Kentucky
Hospital
Association
*Representing Kentucky Health Care Organizations*

June 30, 2014

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

***RE: CMS-1607-P, Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2015 Rates; Quality Reporting Requirements for Specific Providers; Reasonable Compensation Equivalents for Physician Services in Excluded Teaching Hospitals; Provider Administrative Appeals and Judicial Review; Enforcement Provisions for Organ Transplant Centers; and Electronic Health Record Incentive Program (Vol. 79, No. 94), May 15, 2014***

Dear Ms. Tavenner:

The Kentucky Hospital Association (KHA) represents all 130 hospitals in the Commonwealth of Kentucky. On behalf of our members, we appreciate the opportunity to comments on CMS's hospital inpatient prospective payment system (IPPS) proposed rule for fiscal year (FY) 2015. We will submit comments separately on CMS's proposed changes to long term care hospital (LTCH) PPS.

**KHA and its members have serious concerns about certain aspects of the Hospital-acquired Condition (HAC) Reduction Program proposals, the Hospital Re-admission Reduction Program (HRRP), the Medicare Disproportionate Share (DSH) Program, the Inpatient Quality Reporting (IQR) program proposals, Area Wage Index and the proposed changes to the cost report requirements related to the jurisdiction of the Provider Reimbursement Review Board (PRRB). As CMS requested, KHA, through endorsement of AHA's submitted comments, copy attached, is providing input on the design of an alternate payment methodology for short inpatient hospital stays, which would supplement the existing "two-midnight" policy.**

## HOSPITAL-ACQUIRED CONDITION (HAC) REDUCTION PROGRAM

Beginning in FY 2015, the Affordable Care Act (ACA) requires CMS to impose a 1 percent reduction in Medicare payments for hospitals in the top quartile of risk-adjusted national HAC rates. AHA and KHA continue to support initiatives to reduce preventable patient harm,

and support quality measurement and pay-for-performance programs that effectively promote improvements in patient safety. **However, we remain very concerned that the HAC policy is poorly designed.**

The overlap of measures between the HAC program and the hospital value-based purchasing (VBP) program creates the potential for unfair double payment penalties, and could send conflicting signals about the true state of hospital performance. The claims-based patient safety composite indicator (PSI 90) comprising 35 percent of a hospital's performance falls well short of the level of rigor needed for measures in accountability applications. We are concerned that PSI 90 focuses predominantly on surgical issues which disproportionately penalize teaching and large hospitals. **Therefore, we urge CMS to adopt several changes to the HAC program – such as eliminating the overlap of measures between the HAC and VBP programs, and developing a plan to identify and implement alternative measures to the PSI 90 – that would more effectively promote hospital improvements in patient safety, and improve the fairness of the program.**

**HOSPITAL RE-ADMISSION REDUCTION PROGRAM (HRRP)**

The HRRP assesses penalties on hospitals for having "excess" readmission rates when compared to expected rates. **We continue to be disappointed that CMS has again failed to propose a process for excluding readmissions unrelated to the initial reason for admission in calculating the measures, as mandated by the ACA. The agency has again failed to propose to adjust the program's measures for sociodemographic factors.**

Kentucky hospitals have been among the states hardest hit by the Hospital Readmissions Reduction Program. In FY 2014, 88% of Kentucky's 65 PPS hospitals were penalized, compared to about two-thirds of hospitals nationally. Also, four of the 18 hospitals nationally which received the maximum two percent payment penalty were located in Kentucky. In FY 2014, Kentucky ranked 46$^{th}$ in readmissions among heart attack patients, 42$^{nd}$ among heart failure patients, and 47$^{th}$ among pneumonia patients. In both FY 2013 and 2014, the Readmissions Reduction Program cut Kentucky hospital payments by about $ 6 million. The disproportionate impact on Kentucky is largely a reflection of the high level of poverty in the state combined with a lack of available alternative services. To illustrate this point, Kentucky hospitals having high readmission penalties are predominately located in Eastern Kentucky, an area with some of the highest levels of poverty in the country, or in other rural areas which are also medically underserved. KHA has long argued that CMS should adjust its readmission penalties to account for socio-economic conditions and the lack of medical services. Hospitals should not be penalized for factors beyond their control – such as lack of primary care, rehabilitation, mental health services, or inadequate transportation - which affect whether a patient is readmitted. Recently, MedPAC, an independent agency that advises Congress on the Medicare program, has found that hospitals servicing large shares of lower income patients tend to have higher readmission rates and are more likely to pay readmission penalties. A study published by the U.S. National Library of Medicine National Institutes of Health had a similar finding. Even CMS's own data shows that 77% of hospitals serving the most poor patients faced penalties compared to only 36% of hospitals with the fewest poor patients.

**We remain deeply concerned that, without sociodemographic adjustment, readmissions penalties will continue to disproportionately accrue to hospitals treating our nation's poorest and most vulnerable patients. Therefore, we urge CMS to make changes to this program so not to penalize hospitals for factors beyond their control.**

**Medicare Disproportionate Share Hospital (DSH) Program**

The Patient Protection and Affordable Care Act (ACA) requires that, beginning in FY 2014, hospitals initially receive 25 percent of the DSH funds they would have received under the current formula ("empirically justified DSH payments") with the remaining 75% percent to be distributed from a pool of funds to all DSH hospitals. This pool is to be reduced as the percentage of uninsured individuals declines and is to be distributed based on the proportion of total uncompensated care each Medicare DSH hospital provides relative to the national total.

One of the underlying purposes of the ACA was to better target DSH payments to those hospitals that treat a large portion of uninsured patients through the "uncompensated care add-on payment". CMS's consultants developed a core definition of "uncompensated care" limited to bad debt and charity care. Although several stakeholders recommended inclusion of Medicaid underpayments because such shortfalls represent non-payment for low income populations, the consultants recommended against including Medicaid for several reasons[1]:

1) It lacks consistency with the GAO, AHA and MedPac's more narrow definition of uncompensated care
2) Using Medicare funds to cross subsidize Medicaid
3) Reallocating funds toward hospitals with high Medicaid payer mix and low Medicaid payments and away from hospitals with high uninsured payer mix
4) Lack of transparency in actual Medicaid underpayments net of supplemental funding
5) Potential reduction in Medicaid shortfall due to proposed expansion of the uncompensated care definition as it relates to the Medicaid DSH hospital-specific limit.

**KHA and Kentucky's hospitals continue to strongly oppose CMS's use of inpatient days of Medicaid patients plus inpatient days of Medicare SSI beneficiaries as a proxy for measuring the amount of uncompensated care each hospital provides. This decision contradicts Congressional intent because it will not appropriately target DSH patients to the very hospitals with the highest burden of uncompensated care and instead will reward hospitals in states where Medicaid has already been expanded and which have instituted upper payment limit (UPL) programs where such hospitals are already receiving 100% of their allowable costs for treating Medicaid patients.**

[1] Dobson/DaVanzo, KNG Health Consulting, "Improvements to Medicare Disproportionate Share Hospital (DSH) Payments, Final Report, May 2013.

Hospitals in states with broader Medicaid eligibility have more Medicaid days which will result in a larger prorata proportion of the fixed Medicare DSH pool, but the formula simply equates all Medicaid days as equal, without any consideration given to adequacy of Medicaid payments that hospitals are receiving. Medicaid inpatient hospital payments in Kentucky cover only 75% of allowable costs, and results in a shortfall of approximately $264 million annually. Many other states have enacted provider taxes which are federally matched and used to enhance Medicaid payment rates to hospitals to the "upper payment limit (UPL)." Under the proposed Medicare DSH formula, hospitals will receive more Medicare DSH payments simply if they have a large number of Medicaid days relative to other hospitals, even if those days are being reimbursed at 100% of Medicare allowable costs! Thus, the proposed formula not only fails to target payment to the hospitals in poverty stricken states with fewer Medicaid days and higher bad debt and charity costs, but it will reward hospitals in Medicaid expansion states with additional payments which do not even have a Medicaid shortfall due to UPL programs which are covering costs.

CMS indicated it considered using charity care, bad debt and other data from the hospital cost report worksheet S-10 to measure uncompensated care, but decided against using it over concerns of the accuracy of the data. **KHA suggests as an alternative that CMS consider using uncompensated care data gathered by each state Medicaid agency as part of their required annual Medicaid DSH audit. This data is hospital specific, audited, and contains uncompensated costs from services hospitals provide to uninsured patients as well as their Medicaid shortfall. This data would be a more appropriate representation of uncompensated costs, and to the extent that Medicaid is included, it would only contain a hospital's actual Medicaid shortfall. Using this data would more fairly distribute the fixed pool of Medicare DSH funds to target those facilities with a high proportion of indigent patients. In addition, we urge CMS to immediately review and improve both the form and the instructions for completion of the Worksheet S-10 so that the data captured through this form can be used on an ongoing basis for distributing the pooled Medicare DSH funding.**

In addition, KHA recommends that CMS make DSH distributions through a per discharge add on rather than on a periodic interim basis to prevent the possibility for underpaying sole community hospitals (SCH). CMS's proposal to not account for the additional DSH payments in determining whether the SCH's federal IPPS rate or their hospital specific rate is higher could result in certain SCHs being paid a lower amount – their hospital-specific rates when they would otherwise have been paid higher federal PPS rates. We do not believe that the ACA contains any language to support Congressional intent to further cut hospital payments by distributing additional DSH payments on a periodic interim basis.

**IQR PROGRAM CHANGES**

CMS proposes extensive changes to the IQR program, including an expansion of the voluntary electronic clinical quality measure (eCQM) reporting option, the removal of 15 chart-abstracted measures, and the addition of five new measures. **We are concerned that some of the proposed methods to encourage participation in the voluntary electronic reporting**

**option and to align clinical quality measure reporting in the IQR program and Medicare EHR Incentive Program undermine the goals of the IQR Program – namely, continuous hospital quality improvement. We are also concerned that CMS proposes several new measures for the IQR are not NQF-endorsed. The following five measures: CABG readmissions, CABG mortality, heart failure payments per episode of care, pneumonia payment per episode of care and severe sepsis and septic shock management bundle should not be added to the IQR program at this time.**

**WAGE INDEX**

In addition to the AHA comments on New Labor Market Delineation, KHA and Kentucky's hospitals continue to have strong feelings about the Massachusetts "Bay State Boondoggle" and the structure of the current wage index systems that perpetuates lower Medicare payments to states with lower wage index. To that end, KHA offers the following comments.

Since 2011, Massachusetts hospitals have benefitted from more than half a billion dollars in additional payments through a one-sentence amendment in Section 3141 of the Affordable Care Act (ACA). The amendment adjusted payments to all Massachusetts hospitals through an obscure Medicare funding mechanism designed to ensure that hospitals in urban areas are not reimbursed at lower rates than the state's rural hospitals. In 2008, the Nantucket Cottage Hospital — a small, 19-bed Massachusetts hospital which annually serves about 150 Medicare patients and is located in an area deemed to be rural — converted from a critical access hospital to a PPS hospital. As a result of the conversion, the wage data of this one hospital was used to establish a rural floor for the entire state of Massachusetts. Typically, rural hospitals have lower wages, but due to its high cost of living, wages on the island of Nantucket are considerably higher than hospitals on the Massachusetts mainland so the wage index for all hospitals was substantially increased. Since no urban hospital can receive less than the rural floor, the net effect of this change was to treat all other 81 hospitals in Massachusetts as if they were on an island with the associated higher labor costs. There is clear evidence that the state's hospitals worked to create this system advantage which even CMS in its federal regulations called a "manipulation" of the Medicare rural floor payment system. The amendment added to the ACA required that funding to balance increased payments to Massachusetts hospitals be nationally budget neutral, meaning that it would come from reduced payments to all other hospitals in the country which themselves are struggling to care for Medicare patients. ***The impact is a reduction of nine million dollars annually in Medicare payments to Kentucky's hospitals.***

Additionally, there is need for a long-term correction to the Medicare area wage index to bring payment equity to states such as Kentucky which are being harmed by the current wage index system that perpetuates lower Medicare payments to Kentucky's hospitals. The wage index of Kentucky's urban and rural hospitals is lower than that of most surrounding states and comparable urban areas. The gap is widening between hospitals located in states receiving the highest wage index compared to those receiving the lowest. Because the wage index affects from 62% to 69% percent of a hospital's payment and wage index adjustments are budget neutral, these growing disparities are harming the ability of Kentucky hospitals to receive

adequate payments necessary to care for patients and maintain services and jobs in their communities.

### Cost Report Requirements and PRRB Jurisdiction

**The KHA urges CMS to abandon its proposal to eliminate the current provision that gives the PRRB jurisdiction over specific items on a provider's cost report when the provider either claims reimbursement on its cost report for the item or self-disallows the item and files the cost report under protest. CMS should also withdraw its proposal that would require a provider to include on its cost report all items for which it is requesting payment as a condition for payment for those items.**

### Alternative Methodology for Short Inpatient Hospital Stays

CMS finalized its "two-midnight" policy in the FY 2014 inpatient PPS final rule. Under this policy, CMS will generally consider hospital admissions spanning two midnights as appropriate for payment under the inpatient PPS. We support the decision to pay these cases under Part A. In contrast, hospital stays of less than two midnights will generally be considered outpatient cases, regardless of clinical severity. **Although we appreciate CMS's attempt to clarify what is required for payment of inpatient hospital services under Medicare Part A, the two-midnight policy is an arbitrary time-based benchmark that clouds the role of physician judgment. CMS itself professes to hold physician judgment paramount, but this arbitrary standard seems to override that longstanding policy.**

We strongly believe that CMS must appropriately and adequately reimburse hospitals for the care they provide. The existing two-midnight policy fails to meet this standard for medically necessary inpatient stays that span less than two midnights. However, we believe that a short-stay payment (SSP) policy, which would supplement the existing two-midnight policy, could reimburse hospitals more accurately for the resources they use to treat beneficiaries during these short stays.

AHA set forth a set of principles that we urge CMS to consider in crafting an SSP policy. At the highest level, we believe the decision to admit a patient to the hospital for inpatient hospital services should be made by a physician, in accordance with the physician's medical judgment. The two-midnight and SSP policies would then govern how admissions are paid.

If you have any questions, please feel free to contact me or Steve Miller, Vice President of Finance, at (502) 426-6220 or (800) 945-4542 or ngalvagni@kyha.com or smiller@kyha.com.

Sincerely,

Nancy C. Galvagni
Senior Vice President

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