiate lower payment rates with hospitals providing high levels of uncompensated care or to simply not include these hospitals in their networks of providers.

There is a way to eliminate the distortion to the pricer. As we stated in our comment on the FY 2016 inpatient proposed rule, CMS could pay hospitals on a periodic basis for their FFS and MA patients (e.g., a quarterly lump sum payment at the start of each quarter) rather than include the uncompensated care payments as an add-on in the pricer. This could work as follows:

- CMS would first compute the aggregate FFS uncompensated care payments.
- Second CMS would compute the proportional uncompensated care payment that would be due from MA plans. For example, the implicit uncompensated care payments in MA plan benchmarks would be computed as a specific percentage of FFS uncompensated care payments. CMS then would increase the FFS uncompensated care pool by that percentage and reduce the MA benchmarks by an equal amount to reflect removing the uncompensated care payments from the benchmark in each county. In other words, CMS would pay the FFS and MA shares of uncompensated care costs directly, just as CMS directly pays the FFS and MA shares of direct graduate medical education costs.

- Therefore, uncompensated care payments would not be included in the MA benchmarks, just as the indirect medical education payments that CMS makes on behalf of MA plans are not included in the MA benchmarks.
- CMS would distribute this combined (FFS and MA) uncompensated care pool based on each hospital's share of historic uncompensated care costs. Unlike the current policy (that requires reconciliation due to not knowing the number of discharges that will take place during a year) this policy would eliminate the need for reconciliation.

This would allow uncompensated care payments to be distributed among hospitals more equitably. Providing uncompensated care would no longer disadvantage hospitals with respect to price negotiations with MA plans. As enrollment in MA plans expands, it becomes more important to not distort the price signals being sent to MA plans as they set up preferred provider networks.

Required adjustments for documentation and coding

The American Taxpayer Relief Act of 2012 (ATRA) requires the Secretary to recover \$11 billion by 2017 to recoup past over payments that stem from changes in documentation and coding of inpatient claims following the introduction of MS-DRGs. OACT has estimated that this will require a 1.5 percent reduction to the standardized amount in 2017, bringing the full adjustment for documentation and coding (including three prior adjustments of 0.8 percent) to 3.9 percent for FY 2017. This means that 2017 inpatient rates are expected to be 3.9 percent lower than they would have been without the temporary adjustment. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) mandates that this adjustment will partially continue past 2017. Instead of fully offsetting the 3.9 percent reduction with a 3.9 percent increase in FY 2018 as would have taken place under prior law, MACRA requires that CMS only make a 0.5 percent positive adjustment for six years from FY 2018 through FY 2023. The six mandated adjustments of 0.5 percent will eventually offset 3 percent of the 3.9 percent documentation and coding adjustment.

Comment: As we have stated in the past, we support recovery of past over payments due to changes in documentation and coding. The law stipulates the amount of the recovery and the

timing of the recovery. In addition, MACRA stipulates the degree to which the recovery adjustments will be phased out. CMS has little discretion and is proceeding as required by law. However, when making update recommendations to Congress for 2018 and beyond, the Commission will consider the net effect of the mandated changes in ATRA and MACRA on the adequacy of Medicare payment rates to hospitals.

Proposed changes in quality metrics and incentives

We support CMS's proposal to decrease the number of process measures and increase the number of outcome measures for quality reporting and value-based purchasing programs, but have concerns about proposed condition-specific efficiency/cost measures.

Inpatient quality reporting

CMS proposes to decrease the total number of measures required for the Inpatient Quality Reporting (IQR) program from 68 measures in FY 2018 to 55 measures in FY 2019. The proposed changes would:

- Remove 13 electronic clinical quality measures (eCQM). This will reduce the number of eCQMs reported from 28 to 15.
- Remove 2 structural measures.
- Remove 2 chart-abstracted measures.
- Add 3 condition-specific episodes cost measures rather than only use the all-condition measure currently being computed.
- Add a measure for excess days in acute care after hospitalization for pneumonia

Value-based purchasing programs

In FY 2017 the hospital VBP program will be based on 22 measures spread across 4 domains of care: clinical care, safety, efficiency and cost reduction, and patient- and caregiver-centered experience of care. In FY 2018 it will use 20 measures, as 2 process of care measures are being

removed. The program will be funded from 2 percent of base operating payments, all of which will be redistributed back to hospitals. CMS is not proposing any changes to either the FY 2017 or FY 2018 VBP program in this year's rule. Compared to FY 2016, there will be fewer process of care measures in FY 2017 and FY 2018 and there will be more uniform weighting across the four dimensions of the VBP.

Comment: For several years, the Commission has urged CMS to move Medicare's quality measurement system away from the use of clinical process measures and toward the use of outcome measures, and therefore we appreciate and strongly support CMS's proposals to reduce the number of process measures that use medical chart-abstracted data as well as the reduction in the number of electronic clinical quality measures being reported.

With respect to episode spending measures, we strongly object to the use of the proposed condition-specific cost measures in the IQR or VBP programs. We believe hospitals should be provided actionable service-line specific relative cost information, but be rewarded or penalized based on a broad all-condition 30-day cost measure. We supported adding the all-condition Medicare Spending per Beneficiary (MSPB) measure to the IQR and VBP programs, because we agree that hospital performance should be evaluated both on the quality of care and the cost of care. However, the proposed condition-specific cost measures would have smaller numbers of hospital-specific observations than the current all-condition measure which pools information from all inpatient conditions. Splitting the pool of information on costs into condition-specific measures would result in more random variation without providing clear additional information about the average costliness of the hospitals' care. It is likely that there will be substantial variability in hospitals' ability to report statistically reliable information on all of the proposed measures, given variation in volume. To ensure reliability and provide a broad incentive to reduce costs across all types of services, we believe it is important that the cost measures used should be as broadly based as possible. Each provider could be given condition-specific costs of care to understand what may be driving their aggregate MSPB performance, but we do not think Medicare should base financial incentives on condition-specific cost measures.

The hospital readmissions reduction program can be improved with certain statutory changes

The Commission maintains that the hospital readmission reduction program (HRRP) has been a success as hospitals have worked to improve care transitions which has helped to lower hospital readmission rates. The program has protected beneficiaries from the risks of adverse outcomes inherent in institutional transitions as well as generated savings for the Medicare program and beneficiaries. The Commission strongly supports having a hospital readmission reduction program as part of the Medicare hospital payment system.

CMS is making no substantive changes to the readmission reduction program in this years proposed rule. Most of the changes CMS made to the program were made in the FY 2016 final rule which affects policies going into place in FY 2017. The main changes going into place in FY 2017 include:

- Modification to the pneumonia readmission measure to include readmission for patients with a primary discharge diagnosis of aspiration pneumonia or sepsis with pneumonia as a secondary condition.
- Adding Coronary Artery Bypass Graft (CABG) surgery to the readmission reduction program.

Comment: With the addition of the CABG readmission measure to the readmission reduction program we are concerned about the potential double counting of cases covered under the program. Twenty-six percent of CABG cases are also AMI cases. This will potentially result in cases being counted under both the AMI and CABG readmission measures. Cases should only count under either AMI or CABG to prevent double counting.

While CMS implemented the hospital readmissions reduction program (HRRP) according to statute, the Commission continues to believe that the law could be changed to permit use of an all-condition readmission measure with a fixed target as discussed in our June 2013 Report to the

Congress.¹ Given a fixed target, penalties would decline if hospitals' collective performance improves. In addition, our June 2013 report discussed 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 changes could be made in a budget neutral manner with the savings from moving to an all-condition measure offsetting the cost of fixing the current payment formula. These actions would require legislative changes because the current formula used to compute the readmission penalty is set in law.

The star rating program

CMS is also developing a star rating program whereby hospitals will be given overall star ratings. We suggest this system of star ratings should reflect the variables used in value-based purchasing and highlight patient outcomes rather than process measures. In cases where the volume of Medicare cases is too few to reasonably measure quality CMS should explicitly state that the small number of observations does not allow it to accurately assess a hospital's quality. To overcome this limitation, CMS could move toward using all-condition measures rather than measuring cost and outcomes on specific conditions. This is similar to our proposal to stay with all-condition episode cost measures (as discussed above for VBP) and similar to the move toward an all-condition readmission measures as discussed in the prior paragraph.

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

The 2017 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. We recommended Congress repeal the existing hospital wage index statute and replace it with a new wage index system described below. The repeal should include removing the more than 1,000 individual hospital reclassifications that occur each

¹ Medicare Payment Advisory Commission. 2013. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

year, which are either stipulated in law or implemented through regulation. The repeal also would 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.

The system we proposed is similar to recommendations made by the Institute of Medicine. Both sets of recommendations would eliminate the need for the system of geographic reclassification and exceptions that is currently in place.²

Changes to the long-term care hospital (LTCH) prospective payment system (PPS)

Medicare makes substantially different payments for patients with similar conditions depending on whether they are treated in an acute-care hospital (ACH) or a LTCH. The Pathway for SGR Reform Act of 2013 established “site-neutral” payments for specified cases in LTCHs, beginning in fiscal year (FY) 2016. Under the law, Medicare will pay the LTCH PPS standard federal

² 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.

payment rate (LTCH standard payment rate) for LTCH discharges that had an immediately preceding ACH stay and:

- the ACH stay included at least three days in an intensive care unit (ICU), or
- the discharge receives an LTCH principal diagnosis indicating the receipt of mechanical ventilation services for at least 96 hours.

All other LTCH discharges—including any psychiatric or rehabilitation discharges, regardless of ICU use—will be paid an amount based on Medicare’s ACH payment rates under the inpatient prospective payment system (IPPS) (including outlier payments) or 100 percent of the costs of the case, whichever is lower. These site-neutral payments will be phased in over multiple years based on each LTCH’s cost reporting period.

In the April 27, 2016 rule, CMS proposes a -1.1 percent adjustment for high-cost outlier (HCO) payments, alignment of the limitation on beneficiary charges for “subclause (II)” LTCHs, revisions to the 25-percent threshold policy, and quality measures to meet the requirements of the IMPACT Act of 2014. In the interim final rule released April 21, 2016, CMS implements a provision of the Consolidated Appropriations Act of 2016 that exempts certain discharges from certain LTCHs from receiving the site-neutral payment rate. Our comments below address each of these elements of the recently released proposed and interim final rules.

High-cost outlier (HCO) adjustment

CMS estimates that the FY 2016 fixed-loss amount will result in HCO payments equal to 9.1 percent of estimated LTCH standard payment rate payments, which is higher than the estimate used in setting FY 2016 payment rates. CMS proposes to set the fixed-loss amount for cases paid under the LTCH standard payment rate such the HCO pool would equal 8.0 percent of estimated payments in FY 2017. This year’s proposed HCO amount results in a 1.1 percent estimated decrease in HCO payments from FY 2016.

Comment: The Commission expects large fluctuations to occur in the fixed-loss amount following implementation of major policy changes, similar to those that occurred following the implementation of the LTCH PPS. In this context, the Commission supports CMS' proposal to set the fixed-loss amount so that outlier payments equal 8.0 percent of payments for cases paid under the LTCH standard payment rate.

Revising the 25-percent threshold

In fiscal year 2005, CMS established the 25-percent threshold in an attempt to prevent LTCHs from functioning as units of ACHs by decreasing payments for discharges from LTCHs that admit a large share of their patients from a single ACH. The 25-percent threshold 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 an area with an MSA-dominant 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 are 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 is prohibited from applying the 25-percent threshold to freestanding LTCHs before July 1, 2016 and permanently prohibited from applying the 25-percent threshold policy to certain co-located facilities. For FY 2017, CMS proposes to implement the 25-percent threshold policy across LTCH cases paid under the LTCH standard payment rate and the site-neutral rate. CMS also proposes to revise the policy in several ways including: aligning the implementation dates for cost-reporting periods starting on or after October 1, 2016; and evaluating the threshold on the basis of the provider's CMS certification number (CCN). To qualify for a less-restrictive threshold, CMS proposes to require that all LTCH locations within a single CCN to be classified as rural or as located in an area with an MSA-dominant hospital.³

³ An MSA-dominant hospital is an acute-care hospital that has discharged more than 25-percent of the total hospital Medicare discharges in the MSA where it is located. CMS proposes that LTCHs located in these MSAs qualify for a less-restrictive threshold.

Comment: The Commission supports CMS’s proposal to apply the 25-percent rule to all LTCH discharges, including those paid under the site-neutral rate. Some may argue that with the implementation of the Pathway for SGR Reform Act’s provisions reforming the LTCH PPS, the 25-percent rule is no longer necessary, as many cases previously paid a higher LTCH standard payment rate will now be paid a lower site-neutral rate. Thus, the argument would go, the financial incentives for an LTCH to admit cases that could be effectively treated in a lower-cost setting have been rendered moot, and it is no longer necessary control an LTCH’s source of admissions through the 25-percent rule.

The Commission disagrees with such arguments for two reasons. First, we note that the Pathway for SGR Reform Act of 2013 used a broader definition of cases eligible for the LTCH standard payment rates than MedPAC modeled in our analytic work and our 2014 recommendation to the Congress. Therefore, there are still cases that could be treated in a lower-cost setting that would receive LTCH standard payment rates if admitted to an LTCH. Second, the impacts of payment system revisions on LTCHs and their admitting practices are not yet fully understood. LTCHs may respond to the new payment changes in ways not contemplated by the policy that could have adverse effects on the Medicare program and its beneficiaries. Therefore, we believe there is still at least a short-term need to maintain the 25-percent rule and apply it to all LTCH discharges, as CMS proposes in this rule.

Calculating high-cost outlier payment for cases paid a “site-neutral” rate

The Pathway for SGR Reform Act of 2013 mandates that cases that do not qualify to receive the full LTCH PPS payment rate receive the lesser of an IPPS-comparable rate (plus applicable outlier payment) or an amount equal to the estimated cost of the case, as described previously. The IPPS-comparable rate uses the IPPS standardized payment amounts finalized through the annual rulemaking which includes an adjustment for budget neutrality to account for cases that are HCOs. In the FY 2016 final rule, CMS finalized that HCO payments for LTCH cases paid under the site-neutral payment rate would be calculated based on the IPPS fixed-loss amount. CMS assumed that these cases would likely mirror the costs and resource use for IPPS cases assigned to the same

MS–DRG. CMS proposes to use the IPPS fixed-loss amount for LTCH site-neutral cases again in FY 2017. As in FY 2016, CMS proposes to reduce payment for site-neutral cases by 5.1 percent (or an adjustment of 0.949) to account for the estimated LTCH HCO payments for those cases in FY 2017.

Comment: The Commission has long held that payments to providers should be properly aligned with the resource needs of beneficiaries and, subject to risk differentials, payment for the same services should be comparable regardless of where the services are provided (Medicare Payment Advisory Commission 2009). Such “site neutrality” helps to ensure that beneficiaries receive appropriate, high-quality care in the least costly setting for their clinical conditions. The Commission recognizes that the establishment of site-neutral payments under the Pathway for SGR Reform Act of 2013 leaves the Secretary little discretion in setting the amount CMS pays for site-neutral cases defined by law as the lesser of either an IPPS-comparable rate or 100 percent of the cost of the case. This “lesser of” mechanism does not equalize payments across provider types; instead, it could result in the LTCH receiving a lower payment than what it would have received for a similar IPPS discharge.

CMS proposes to use the IPPS fixed-loss amount to determine if a discharge paid under the site-neutral rate qualifies to receive an HCO payment again for FY 2017. CMS sets the IPPS fixed-loss amount each year at a level that it estimates will result in aggregate HCO payments equal 5.1 percent of total IPPS payment. To account for the spending attributed to these outlier payments, CMS reduces the IPPS base payment rates to maintain budget neutrality in the IPPS. The IPPS-comparable rate used to pay for site-neutral cases in LTCHs includes an adjustment for budget neutrality to account for spending associated with HCOs.

With the Commission’s payment principles in mind, MedPAC urges CMS to eliminate the proposed payment adjustment for discharges paid the site-neutral rate to account for outlier payments under this payment methodology. Given that the IPPS standard payment amount is already adjusted to account for HCO payments, CMS’ proposal to reduce the site-neutral portion of the LTCH payment by a budget neutrality adjustment of 0.949 is duplicative and exaggerates

the disparity in payment rates across provider settings. Given this duplication, CMS should not adjust the site-neutral rate further.

LTCH Quality reporting

The IMPACT Act of 2014 requires the implementation of several quality and resource use measures that are standardized and interoperable across post-acute care settings including measures of: function and cognition, skin integrity, medication reconciliation, incidence of major falls, the transfer of health information and care preferences, readmissions, discharge to community, and resource use. The LTCH proposed rule discusses four measures for adoption in the LTCH quality reporting program: drug regimen review with follow up, the resource use measure (Medicare spending per beneficiary–Post Acute Care LTCH), discharge to community, and potentially preventable readmissions within 30 days after discharge from the LTCH. CMS invited comments on how socioeconomic (SES) factors should be used in the resource use and quality measures.

Comment: Because the goal of cross-cutting measures is to gauge and compare care provided across PAC settings, it is critical that each measure use uniform definitions, specifications (such as inclusions and exclusions), and risk-adjustment methods. Otherwise, differences in rates across settings could reflect differences in the way the rates were constructed rather than underlying differences in the quality of care. Our work on the design of a unified PAC payment system and the work of others indicate considerable overlap in where beneficiaries are treated for similar PAC needs. These results indicate it is imperative that quality and resource use measures are directly comparable across settings so that Medicare can evaluate the value of its purchases and beneficiaries can make informed choices about where to seek care. Separate measures will continue to be used to evaluate each PAC setting in isolation rather than support cross-setting comparisons of PAC providers. We emphasize this principle in our discussion of the MSPB measure, but note that the principle applies to all four of the IMPACT measures discussed here.

The Commission recognizes that socio-economic status (SES) factors can play a role in the outcomes for quality and resource use measures. One way to consider SES factors is to include

them in the risk adjustment method. The Commission does not support this approach because it results in adjusted rates (or spending) that hide the actual disparities in care, and could reduce pressure on providers to improve care for the poor. The Commission believes that a better way to address any differences in outcomes is to compare rates (or spending) that have not been adjusted for SES across “peer” providers that have similar shares of, for example, low-income, beneficiaries. This way, the outcome rates remain intact but the comparisons are “fair” because providers are compared with other providers with similar shares of low-income beneficiaries.

To promote transparency for beneficiaries and competition across providers, the Commission supports the public reporting of the cross-cutting quality measures. CMS should move towards reporting the cross-cutting measures quality measures for all providers in each setting.

Drug regimen review conducted with follow-up for identified issues—CMS is proposing to adopt a drug regimen review measure that reports the percentage of resident stays in which a drug regimen review was conducted at the time of admission and timely follow-up with a physician each time potentially clinically significant medication issues were identified. The purpose of the measure is to encourage PAC providers to perform a review of all medications a patient uses to identify and resolve any potential adverse effects and drug reactions (including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy).

Comment: The Commission supports CMS’s proposed medication reconciliation measure. The medication and reconciliation and follow-up process can help reduce medication errors that are especially common among patients who have multiple health care providers and multiple comorbidities. In addition to the measure proposed, MedPAC encourages CMS to assess whether PAC providers conduct medication reconciliation when discharging their patients. For example, CMS could also measure whether a PAC provider sends discharge medication lists to either the next PAC provider or, if being discharged home, to the patient’s primary care provider.

Medicare spending per beneficiary (MSPB)–Post-acute care LTCH—CMS proposes a measure of resource use that includes the average risk-adjusted total Medicare spending per beneficiary

during the LTCH stay and the 30 days after discharge from the LTCH. By holding LTCHs accountable for resource use over episodes of care, the measure will increase a provider's responsibility for care furnished during their own "watch," a safe transition to the next setting or home, and for care during the next 30 days. CMS is developing separate MSPB measures for each of the four PAC settings; the proposed rule describes the MSPB-PAC LTCH measure.

Comment: The Commission supports the adoption of a resource use measure that promotes providers' responsibility for episodes of care. By reporting provider's performance regarding resource use during their patients' stays plus 30 days after discharge, the measure will ready providers for broader payment reforms that extend providers' responsibility for episodes of care, such as bundled payments. However, the Commission does not support the development of setting-specific measures. We believe a uniformly defined resource use measure for all four PAC settings, rather than separate measures for each PAC setting (such as the MSPB-PAC LTCH), will better meet the intent of the IMPACT Act and enable comparisons across PAC settings. Under a single measure, the episode definitions, service inclusions/exclusions, and risk adjustment methods would be the same across all PAC settings.

Until there is a uniform PAC PPS and payment differences between settings are eliminated, the Commission appreciates that a single measure would, without other adjustment, consistently advantage lower-cost settings and disadvantage higher-cost settings due to the large spending differences associated with the initial PAC stay across the settings. Therefore, to assess providers' performance in the near term, CMS should use a single measure and compare providers within each setting (i.e. a LTCH's spending would be compared with other LTCHs' spending, an IRF's spending would be compared with other IRFs, et cetera). In the future, comparisons of the single measure could be made across all PAC settings.

Discharge to community—This measure is a risk-adjusted rate of FFS beneficiaries who are discharged to the community following a PAC stay and do not have unplanned hospital readmissions during the 31 days following discharge to the community. CMS proposes to gather the discharge status from the PAC claim.

Comment: The Commission supports this measure; it has used a similar measure to track the quality of SNFs and IRFs for several years. However, the Commission urges CMS to confirm discharge status by matching claims between the discharging PAC provider and any subsequent institutional provider (a hospital, IRF, SNF, or LTCH). CMS evaluated the accuracy of the discharge status field on the PAC claim by examining the agreement between the “discharge status” on the PAC claim and the presence of a subsequent acute hospital claim. The agreement between the PAC claim and hospital claim was high (about 90 percent) but the agreement between PAC claims (for example, an LTCH claim indicated the beneficiary was discharged to a SNF and there was a subsequent SNF claim) was not reported. To ensure that rates reflect actual performance, “discharged to the community” should be confirmed with the absence of a subsequent claim to a hospital, an IRF, SNF, or a LTCH.

Potentially preventable 30-day post-discharge readmission—This measure assesses a facility’s risk-adjusted rate of unplanned, potentially preventable hospital readmissions for Medicare FFS beneficiaries in the 30 days after discharge from the LTCH.

Comment: The Commission supports this measure, believing that LTCHs should be held accountable for safe transitions to the next setting (including home). MedPAC has tracked a post-discharge readmission measure over multiple years for SNFs and IRFs. As noted above, the measure definition and risk adjustment should be identical across the four PAC settings so the post-discharge rates can be meaningfully compared.

Rural reclassification of LTCHs

The Consolidated Appropriations Act of 2016 (CAA) establishes a temporary exception from the site-neutral payment rate for certain wound care discharges from certain LTCHs. In order to qualify for this exemption, the LTCH must have participated in Medicare as an LTCH, been co-located with another hospital as of September 30, 1995, meet certain other operating requirements, and be located in a rural area. The CAA defines a “rural” LTCH as being either located in a rural area or “treated” as a rural hospital based on reclassification. The rural reclassification historically has only applied to subsection (d) hospitals, which excludes LTCHs by definition. CMS proposes

to apply the existing rural reclassification process for subsection (d) hospitals to certain LTCHs for the sole purpose of qualifying for this temporary exception. CMS further specifies that these facilities would not be treated as rural for any other provision including, but not limited to, the 25-percent threshold policy and wage index.

Comment: The Commission strongly opposes this temporary exception from the site-neutral payment rate. While statute requires CMS to provide an exception for certain discharges involving wound care in certain LTCHs, the Commission urges CMS to apply this exception as narrowly as possible. The Commission does not understand the basis for CMS' proposal to apply the subsection (d) hospital reclassification policy to LTCHs for purposes of this exception and requests that CMS provide a detailed explanation of the rationale for proposing this reclassification. Geographic reclassification distorts wage indexes for subsection (d) hospitals which the Commission discussed in its 2007 Report to Congress. The Commission has long held that the existing hospital wage index should be repealed and replaced eliminating the need for the distorting geographic reclassification policies of IPPS hospitals. Given that LTCHs have not previously qualified for any geographic reclassification, introducing this concept in the LTCH setting creates a precedent against the Commission's principles and previous recommendations.

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,

A handwritten signature in black ink that reads "Francis J. Crosson M.D." in a cursive style.

Francis J. Crosson, M.D.
Chairman