American Hospital Association

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Glenn M. Hackbarth
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Dear Mr. Hackbarth:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, the American Hospital Association (AHA) wishes to express our deep concern with the Medicare Payment Advisory Commission's (MedPAC) current research on potential long-term care hospital (LTCH) reforms. At its April meeting, MedPAC staff discussed reform approaches that would eliminate the LTCH prospective payment system (PPS) and make all payments for LTCH services under the inpatient PPS. These reforms define a new subcategory of patients – chronically, critically ill (CCI) patients – a subset of the high-acuity for whom LTCHs would receive an increased inpatient PPS payment. MedPAC defines CCI patients as patients receiving eight or more days of intensive care unit (ICU) services in either an LTCH or during an immediately prior stay in a general acute hospital. MedPAC estimated that 40 percent of LTCH patients meet the CCI definition.

The AHA agrees with MedPAC's long-standing calls for more stringent LTCH patient and facility criteria, and we support policies that redirect to other settings LTCH patients who do not represent high-acuity, long-stay cases. However, MedPAC's current research is a notable departure from its prior goal for the LTCH PPS, as stated in 2012 and before, of establishing criteria to identify the types of patients who would benefit from the unique services LTCHs provide. This research makes a dramatic and unfounded leap beyond addressing the problem of LTCHs treating patients who are not both long-stay and high-complexity cases. The options emanating from this research could dramatically lower payments for high-severity cases that do not fall into the CCI category, and potentially lower payments substantially, even for CCI cases. **We are deeply concerned that the commission has not adequately justified the need for such extreme reforms, especially considering how drastically they differ from its prior goal of using criteria to define the type of patient who is appropriate for admission to an LTCH. Rather than continuing on this radical path toward elimination of the LTCH PPS, we urge the commission to consider more reasonable reforms that would maintain the LTCH PPS for a narrower range of appropriate cases. As discussed below, LTCHs provide a very focused scope of services to a unique, high acuity population and**

their ability to continue caring for these patients must be preserved. Finally, we are particularly troubled about this policy direction given that there are no members of the commission who represent post-acute care providers and their perspective, let alone LTCHs.

LTCHs Fill a Unique Role in the Continuum of Care

The LTCH patient population is unique from the population found in other provider settings. First, LTCH patients have the longest average length of stay (27.2 days), which is significantly longer than that of patients in general acute hospitals (5.1 days) and even of patients in ICUs in general acute hospitals (6.7 days). In addition, LTCH patients have an overall severity of illness that is far higher than other settings, including ICUs, and the LTCH case mix is trending toward even higher acuity levels, as noted in analyses by the Centers for Medicare & Medicaid Services (CMS) and MedPAC. As a result, LTCHs have a pronounced focus on treating very ill patients that is unmatched in other hospital settings. CMS's fiscal year (FY) 2014 proposed rule on the LTCH PPS notes the trend of growing acuity:

> *…the shift toward higher severity levels is evident not only within more complex conditions where the patient load is increasing, but also within the less complex conditions where the relative patient load has been declining.* (Page 27627)

A July 2012 report for CMS by Kennell and Associates supports this finding:

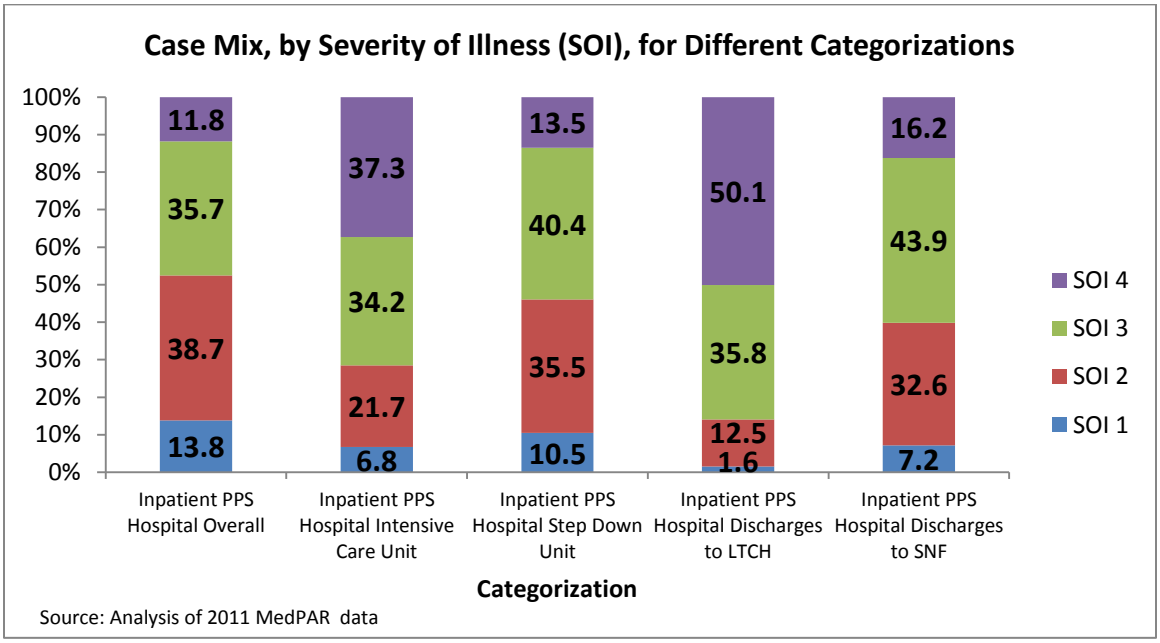
> *…the data on primary conditions, the mix of co-morbidities and the mix of major treatments all indicate a higher level of clinical complexity in LTCHs relative to other settings and suggests related differences in care organization, professional staffing and payment across these providers.*

Comparing services and patients in LTCHs with other post-acute settings, general acute hospitals, and hospital step-down units, the Kennell report found a unique clinical focus for LTCHs:

> *…LTCHs are much more focused on intense respiratory care, and they also have a much higher proportion of patients receiving the types of treatments normally associated with higher nursing efforts…[with] higher proportions of patients with central lines, wound care procedures and TPN [total parenteral nutrition].*

To analyze the distinct role of LTCHs relative to other settings, the AHA examined discharge data from general acute care hospitals and compared the overall severity of illness of patients in various settings. These data are presented in the table below and show that patients discharged to LTCHs already have the highest case mix when compared to other settings. Specifically, half of the patients discharged to an LTCH have

a severity of illness (SOI) level of 4 (extreme severity) compared to just over one-third of patients cared for in the ICU, as measured by the APR-DRG grouper using 2011 Medicare claims data.



In prior policy discussions, both MedPAC and CMS compared the LTCH role to that of step-down units in general acute care hospitals. Step-down units provide a level of care that falls between that of ICUs and medical-surgical units in general acute hospitals. These data call into question the accuracy of comparing the clinical role served by LTCHs with that of step-down units, given that the SOI distribution for step-down units is much closer to the SOI distribution for skilled-nursing facilities than for LTCHs.

LTCHs Provide Value for Very Sick Patients

As noted by MedPAC, prior studies assessing the value of LTCH services for the *overall* LTCH population have found mixed results. But when looking at *very sick* patients, the setting has been shown to provide value, such as equal or lower Medicare payments, lower mortality, and higher chance of being discharged home. The transition in recent years to a mix of higher-acuity patients in LTCHs is noteworthy, as LTCHs are appropriately directing their services to patients for whom they provide the greatest value. The AHA agrees that patients should be treated in the most clinically appropriate settings and supports the acceleration of this shift by establishing minimum LTCH admissions standards. Such standards should focus the field to an even greater extent on treating the highest-acuity, long-stay patients and discouraging the admission of patients with low acuity and those medically suitable for admission to an inpatient rehabilitation facility, inpatient psychiatric facility, or skilled-nursing facility.

In addition to the trend toward higher-acuity LTCH admissions, recent research on LTCH effectiveness[1] supports the value of the LTCH model of care:

> *In our national study of elderly Medicare beneficiaries, patients with chronic critical illness transferred to LTACs experienced similar 1-year survival and lower 180-day hospitalization-related costs compared with patients who remained in acute care ICUs. These results were robust to varying assumptions about patients and hospitals eligible for the analysis, with some sensitivity analyses suggesting that LTACs might improve survival for patients when the population of eligible patients is expanded to include those earlier in their ICU course.* ***Our study provides important conceptual support both for the LTAC model*** *in chronic critical illness and for the utility of comparative effectiveness research in evaluating the organization of care for the critically ill.* [Emphasis added.]

Further, based on site visits with general acute care hospitals, the July 2012 Kennell Report found that LTCHs' concentrated clinical programs may be difficult for general acute hospitals to provide:

> *…general acute hospitals often mentioned the advantages of LTCHs' greater provision and better organization of therapy, as well as their more structured weaning protocols. At several IPPS sites we asked why their own critical areas could not provide this added level of therapy support. Clinicians in two hospitals commented that they staff the critical care areas for the more typical short-stay ICU patients, and that efficient nursing and therapy staffing for the long-term critically ill patient is problematic unless several such patients need these services at the same time.*

These findings, which show LTCHs have unique capabilities and that there is a set of patients for whom the level of care in LTCHs is appropriate and desirable, do not align with the extreme nature of MedPAC's research options to eliminate the LTCH PPS.

MEDPAC'S PROPOSALS WOULD EXCLUDE APPROPRIATE LTCH PATIENTS

We are concerned that MedPAC's eight ICU day criterion is arbitrary and excludes appropriate LTCH patients. MedPAC should not rely on an arbitrary number of ICU days to define CCI patients, but on patients' characteristics including clinical condition and severity of illness. For example, MedPAC has not discussed the overall clinical status and SOI levels of CCI patients and non-CCI patients in LTCHs. In addition,

[1] "Effectiveness of Long-term Acute Care Hospitalization in Elderly Patients with Chronic Critical Illness," J.Kahn, MD, et al. *Medical Care.* January 2013. The study defined "chronic critical illness" as patients having received mechanical ventilation and 14 or more ICU days.

MedPAC presented no clinical rationale for excluding from the CCI category many cases with the highest acuity levels. **It is inappropriate and unwarranted to exclude from the CCI definition LTCH patients who have extreme or major SOI levels. The AHA believes that these patients with high acuity and significant resource use should be the focus of LTCH payment reform.** Since MedPAC presented no analysis on the *clinical* characteristics of CCI patients in LTCHs versus general acute care hospitals, we urge the commission to conduct such analyses comparing severity of illness, length of stay and treatments for patients cared for in these two settings.

In addition, under the potential reform options, CCI patients in general acute care hospitals and LTCHs would receive the same payment. As such, MedPAC also must report on proposed CCI payment amounts including comparisons to current inpatient PPS and LTCH PPS payment for CCI cases – including reporting such comparisons at the DRG level – so that the impacts of its reform options are fully transparent.

MEDICARE ALREADY PAYS BELOW LTCH RATES FOR MANY PATIENTS

In FY 2013, to discourage the admission of short-stay cases, CMS expanded the number of LTCH short-stay cases receiving reduced payments. Under the revised policy, 27 percent of LTCH cases received reduced payments in 2012, which for some short stay cases are as low as the inpatient PPS-comparable amount. This expanded LTCH short-stay outlier policy eliminates overpayment concerns for LTCH short-stay patients. And, as stated above, patients with high acuity and long stays are the patients on whom LTCH should focus. Therefore, the policy question of whether Medicare is overpaying for LTCH services applies only to long-stay patients in LTCHs who have lower acuity levels. **Addressing this concern by eliminating the LTCH PPS is draconian and unwarranted. We prefer a clinically-based set of criteria with minimum standards for LTCH admission.** To help achieve this goal, the AHA is working with our LTCH members to refine a proposal on minimum standards that would eliminate all low-complexity cases from the LTCH setting.

MEDPAC'S PROPOSALS WOULD GREATLY AFFECT THE INPATIENT PPS

MedPAC's proposals to make all payments for LTCH services through the inpatient PPS would have extensive ramifications for general acute care hospitals paid under the inpatient PPS, which were only minimally mentioned during the April 5 meeting. We are concerned that MedPAC has not sufficiently explored and explained all such consequences for stakeholders. We would expect that a review of the impact of potentially transitioning LTCH patients to the inpatient PPS also would include an assessment of *net* improvements in Medicare payments and quality of care, including readmissions, for each of these subsets of both the general acute care hospital and the LTCH populations: CCI patients, non-CCI patients, short-stay outliers, non-short stay cases, patients with SOI level 3 and, separately, SOI level 4.

We strongly encourage MedPAC to re-evaluate and redirect its current LTCH research toward clinical characteristics of patients, including severity of illness. Rather than continuing on the radical path toward proposing LTCH PPS elimination, we urge the commission to focus its research on identifying the types of patients who would benefit from the unique services of LTCHs.

Thank you for considering our feedback. If you have any questions, please contact me or Rochelle Archuleta, senior associate director of policy, at (202) 626-2320 or rarchuleta@aha.org.

Sincerely,

/s/

Linda E. Fishman
Senior Vice President, Public Policy Analysis and Development