

March 23, 2018

Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
Hubert H. Humphrey Building  
Mail Stop 314-G  
200 Independence Avenue, S.W.  
Washington, DC 20201

***Re: Concerns regarding Payment for LTCH PPS Site-neutral Cases and the LTCH 25% Rule.***

Dear Ms. Verma:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations – including 267 long-term care hospitals (LTCH) – the American Hospital Association (AHA) asks the Centers for Medicare & Medicaid Services (CMS) to analyze and help address the current underpayment of LTCH site-neutral cases, which threatens access to care. In particular, we reiterate our call for the elimination of a duplicative budget-neutrality adjustment (BNA) being applied to Medicare payments for LTCH site-neutral cases – an unwarranted 5.1 percent cut. Lastly, we again urge CMS to permanently eliminate the LTCH 25% Rule policy.

### **Background on LTCH Site-neutral Payment Policy and the Duplicative BNA**

The Bipartisan Budget Act of 2013 established a site-neutral payment rate for certain LTCH cases. Since the policy's implementation began in fall 2015, it has affected approximately one out of two LTCH cases. Once fully phased-in, the site-neutral payment rate will be only 49 percent of the standard LTCH prospective payment system (PPS) rate.

However, when paying site-neutral cases, CMS applies two BNAs related to high-cost outlier (HCO) payments: the first occurs during the establishment of the inpatient PPS rates used as the basis for LTCH site-neutral payment, the second occurs while setting the LTCH payment



amount. **The AHA and Medicare Payment Advisory Commission (MedPAC) both agree that the second adjustment is duplicative and should not occur.** This is because the inpatient PPS-standard payment amount – the basis for the LTCH site-neutral “IPPS-comparable payments” – already is adjusted to account for HCO budget neutrality. Specifically, in its May 31, 2016 comment letter on the fiscal year (FY) 2017 inpatient PPS/LTCH PPS proposed rule, MedPAC states that:

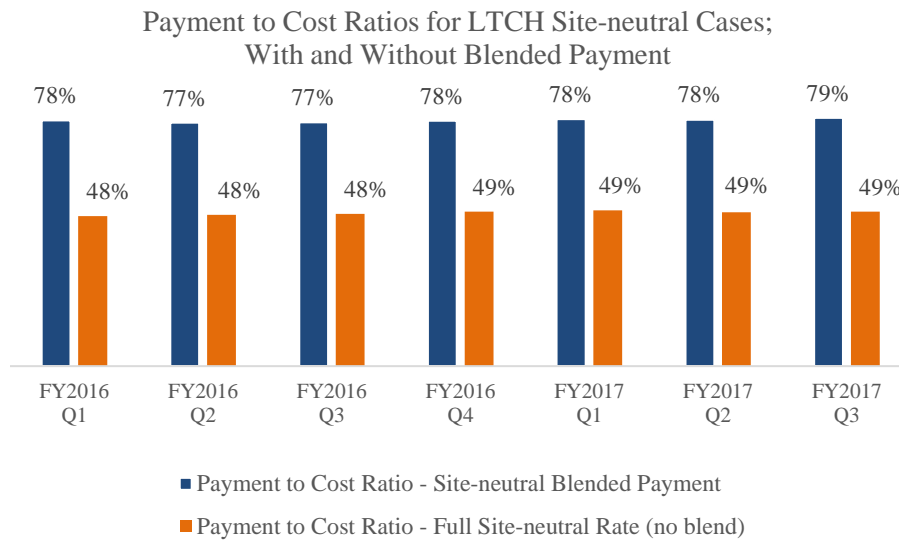
*“[g]iven that the IPPS standard payment amount is already adjusted to account for HCO payments, CMS’ proposal to reduce the site-neutral portion of the LTCH payment by a budget neutrality adjustment of 0.949 is duplicative and exaggerates the disparity in payment rates across provider settings. Given this duplication, CMS should not adjust the site-neutral rate further.”*

The AHA’s concerns regarding the duplicative BNA were explained in detail in our prior [comment letters](#) on the FYs 2017 and 2018 proposed rules for the LTCH PPS, as well as during in-person meetings and calls with CMS staff.

In partial recognition of these concerns, CMS, in FY 2017, stopped applying the second BNA to the high-cost outlier portion of LTCH site-neutral payments. However, it still applies it to base payment. Based on our analysis of FY 2016 MedPAR data, the AHA estimates that the second BNA inappropriately reduces aggregate payments (of the fully implemented policy) by approximately \$28 million per year, a substantial amount.

### **Underpayment of LTCH Site-neutral Cases**

**While the AHA previously has weighed in regarding the redundant BNA, our concerns have grown due to our recent analysis demonstrating the vast underpayment that is occurring for LTCH site-neutral cases.** This underpayment threatens access to care and is unnecessarily exacerbated by the unwarranted 5.1 percent BNA. Specifically, as shown in the chart below, under the full site-neutral policy, average payment covers only 49 percent of the cost of care, even though these cases have a high level of medical complexity, on average. Unfortunately, even under the 50/50 blended payments during the transition to full site-neutral payment, only an average of 79 percent of costs are covered.



Our analyses show that these substantial underpayments are occurring because, contrary to CMS’s projections, the acuity level and cost of care for LTCH site-neutral cases far exceed those of comparable inpatient PPS cases.<sup>1</sup> **While we agree with CMS that the field is still in flux as it adapts to site-neutral payment, we urge the agency in its upcoming FY 2019 rulemaking not to overlook this misalignment.** One key driver of the higher cost of treating site-neutral cases is that they have a higher average level of clinical acuity. Specifically, we found that 54 percent of these cases have between one and four complications and comorbidities/major complications and comorbidities (CC/MCC), while 42 percent have five or more CC/MCCs. Compared to inpatient PPS cases (those with fewer than three ICU days), 62 percent have one to four CCs/MCCs but only 12 percent have five or more (see table below). Consistent with their higher acuity levels, LTCH site-neutral cases also have an average length of stay of 25.1 days, which is much more similar to that of LTCH cases paid a standard rate than to the 4.0 day average length of stay for comparable inpatient PPS cases. The contrast is equally stark when comparing Medicare payment-to-cost ratios: 0.47 for LTCH site-neutral cases, and 0.99 for inpatient PPS cases with fewer than three ICU days.<sup>2</sup> Average costs per case for these cases were \$32,941 and \$11,190, respectively.<sup>3</sup> **Collectively, these data, which also are presented in the chart below, show that LTCH site-neutral cases are, on average, sicker and cost three times more than inpatient PPS cases with fewer than three ICU days. Yet, the full site-neutral rate covers less than half the cost of care.**

<sup>1</sup> 2016 MedPAR data.

<sup>2</sup> Note that overall, Medicare payments to general acute-care hospitals covered only 87 cents for every dollar spent caring for Medicare patients in 2016.

<sup>3</sup> FY 2016 cases with FY 2018 payment parameters.

Comparing LTCH Site-neutral Cases & Inpatient PPS Cases with Fewer than 3 ICU Days*		
	IPPS Cases with <3 ICU Days	LTCH Site-neutral Cases
Number of Cases	6,974,091	50,781
Length of Stay	4.0	25.1
% of Cases with 1-4 CC/MCCs	62%	54%
% of Cases with 5+ CC/MCCs	12%	42%
Average Cost	\$11,190	\$32,941
Average Medicare FFS Payment**	\$11,108	\$15,592
Payment to Cost Ratio	0.99	0.47

\*FY 2016 cases with FY 2018 payment parameters

\*\*Without the site-neutral blend.

In summary, AHA continues to have the following concerns:

- The clinical and cost profile of LTCH site-neutral cases continues to be misaligned with its inpatient PPS-based payments, as recognized by CMS in its FY 2018 rulemaking, and is driving systematic underpayment of these cases.
- The second BNA lacks a policy justification and, as noted by MedPAC, compounds the underpayment of LTCH site-neutral cases.

**Given these concerns, we call on CMS in the FY 2019 proposed rule to remove the second BNA applied to LTCH site-neutral cases. In addition, in alignment with its plan put forth in the FY 2018 LTCH PPS final rule that stated CMS would continue to monitor the differential between LTCH site-neutral and inpatient PPS cases, we encourage the agency to use the pending proposed rule to share with stakeholders its promised analyses comparing these two groups.** In particular, a DRG-level study comparing the relative levels of clinical severity, lengths of stay, cost, and Medicare payment would be of great value to beneficiaries, policymakers, and stakeholders.

### Concerns with the LTCH 25% Rule

Under the 25% Rule, which CMS first implemented in FY 2005, admissions from a particular referring hospital that exceed an annual threshold are subject to a payment reduction from a LTCH standard rate to an inpatient PPS equivalent rate. The AHA is pleased that CMS paused full implementation of this rule during FY 2018 in order to study the impact of site-neutral payment absent the behavioral impact of the 25% Rule. Specifically, CMS stated that it will

examine whether the LTCH site-neutral payment system renders the 25% Rule unnecessary. **While we support the FY 2018 pause, we note that our overriding concerns about the 25% Rule remain and are the basis for our continued call for CMS to permanently withdraw the policy.** Specifically, we firmly opposed the 25% Rule because it materially reduces payments for care provided to patients who meet the statutory criteria for a full LTCH PPS rate. Further, given the scale of LTCH cuts under site-neutral payment, implementing the 25% Rule payment penalties would unjustifiably exacerbate the instability and strain on the field, which would threaten access for the high-acuity, long-stay patients that require LTCH-level care. Our 25% Rule concerns are fully enumerated in our comment letter on the FY 2018 LTCH PPS proposed rule.

Thank you for considering our requests. Please contact me if you have questions or feel free to have a member of your team contact Rochelle Archuleta, director of policy, at [rarchuleta@aha.org](mailto:rarchuleta@aha.org).

Sincerely,

Thomas P. Nickels  
Executive Vice President