March 29, 2005

Mark McClellan, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington DC 20201

Re: File code CMS-1483-P

Dear Dr. McClellan:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule entitled *Medicare Program; Prospective Payment System for Long-Term Care Hospitals: Proposed Annual Payment Rate Updates, Policy Changes, and clarification; Proposed Rule*, 70 Fed. Reg. 5724 (February 3, 2005). We appreciate your staff's work on this prospective payment system, particularly given the competing demands on the agency. We have six comments, many based on analyses we conducted and presented in the Commission's June 2003 and June 2004 reports.

First, the Commission notes the rapid growth of long-term care hospitals (LTCHs) and the consequent rapid growth in Medicare spending. LTCHs more than tripled (105 v. 350) from 1993 through 2004. Medicare spending for care furnished in these facilities has increased almost 8-fold from $398 million in 1993 to an estimated $3 billion for rate year 2006. In the last year alone, Medicare certified over 30 new LTCHs. The growth in facilities in the last few years, largely driven by the increase in for-profit facilities, is one factor that suggests Medicare payments for these facilities may be more than adequate.

Second, the uneven geographic distribution of these entities suggests that similar Medicare patients are served in alternative settings, such as acute care hospitals or skilled nursing facilities instead of LTCHs. This raises the possibility that at least some of these patients can be cared for by other, perhaps less expensive providers.

Third, we found that patients treated in long-term care hospitals cost Medicare more on average, but the difference was not statistically significant when the comparison focused on patients most appropriate for LTCH care. As a result, we recommended that long-term care hospitals be defined by facility and patient criteria that ensure that patients admitted are medically complex

and have a good chance of improvement. We also recommended that the Quality Improvement Organizations review admissions for medical necessity and monitor these facilities for compliance with the defining criteria. Details of these recommendations are available at www.medpac.gov.

Fourth, we agree with your requirement that LTCHs-within-hospitals report to you when they are colocated with other providers and the provider numbers of the colocated facilities. This will allow policymakers and researchers to systematically identify LTCHs-within-hospitals and monitor them.

Fifth, we are pleased that you are in accordance with our recommendations and look forward to the results of your study of the feasibility of implementing them. We also look forward to the results from the other research on LTCHs you are conducting, including:

- Comparison of LTCH patients and outlier patients in acute care hospitals;
- Examination of LTCH patients with diagnoses typically seen in inpatient rehabilitation facilities;
- Medical record reviews to monitor changes in service use over time;
- Evaluation of long-term LTCH patients to determine whether they should be treated in skilled nursing facilities; and
- Examination of LTCHs' patients to determine whether they are being retained in LTCHs beyond their need for LTCH-level care.

Finally, we encourage CMS to examine carefully the evidence that LTCHs may be paid more than adequately and use the agency's authority to correct any discrepancy in the PPS rates. We believe that long-term care hospitals raise significant questions for Medicare's post-acute care services and that both MedPAC and CMS must continue our work to answer these questions.

Sincerely,

Glenn M. Hackbarth
Chairman

GH/SK/amd