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Statement for the Record

Hearing on
Long-Term Acute Care Hospitals
in the
Subcommittee on Health
of the
Committee on Ways and Means
of the
U.S. House of Representatives

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The American Hospital Association (AHA), on behalf of our 4,700 member hospitals and health care systems, and 31,000 individual members, appreciates the opportunity to submit a statement concerning Long-Term Care Hospitals (LTCHs). Our remarks focus on the AHA's primary concerns related to the LTCH proposed rule issued by the Centers for Medicare & Medicaid Services (CMS) for rate year (RY) 2007. This proposed rule recommends several significant changes that are of concern to the AHA – most notably the proposal to omit the 3.6 percent market basket update and to change the short-stay outlier (SSO) policy. The alarming net impact of this proposal – negative 14.7 percent – is excessive and would severely and inappropriately threaten patient access to LTCH care.

LTCHs serve a critical role for medically-complex patients who are anticipated to need a long hospital stay, such as ventilator and burn patients. Many LTCHs have developed specific clinical protocols for treating patients with a high severity of illness. Currently there are about 350 LTCHs, which are defined by their long average length of stay (ALOS) of 25 days or greater - significantly longer than the ALOS for general acute hospitals, 5.6 days.

CMS Proposal on Short Stay Outliers is Misguided and Excessive

A system based on averages. An essential principle for all Medicare prospective payment systems is that payments are based on the average cost of all patients treated under that system, given the clinical characteristics and the cost of treatments associated with a particular group of patients. For the system of averages to be fair and sustainable, patients with below-average costs are needed to offset losses experienced for patients with above-average costs. The significance of upholding this principle has been validated by CMS on many occasions.

When the LTCH PPS was introduced in 2003, the agency stated in the *Federal Register* that paying for cases treated in excluded hospitals, such as LTCHs, under the inpatient PPS would be "inaccurate and unfair" since these cases were not included in the inpatient PPS system of averages. The agency also noted that paying LTCHs under the inpatient PPS could result in the systematic underpayment of LTCHs. We support CMS' views and therefore, as discussed below, feel that **the proposed SSO changes would violate the integrity of the LTCH PPS by applying inpatient PPS rates to an LTCH population that is dramatically different from the inpatient PPS population.**

In addition, it is critical that each Medicare PPS sets payments at a level that covers the cost of providing care. Doing so helps ensure that providers have the resources to deliver appropriate care in a safe manner. Under this proposed rule, CMS would exclude the 3.6 percent market basket update and reduce overall LTCH payments by 11.1 percent, largely through the proposed SSO changes. Based on analysis by The Lewin Group, **the combined impact of CMS' recommendations for RY 2007 would lower Medicare payments to LTCHs to 5 percent below the cost of providing care. This unjustifiable outcome would irresponsibly threaten the ability of providers to safely care for their patients.**

CMS proposes to significantly modify the LTCH SSO policy, which is intended by CMS to discourage LTCHs from admitting short-stay cases. SSO cases have a duration that is up to 5/6 of the geometric mean ALOS for a particular LTCH diagnosis-related group (DRG). Currently, SSO cases are paid the lesser of the following:

- the full LTCH DRG payment;
- 120 percent of the LTCH DRG per diem; or
- 120 percent of the cost of the SSO case.

CMS proposes to modify the current SSO policy in two ways:

- lower the SSO case reimbursement based on 120 percent of cost to 100 percent; and
- add a new, and substantially lower, payment alternative – an amount "comparable" to the DRG rate under the inpatient PPS.

The proposed SSO policy falsely equates a short-stay outlier case as an inappropriate LTCH admission. The rule overlooks the fact that by its very design, the LTCH PPS

presumes a range of lengths of stay including cases above and below the ALOS. CMS states its concern that SSO cases represent 37 percent of all LTCH cases and that SSO cases "may indicate a premature discharge from the acute-care hospital and an unnecessary admission to the LTCH." However, length of stay on its own is neither an effective nor insightful indicator of medical necessity.

Given that the definition for SSO cases includes 5/6, or 83 percent, of the cases with a LOS below the mean, CMS should presume that a significant proportion of all LTCH cases would fall within the SSO range. The agency should not expect that the 37 percent rate of SSO cases would continue to drop indefinitely, given the current SSO definition. When the LTCH SSO definition is applied to the inpatient PPS, approximately 40 percent of inpatient PPS cases satisfy the LTCH SSO definition – a rate similar to the LTCH SSO rate. Therefore, a SSO level in the current range should be expected and not viewed as an indication of misconduct. If CMS wants to see the percentage of SSO cases decline further, then the definition for SSO cases needs to be changed.

The LTCH SSO policy should not be adopted as proposed. CMS' proposal is based on the unsubstantiated bias that all SSO cases are inappropriate admissions and would penalize LTCHs for treating patients who are clinically appropriate for the setting.

LTCHs care for a distinct population. CMS states that by treating SSO cases, LTCHs may be "functioning like an acute-care hospital." However, in taking this position CMS has overlooked essential differences between the LTCH case mix, including SSO cases, and the case mix treated by hospitals under the inpatient PPS. For instance, The Lewin Group has compared common LTCH and inpatient PPS DRGs and found that the case-mix index (CMI) for LTCH SSO cases is more than double the CMI for general acute hospitals.

A dramatic difference also is found when comparing ALOS. LTCH SSO cases have an ALOS that is more than twice as long as the ALOS for inpatient PPS hospitals, 12.7 days versus 5.6 days, respectively. Analysis by Avalere Health using All Patient Refined DRGs found that for both the total LTCH population and the LTCH SSO population, the presence of the highest levels of medically complex patients (Levels 3 and 4) is approximately double the rate found in general acute hospitals. **Similarly high-severity levels for both the LTCH population and LTCH SSO cases highlight the inability of referring general acute hospitals and admitting LTCHs to identify SSO cases upon admission to the LTCH.** This reality of treating severely ill patients directly challenges CMS' assertion that all SSO cases result from intentionally inappropriate transfers to LTCHs. In addition, these data make a clear case that the **patients treated in LTCHs, including SSO cases, are fundamentally different than the patients treated in general acute hospitals.**

These analyses of patient severity and cost also validate the need for a separate LTCH payment system with weights and rates based on the unique population treated by LTCHs. The studies affirm the inappropriateness of applying an inpatient PPS payment –

based on the average cost of treating an entirely different set of patients – to LTCHs. The inpatient PPS rates, even when adjusted for outliers, are not designed or intended for the high-complexity, long-stay population treated in LTCHs. As such, **the agency's proposal to include inpatient PPS rates among the payment alternatives for SSO cases is unjustifiable since it is in direct violation of the Medicare principle of establishing payments based on the average cost of treating specific types of patients.** And in this case, the LTCH and general acute populations are distinctly unique from one another.

AHA Recommendations

The AHA recognizes that recent LTCH growth is appropriate for close oversight by Congress, CMS and others. However, **efforts to slow LTCH growth should be based on balanced and thoughtful policymaking that ensures access for patients who are medically appropriate for LTCH care.** At the facility level, adding criteria to the current 25-day ALOS requirement would produce a major improvement in focusing LTCH care on specific populations. At the patient level, expanding medical necessity review by clinical experts would achieve the goals of prudently using Medicare resources and preserving the rights of beneficiaries to access necessary care. **These balanced approaches, discussed in greater detail below, should be utilized rather than the blunt policies such as the current cap on host-hospital referrals for co-located LTCHs and the proposed SSO policy changes.** Both of these policies fail to focus on the clinical characteristics and needs of patients and instead rely on overly broad, non-clinical proxies (LOS and referral source) to determine whether an LTCH admission is appropriate.

Develop more specific LTCH criteria. We fully support the June 2004 and March 2006 recommendations by the Medicare Payment Advisory Commission (MedPAC) to develop more specific LTCH criteria that would expand the current facility qualification criterion to target medically-complex, long-stay patients. The pending recommendations from the Research Triangle Institute International (RTI) are highly anticipated and should be thoroughly examined by CMS and the LTCH field. **We are committed to collaborating with CMS and other LTCH organizations to use the RTI findings as a basis for expanding the current LTCH criterion to ensure that LTCH services are targeted to patients who are clinically appropriate for the setting. This endeavor should be a top priority for CMS and others concerned about rapid LTCH growth.**

Expand QIO review. We also strongly endorse the June 2004 MedPAC recommendation to require CMS' Quality Improvement Organizations (QIOs) to review long-term care hospital admissions for medical necessity and monitor LTCH compliance with the expanded qualification criteria. Although CMS has declined to include the review of LTCH cases within the QIO scope of work, in 2004 the agency reinstituted QIO review of a small national sample of approximately 1,400 cases, which resulted in the denial of 29 percent of the reviewed cases. We believe this effort demonstrates that the QIOs are equipped to perform this function in a manner that preserves access for patients who need

LTCH-level care while identifying and denying payment for cases that should be treated in another setting.

QIO review places the decision of where a patient should be treated in the hands of licensed physicians and nurses, rather than penalizing LTCHs for treating cases simply based on the LOS or referral source. When reviewing LTCH cases for medical necessity, QIOs apply professionally developed criteria; an assessment of the appropriate medical care available in the community; and national, regional and local norms. QIO review also includes safeguards that protect the interests of Medicare beneficiaries. Under the QIO review process, beneficiaries and their physicians are eligible to discuss a particular case with the QIO reviewer prior to a determination. In addition, the QIO reviewer is required to explain "the nature of the patient's need for health care services, including all factors that preclude treatment of the patient…" QIO review also includes appeal rights for beneficiaries. This system would be clinically-focused and therefore a more effective means of ensuring appropriate patients are treated in LTCHs than the agency's SSO proposal and the current policy pertaining to host-hospital referrals to co-located LTCHs.

CMS should authorize and fund expanded QIO review, which would provide assurance to Congress and the Secretary that Medicare funds are being utilized prudently while preserving the access rights of Medicare beneficiaries. Expanded QIO review would be an effective complement to new, more specific LTCH criteria. In tandem, these changes would help ensure that LTCHs are serving appropriate patients.

SSO policy changes. The proposed SSO changes wrongly assume that the SSO population is homogeneous. The SSO population includes cases with LOS ranging from one day to 30 days, and some even qualify for LTCH high-cost outlier status. **Given this wide variability, all SSO cases should not be treated the same under the LTCH PPS. CMS should change the way it identifies and pays for SSO cases and implement the following SSO changes:**

- Establish a method for identifying a subset of SSOs – very short-stay cases – to ensure there is no incentive to transfer patients who may be near death.
- This subset of very short-stay cases should be paid at 100 percent of costs.
- LTCH cases with a LOS greater than 20 days should be removed from the SSO definition. Any case of such a substantial duration is clearly not suitable for a downward payment adjustment. Cases with LOS in this range are obviously consistent with the population intended for the LTCH setting and should be eligible for the full LTCH DRG payment.
- Remaining SSO cases should continue to be paid under the current SSO policy.

The AHA appreciates the opportunity to share its views with the subcommittee. We look forward to working with Congress to ensure that LTCHs preserve the ability to treat patients who are suitable for this important acute setting.