



**American Hospital
Association**

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

December 11, 2013

Glenn M. Hackbarth, J.D.
Chairman
Medicare Payment Advisory Commission
Suite 701
425 Eye Street, N.W.
Washington, DC 20001

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 reiterate our deep concern about the Medicare Payment Advisory Commission's (MedPAC) current policy proposals on potential reforms to the payment system for long-term care hospitals (LTCHs). A proposal to reform LTCH payment, based on multiple clinical criteria that would preserve the unique role of LTCHs in caring for the most severely ill patients, is currently being considered in Congress. In addition, we have significant concerns regarding the commission's discussions on site-neutral payment for selected patients treated in inpatient rehabilitation facilities (IRFs) and skilled-nursing facilities (SNFs).

Our concerns are outlined in greater detail below.

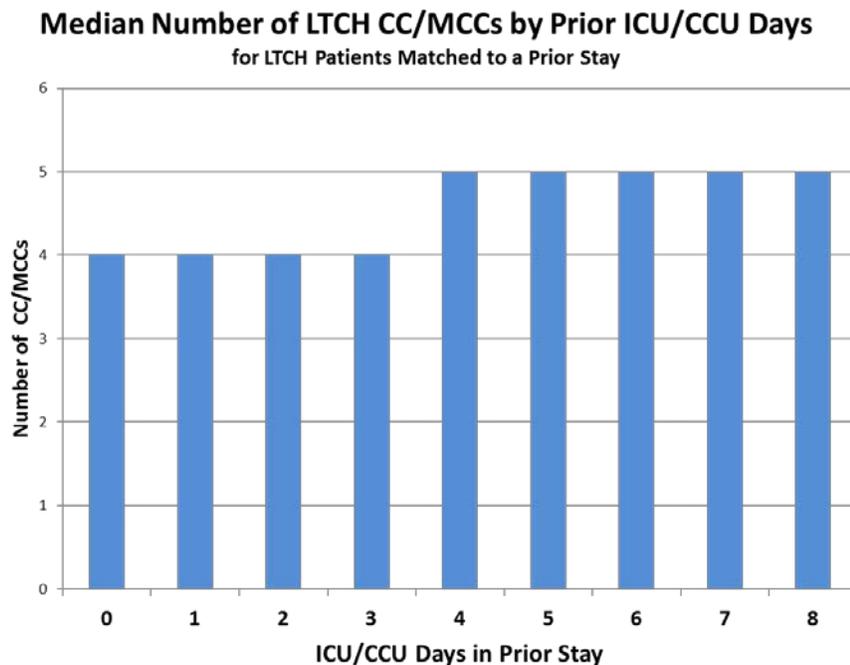
MEDPAC'S LTCH PAYMENT POLICY PROPOSALS

AHA has long supported patient criteria to preserve LTCH services for the sickest patients who need extended hospital stays. However, we strongly oppose the two LTCH payment policy proposals that would eliminate the LTCH prospective payment system (PPS) and transition all payments for LTCH services to the inpatient PPS. These reform approaches, discussed most recently at the November meeting, are based on a new subcategory of patients – chronically, critically ill (CCI) patients – who are defined by the number of intensive care unit (ICU) and coronary care unit (CCU) days during their LTCH stays or prior general acute care hospital stays. MedPAC estimates that 40 percent of current LTCH patients would meet the new CCI criteria under the inpatient PPS, with additional inpatient PPS patients also meeting the criteria.



MedPAC’s proposals use a single-pronged test—an arbitrary CCI criterion—to determine which cases would be eligible for higher payment and at the same time, would reduce payment for every LTCH patient, including those with the highest levels of medical acuity. The two MedPAC reform proposals would pay current LTCH cases at the inpatient PPS rate instead of an LTCH PPS rate. Under the first proposal, LTCHs and general acute care hospitals would receive a new inpatient PPS outlier payment for their CCI patients. The remainder of current LTCH cases would be paid a traditional inpatient PPS Medicare Severity-Diagnosis-Related Group (MS-DRG) rate. The second reform proposal would pay for CCI patients based on new inpatient PPS MS-DRGs that account for higher severity cases. As with the first proposal, non-CCI cases would be paid the traditional inpatient PPS MS-DRG rate.

MedPAC’s CCI Proposals Do Not Fully Define High-acuity Patients. The CCI metric has little to do with the number of complications and comorbidities (CCs) or major complications and comorbidities (MCCs) of very sick patients. The table below shows that, as the number of ICU/CCU days increases from zero to eight for LTCH patients, the average severity of illness (as indicated by LTCH CC/MCCs) does not increase in a corresponding fashion.



Source: 2010 and 2011 Inpatient Standard Analytical Files.

Note: Prior stay is defined as one where the LTCH patient was admitted within 30 days after the prior inpatient hospital discharge and is not limited to STACH discharge only as some LTCH patients are admitted from other facilities e.g., inpatient psych or rehab (freestanding or distinct part unit), rural

This analysis demonstrates that it is inaccurate to determine payment levels for LTCH cases based solely on a single, arbitrary ICU/CCU metric. Rather, this metric must be paired with more robust and reliable indicators of medical acuity, such as the CC/MCC metric or other clinical metrics that identify high acuity cases, in order to have a meaningful correlation between payment and severity of illness.

The CC/MCC and other metrics, such as procedure codes or MS-DRGs identifying ventilator cases, are already available on inpatient PPS and LTCH PPS claims and, in the case of CC/MCCs, are used by the Centers for Medicare & Medicaid Services (CMS) to identify cases with higher severity-of-illness and to assign higher payment for these cases.

We strongly encourage MedPAC to re-evaluate its current path toward LTCH PPS elimination, and to consider using ICU/CCU days and other clinical metrics to identify a set of high-acuity patients for whom LTCH-level care and payments are appropriate and warranted.

AHA's Alternative Approach. The AHA supports MedPAC's long-standing call for more stringent LTCH patient and facility criteria. To ensure LTCHs' ability to care for their patients' unique clinical needs and acuity levels, AHA has developed a legislative proposal to establish new rigorous minimum clinical standards for LTCHs. Our proposal uses *multiple* criteria, including clinically based criteria and a CCI-like metric from the prior hospital stay to identify the sickest patients. Under this proposal, the highest acuity LTCH cases would be reimbursed at the LTCH PPS rate, while the remaining, lower-acuity cases would be reimbursed at an inpatient PPS rate.

The AHA supports a multi-pronged clinical test to identify the sickest patients who would be eligible for LTCH PPS reimbursement. Specifically, in our legislative proposal, a patient would qualify for LTCH PPS reimbursement by meeting any one of the following criteria:

- meeting a minimum number of ICU/CCU days in the prior inpatient stay;
- meeting a minimum number of inpatient PPS CCs/MCCs in the prior inpatient stay;
- qualifying as a high-cost outlier in the prior inpatient stay; or
- having a ventilator procedure in the prior inpatient stay or in the LTCH.

We believe our approach is balanced and accurate and aims to preserve the LTCH setting for the sickest Medicare beneficiaries who need extended hospital stays.

SITE-NEUTRAL PAYMENT FOR IRFs AND SNFS

At its November meeting, MedPAC initiated a discussion of the concept of site-neutral payments for IRF and SNF patients with certain conditions. Most recently, policy

discussions about site-neutral payment for these two settings have focused primarily on joint replacement cases. **The AHA is very concerned about IRF/SNF site-neutral proposals for two reasons. First, IRFs are required to admit only patients who require hospital-level services, and payments should reflect the cost of providing that level of care. SNF rates are wholly inadequate for IRF-level care.** IRFs provide unique clinical value for patients who require hospital-level care and intensive rehabilitation after an illness, injury or surgery, with some of the key differences in the scope of services provided by these two settings outlined in the chart below.

IRFs vs. SNFs

Required by Medicare	IRFs	SNFs
Close medical supervision by a physician with specialized training	Yes	No
24-hour rehabilitation nursing	Yes	No
Multidisciplinary team approach	Yes	No
3 hours of intensive therapy; 5 days per week	Yes	No
Patients must require hospital-level care	Yes	No
Physician approval of preadmission screen and admission	Yes	No
Medical care and therapy provided by a physician-led multidisciplinary medical team including specialty trained registered nurses	Yes	No
Readmission rates to general acute hospitals	9.5% (2010)	19.2% (2011)
Discharge rate to community	71.0% (2010)	27.8% (2011)
2011 Medicare fee-for-service spending	\$6.54 billion	\$31.3 billion
Projected Medicare margins for 2013 (Freestanding SNF margins only)	8.5%	12-14%

The data cited in this document are drawn from the Medicare Payment Advisory Commission's March 2013 Report to Congress, and the FY 2012 SNF Final Rule.

For example, only in IRFs do patients receive three or more hours of therapy per day as part of a plan of care that is developed and actively overseen by a specialty physician and carried out by an inter-disciplinary medical team. The physician oversight role and the care provided by interdisciplinary medical teams are found only rarely in SNFs. Moreover, most nursing care in IRFs is provided by specially trained registered nurses, a far higher level of nursing care than is provided in most SNFs. As a result, the patient population and scope of services found in IRFs are highly distinct from those found in SNFs.

Second, MedPAC's site-neutral discussions fail to consider the significant scrutiny IRFs have undergone in recent years. This scrutiny has led to multiple interventions, which include the implementation of new, stricter criteria for IRF patients, multiple payment cuts and other policy restrictions. For example, CMS took concrete regulatory action in January 2010 to further distinguish the IRF and SNF populations, implementing IRF admission criteria specific to Medicare patients. Collectively, these interventions

have reshaped the population treated in IRFs by dramatically reducing the overall volume of IRF patients and steadily increasing the medical complexity of patients treated in this distinct setting. Much of the data presented at the November meeting was from a period prior to the January 2010 changes, and did not account for the increased severity of illness in the IRF population, as has been reported subsequently in recent MedPAC reports to Congress.

CMS's CARE TOOL

The CMS-developed patient assessment instrument for post-acute care, the Continuity Assessment Record and Evaluation (CARE) Tool, has been the subject of much interest among policymakers and post-acute care providers. The AHA supports the original purpose of the tool, which was to establish common metrics for collecting consistent data on the clinical status and health resources provided to patients in all post-acute settings – home health agencies (HHA), SNFs, IRFs and LTCHs.

MedPAC discussed the CARE Tool at its November meeting, but we believe several misperceptions about the tool need to be clarified. Specifically, while the underlying concept for the CARE Tool is widely supported, the existing tool has been criticized for being too lengthy and time consuming and for failing to capture the clinical complexity and medical resources needed to treat sicker patients, especially LTCH patients. However, CMS appears to have scaled back its plans to use the CARE Tool across all settings, and instead, is pursuing a far narrower goal of using *elements* of the CARE Tool to augment and improve consistency across the existing post-acute tools. AHA members participating in the Center for Medicare & Medicaid Innovation (the Innovation Center) bundling demonstration Models 2 and 3 report that CMS recognized that the full CARE Tool was too burdensome, and instead mandated that the bundlers use a streamlined version of the tool, called the B-Tool. Demonstration participants report more acceptance of the B-Tool.

We encourage policymakers to look beyond the CARE Tool and B-Tool to other post-acute assessment instruments for viable options to achieve consistent measurement and reporting across settings. To that end, in November, the AHA convened a group of experts from hospitals and post-acute care providers to review and discuss five discharge support tools that are being used by hospitals and private payers to assess patient characteristics and post-acute needs when discharging from general acute-care hospitals. Each of these tools is quite different from the CARE Tool and has a more streamlined design. Moreover, each offers great promise for standardizing discharge processes by supporting clinician-led decision making regarding whether post-acute services are needed (and if so, which type), for improving transitions of care across

Glenn M. Hackbarth

December 11, 2013

Page 6 of 6

settings, and for reducing avoidable readmissions. MedPAC and CMS representatives participated in this discussion, and the forthcoming report from this meeting will be shared with MedPAC.

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

cc: Mark Miller