MEDPAC Medicare Payment Advisory Commission

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May 23, 2017

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

RE: File code CMS–1677–P

Dear Ms. Verma:

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 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices; Proposed Rule* published in the *Federal Register* on April 28, 2017. The rules revise the hospital inpatient prospective payment system, the long-term care hospital (LTCH) payment system, and quality reporting requirements for specific providers. In view of the competing demands on their time, we especially appreciate your staff's efforts to improve these hospital payment systems.

In this letter we comment on seven key issues:

- Using the S-10 data for uncompensated care payments
- Accounting for social risk factors in quality metrics and incentives
- Changes in the Hospital Readmission Reduction Program
- Volume incentives and patient selection incentives at physician-owned hospitals
- The large number of wage index exceptions
- Changes to LTCH payments and hospital-within-hospital regulations
- Transparency for national accrediting organizations

Using S-10 data for 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 policy pays higher inpatient rates for low-income Medicare patients, but it also indirectly subsidizes 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 updated 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 be returned to Medicare Part A trust fund as savings assuming the rate of uninsurance remains below the rate of uninsurance in 2013 (presumably reducing the need for uncompensated care payments below the 2013 level). CMS determined that the size of the pool of potential DSH and uncompensated care dollars will be $16 billion in FY 2018.[1] CMS is proposing to allocate the potential pool of dollars as follows:

1) CMS pays 25 percent of the pool ($4 billion) based on the traditional **DSH** formula.

2) The remaining 75 percent of the pool ($12 billion) is further divided into two parts: savings for

[1] The size of the potential DSH and Uncompensated care pool has expanded from $12 billion in 2013 to $16 billion in 2018 due to a combination of the growth in Medicaid days (which increases hospitals' DPPs), increases in the Medicare case mix, and higher Medicare base rates through annual updates. The DSH calculation is a percentage add-on to hospitals' base payment rates. Therefore, as base payments and case mix increase, the size of the DSH pool increases.

the trust fund and payments for uncompensated care.

a) For every 1 percent decline in the rate of uninsurance, the share of the remaining pool allocated to trust fund savings increases by 1 percentage point. CMS estimated that the rate of unisurance has declined by 42 percent since the passage of PPACA. This means that 42 percent of the $12 billion ($5 billion) will be **savings for the Medicare Part A trust fund.**

b) The remaining $7 billion ($12 billion x 58 percent) will be distributed to partially pay for **uncompensated care** costs at hospitals in 2018. The distribution of these payments depends on each hospital's estimated share of uncompensated care.

3) On net hospitals will receive a total of **$11 billion in combined Medicare DSH and uncompensated care dollars**.

The $7 billion dollars in uncompensated care payments will be distributed to hospitals based on a CMS estimate of each hospital's share of all DSH hospitals uncompensated care costs. Historically CMS has estimated uncompensated care costs using each hospital's share of Medicaid days and Medicare SSI days a proxy for its share of uncompensated care costs. However, starting in FY 2018 CMS proposes to transition to using actual reported uncompensated care costs from worksheet S-10 of the Medicare cost reports. For FY 2018, CMS will estimate each hospital's share of uncompensated care using a blend of three years of historical data from 2012, 2013 and 2014 cost reports. For the first two years, CMS will continue to use Medicare SSI days and Medicaid days from the 2012 and 2013 cost report as proxies for uncompensated care costs. For the third year, CMS will use 2014 reported uncompensated care costs on each hospital's schedule S-10 of the Medicare cost report. CMS expects to transition fully to using S-10 data over three years so that the computation will be based entirely on S-10 data by 2020. This will allow the approximately $7 billion in uncompensated care payments to be distributed using a direct measure of uncompensated care rather than using Medicaid days as a proxy.

Comment

We support the proposal to phase in using worksheet S-10 to compute uncompensated care costs. 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 Medicare 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 $4 billion in 2018. Because the DPP is dominated by the Medicaid share of patient days, the $4 billion will largely be distributed to hospitals with high Medicaid shares. The net result is that Medicare DSH dollars often fully compensate for the difference between Medicaid base rates and costs, meaning their often is no net "shortfall" for Medicaid admissions. Given that Medicaid losses are often covered by traditional DSH payments, it does not make sense to also distribute Medicare uncompensated care dollars based on Medicaid days. Those dollars should be distributed based on actual measures of uncompensated care costs.

The shift to using the S-10 will have the effect of increasing the share of the uncompensated care pool that goes to hospitals with high levels of uncompensated care in the emergency room and relatively few Medicaid days. For example, CMS projects a 31 percent increase in rural hospitals' uncompensated care payments in 2018. This is not surprising given that many of these hospitals tend to be focused on outpatient care and have material levels of uncompensated care costs in the emergency room. Hospitals with large numbers of Medicaid inpatient days but relatively little uncompensated care will receive a smaller share of the uncompensated care pool.

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 and to exclude "Medicaid shortfalls" (i.e. the difference between

Medicaid program payments and Medicaid costs). We agree with this proposal. It is inappropriate for Medicare to include "Medicaid shortfalls" when estimating uncompensated care costs for three reasons. First, the level of "shortfall" will depend on a specific hospital's cost structure and the state determined level of Medicaid payments (including Medicaid DSH payments) it receives from state Medicaid programs. It would be inappropriate for Medicare to signal to the states that CMS 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 making the computation of Medicaid "shortfalls" complex. Third, Medicare will still make $4 billion in traditional DSH payments in 2018. As discussed above, Medicaid patients are often profitable after considering Medicare DSH payments. Therefore, for reasons of principle, operational complexity, and because Medicare DSH payments may already be covering the Medicaid "shortfall," the Medicaid "shortfall" should not be included when Medicare computes uncompensated care costs.

Mechanics of reporting uncompensated care costs

Uncompensated care costs are computed by multiplying bad debt amounts and charity care charges by a cost-to-charge ratio (CCR). Many hospital organizations have correctly pointed out that errors can occur in hospital reported charges and in hospital reported CCRs. While CMS notes that these errors have been reduced over time, there is room for further improvement. To limit the effect of reporting errors on the allocation of uncompensated care payments, CMS could take some basic data editing steps.

First, CMS has proposed to correct for errant CCRs by placing an upper limit on CCRs of 0.937 and replace CCRs above that limit with the state-wide average CCR. In total CMS estimates that

140 hospitals had an unusually high or missing CCR. Rather than immediately using the state-wide CCR, we suggest that CMS instruct the MACs to use 2015 S-10 data if the 2015 data are available and the 2014 data has missing or unusual values. While not all hospitals will have 2015 data available by this summer, many will. If the hospital's CCR is unusually high in 2014 and 2015, and the hospital believes its reported CCR is correct, it should be required to provide the MAC with data supporting its CCR before being allowed to use that CCR. If no data are provided to the MAC in a timely fashion, then CMS could use the state-wide CCR as it has proposed.

Second, a hospital's charges may also have errors that could result in overstating uncompensated care costs. To limit the effect of aberrant charges, CMS could screen out S-10 cost reports with high levels of reported uncompensated care relative to total operating costs reported on the cost reports (e.g., 50 percent of operating costs). We expect that there will be very few hospitals where potential data errors trigger this screen. The MAC could again use 2015 S-10 data if they are available and not outside the screen. In addition, if the hospital insists that the data are correct, the MAC could require the hospital to provide support for that level of uncompensated care costs. If the hospital does not provide audited financial statements supporting the uncompensated care reported on the S-10, the reported uncompensated care would be reduced down to the threshold of 50 percent of operating costs.

In sum, the proposal to use S-10 data is a major step toward improving the allocation of uncompensated care payments. There will be some issues in uncompensated care costs, but the issues are manageable. As we showed in last year's comment letter, even without any corrections to past S-10 submissions, the S-10 data are a far better predictor of audited uncompensated care costs than the Medicaid and SSI day proxies.

Accounting for social risk factors in quality metrics and incentives

CMS has been reviewing reports prepared by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the National Academies of Sciences, Engineering, and Medicine on the issue of accounting for social risk factors in CMS's value-based purchasing and quality reporting programs. CMS has also been monitoring and awaiting results from the National Quality Forum's (NQF) 2-year trial period in which quality measures seeking endorsement are assessed to determine whether risk adjustment for selected social risk factors is appropriate. At the end of the trial, NQF will issue recommendations on the future inclusion of social risk factors in risk adjustment for these quality measures. As CMS continues to consider the analyses from these reports and awaits the results of the NQF trial on risk adjustment for quality measures, the agency seeks public comment on whether and how to incorporate social risk factors in Medicare programs, including the Hospital Readmissions Reduction Program (HRR).

Comment

In December 2016, ASPE released the "Social Risk Factors and Performance Under Medicare's Value-based Purchasing Programs" report to the Congress mandated by the Improving Medicare Post-Acute Care Transformation (IMPACT) Act. The report provides empirical analysis of the effects of six social risk factors (i.e., dual eligibility, residence in low-income areas, Black race, Hispanic ethnicity, rural residence, disability) on the nine Medicare quality payment programs including the Hospital Readmission Reduction (HRR) program. The report included two main findings:

1. Beneficiaries with social risk factors had worse outcomes on quality measures, regardless of the providers they saw, and dual eligibility status was the most powerful predictor of poor outcomes among the social risk factors.
2. Providers that disproportionately served beneficiaries with social risk factors tended to have worse performance on quality measures, even after accounting for their beneficiary mix.

ASPE found clinical risk factors (age, gender, medical comorbidities) had a substantial effect on readmission rates. They also found that dual eligibility status is independently associated with worse outcomes, and dually enrolled beneficiaries are more likely to see lower-quality providers.

However, providers serving a high proportion of beneficiaries with social risk factors tended to perform worse in part due to the patient population, and in part due to the provider's poor performance overall.

ASPE simulated the effect of three different potential policy solutions to account for social risk factors in each of the Medicare programs.

- Adjust quality and resource use measures
- Stratify providers into groups by proportion at-risk
- Create separate payment adjustments

MedPAC has generally supported the second solution of using peer grouping or stratification. [2] This approach is straightforward to implement, since no additional measure-level research is needed (i.e., working with measure developers to run new risk-adjustment models). The stratification report also does not minimize incentives to improve for providers with high shares of beneficiaries with social risk factors, and does not "mask" provider performance. Instead, providers would compare their unmasked performance (the rate would still have been adjusted for differences in patient age, sex, and comorbidities) with providers with similar risk factors. For example, risk-adjusted readmission performance would be compared for hospitals with similar shares of low-income patients, and payment adjusted based on whether hospitals met performance targets in their peer group.

Changes in the Hospital Readmission Reduction (HRR) Program

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 protects beneficiaries from the risks of adverse outcomes inherent in institutional transitions as well as generates savings for the Medicare program and beneficiaries.

[2] Medicare Payment Advisory Commission. 2013. *Report to the Congress: Medicare and the Health Care Delivery System*. Washington, DC: MedPAC.

The Commission strongly supports the Hospital Readmission Reduction Program as part of the Medicare hospital payment system; however, we have recommended refining the program.[1]

In our June 2013 report to the Congress, the Commission discussed evaluating hospital readmission rates against a peer group of hospitals with similar shares of low-income Medicare beneficiaries as a way to adjust readmission penalties for socioeconomic status. Congress enacted a similar proposal in the 21st Century Cures Act of 2016. The Cures Act requires CMS to compare hospitals against hospitals with similar shares of full-benefit dual-eligible beneficiaries. CMS has proposed to divide hospitals into quintiles based on the share of their Medicare patients (FFS and MA patients) that are full-benefit dual-eligible beneficiaries. Hospitals that have readmission rates above the median of their quintile would face a readmission penalty.

Comment

We are generally supportive of the policy and approach CMS is taking to implement the law. However, we would suggest two minor adjustments. First, CMS should base the quintiles only on the share of FFS patients that are fully dual-eligibles, not on all FFS and MA patients. The penalty will not apply to readmissions of MA patients and we believe their risk characteristics could distort the risk profiles of hospitals because the income characteristics of FFS and MA patients may differ for particular hospitals. Second, in our own readmission work we found that hospitals in the highest decile of low-income shares tended to have higher readmissions than those in the eighth or ninth decile. Therefore, we suggest using deciles rather than quintiles to more completely acknowledge the challenges of hospitals with the highest share of low-income patients.

Volume incentives and patient selection incentives at physician-owned hospitals

CMS has asked for public comments on the appropriate role of physician-owned hospitals in the delivery system. In 2005, Congress mandated that MedPAC report on physician owned-hospitals.[3] The findings from that report are still relevant today.

Comment

In the Commission's 2005 report, we raised concerns regarding patient selection and the effect of financial incentives on the volume of care. We found that physician-owned specialty hospitals tended to treat fewer Medicaid patients and more low-severity Medicare patients. Following our report, the Medicare inpatient payment system was changed to allow higher payments for cases with greater severity. However, CMS can only adjust payments based on comorbidities reported on claims. It is possible that physicians have greater information regarding the expected cost and riskiness of the case. This could lead to continued patient selection where physicians conduct surgery on the easier and more profitable cases at their hospital and then conduct surgery on the more difficult cases at the community hospital. A study of Texas hospitals found that surgeons who were investors in a cardiac hospital tended to have lower than expected risk-adjusted mortality rates for the patients they admitted to their cardiac hospital. But these same physicians had higher than expected risk-adjusted mortality rates for the patients they admitted to the community hospital. In addition, the risk-adjusted mortality rates at the community hospitals were higher for physicians who had invested in competing hospitals than for physicians who had not invested in competing hospitals.[4] It suggests that physicians can engage in patient selection in ways that cannot be fully adjusted for with the available risk-adjustment tools.

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[3] Medicare Payment Advisory Commission. 2005. *Report to the Congress: Physician-owned specialty hospitals*. Washington, DC: MedPAC.

[4] O'Neill, L., and A. J. Hartz. 2012. Lower mortality rates at cardiac specialty hospitals traceable to healthier patients and to doctors' performing more procedures. *Health Affairs* 31, no. 4 (April): 806-815.

We also found that communities that gained a physician-owned cardiac hospital had higher growth rates of cardiac surgeries per capita than other communities.[5] This could be due to the increased capacity in the communities. It could also be a result of some physicians changing their practice patterns to a degree due to financial incentives. When a physician owns a hospital, his or her marginal profit from additional surgeries increases.

The financial risk to the Medicare program from physician-owned hospitals is that overall volume of services will increase. The risk for competing community hospitals is that owners of physician-owned specialty hospitals will engage in patient selection in ways that cannot be fully adjusted for with available risk-adjustment methods.

The large number of wage index exceptions

The 2018 IPPS proposed rule contained some technical changes to the wage index system, which adjusts payment rates to account for local input prices. The data tables accompanying the proposed rule list and increasing number of wage index reclassifications, with 987 of 3,354 hospitals reclassifying to another geographic area. Most reclassifications operate in a budget neutral manner. Therefore, when one hospital reclassifies to a different location with a higher wage index, the payment rates to other hospitals decline. The large number of reclassifications and other adjustments raises questions regarding whether the current wage index is equitably adjusting payments for local input costs.

Comment

For several years, the Commission has noted significant concerns about the current wage index system including; the inaccuracy and circularity of hospital-reported data, the large volume of reclassifications and exceptions permitted, the bias of occupational mix, and the administrative

[5] Stensland, J., and A. Winter. 2006. Do physician-owned cardiac hospitals increase utilization? *Health Affairs* 25, no. 1 (January-February): 119-129.

complexity of the wage index system overall. In more recent years, the rural floor wage index policy has been a cause for concern nationally, because urban hospitals in certain states have had their wage indexes set equal to the highest wage index of any rural hospital in their respective state. As a result, hospitals in such states draw Medicare money away from hospitals in other states. In light of our various concerns about the current wage index system, we wish to reiterate our recommendations on wage index reform, included in the Commission's 2007 Report to Congress. [6] We recommended that the Congress repeal the existing hospital wage index. We would remove the more than 900 individual hospital reclassifications and other exceptions that occur each year, which are either stipulated in law or implemented through regulation, and also give the Secretary the authority to establish a new wage index system. Our recommended wage index system would:

- Use compensation data from all employers together with hospital industry-specific occupational weights;
- Adjust at the county level to smooth large differences between counties; and
- Include a transition period to mitigate large changes in wage index values.

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.[7]

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

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

Changes to LTCH payments and hospital-within-hospital regulations

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 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 28, 2017 rule, CMS proposes changes to payments for LTCH short-stay outlier (SSO) cases, a -0.6 percent adjustment for high-cost outlier (HCO) payments, and a one-year delay in implementing the 25-percent threshold policy.

Changes to payments for short-stay outlier (SSO) cases

Since FY 2003, CMS has applied an SSO policy for cases with covered lengths of stays that are less than or equal to 5/6 of the geometric average length of stay for each MS-LTC-DRG. The amount Medicare pays to LTCHs for an SSO case is the lowest of four amounts: 100 percent of the cost of the case; 120 percent of the per diem amount for the Medicare severity long-term care diagnosis related group (MS–LTC–DRG) multiplied by the patient's length of stay; the full MS–LTC–DRG payment, or; a blend of the IPPS amount for the same type of case and 120 percent of

the MS–LTC–DRG per diem amount, with the LTCH per diem payment amount making up more of the total amount as the patient's length of stay increases.

CMS applies a different standard to cases with "very short" lengths of stay—those with stays less than or equal to the IPPS average length of stay for the same type of case plus one standard deviation. These cases are called very short-stay outliers (VSSOs). VSSOs are also paid the lowest of four payment amounts: the first three listed previously for SSOs or an amount comparable to the IPPS payment rate rather than a blended amount.

Because SSO cases are paid the "lesser of" various payment options, while non-SSO cases are paid the full MS-LTC-DRG payment, there is an economic incentive to hold a beneficiary beyond the SSO threshold in order to increase the LTCH PPS payment for the case. As CMS notes, we identified this problem and found that within a given MS-LTC-DRG, the frequency of discharges rises sharply after the SSO threshold is met, strongly suggesting that LTCHs' discharge decisions are influenced at least as much by financial incentives as by clinical incentives.

For FY 2018 and beyond, CMS proposes to revise the payment for SSOs so that payment would be based only on the blended option described above. Payment for SSOs would be a single graduated per diem, calculated using a blended payment rate that, as the length of stay increases, consists of a decreasing portion of the payment amount paid at the IPPS per diem amount and an increasing portion paid at 120 percent of the MS-LTC-DRG per diem amount, with a maximum payment set at the full LTCH PPS standard payment rate. This proposal would result in paying LTCH SSO cases with shorter lengths of stay more like an IPPS case, while LTCH cases with a relatively longer length of stay would be paid more like a non-short-stay LTCH PPS case.

CMS estimates that the proposed changes will increase spending by approximately $102 million, after accounting for changes in discharge timing, and proposes to apply a one-time adjustment for budget neutrality to the LTCH PPS standard payment rate.

Comment

The Commission strongly supports CMS' proposal to change the payment methodology for SSOs in LTCHs. For several years, the Commission has shown the increase in discharges immediately following the SSO threshold for certain MS-LTC-DRGs and has expressed concern regarding the financial incentives for facilities to wait to discharge beneficiaries until after the SSO threshold. Thus, the Commission concurs that the data strongly suggest that LTCH's discharge decisions are influenced by financial incentives in addition to clinical indicators. We agree with the proposed policy change. The Commission further supports implementing this policy in a budget-neutral manner.

High-cost outlier (HCO) adjustment

CMS estimates that the FY 2017 fixed-loss amount will result in HCO payments equal to 8.6 percent of estimated LTCH standard payment rate payments, which is higher than the target mandated by law. This means that CMS set the fixed-loss threshold too low in FY 2017. CMS proposes to set the fixed-loss amount for cases paid under the LTCH standard payment rate such the HCO pool would equal 7.975 percent of estimated payments in FY 2018.[8] This year's proposed HCO amount results in a 0.6 percent estimated decrease in HCO payments from FY 2017, correcting for FY 2017 overpayments.

Comment

As we discussed last year in our comment letter on the FY17 LTCH proposed rule, 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

[8] Beginning with FY 2018 and applicable to discharges that qualify to receive the LTCH Federal payment rate, the 21st Century Cures Act requires CMS to adjust the standard Federal payment to ensure budget neutrality for HCO payment as if estimated aggregate HCO payments remain at 8 percent, while the fixed-loss amount for the HCO payment is set so that estimated aggregate HCO payments equal 7.975 percent of estimated aggregate payments.

outlier payments equal 7.975 percent of payments for cases paid under the LTCH standard payment rate.

Delaying the implementation of the 25-percent threshold

In fiscal year (FY) 2005, CMS established the 25-percent threshold (that limits the share of an LTCH's cases that can be admitted from a single ACH) 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 was prohibited from applying the 25-percent threshold to freestanding LTCHs before July 1, 2016 and is permanently prohibited from applying the 25-percent threshold policy to certain co-located facilities. For FY 2017, CMS finalized a policy to implement the 25-percent threshold policy across LTCH cases paid under the LTCH standard payment rate and the site-neutral rate. Congress delayed the implementation of the 25-percent threshold policy through FY 2017. In the proposed rule for FY 2018, CMS proposes to further delay the 25-percent threshold policy through FY 2018.

Comment

The Commission has historically supported the implementation the 25-percent threshold policy to help ensure that long-term care hospitals do not function as step-down units of acute care hospitals and that decisions about admission, treatment, and discharge in both acute care hospitals and LTCHs are made for clinical rather than financial reasons. Some have argued that with the implementation of the Pathway for SGR Reform Act's provisions reforming the LTCH PPS, the 25-percent threshold policy is no longer necessary. However, the Commission notes that the

Pathway for SGR Reform Act of 2013 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, the Commission concludes that there are still cases that could be treated in a lower-cost setting that would receive the LTCH standard payment rate under current law. Therefore, we believe the 25 percent rule should be maintained.

Changes to the hospital-within-hospital regulations for hospitals excluded from the inpatient prospective payment system (IPPS):

The term hospital-within-hospital (HwH) describes a hospital that occupies space within another hospital or co-locates in one or more separate buildings located on the same campus as buildings used by another hospital. Beginning in fiscal year 1998, CMS implemented regulations to address concerns that HwH LTCHs were effectively functioning as step-down units by the co-located acute care hospital paid under the IPPS. Specifically, to be paid as an LTCH, rather than based on the IPPS, CMS regulations require that LTCH HwHs must have a governing body, a chief medical officer, medical staff, and a chief executive officer separate from that of the hospital with which it is co-located. In addition, the LTCH HwH must have either perform certain specified basic hospital functions on its own and not receive them from the host hospital or a third entity that controls both hospitals; or the HwH must receive at least 75 percent of its inpatients from sources other than the co-located hospital; or LTCH HwHs must demonstrate their separateness by showing that the cost of the services that the hospital obtains under contracts or other agreements with the co-located hospital or a third entity that controls both hospitals is no more than 15 percent of the hospital's total inpatient operating cost. CMS later extended application of the HwH regulations to all classifications of IPPS-excluded hospitals including inpatient rehabilitation facilities (IRFs), inpatient psychiatric facilities (IPFs), cancer hospitals, and children's hospitals that are co-located with another hospital. However, hospitals that were IPPS-excluded HwHs before October 1, 1995 are not required to comply with the separateness and control regulations.

CMS proposes to amend regulations pertaining to HwHs such that the current regulations would only apply to IPPS-excluded HwHs co-located within IPPS hospitals. This means that IPPS-excluded HwHs, including LTCHs, IRFs, IPFs, cancer hospitals, and children's hospitals would be able co-locate with other IPPS-excluded hospitals without meeting the separateness and control requirements. CMS also solicits comments, without a proposal, on eliminating the separateness and control requirements for IPPS-excluded HwHs located in IPPS hospitals.

Comment

The Commission generally supports the concept of a single entity that provides IPPS-excluded hospital services and has discussed a parallel concept in context of our unified PAC PPS work over the past two years. When Medicare begins to pay PAC providers under a single payment system, it will need to give providers more flexibility to offer services that span the PAC continuum of care. For example, a more flexible structure would give providers the option to consolidate separate PAC operations into a single, larger institutional PAC unit to achieve greater economies of scale. Likewise, low-occupancy IPPS-excluded hospitals or PAC providers would have the flexibility to convert unused capacity to become an institutional PAC provider serving a broader mix of patients. Given our work with the unified PAC PPS, the Commission supports CMS' proposal to remove the separateness and control requirements for co-located LTCHs, IRFs and SNFs.

In response to CMS' request for comments regarding whether separateness and control requirements are still necessary for IPPS-excluded HwHs that are co-located with IPPS hospitals, the Commission has concerns regarding certain types of IPPS-excluded HwHs, such as LTCHs and cancer hospitals. The Commission agrees that the new LTCH criteria (a three-day ICU stay) would mitigate some of the misuse that could occur without the separateness and control regulations. We remain concerned that without implementation of the 25-percent threshold, or alternative policy, some IPPS hospitals would increasingly use LTCHs as step-down units. The Commission also notes 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, the Commission concludes that CMS

should continue to maintain the separateness and control requirements for HwH LTCHs located in IPPS hospitals.

Lastly, the Commission disagrees that the separateness and control requirements for HwHs are unnecessary for IPPS-excluded cancer hospitals co-located with IPPS hospitals. Currently, 11 cancer hospitals are deemed exempt from the IPPS and receive payment for inpatient hospital services they furnish on the basis of reasonable cost. As a general principle, the Commission disagrees with having a cost-based hospital operating within an IPPS hospital. Mixing PPS and cost-based payments would create opportunities for cost-accounting inaccuracies. In addition, it would create a situation where identical services would be paid two different rates in two parts of the hospital (the cost-based rate and the PPS rate). To prevent misuse of the IPPS-excluded cancer hospital program, CMS should continue to require that these facilities to maintain their separateness and control.

Transparency for national accrediting organizations

Currently, hospitals and other providers (e.g., home health agencies, hospice, psychiatric hospitals) can demonstrate compliance with Medicare conditions of participation by review of a state survey agency or a CMS-approved accrediting organization (AOs). AOs currently do not make their survey reports publicly available, unlike state survey results, which are made public on several websites. CMS has found a continued trend of high disparity rates between AO deficiency findings compared to serious, condition-level deficiencies found by state survey agencies. CMS proposes that approved AOs now be required to post their hospital and other provider survey reports and plans of corrections on their website.

Comment

We support CMS's proposal to increase transparency and program integrity by requiring hospital and other provider AOs to release their survey results, and urge CMS to implement this requirement as soon as feasible. The proposed requirement to increase transparency can enable

Medicare beneficiaries make more informed decisions where to receive health care, and encourage providers to improve the quality of care and services they provide.

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,

Francis J. Crosson, M.D.
Chairman