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

RE: (CMS–1529–P) Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Proposed Annual Payment Rate Updates, and Policy Changes; and Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes, (Vol. 72, No. 21), February 1, 2007

Dear Ms. Norwalk:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 37,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed changes to the long-term care hospital (LTCH) prospective payment system (PPS). We are troubled by CMS' proposed expansion of the 25% Rule on patient referral source, changes to the short-stay outlier policy and an offset for coding changes. However, we support the move to re-weight the LTCH diagnosis-related groups (DRGs) in a budget-neutral manner.

EXPANSION OF THE 25% RULE TO FREESTANDING AND GRANDFATHERED LTCHS

In its fiscal year (FY) 2005 rule, CMS implemented payment limitations for LTCHs that are co-located with other hospitals in response to concerns about "inappropriate patient shifting" between acute care hospitals and LTCHs. Under the rule, when an LTCH is co-located with another hospital, no more that 25 percent of the LTCH's admissions from the co-located hospital will be paid at the full LTCH prospective payment rate. If the LTCH receives more than 25 percent of its admissions from the co-located hospital, the LTCH payments will be reduced for those patients exceeding the limit. CMS adopted the 25% Rule, in part, to address its concern that locating an LTCH within an acute care hospital might encourage the shifting of patients from host hospitals to co-located LTCHs for financial – rather than medically appropriate – reasons.

As part of its annual LTCH PPS payment update for 2008, CMS proposes to extend the 25% Rule to all LTCHs, including freestanding and satellite facilities, as well as LTCHs that were exempted from the original 25% Rule. To accommodate LTCHs located in rural areas or in metropolitan statistical areas (MSAs) served by one or more "MSA dominant hospitals" (i.e., hospitals that generate more than 25 percent of the Medicare discharges in the MSA), the agency increases the referral limitation to 50 percent. However, this move falls short of addressing the unique needs of most LTCHs and the general acute care hospitals that rely on them as part of their community's health care continuum.

As with the existing 25% Rule application, CMS' proposed expansion to all LTCHs lacks any meaningful relationship to the clinical appropriateness of LTCH admissions. LTCHs provide intense care to patients who require longer lengths of stay than a typical patient in an inpatient hospital, such as those on ventilators or burn victims. Any proposed policy regarding LTCHs should ensure access for patients for whom LTCH care is medically appropriate– a view supported by the Medicare Payment Advisory Commission. CMS is making payment decisions based on an arbitrary percentage. Last year, CMS released a report by the Research Triangle Institute (RTI) that identified feasible patient and facility criteria that would help distinguish LTCHs from other acute care facilities. However, CMS has not yet used the report to produce specific policy recommendations.

Rather than limiting access to LTCH services through payment cuts, we urge CMS not to move forward with the proposed rule, but to work with the RTI and LTCH providers to develop appropriate facility and patient-centered criteria to determine the types of patients that should be treated in LTCHs.

SHORT-STAY OUTLIERS

The LTCH short-stay outlier policy applies to cases with a length of stay up to 5/6 of the geometric mean length of stay for a particular diagnosis. In rate year (RY) 2007, CMS modified the LTCH short-stay outlier policy by adding the fourth payment alternative described below; as a result, Medicare payments to LTCHs were reduced by an estimated $156 million. Currently, short-stay outlier cases are paid the lesser of four payment alternatives:

- 100 percent of patient costs;
- 120 percent of the per diem of the LTCH DRG payment;
- the full LTCH DRG payment; or
- a blend of the general hospital inpatient PPS per diem and 120 percent of the LTCH PPS per diem. As a patient's length of stay increases, the LTCH DRG portion of the blend increases.

CMS' analysis of FY 2005 MedPAR data shows that 42 percent of LTCH short-stay outlier cases had lengths of stay that were less than or equal to the comparable length of stay (plus one standard deviation) for general acute care hospitals. Further data analysis shows that for ventilator and ventilator/tracheotomy patients, the number of post-intensive care days in the

general acute care hospital drop significantly if the patient is discharged to an LTCH – 42 percent and 77 percent, respectively. From these analyses, CMS concludes that for cases with a length of stay equal to or less than the comparable general acute hospital stay, a full LTCH payment is inappropriate. The RTI included this proposal in its report to CMS last year.

LTCH patient severity and costs are very different from general acute care patients and validate the need for a separate LTCH payment. Concerns about early discharge from the general acute setting and "double" payment for LTCH cases are already addressed by use of the post-acute care transfer provision that reduces the PPS payment to general acute hospitals that discharge patients to an LTCH. The current short-stay outlier policy significantly reduces payments to LTCHs. Additional changes to further cut LTCH payment are unnecessary. **We urge CMS to omit its proposed short-stay outlier policy from the final rule.**

INFLATIONARY UPDATE AND BEHAVIORAL OFFSET FOR CODING CHANGES

For RY 2008, CMS forecasts a LTCH PPS market basket of 3.2 percent based on the rehabilitation, psychiatric and long-term care market basket. Unlike most Medicare payment systems, federal statute does not require CMS to annually apply a full market basket update to the LTCH PPS. In fact, CMS proposes to partially offset the 3.2 percent market basket update with a coding adjustment of negative 2.49 percent, intended to account for coding increases in FY 2005.

For 2005, CMS calculated a *total* case mix index increase of 3.49 percent, which the agency believes is partially due to coding behavior, called "*apparent* case mix," and partially due to the increased cost of treating more resource intensive patients, called "*real* case mix." CMS based its projected growth in real case mix of 1.0 percent on experience and patterns in the general acute inpatient PPS. Therefore, for RY 2008, CMS is recommending a coding adjustment of negative 2.49 percent that reflects CMS' estimates of *total* case mix index increase minus *real* case mix index increase in FY 2005 (3.49 – 1.0 = 2.49). With the agency's proposed negative 2.49 percent coding adjustment, the actual RY 2008 update would be only 0.71 percent.

CMS should use the full market basket index projection for updating LTCH payments – the 2.49 percent downward adjustment is unwarranted. CMS' policies over the last two years have reduced LTCH payments by more than 7 percent. With hospital input costs increasing significantly due to inflation, a full market basket update is warranted.

BUDGET-NEUTRAL RE-WEIGHTING OF THE LTCH DRGS

As the sole exception under Medicare, the LTCH DRGs may be re-weighted in a non-budget-neutral manner – a method that CMS utilized in RY 2007 to reduce Medicare payments to LTCHs. LTCH DRG re-weighting coincides with the annual re-weighting of the DRGs for general acute care hospitals, and takes effect each October 1. It captures changes in the relative cost of treating patients in each of the 538 LTCH DRGs, such as treatment patterns, technology

and number of discharges per DRG. In the proposed rule, CMS recommends that the annual re-weighting of the LTCH DRG be conducted on a budget-neutral basis, beginning October 1, 2007. This provision would be included in the FY 2008 proposed and final rules for the inpatient PPS. The agency is proposing this change since analysis of claims from FYs 2003 through 2005 indicates that LTCH coding practices have stabilized, and therefore, the most recent case mix increases are primarily due to higher patient severity rather than coding behavior, which had been identified as the primary cause in prior years. **The AHA supports re-weighting the LTCH DRGs in a budget-neutral manner and urges CMS to move forward with this proposal.**

If you have any questions, please feel free to contact me or Don May, vice president for policy, at (202) 626-2356 or dmay@aha.org.

Sincerely,

Rick Pollack
Executive Vice President