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March 20, 2008

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

RE: (CMS-1393-P) Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2009: Proposed Annual Payment Rate Updates, Policy Changes, and Clarifications. (Vol. 73, No. 19), January 29, 2008.

Dear Mr. Weems:

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 for 2009.

CMS proposes to return LTCHs from the current rate year budget period that begins on July 1 to the fiscal year cycle beginning on October 1. This proposal would result in a single, consolidated rulemaking process for LTCHs that corresponds with the inpatient prospective payment system annual update. As a transition, CMS proposes that the rate year 2009 LTCH payment system rates apply for 15 months – from July 1, 2008 through September 30, 2009. The AHA supports CMS' proposal to return the LTCH PPS to the fiscal year calendar and the transition. However, we have concerns about several other proposals included in the proposed rule.



PROPOSED CODING REDUCTION

The Rehabilitation, Psychiatric and Long-term Care (RPL) market basket used for the LTCH prospective payment system estimates that costs will increase by 3.5 percent over 2008 levels in 2009. CMS is proposing to offset the RPL market basket with a 0.9 percent coding reduction to adjust for coding behavior by LTCHs in 2005 and 2006. This coding cut is inappropriate for several reasons.

CMS' analysis related to the portion of case-mix change that is attributable to increased case mix, or "real" case mix, is outdated and unrelated to the LTCH payment system. The RAND Corporation analysis cited by CMS to quantify the "real" portion of case mix changes from 2005 to 2006 – 0.9 percent – is based on inpatient prospective payment system data from 1987 and 1988. In the two decades since this data was collected, health care has advanced dramatically. Acuity levels for Medicare fee-for-service beneficiaries have changed due to greater clinical capacity, longer life expectancy, and the migration of less sick and younger Medicare beneficiaries to Medicare Advantage. Furthermore, the proportion of Medicare beneficiaries suffering from multiple chronic diseases continues to increase. As such, it is inappropriate for CMS to use outdated data from a different care setting as the foundation for the proposed coding reduction. **CMS must produce relevant and current data to correctly quantify "real" case mix in order to accurately explain any proposed cut to offset coding behavior.**

In prior years, CMS supported offsetting market basket reductions for LTCHs based on the presence of positive margins for the field. Given the negative LTCH margins estimated by the Medicare Payment Advisory Commission (MedPAC) – between negative 1.4 and negative 0.4 percent in 2008 – CMS should reconsider this proposed cut. The decreasing and now negative Medicare margins for LTCHs reflect the pressure of recent CMS regulatory changes on the "25% Rule" and short-stay outliers, in addition to other payment cuts, and **the proposed coding offset would inappropriately push Medicare payments even further below the cost of care for LTCH patients.**

Furthermore, as shown in analysis related to the introduction of the Medicare-Severity diagnosis-related groups, the vast majority of LTCH patients already fall into very high case-mix payment categories or are paid outside of the LTCH payment system due to outlier status. In addition, CMS' recent policy changes have altered to some degree the types of patients treated in LTCHs. Therefore any changes in case mix are more reflective of patient severity and complexity rather than coding changes. **As a result, the proposed coding offset should be withdrawn to allow for the full market basket update.**

2009 UPDATE SHOULD BE BASED ON 2008 BASE RATE

The *Medicare, Medicaid and SCHIP Extension Act of 2007* contained numerous LTCH provisions, including a short-term reduction to the LTCH base rate. The law specifically reduces LTCH payments to the 2007 standard rate for discharges occurring between April 1 and June 30, 2008. It does not in any way refer to discharges occurring in rate

year 2009, which begins July 1, 2008. However, the proposed rule uses the 2007 base rate when calculating the 2009 update for the LTCH prospective payment system. This unilateral move by CMS is not authorized by Congress. Instead, the annual update to the LTCH standard rate should be based on most recent rates, costs and other relevant input variables. Therefore, **the LTCH prospective payment system market basket update for rate year 2009 should be applied to the standard amount of rate year 2008 – \$38,356.45.**

ONE-TIME BUDGET NEUTRALITY ADJUSTMENT

In this proposed rule, CMS states its intention to implement a one-time budget neutrality adjustment to adjust for any payments in the first year of the LTCH prospective payment system that exceed what CMS would have paid under the prior *Tax Equity and Fiscal Responsibility Act* (TEFRA) payment system. CMS should bear in mind that Congress did not mandate such an adjustment, as the agency has recognized in several prior regulations by stating that an adjustment may be possible if necessary. In addition, CMS is prevented by the *Medicare, Medicaid and SCHIP Extension Act of 2007* from proceeding with a one-time budget neutrality adjustment for a three-year period, which concludes in December 2010.

In the proposed rule, CMS describes its methodology for calculating an adjustment – an estimated negative 3.75 percent cut – that it plans to implement after the three-year period.

CMS has already implemented numerous LTCH cuts since introducing the prospective payment system in 2003; including reduced or omitted market basket increases, coding reductions, and regulatory action on the 25% Rule and short-stay outliers. Each of these cuts in essence rebased the LTCH prospective payment system standard rate, and should be acknowledged when assessing the need for an adjustment to ensure budget neutrality for 2003.

In 2002, prior to the commencement of the LTCH prospective payment system, MedPAC reported a 0.4 percent Medicare margin for these facilities, demonstrating that TEFRA payments that were only slightly above LTCH costs. MedPAC's 2008 LTCH margin projections are negative 1.4 to negative 0.4 percent, indicating that LTCH payments are very close to costs and have, in fact, dropped below costs. As such, it appears that CMS' concerns that Medicare payments under the LTCH prospective payment system are excessive have been effectively addressed through other regulatory cuts. In effect, CMS has rebased the LTCH prospective payment system to the point where costs actually exceed Medicare payments. Since there is no need for a one-time budget neutrality adjustment, the AHA urges CMS to drop any plans for such an adjustment in the future.

RTI ANALYSIS OF LTCH CRITERIA

The AHA appreciates the efforts by CMS and the Research Triangle Institute International (RTI) to assess the potential for expanded LTCH patient and facility criteria. RTI's findings on LTCH care for the most common ventilator patients – lower mortality, higher discharge rates and equal or lower Medicare payments – support further efforts to develop and finalize criteria to help distinguish LTCH patients from patients treated in other settings.

However, the most recent LTCH technical expert panel hosted by RTI in November 2007 raises some concerns. It is unclear why the panel's agenda was primarily focused on patients requiring mechanical ventilation when these patients account for only 15 percent of LTCH case mix, and RTI and other experts acknowledge that developing criteria for this patient population presents the fewest challenges. If the primary challenge in developing LTCH criteria pertains to the remaining 85 percent of LTCH patients, as CMS has stated to Congress, it is appropriate for CMS to support another LTCH panel and for additional resources to be dedicated toward developing criteria for this larger and more difficult population. This and other efforts should focus on preparing a full set of LTCH criteria for consideration by the field and other stakeholders, with a focus on implementing sound criteria as quickly as possible.

Today virtually every LTCH is using screening criteria to identify patients that are clinically suitable for admission. We suggest that future efforts to expand LTCH criteria incorporate the existing criteria, which have acknowledged weaknesses that could be evaluated and corrected, rather than beginning from scratch.

If you have any questions about these comments, please feel free to contact me or Rochelle Archuleta, senior associate director for policy, at (202) 626-2356 or rarchuleta@aha.org.

Sincerely,

Rick Pollack
Executive Vice President