American Hospital Association

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June 18, 2010

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

RE: CMS-1498-P, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2011 Rates; Effective Date of Provider Agreements and Supplier Approvals; and Hospital Conditions of Participation for Rehabilitation and Respiratory Care Services Medicaid Program: Accreditation Requirements for Providers of Inpatient Psychiatric Services for Individuals Under Age 21; Proposed Rule (Vol. 75, No. 85), May 4, 2010.

Dear Ms. Tavenner:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 40,000 individual members – including 250 long-term acute care hospitals (LTACHs) – the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule for the inpatient and LTACH prospective payment system (PPS) for fiscal year (FY) 2011. This letter contains only our comments on the proposed LTACH payment reduction for documentation and coding; our comments on the inpatient PPS provisions were submitted separately.

Under the proposed rule, as revised by the May 4 supplemental proposed rule, LTACH payments will increase by an estimated 0.3 percent in FY 2011. This increase includes a 2.4 percent market basket update, a 2.5 percent reduction for documentation and coding changes, and other policy changes, including a payment cut authorized by the *Patient Protection and Affordable Care Act*, and payment increases for high-cost outlier and short-stay outlier cases.

We believe CMS' proposed documentation and coding adjustment is overstated and should be recalculated to address several key flaws. The methodology used to calculate the 2.5 percent reduction inflates the impact of provider documentation and coding on LTACH case-mix by failing to account for real increases in the acuity level of LTACH patients. Further, CMS' methodology inappropriately fails to look at more than one set of patient claims in order to capture change in case-mix over time.

BACKGROUND

FY 2007 through 2009 Documentation and Coding Reduction. Historically, CMS has incorporated changes in patient severity, or real case-mix change, into LTACH PPS adjustments for documentation and coding. CMS has imposed annual payment reductions for alleged LTACH coding and documentation since FY 2007. The rationale provided by CMS for the cuts in FYs 2007, 2008 and 2009 was the general need to "account for changes in coding practices that do not reflect increased patient severity." CMS also used the results of its review of LTACH margins as justification for documentation and coding-related payment reductions. In the final rules for each the three years, CMS quantified overall case-mix change and also estimated and subtracted the portion of total case mix that was attributable to real changes in patient severity. By subtracting real case-mix change, CMS applied a payment reduction for only the portion of overall case-mix change that the agency claimed was due to documentation and coding behavior. While we opposed these reductions, CMS' approach rightfully acknowledged real case-mix change.

FY 2010 Documentation and Coding Reduction. For FY 2010, CMS introduced a new methodology for measuring LTACH case-mix change; it applied this method to the inpatient PPS as well. CMS' justification for the FY 2010 documentation and coding reduction remained the same as in prior years, that is, to ensure that payments "accurately reflect changes in LTACHs' true cost of treating patients, and should not be influenced by changes in documentation and coding that do not reflect increase in patients' severity of illness." The final rule also notes that the transition from the LTC-DRGs to the MS-LTC-DRGs, which began in FY 2008, was "a relevant factor" when determining the appropriate adjustment for documentation and coding.

Using the new methodology CMS analyzed LTACH documentation and coding in FYs 2007 and 2008, for which the agency found 0.5 percent and 1.3 percent increases, respectively. As a result, CMS proposed that a combined LTACH documentation and coding reduction of 1.8 percent be implemented in FY 2010. In the final rule for FY 2010, CMS postponed the adjustment for FY 2008 to allow for further data analysis and implemented only the 0.5 percent cut to adjust for alleged documentation and coding-related changes in case mix for FY 2007.

FISCAL YEAR 2011 PROPOSED DOCUMENTATION AND CODING REDUCTION

For FY 2011, CMS used the same flawed methodology to calculate a cumulative 2.5 percent LTACH case-mix change for FYs 2008 and 2009. As such, the regulation proposes a prospective documentation and coding cut of 2.5 percent to the FY 2011 LTACH PPS federal standard rate. CMS' calculation again fails to quantify and adjust for the portion of overall case-mix change that is attributable to real case-mix change. The result is an inflated documentation and coding cut being proposed for FY 2011.

To calculate the documentation and coding effect for FYs 2008 and 2009, CMS divided the case-mix index (CMI) obtained by running the FY 2008 and 2009 claims data (through December 2009) through the FY 2009 GROUPER by the CMI obtained by running these same data through the FY 2007 GROUPER, which yielded 1.0248, or an increase of 2.4 percent. CMS states that this 2.4 percent is comprised of documentation and coding change, as well as GROUPER change. CMS asserts that none of this 2.4 percent can be deemed "real" case-mix change because the analysis only uses one set of claims and, therefore, one set of patients.

To determine the effect of GROUPER changes, CMS divided the CMI obtained by running the FY 2007 claims data through the FY 2009 GROUPER by the CMI obtained by running these same FY 2007 claims data through the FY 2007 GROUPER, which yielded 0.9999, or an increase of 0.19 percent. CMS then divided 1.0248 by 0.9999 to yield 1.025, or a documentation and coding-related increase of 2.5 percent in FY 2009.

The AHA believes there are two fundamental flaws in CMS' methodology for determining the effect of documentation and coding on LTACH case-mix in both FYs 2008 and 2009. First, **CMS is using a methodology that, due to design limitations, is incapable of detecting real case-mix change. CMS has failed to explain why it is appropriate to abandon the calculation of real case-mix, which it relied on in the past to avoid overstating documentation and coding offsets. The absence of real-case mix change analysis under the current methodology prevents CMS from accurately accounting for changes in patient acuity on LTACH case-mix in these years. As a result, the proposed documentation and coding reduction for FY 2011 is artificially inflated and should be recalculated using a method that is designed to capture any real case-mix change.**

We believe that the overall medical acuity of LTACH patients in FYs 2008 and 2009 *did* increase as part of an ongoing trend of LTACHs responding to scrutiny from CMS, Recovery Audit Contractors (RAC), Congress and the Medicare Payment Advisory Commission. Under this payment scrutiny, LTACHs began to take steps to distinguish their patient mix from those treated in general acute hospitals and other post-acute settings. Furthermore, LTACHs were the subject of intensive medical necessity review by Washington Physicians Services (WPS), a CMS contractor, in FYs 2008 and 2009, which involved review of LTACH claims to validate whether LTACH patients needed the scope of acute care services provided by an LTACH and whether each LTACH patient received medically appropriate treatments. These WPS reviews had the effect of raising overall real case-mix for LTACHs, as the field narrowed admissions practices to avoid WPS (and RAC) payment denials based on a lack of medical necessity. CMS must change its case-mix methodology for determining documentation and coding-related changes to a method that is capable of examining the effect of the WPS audits and other factors that influence LTACH case-mix and adjust for any impact on patient acuity.

Our second major concern with the proposed methodology is that it inappropriately looks at only one set of patient claims, the FY 2008 and 2009 claims, and, therefore, it is not able to study change from one point in time to the next. This is a significant variation from the documentation and coding methodology used by CMS in rulemaking for FYs 2007 through

2009, for which the agency assessed how the case-mix for one set of claims compared with case-mix for the claims from the subsequent time period. CMS states that none of the 2.5 percent increase it found can be deemed "real" case mix change because the analysis looks at only one set of patient claims. We assert that, similarly, this increase cannot be deemed documentation and coding change either because the analysis looks at only one year of patient claims, which, by definition, are coded identically. **Analyzing a single year of claims is not the correct methodology for determining whether there is a change in documentation and coding practices relative to prior years.**

Rather than quantifying the real and apparent case-mix change that contributes to overall case-mix change, CMS' approach quantifies a case-mix increase that actually reflects differences in how the two DRG systems are designed to measure CMI. It should come as no surprise that the same set of claims for FYs 2008 and 2009 have different CMIs when grouped under the original LTC-DRGs compared to the MS-LTC-DRGs because, as CMS stated when it implemented the MS-LTC-DRGs, they were designed "to better recognize severity of illness among patients." In fact, it is possible that hospitals have maintained an absolutely consistent level of documentation and coding all along, but the MS-LTC-DRGs simply recognize the consistent level of documentation and coding differently. **CMS must replace this erroneous methodology.**

As an alternative approach, it would be instructive for CMS to conduct analysis to assess historical trends in LTACH case-mix change. By applying the alternative approach to inpatient PPS claims, the AHA found that CMS' current methodology for calculating the documentation and coding effect produced an inaccurate and excessive proposed payment reduction. Our analysis found that a significant portion of inpatient PPS case mix change in FYs 2008 and 2009 is actually the continuation of historical trends, rather than the effect of documentation and coding changes that were initiated by the introduction of the MS-DRG classification system. Given the similarities in the two payment systems, it is also appropriate for CMS to utilize this alternative methodology for the LTACH PPS in order to accurately measure case-mix change. Please refer to the discussion that begins on Page 6 of the AHA's comment letter on the FY 2011 inpatient PPS proposed rule for more detail.

Given our concerns, the 2.5 percent reduction for documentation and coding imposes an excessive and unwarranted payment cut to LTACHs. The rule proposes a reduction in the LTACH standard payment below the FY 2010 level that will prevent LTACH payments from keeping up with inflation and increasing costs. Furthermore, the cumulative LTACH payment reductions for documentation and coding since rate year 2007, including the proposed FY 2011 cut, total 10.39 percent – an excessive reduction that is particularly unjustified when considering the stated methodology concerns. Cuts of this magnitude are creating an unsustainable environment for LTACHs and the patients they serve. We encourage CMS to adopt an alternative methodology that acknowledges historical trends in case-mix change and decreases this excessive documentation and coding-related reduction.

Thank you for the opportunity to comment on this proposed rule. 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