

March 20, 2006

Mark McClellan, MD, PhD
Administrator, Center for Medicare & Medicaid Services
Attn: CMS-1485-P
PO Box 8011
Baltimore, MD 20244-8011

**RE: Medicare Program; Prospective Payment System for Long-Term Care Hospitals;
Proposed Annual Payment Rate Updates Policy Changes, and Clarification; Proposed
Rule**

Dear Dr. McClellan:



The Catholic Health Association of the United States (CHA) is pleased to provide comments on the above proposed rule published by CMS in the *Federal Register* on January 27, 2006. CHA is the national leadership organization of the Catholic health ministry, representing more than 2,000 sponsors, systems, facilities, and related organizations that form the nation's largest group of not-for-profit health care.

Our comments are based on the input from CHA members including long-term care hospital (LTCH) providers, as well as written and oral testimony provided by CMS, MedPAC, and other LTCH representatives at a hearing of the House Ways and Means Subcommittee on Health on March 15, 2006.

CHA is seriously concerned about the impacts the proposed rule will have on beneficiaries and their access to LTCH services. With the proposed rule offering no market basket update for 2007, and cutting current LTCH payments by an additional 11.1 percent, the net 14.7 percent reduction would be devastating for LTCHs, likely forcing some out of business. This would deprive the medically complex, often ventilator-dependent Medicare patients of access to those providers who know their needs best: LTCHs, which have the specialized expertise and dedicated multi-disciplinary teams to optimize patient outcomes. Without the availability of LTCHs, patients are often kept in an acute hospital's intensive care unit, which is geared more to shorter term stabilization of patients, as opposed to restoring patients to optimal health and independence.

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Unfortunately, it appears CMS's proposed rule is being dictated heavily by Medicare savings targets, when patient access and well being should be the primary policy driver. This fiscally biased approach to LTCH reimbursement policy still leaves the most important issue unaddressed: assuring placement of patients in the most appropriate care setting.

CHA is perplexed by the fact that CMS would propose such draconian cuts in LTCH reimbursement, when both CMS and LTCH providers agree that the most pressing priority is the creation and usage of a set of uniform, clinically based patient assessment and placement criteria, to assure beneficiaries are treated in the most appropriate post-acute care setting based on medical need. It is hard to conceive why CMS is proposing such dramatic payment changes now, especially regarding its short-stay outlier policy, when in just two months a CMS commissioned study on LTCH-PPS payment policies will be issued with recommendations by its contractor, Research Triangle Institute. Why not simply wait for the results of this important research before proposing such drastic cuts, especially when they could do so much harm to beneficiaries and providers alike?

In addition, CHA feels CMS is undermining the basic premise of prospective payment systems, which use average patient stays and costs to set fixed DRG rates. The proposed rule departs from this approach, penalizing LTCHs for patients whose stays are 5/6 or less of the geometric mean length of stay for a given DRG. This is patently unfair to LTCH providers, which will now lose at both ends of the scale—for the vast majority of patients with short-

stays, and for all those with long stays as well. By continually changing the rules of the game, and shifting away from payment based on averages, CMS has greatly undermined LTCHs' ability to conduct rational financial planning and placed their continued existence in jeopardy.

At the March 15, 2006 LTCH-PPS hearing held by the House Ways and Means Subcommittee on Health, testimony was provided by CMS, MedPAC, and representatives of the LTCH industry. Chairperson Nancy Johnson noted that the proposed CMS rule would threaten LTCH industry viability, swinging Medicare margins from +9.17 percent to -4.90 percent, on average. However, CMS's Herb Kuhn acknowledged that only the largest LTCH providers would be able to sustain positive margins, meaning smaller facilities would experience negative Medicare margins far in excess of -4.9%. In fact, these estimates may be conservative. Two CHA members, Youville Hospital and Rehabilitation Center and Dubuis Health Systems, both classified as large LTCH providers, are projecting huge Medicare revenue losses of 16 percent and 13 percent, respectively. If the proposed CMS rule takes effect, both these providers have intimated that cessation of operations is a very real possibility, meaning thousands of medically complex Medicare beneficiaries would no longer be able to get the care they truly need.

CHA agrees strongly with Representative Johnson's statements that the entire LTCH industry may be put at risk if CMS's proposed rule is implemented, and that cuts of this magnitude are unprecedented for a specific provider type. All parties at the hearing, including CMS, agreed that the most important issue requiring immediate attention is the lack of uniform patient assessment and placement criteria to assure patients receive the right care in the most appropriate post-acute setting. Consensus already exists that such criteria are absolutely necessary, and that achieving agreement on these criteria should be a first tier program priority.

As a number of persons testified at the hearing, it is very hard to predict which patients will respond quickly to LTCH care, and which will have longer stays. In fact, according to the Lewin Group's just released analysis of CMS's RY 2007 LTCH-PPS proposed rule, under the new CMS definition of short-stay outliers, stays less than 5/6 of the geometric mean would *always* account for about 30 to 40 percent of cases, regardless of expected stay thresholds and LTCH requirements for admission. So, CMS's assumption that a change in its short-stay outlier policy will significantly impact the relatively high proportion of short-stay discharges, currently about 40 percent, is erroneous when pure statistics are applied.

To better predict which patients will have shorter stays, what is truly needed is a carefully refined set of patient assessment and placement criteria. The goal of these criteria would be to assure patients are referred to the most appropriate post-acute setting. Once patient placement becomes more accurate and consistent, post-acute care payment systems' accuracy and fairness should follow suit, doing away with the annual precipitous swings in reimbursement now being experienced.

In contrast to today, a more orderly and clinically based patient placement system will help stabilize the LTCH industry, increase competition and efficiency, and ensure beneficiaries' level of care needs are matched to the most appropriate care setting, not influenced by Medicare budgetary targets.

CHA Recommendations

The CHA urges CMS to take the following actions:

- **In preparing the LTCH-PPS final rule, CMS should drop the proposed changes in short-stay outlier reimbursement which appear in the proposed rule.**

The impact of this sudden and dramatic cut in reimbursement could force many LTCH providers to close their doors, and deprive medically complex Medicare

beneficiaries of access to care which is specifically designed to meet their unique needs. Not only would access be harmed, there would likely be shrinkage in the number of LTCH providers, undermining the competitiveness and efficiency of the marketplace.

- **CMS should work in close collaboration with the LTCH industry to develop and achieve consensus on a set of patient assessment and placement criteria which will assure patients are placed in the most appropriate post-acute setting (either LTCHs, skilled nursing facilities, or inpatient rehabilitation facilities).**

Development and use of such criteria is essential to ensure patients are placed in the most appropriate care setting and have the best care outcomes. Just such an effort is already underway, with CMS sponsoring the work of MassPRO, a Medicare Quality Improvement Organization contractor, to formulate a modernized set of patient-level screening criteria for the LTCH industry. MassPRO is also working collaboratively with the National Association of Long Term Care Hospitals (NALTH), testing five sets of NALTH-developed screening criteria to ensure that severity of illness and intensity of treatment are appropriate and valid. According to testimony provided by MassPRO's Laura Moore, "our assessment so far is that these criteria are on the right track – they address the complex medical conditions of long-term care hospital patients, and we believe that providing a standard, consistent measurement tool will not only improve quality of care but also help protect the Medicare Trust Fund by reducing inappropriate admissions."

- **Before issuing the LTCH-PPS final rule for RY 2007, in addition to considering all comments submitted on the proposed rule, CMS should fully review and weigh the data and recommendations of the forthcoming RTI report, as well as data and analyses provided by the LTCH industry, including the recently released report from the Lewin Group.**

The data and conclusions that these forthcoming reports will hold could significantly alter CMS's perspective on what refinements in the LTCH-PPS are truly needed to assure greater payment accuracy, and represent another major reason why CMS should not implement its proposed rule for short-stay outliers.

Conclusion

CHA believes the proposed CMS LTCH-PPS rule for RY 2007 represents an ill advised approach to shifting the mix of patients seen in LTCHs. These dramatic cuts in reimbursement are being proposed in a vacuum regarding what constitutes medically appropriate placement, putting patient health and well being at risk.

Testimony provided to Congress asserts how difficult it is for health professionals to accurately predict which LTCH patients will have long or short-stays. Yet, CMS's proposed rule assumes instituting a blunt financial disincentive will suddenly impart medical clairvoyance to providers, who are simply using their best professional judgment on where to best place a patient for post-acute care.

In the long run, clinical consensus on patient assessment and placement criteria should result in much great accuracy in assuring the most appropriate post-acute setting, helping to eliminate payment inaccuracies, improving quality, and getting the patient discharged as soon as is medically prudent. The turbulence in post-acute PPS systems which now exists is the result of each provider type operating in a silo, all competing for the same patients, without clear clinical guidelines as to which setting is best for a given patient.

CHA believes the best solution is having a set of patient placement criteria that is uniform across all care settings, not only producing the best quality for patients, but ultimately

reducing the payment inaccuracies and inefficiencies which currently exist. CMS must work with all post-acute care providers to develop consistent, accurate, and rational policies for where patients are placed, and give the industry time to implement this new order without fear of precipitous and potentially lethal, anti-competitive CMS policy changes.

Your consideration of CHA's comments is deeply appreciated.

Sincerely,

A handwritten signature in black ink that reads "Michael Rodgers". The signature is written in a cursive style with a long horizontal flourish at the end.

Michael Rodgers
Senior Vice President
Advocacy and Public Policy