



**American Hospital
Association**

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June 26, 2009

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

RE: CMS-1406-P, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2010 Rates and to the Long-Term Care Hospital Prospective Payment System and Rate Year 2010 Rates; Proposed Rule (Vol. 74, No. 98), May 22, 2009.

CMS-1406-P2, Medicare Program; Proposed Rate Year (RY) 2010 Medicare Severity-Long-Term Care Diagnosis-Related Group (MS-LTC-DRG) Relative Weights and High-Cost Outlier Fixed-Loss Amount (Vol. 74, No. 105), June 3, 2009.

CMS-1337-IFC, Medicare Program; Revisions to FY 2009 Medicare Severity-Long-Term Care Diagnosis-Related Group (MS-LTC-DRG) Weights (Vol. 74, No. 105), June 3, 2009 .

Dear Ms. Frizzera:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our nearly 40,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to respond to the long-term care hospital (LTCH) provisions in the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2010 inpatient prospective payment system (PPS) proposed rule. Our comments on the proposed changes to the inpatient PPS were submitted separately. In this letter, we also address the proposed rule supplement and interim final rule, both published in the June 3 *Federal Register*, which propose a correction to an error CMS made when calculating the FY 2009 LTCH PPS relative weights.

FY 2010 PROPOSED RULE

LTCH Performance. Medicare margins for LTCHs have decreased considerably in



recent years. For 2009, the Medicare Payment Advisory Commission (MedPAC) projects an overall LTCH Medicare margin of 0.5 percent – nearly a 9 percent decrease over the past five years. The decreasing Medicare margins for LTCHs reflect the pressure of recent CMS regulatory changes, such as implementation of the “25% Rule,” revisions to its short-stay outlier policy and other payment cuts. While CMS previously supported offsetting market basket reductions for LTCHs based in part on the presence of positive margins, this scenario no longer exists.

Documentation and Coding Adjustment. Despite the changed Medicare margins for LTCHs, CMS proposes a 2.4 percent market basket increase for LTCHs in rate year (RY) 2010, which would be offset by a combined 1.8 percent reduction to account for documentation and coding behavior in both 2007 (-0.5 percent) and 2008 (-1.3 percent). **The recently implemented LTCH cut of -3.9 percent for June through September 2009 pushes LTCH’s Medicare margins below MedPAC’s prior estimate for FY 2009 – the first negative Medicare margin for LTCHs. The proposed RY 2010 coding reduction further erodes average LTCH margins to an unprecedented, even lower negative rate.**

The proposed -1.8 percent coding reduction would continue the series of LTCH coding cuts CMS implemented in RYs 2007, 2008 and 2009. However, the method CMS uses to calculate the reduction, consistent with that used to calculate the proposed inpatient PPS coding and documentation reduction for 2010, varies substantially from the method used to calculate the prior LTCH coding reductions. CMS’ methodology for the prior reductions estimated both apparent *and* real case mix, and used both components of case-mix change to calculate the amount of the coding reduction. The prior LTCH coding reductions were then solely applied to the apparent case mix portion of overall case mix, which is the portion attributable to coding and documentation practices.

Calculation of Proposed 2007 Adjustment. To analyze the impact of LTCH documentation and coding-related practices from 2006 to 2007, CMS first divided the case-mix index (CMI) obtained by running the FY 2007 claims data through the FY 2007 GROUPER software by the CMI obtained by running these same data through the FY 2006 GROUPER, which yielded 0.974, or a decrease of 0.26 percent. CMS attributes this change to both documentation and coding changes, as well as to GROUPER changes.

As a next step, CMS estimated the specific effect of the calibration of the GROUPER by dividing the CMI obtained by running the FY 2006 claims data through the FY 2007 GROUPER by the CMI obtained by running these same data through the FY 2006 GROUPER, which yielded 0.969, or a decrease of 0.31 percent. Finally, to estimate the documentation and coding effect, CMS divided overall case-mix change by the portion of change related to the GROUPER effect (0.974 divided by 0.969) to yield 1.005, which produced CMS’ proposed coding reduction of 0.5 percent for FY 2007.

Calculation of Proposed 2008 Adjustment. CMS used the same methodology to analyze the impact of LTCH documentation and coding-related practices from 2007 to 2008,

using FYs 2007 and 2008 claims data and the FYs 2007 and 2008 GROUPERs. The analysis yielded a case-mix increase of 1.1 percent, which CMS attributes to both documentation and coding changes, as well as GROUPER changes. The subsequent stages of the calculation yielded a grouper effect of 0.99, and an estimated documentation and coding effect of 1.013, which produced CMS' proposed coding reduction of 1.3 percent for FY 2008.

In its discussion of these calculations, CMS made no mention of any analysis to isolate "real" case mix change for LTCHs in 2007 and 2008. It is important to note that in developing the proposed FY 2010 adjustment for inpatient coding and documentation, CMS attempted to distinguish inpatient documentation and coding changes from real case-mix changes, but was unsuccessful due to problems with the data. **We strongly feel that it is inappropriate for CMS to overlook the issue of real case mix change for 2007 and 2008 LTCH claims, and urge the agency to revisit its calculation of the proposed 1.8 percent cut to explicitly examine real case mix change for LTCHs in 2008, 2007 and the years prior to establish a pattern of change.**

In the proposed rule, CMS presents no rationale for a plateau or decrease in real case-mix change for LTCHs in 2007 and 2008. In fact, it is unlikely that real case mix would have declined in FYs 2007 and 2008 because, at that time, there were discussions and substantial regulatory activity to establish more detailed, clearer LTCH criteria – which reinforced to the LTCH field that CMS was placing greater emphasis on the need to distinguish LTCHs from inpatient hospitals and other post-acute settings. CMS proposed and implemented regulatory changes, such as the 25% Rule and various short-stay outlier changes, to narrow the types of patients who are accepted in LTCHs, with a greater focus on higher severity cases. In December 2007, Congress authorized expanded medical necessity review of LTCHs, placing greater scrutiny on the types of patients treated in LTCHs. In addition, CMS engaged in research on the distinction between LTCHs and other care settings, and shared its findings with providers, which made CMS' intentions to restrict LTCH access very clear. And finally, the field as a whole agreed that LTCHs needed to be more selective about the patients they treat, as demonstrated by national LTCH organizations' efforts to establish criteria to ensure that the right patients are treated in LTCHs.

Furthermore, as discussed when CMS proposed the implementation of the Medicare Severity-Long-Term Care Diagnosis-Related Groups (MS-LTC-DRG), for the vast majority of cases, LTCHs have either no opportunity or little reason to revise coding. Three-fourths of LTCH cases have no opportunity for higher coding since they already are at the highest severity level, are coded in single-member DRG families or are paid at or below cost because they are short-stay outliers. In addition, a majority of the remaining cases have little reason to change codes since they are either subject to the 25% Rule and their referral source dictates a payment reduction, or they fall into DRGs for which coding changes would yield minimal increases in payment. Based on this important point, CMS did not apply a behavioral offset to LTCHs like it did to inpatient PPS hospitals when the MS-DRGs were implemented. Therefore, it is extremely unlikely

that coding and documentation behavior impacted LTCH case mix in 2007 and 2008 (and every other year), and more likely that LTCH case mix changes for these years reflect an increase in patient severity.

Given these considerations, it is especially important that CMS' analysis to estimate case-mix change in FYs 2007 and 2008 be expanded to calculate the real case mix change that likely occurred at that time, rather than use the currently proposed methodology and its findings as an inadequate rationale for the proposed 1.8 percent cut. **The proposed LTCH coding and documentation adjustment for RY 2010 should be withdrawn.**

RTI Research Findings. CMS contracted with the Research Triangle Institute (RTI) to develop more specific LTCH criteria. CMS' discussion of the RTI's findings in the proposed rule is critical of the role of LTCHs in the continuum of care and ignores findings of similar research conducted by MedPAC and others:

- For some patients, care in an LTCH can be more expensive but outcomes are better, resulting in overall cost effectiveness for the Medicare program;
- For the most severely ill patients, there is no statistically significant difference in episode costs between patients treated in LTCHs and patients treated in other settings;
- Care in an LTCH saves the Medicare program money for patients with tracheotomies;
- LTCH treatment increases Medicare savings over a 6 month period by approximately \$10,000 per patient; and
- For patients that were treated in acute care hospitals for ventilator weaning, LTCHs achieve better outcomes at lower cost to the Medicare program.

In addition, we are concerned with several aspects of RTI's LTCH work. First, as we have noted in prior comments, RTI's 2008 Technical Expert Panel discussions should not be used as a basis for policy recommendations since the cross-section of participants included highly atypical inpatient hospital step-down units, which provide specialized programs rarely found in general acute care hospitals.

It also is important to note that the public RTI analysis discussed in the proposed rule is based on calendar year 2004 data. Many LTCH regulations have been implemented since then that have changed LTCH clinical and operational practices, and these changes should be taken into account. While the analysis based on 2004 data is important, it is equally important that CMS share its more recent LTCH analysis and related data so that stakeholders are not relying on research that is not reflective of the current LTCH regulatory and business environment.

The proposed rule says that RTI's Phase III report has been posted on the CMS Web site; however, it has not yet been posted with the Phases I and II reports. Having access to these reports and associated data will help the LTCH field better understand CMS' work

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on LTCHs and participate in the policy process in a more informed manner. We encourage CMS to support this level of transparency. **CMS should withdraw its analysis in the proposed rule that is based on the RTI Phase III report until the report has been disseminated to stakeholders in a manner that allows for evaluation and comment.**

INTERIM FINAL RULE FOR FY 2009

On May 29, CMS issued two LTCH regulations – an interim final rule with comment period and a supplement to the RY 2010 LTCH PPS proposed rule – to correct an erroneous calculation the agency made when it applied the two-step budget neutrality adjustment to the LTCH PPS relative weights for FY 2009. To correct for the adjusted FY 2009 relative weights, CMS has re-issued the proposed 2010 weights, raised the proposed 2010 outlier loss threshold and implemented a four-month payment cut for LTCHs, which took effect June 3. **When recalculating the 2009 LTCH weights, CMS used 2007 data. We urge the agency to recalculate the correction using the most recent available date – the 2008 claims.**

CMS estimates that the budget neutrality adjustment error produced 2009 relative weights that are higher by approximately 3.9 percent, and resulted in overpayments of approximately \$130 million from July 2008 through May 2009. CMS will not recoup these funds, but is applying a prospective, across-the-board cut for the final four months of FY 2009 to correct for this error (FY 2009 consists of 15 months due to a transition from RY to FY for the LTCH PPS). CMS estimates the payment cut will reduce Medicare payments to LTCHs by \$43 million, or approximately 0.9 percent of overall FY 2009 LTCH payments. As a result of this re-weighting, the proposed 2010 high cost outlier loss threshold is raised to \$18,868 from \$16,059. **LTCHs are not able to bear the scale of this cut in addition to the proposed RY 2010 coding reduction. The \$43 million cut imposes a significant burden on each provider, given the small number of LTCHs – approximately 400.**

If you have any questions, please feel free to contact me or Rochelle Archuleta, senior associate director for policy, at (202) 626-2320 or rarchuleta@aha.org.

Sincerely,

Rick Pollack
Executive Vice President