

June 9, 2015

Andy 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-1632-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 Policy Changes and Fiscal Year 2016 Rates; Revisions to Quality Reporting Requirements for Specific Providers, including Changes Related to the Electronic Health Record Incentive Program* published in the *Federal Register* on April 30, 2015. The rule revises 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 and limited resources, we especially appreciate your staff's efforts to improve these hospital payment systems.

In this letter we comment on five issues:

- Changes to the LTCH prospective payment system
- Quality measurement and value-based payment
- Computing and distributing uncompensated care payments
- The hospital readmissions reduction program
- The wage index system

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 long-term care hospital. The Pathway for SGR Reform Act of 2013 establishes “site-neutral” payments for specified cases in LTCHs, beginning in fiscal year 2016. Under the law, Medicare will pay the higher LTCH payment rates 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.

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. With these principles in mind, the Commission recommended in our March 2014 report to the Congress that Congress reform the LTCH payment system to reduce incentives for LTCHs to admit lower acuity patients—who could be appropriately cared for in other settings at a lower cost to Medicare—by directing CMS to pay higher LTCH rates only for higher acuity LTCH cases. In the absence of standardized assessment data, the Commission determined that length of stay in the ICU is the best available proxy measure of case complexity and a good predictor of intensive resource use during

post-acute care episodes that begin with an ACH stay. We recommended that CMS pay higher LTCH rates only for LTCH cases with eight or more days in an ICU during an immediately preceding ACH stay.

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 and in implementing the criteria by which cases would qualify to receive the LTCH PPS standard payment rate. The Commission remains concerned about these two features of the legislation. First, the defined payment level for site-neutral cases is 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 would have been received for a similar IPPS discharge. Second, a threshold of fewer than eight days is too low to distinguish the truly LTCH-appropriate cases and Medicare will continue to pay too much for many cases that could be cared for appropriately in lower cost settings. However, we realize it will take legislative action to address these issues with the payment formula and the ICU criteria specified by law.

In the April 30, 2015 rule, CMS proposes an update to the LTCH PPS standard rate, a methodology for implementation of the site-neutral policy, public reporting of LTCH quality measures, and the selection of quality measures to meet the requirements of the IMPACT Act of 2014. Our comments below address each of these elements of the proposed rule.

Payment update

CMS proposes to increase Medicare’s payment rates for LTCHs by 1.9 percent, reflecting a market basket increase of 2.7 percent, a 0.6 percentage point reduction for productivity adjustment as required by the Patient Protection and Affordable Care Act (PPACA), and an additional 0.2 percentage point reduction also required by PPACA.

Comment: CMS is not statutorily required to update the LTCH PPS rate. In our assessment of the adequacy of Medicare payments to LTCHs in our March 2015 report to the Congress, we reviewed

many factors—including indicators of beneficiary access, the volume of services, the supply of providers, and access to capital— and concluded that no update for fiscal year 2016 is warranted. Medicare’s current level of payments appears more than adequate to accommodate cost growth, even before any update. The aggregate Medicare margin for LTCHs in 2013 was 6.6 percent, the fifth year in a row that it exceeded five percent. By contrast, the industry-wide IPPS Medicare margin has been negative for the average provider and close to zero for the relatively efficient providers in recent years. In March 2015, we therefore reiterated our previous recommendation that the Secretary eliminate the market basket update to LTCHs for 2016. Given the financial pressures facing the Medicare program, we urge the Secretary to accept this recommendation in setting the LTCH payment rate for 2016.

Setting base payment rates for LTCH services

The Pathway for SGR Reform Act establishes two distinct payment groups for LTCH discharges under a revised payment system. Historically, CMS has based its LTCH payment rates and relative weights for each Medicare severity long-term care diagnosis related group (MS-LTC-DRG), on data for *all* LTCH cases. CMS proposes to calculate a new LTCH base payment rate and new relative weights for each MS-LTC-DRG based solely on the most recent available standardized data associated with discharges meeting the specified patient-level criteria. These discharges are considered under the law to warrant higher LTCH payments. CMS also proposes to maintain budget neutrality—aggregate LTCH payments for these higher acuity LTCH patients should be held to the same aggregate payments these cases receive currently.

Comment: MedPAC agrees with these approaches.

Determining criteria to receive the full LTCH PPS standard payment rate

The Pathway for SGR Reform Act of 2013 requires that, to be paid the higher LTCH rate, discharges have an immediately preceding ACH stay and that the ACH stay included at least three days in an intensive care unit or the discharge receives an LTCH principal diagnosis indicating the receipt of mechanical ventilation services for at least 96 hours. CMS proposes a method to

determine whether an LTCH discharge is considered to have an “immediately preceding ACH stay.” CMS also proposes criteria to determine whether a beneficiary has received the specified ICU or ventilator services.

Defining an “immediately preceding” ACH stay

CMS proposes to define “immediately preceding ACH stay” based on two criteria. First, an ACH discharge on the same day as LTCH admission or within a one-day window preceding LTCH admission. Second, the patient discharge status code on the discharging ACH claim must indicate that the patient was discharged to an LTCH.

Comment: The Commission supports CMS’ proposed discharge and admission date criteria. MedPAC analysis has found that over 85 percent of LTCH discharges have a prior ACH discharge within one month of LTCH admission. A vast majority of LTCH admissions that follow an ACH discharge (95 percent) occur either on the same day or within one day following the discharge date on the ACH claim. Beyond one day, any increase in time between the ACH discharge and LTCH admission could indicate issues with the discharge planning process or lack of coordination across settings. The Commission has long supported coordination between provider settings to ensure smooth transitions for beneficiaries.

In addition to the discharge and admission date criteria, CMS proposes to require ACHs to code the patient discharge status as either “63” (indicating that the patient was discharged or transferred to an LTCH) or “91” (indicating that the patient was discharged or transferred to an LTCH with expected readmission). The Commission has found that data reported in fields on the claim that are unrelated to payment tend to be less accurate than data reported in fields that are integral to payment. If CMS’ finalizes the proposed narrow window for the dates of ACH discharge and LTCH admission to qualify as “immediately preceding,” this additional reporting requirement is not necessary and instead may inappropriately pay LTCH cases the lower site-neutral rate because of inaccurate ACH coding.

However, if CMS expands the proposed time-based definition of “immediately preceding” ACH stay, then the Commission supports the use of the patient discharge status code as the longer time that exists between the ACH discharge and the LTCH admission, the lower the likelihood that the LTCH admission was intended as post-acute care. Thus, this additional coding requirement becomes increasingly important to better ensure that the LTCH admission was appropriate and intended as part of the ACH discharge planning process.

Determining whether a patient has received necessary ICU services in the ACH

As provided in law, the Secretary is required to use data from revenue center codes 020X or 021X to determine ICU days as part of the patient criteria to receive the full LTCH PPS standard payment rate.¹ CMS also proposes that the use of these codes is consistent with the definition of an ICU under §413.53(d) in order to fulfill the ICU criterion and to be excluded from the site-neutral payment rate.

Comment: CMS’ proposal to use all subcategories to the intensive and coronary care codes is consistent with the method used by the Commission in its 2014 and 2015 recommendations to the Congress. The Commission agrees with this methodology. The Commission also agrees that consistency between use of the revenue center code and §413.53(d) is reasonable. The Commission encourages CMS to monitor coding practice to ensure services provided are consistent with the regulation, as we, too, will be monitoring trends in use across the industry.

Adjusting payments for LTCH cases with unusually short stays

In the LTCH payment system, Medicare may adjust payments for cases with short stays. CMS defines a short-stay outlier (SSO) case as having a length of stay less than or equal to five-sixths of the geometric average length of stay for the case type. Payment for SSO cases equals the lesser of four payment amounts including 100 percent of the cost of the case. For most SSO cases, payment is generally considerably lower than the payment for a non-SSO case in the same MS-LTC-DRG.

¹ The 020X code refers to intensive care while the 021X code refers to coronary care. The “X” in these cases includes subcategory codes as reported on the Medicare claims for IPPS hospitals. This may include general intensive care, general coronary care, or a subcategory such as medical ICU care (0202) or heart transplant (0213), for example.

The SSO policy reflects the notion that patients with lengths of stay similar to those in acute care hospitals should be paid at rates comparable with those under the IPPS. CMS proposes to continue to apply the SSO policy to cases that meet the specified patient criteria and are paid based on the LTCH PPS standard payment rate and to exclude the use of the SSO payment adjustment for cases paid the site-neutral payment rate.

Comment: The Commission agrees that CMS should continue to apply an SSO policy to cases that are not paid under the site-neutral payment rate. The current SSO policy is a better option than no policy, however, under the current policy LTCHs have a strong financial incentive to keep patients until their lengths of stay exceed the SSO threshold for the relevant case type. MedPAC's analysis of LTCH discharge patterns has shown that LTCHs respond to that incentive. Analysis of 2013 lengths of stay shows that the number of discharges rose sharply immediately after the SSO threshold—the point in a patient's LTCH stay at which the LTCH becomes eligible for the full MS-LTC-DRG payment. This pattern held true across MS-LTC-DRGs and for every category of LTCH. The data strongly suggest that LTCHs' discharge decisions are influenced by this financial incentive in addition to clinical indicators.

The Commission has discussed an alternative preferred policy to the current SSO methodology most recently in its March 2015 report to the Congress. This alternative policy would reduce the financial incentives to extend a patient's LTCH stay beyond the SSO threshold by paying a per diem rate for SSOs, up to the maximum of the full standard LTCH payment amount. While the current LTCH SSO policy creates a substantial cliff between the SSO payment and the full LTCH payment, a per diem approach would provide a series of smaller incremental payment steps up to the full LTCH payment. Because the average length of the stay in the LTCH exceeds 26 days, each day represents a fairly small percentage of the total payment. The Commission anticipates that this alternative policy would be implemented in a budget-neutral manner, and thus would have no effect on program costs relative to current policy.

Until CMS implements an alternative SSO policy, it is important to maintain the current SSO policy for cases not paid under the site-neutral payment rate. In this context, the Commission agrees with CMS' proposal that site-neutral cases be excluded from the calculations of SSO thresholds for each MS-LTC-DRG. The SSO thresholds should be calculated based solely on the most recent available length of stay data associated with discharges meeting the specified patient-level criteria. The Commission further agrees with CMS' proposal not to apply the SSO payment adjustment to the site-neutral payment rate because those cases will be paid the lower of cost or the IPPS rate as stipulated in law.

Maintaining adjustment for the "25 percent rule"

In fiscal year 2005, CMS established the 25-percent rule in an attempt to prevent LTCHs from functioning as units of ACHs. The 25-percent rule uses payment adjustments to create disincentives for LTCHs to admit a large share of their patients from a single ACH. The 25-percent rule initially applied only to LTCH hospitals-within-hospitals (HWHs) and LTCH satellites. In July 2007, CMS extended the 25-percent rule to freestanding LTCHs. However, the Congress has delayed full implementation of the 25-percent rule so that most HWHs and satellites will be paid standard LTCH rates for eligible patients admitted from their host hospitals as long as the percentage of Medicare admissions from the host hospital does not exceed 50 percent (instead of the more restrictive 25-percent threshold). In addition, the Secretary is prohibited from applying the 25-percent rule to freestanding LTCHs before July 1, 2016. CMS proposes to apply the 25-percent threshold payment adjustment to site neutral payment rate cases in the same manner as it is applied to the LTCH PPS standard payment rate cases.

Comment: The LTCH payment reform included in the Pathway for SGR Reform Act of 2013 does not address the behavioral concerns that the 25-percent rule intended to mitigate. In light of this, the Commission supports CMS' proposal to continue the current implementation of the 25-percent rule and the expansion of the rule after July 1, 2016 to cases paid under the site-neutral rate until the robustness of the LTCH site-neutral criteria can be assessed and consequences observed.

Maintaining the interrupted stay policy for all LTCH cases

LTCHs receive one payment for “interrupted-stay” patients. An interrupted stay is when an LTCH patient is discharged to an inpatient acute care hospital, an inpatient rehabilitation facility (IRF), or a skilled nursing facility (SNF), stays for a specified period, then returns to the same LTCH. CMS implemented the interrupted-stay policy to discourage LTCHs from discharging patients for a short period of time in an attempt to gain another full payment. The current specified periods of time are: 9 days for an acute care hospital, 27 days for an IRF, and 45 days for a SNF. Under this policy, the interim facility would continue to receive their regular payment as specified under law and the LTCH would receive a single payment for the interrupted stay. In addition, any LTCH discharge readmitted within three days is also considered an interrupted stay. In these cases, the LTCH receives one payment to cover LTCH care in addition to interim care provided at an ACH, IRF, or SNF.

Comment: The Commission agrees with CMS’s proposal to apply the interrupted-stay policy to cases subject to the full LTCH PPS standard payment rate and cases paid the site-neutral amount, given that the site-neutral policy does not address or mitigate any incentives that the interrupted-stay policy is meant to alleviate.

Public reporting of LTCH quality measures

Beginning with fiscal year 2014, CMS reduces the annual market basket update by 2 percentage points for any LTCH that fails to successfully report on a specified set of quality measures. Over the past several years, CMS adopted 12 quality measures for LTCHs, six of which are being used for the FY 2016 payment determination. These include: catheter-associated urinary tract infections (CAUTI), central line-associated bloodstream infections (CLABSI), new or worsened pressure ulcers, percent of patients assessed and appropriately given the seasonal influenza vaccine, and influenza vaccine coverage among healthcare personnel. LTCHs must report data on CAUTI, CLABSI, and flu vaccine coverage among their healthcare personnel through the National Healthcare Safety Network (NHSN), an internet-based surveillance system maintained by the Centers for Disease Control and Prevention. The data elements necessary to calculate the pressure

ulcer measure and seasonal flu vaccine will be collected using the LTCH Continuity Assessment Record & Evaluation (CARE) data set.

CMS proposes to begin public reporting of certain LTCH quality measures, as required by PPACA, beginning by the fall of 2016. The proposed measures for public reporting include the CAUTI and CLABSI measures, the percent of patients with pressure ulcers that are new or worsened, and a previously-finalized measure of all-cause unplanned readmissions within the 30 days post-discharge.

Comment: The Commission commends CMS' proposal to begin public reporting with these outcome measures in FY 2017, because relative to process measures, outcome measures are more directly relevant to, and better understood by, beneficiaries.

Applying quality measures for purposes of the IMPACT Act

The IMPACT Act of 2014 requires the implementation of quality measures and resource use and other measures that are standardized and interoperable across PAC settings. In addition, IRFs, LTCHs, SNFs, and HHAs are required to report standardized patient assessment data. Implementation of a common patient assessment tool will allow the comparison of costs, quality of care, and patient outcomes across all post-acute settings, while controlling for differences in patient condition and other characteristics that affect the cost of care or the patient's capacity to benefit from care. Those comparisons, in turn, would allow us to know what Medicare is buying in each setting and assess the value of the services furnished.

The IMPACT Act requires Medicare to implement a quality measure addressing the domain of "functional status, cognitive function, and changes in function and cognitive function." To meet this requirement, CMS proposes to use a process measure in which each PAC provider would report the percentage of its patients for whom it performed a functional assessment at admission and discharge, and developed a care plan that addresses at least one functional goal.

Comment: The Commission has urged for several years that Medicare's quality measurement system should move away from clinical process measures and toward the use of outcome measures. Therefore, we do not support the process measure CMS is proposing. We urge the agency to use instead an outcome measure that reports actual changes in PAC patients' physical and cognitive functioning while they are under a provider's care, as envisioned in the IMPACT Act.

Inpatient quality reporting and value-based purchasing programs

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

CMS proposes to decrease the total number of measures required for the Inpatient Quality Reporting (IQR) program from 46 in FY 2015 to 45 in FY 2016. The proposed changes would:

- Delete 9 chart-abstracted clinical process measures,
- Add 7 claims-based measures that examine service use and spending during episodes
 - Kidney/UTI clinical episode-based payment measure
 - Cellulitis clinical episode-based payment measure
 - GI hemorrhage clinical episode-based payment measure
 - Lumbar spine fusion/refusion clinical episode-based payment measure
 - Hospital-level, risk-standardized payment associated with a 90-day episode-of-care for elective primary total hip arthroplasty and/or total knee arthroplasty
 - Excess days in acute care after hospitalization for AMI
 - Excess days in acute care after hospitalization for HF
- Add a new survey measure on the patient safety culture in the hospital.

Similarly, CMS proposes transitioning to more outcome measures in the Hospital Value-Based Purchasing (VBP) program in FY 2016, 2017, and 2018. By 2018, the proposal is that the VBP program will use two patient experience measures (HCAHPS and a care transitions measure), three mortality measures (Acute Myocardial Infarction (AMI), heart failure, and pneumonia), seven patient safety measures, and one measure of standardized spending per episode.

Comment: For several years, the Commission has urged moving 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.

With respect to episode spending measures, 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 previously supported adding the 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. Further, any given hospital's ability to report these data may vary from year-to-year. 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.

Therefore, we do not support the use of the proposed condition-specific cost measures in the IQR or VBP programs. Each provider could be given condition-specific costs of care to understand what may be driving their aggregate MSPB performance and give them the flexibility to act on this information, but we do not think Medicare should base financial rewards on condition-specific cost measures at the individual hospital level, given the statistical limitations on the usefulness of such information.

Uncompensated care payments

We continue to see two problems with the proposal for distributing uncompensated care dollars. The first problem is the metric used to estimate each hospital's uncompensated care costs. CMS

proposes to continue using each hospital's number of Medicaid and Medicare SSI (Supplemental Security Income) inpatient days as a proxy for uncompensated care costs. This is a poor proxy as we explain in this letter. Data from worksheet S-10 in hospitals' annual Medicare cost reports provides a better estimate of uncompensated care costs. We urge CMS to transition toward using the S-10 to estimate uncompensated care costs. Second, the proposal to distribute the uncompensated care payments as a per-discharge add-on payment is problematic because the per-discharge add-on distorts prices used by Medicare managed care (MA) plans. The add-on can add over \$10,000 to the price per discharge at some hospitals and \$0 at others. While CMS will reconcile the per discharge payments with the amount of uncompensated care payments due after the year has ended, the process of changing the DRG price based on each hospital's uncompensated care level is problematic. MA plans often base hospital payment rates on FFS rates, and this distortion in FFS prices creates an incentive for MA plans to direct patients away from hospitals providing significant care to the uninsured. In this paper, we discuss two possible ways to remove the distortion to prices. As we stated last year, CMS could provide a common county-wide add on and periodically adjust payments outside of the pricer (e.g., quarterly reconciliation) to assure that each hospital receives its share of uncompensated care payments in a timely manner. A second alternative is to remove FFS uncompensated care payments from the inpatient pricer and have CMS directly distribute uncompensated care payments from the FFS system as quarterly payments to hospitals. CMS would also directly make payments to hospitals for MA plans' share of uncompensated care costs. In essence, the uncompensated care payments would be carved out of the MA plan payments just as indirect medical education payments are currently carved out of MA plan payments. The uncompensated care payments would no longer be included in the MA plan benchmarks. This would eliminate the distortions in the pricer that is used by MA plans when paying hospitals.

The proposed method for setting each hospital's *uncompensated* care payments

Historically Medicare has paid higher inpatient payment rates to hospitals with a high share of low-income patients (or a "disproportionate share" –DSH– of low-income payments), 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 SSI. The Medicaid fraction is the hospital’s share of total inpatient days attributable to Medicaid patients. The 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.² 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.³ In other words, the DSH formula (which used Medicaid and SSI days) failed to direct significantly higher payments to hospitals with high amounts of non-Medicare uncompensated care costs.

In 2010, Congress enacted several changes in the DSH payment policy in the Patient Protection and Affordable Care Act (PPACA). The overall size of the pool of dollars available for DSH and uncompensated care payments is determined using the same DPP method that was previously used to determine the DSH pool. The key change taking place beginning in fiscal year 2014 is that the pool of dollars for DSH payments and uncompensated care payments is allocated into the following categories:

² 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.
Medicare Payment Advisory Commission. 2007. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

³ Medicare Payment Advisory Commission. 2007. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

- CMS pays 25 percent of the pool based on the **DSH** formula.
- The remaining 75 percent of the pool is divided into two parts.
 - One part is 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 number of uninsured individuals falls, the Medicare funds allocated to helping hospitals pay for uncompensated care will decrease. The remainder of the funds not allocated to uncompensated care will be **savings for the Medicare Part A trust fund**. 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.

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

- Bring DSH payments down to 25 percent of the past level (\$3.3 billion in 2016)
- 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. However, the uncompensated care pool is expected to be approximately \$6.4 billion in 2016 and will continue to be significant even after coverage expansion is complete.

CMS has decided to continue to use Medicaid and SSI days as a proxy for a hospital's uncompensated care costs. Therefore, each DSH hospital's uncompensated care payments will purely be a function of the number of Medicaid/SSI days at the hospital.

Comment: A better way to set each hospitals' uncompensated care payments

Our 2007 analysis of data from the GAO and data from the American Hospital Association (AHA) suggests that Medicaid days and low-income Medicare days are not a good proxy for uncompensated care costs.⁴ 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.

Worksheet S-10 in the Medicare hospital cost report provides an alternative measure of uncompensated care burdens that could begin to replace the reliance on Medicaid and SSI shares. Representatives of the hospital industry have stated that CMS needs to move toward using the S-10 to compute charity care levels, but have also expressed concerns that the data still needs to be refined before it is used. However, we find that S-10 data (even in its current imperfect state) is a better predictor of audited uncompensated care costs than the Medicaid/SSI days proxy being used. This year we took a new approach to testing whether S-10 data or Medicaid/SSI days are a better indicator of costs associated with caring for the uninsured. We used 2009 audited data that the Medicaid program collects on the cost of caring for the uninsured for each hospital that receives Medicaid DSH. While the Medicaid audited uncompensated care data cannot be used for Medicare payment because it is only available for about one third of Medicare hospitals, it can be used to determine how closely the S-10 data matches audited uncompensated care data. We used 2009 data because it was the most recent data we could obtain from the Medicaid and CHIP Payment and Access Commission (MACPAC), which has compiled CMS DSH audit information from publicly available files into a more readily analyzable format. The S-10 data on uncompensated cost of caring for the uninsured and the Medicaid/SSI days are from 2011.⁵ The 2011 S-10 data were used because it most closely matches the time frame of the audited uncompensated care data. The correlation between audited uncompensated care data and S-10 data was over .80. The

⁴ Medicare Payment Advisory Commission. 2007. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

⁵ We used the 2011 schedule S-10 Line 23 Column 1 which reports the uncompensated cost of caring for the uninsured. This variable fits the law which gives the Secretary the authority to pick the best proxy for the "costs of subsection (d) hospitals treading the uninsured." Alternatively, the Secretary could use all uncompensated care which is on Line 30 Column 1.

correlation between audited uncompensated care data and Medicaid/SSI days was smaller (about .50). Another (perhaps more intuitive) way to use the correlations is to square them to arrive at the share of the variance in audited uncompensated care that can be explained by each variable. The 2011 S-10 data explained over 60 percent of the variance ($.80^2$) in audited uncompensated care costs. The Medicaid/SSI day variable explained about 25 percent of the variance ($.50^2$). The implication of this comparison is that CMS will more accurately direct dollars toward hospitals with high costs of caring for the uninsured if it uses S-10 data than if it uses Medicaid/SSI days as a proxy for uncompensated care costs.

Given that the S-10 more closely tracks hospital's relative costs of caring for the uninsured, we urge CMS to transition over three years to using S-10 data and simultaneously continue to revise the S-10 as needed. A three-year transition will prevent financial shocks to hospitals and will create an incentive for hospitals to more accurately report uncompensated care on the S-10.

The proposed method for distributing uncompensated care payments

The FY 2014 hospital inpatient proposed rule had anticipated making 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 CMS uses to compute the price for each FFS discharge, managed care companies would not make any payments for their share of uncompensated care costs. Because the uncompensated care payments are included in the Medicare Advantage (MA) plans' benchmarks, the MA plans should be expected to pay those amounts to hospitals. The FY 2014 final rule addressed this concern by making each hospital's uncompensated care payments an add-on within the pricer and then reconciling any overpayments or underpayments after the year ends. This method was continued in 2015 and is proposed for 2016.

Comment: The method of distributing uncompensated care payments distorts DRG prices

Under the proposed system for 2016, one hospital may have an add-on of \$10,000 per discharge and a competing hospital may have \$0 add-on per discharge. The problem is not that one hospital is getting more uncompensated care dollars than another hospital. The intent of the law is to make the uncompensated care payments proportional to each hospital's share of uncompensated care costs. The problem is that the way the payments are distributed distorts the basic DRG pricing system. This creates problematic incentives for MA plans that pay hospitals based on the FFS Medicare pricer. 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 are two ways to eliminate the distortion to the pricer. As we stated in our comment on the FY 2015 inpatient proposed rule, CMS could determine a common add-on amount for each hospital in a county and then periodically (e.g., quarterly) reconcile uncompensated care payments made through the add-on with hospitals actual uncompensated care costs.⁶ The adjustments (outside of the basic DRG payment) would assure that hospitals providing more uncompensated care get higher uncompensated care payments. We made this proposal last year, but some hospitals responded with concerns about the magnitude of quarterly reconciliations. An alternative is to simply not include the uncompensated care payments as an add-on in the pricer at all, and instead 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). 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 would then increase the FFS uncompensated care pool by that percentage

⁶Medicare Payment Advisory Commission. 2014. MedPAC comment letter on CMS's acute and long-term care hospitals proposed rule, June 2, 2014.

and reduce the MA benchmarks by an equal amount to reflect removing the uncompensated care payments from the benchmark in each county.

- The 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 payments to be distributed more equitably, and providing uncompensated care would no longer disadvantage hospitals with respect to price negotiations with MA plans.

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

The Commission believes that the hospital readmission reduction program has been a success as hospitals have worked to improve care transitions which have 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. While CMS implemented the hospital readmissions reduction program (HRRP) according to statute, the Commission continues to believe that the law needs to be changed to address several issues with the design of the payment penalty formula. Specifically, the law may need to be refined to address five issues with the current policy:

- The readmission penalty formula is problematic. Aggregate penalties would remain constant even if national readmission rates decline. More importantly, the condition-specific penalty per excess readmission is higher for conditions with low readmission rates than conditions with high readmission rates. This issue became more important in 2015

when elective total hip and total knee arthroplasty (low readmission rate conditions) were added to the readmission policy. Because the penalty for a hip or knee readmission of roughly \$200,000 per excess discharge is dramatically higher than the revenue from an admission, hospitals may distort care patterns for these patients. To correct this problem, the basic penalty formula needs to be changed.

- 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. This puts hospitals that treat a large share of low income patients at a financial disadvantage under the current program.
- In the 2016 IPPS proposed rule, CMS plans to broaden the types of cases captured by the pneumonia readmissions measure to include aspiration pneumonia, and cases where pneumonia is a secondary diagnosis for patient with a primary diagnosis of respiratory failure or sepsis. A potential issue with this proposed expansion of the pneumonia readmission measure is the double counting of cases in two different readmission measures (pneumonia and chronic obstructive pulmonary disease (COPD)) as both the revised pneumonia measure and COPD measure can include the same cases if respiratory failure is the primary diagnosis and both COPD and pneumonia are listed as secondary diagnoses. This same double counting issue is also a potential issue for the AMI and Coronary Artery Bypass Graft (CABG) readmission measures, as patients who are admitted for AMI and then undergo a cardiac bypass operation during their stay may be counted in both measures. The double counting issues point to an additional problem with using condition specific measures, rather than an all condition measure, in the readmission reduction program.

To address these concerns we discussed using an all-condition readmission measure with a fixed target in our June 2013 Report to the Congress.⁷ The readmission “multiplier” would be removed from the formula and replaced with a penalty that roughly equals the cost of excess readmissions over a fixed target level of readmissions. 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.

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

The 2016 IPPS proposed rule requests comments on a variety of detailed hospital wage index issues. As we did last year, 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 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 2016), 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 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

⁷ Medicare Payment Advisory Commission. 2013. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

- Is implemented so that large changes in wage index values are phased in over a transition period.

The system we proposed is similar to a recommendation by the Institute of Medicine and would eliminate the need for the system of geographic reclassification and exceptions that is currently in place.⁸

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." The signature is written in a cursive, flowing style.

Francis J. Crosson, M.D.
Chairman

⁸ 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.