MEDPAC Medicare Payment Advisory Commission

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March 24, 2008

Kerry N. Weems
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Blvd.
Baltimore, MD 21244-1850

Re: File code CMS-1393-P

Dear Mr. Weems:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services's (CMS's) proposed rule entitled *Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2009: Proposed Annual Payment Rate Updates, Policy Changes, and Clarifications; Proposed Rule.* We appreciate your staff's work on this prospective payment system (PPS), particularly given the competing demands on the agency.

LTCH Payment Update

The proposed rule would change the current schedule for the annual payment rate update, so that both the payment rate update and the update to the classification system used with the LTCH PPS (MS-LTC-DRGs) would be effective October 1 of each year. Currently, the rate year runs from July 1 to June 30. MedPAC agrees that having separate effective dates for the payment rate update and the update to the MS-LTC-DRGs is burdensome and time-consuming for all parties and supports CMS's plan to change it.

The proposed rule updates the standard federal rate by the market basket (3.5 percent), less an amount (0.9 percent) to reflect case-mix increase that is due to changes in coding practice rather than patient severity. That results in a proposed update of 2.6 percent. We suggest the Secretary consider a lower update, as we recommended in our March 2008 Report to the Congress.

MedPAC believes that CMS is justified in making adjustments to payments to reflect case-mix increases due to changes in coding practice. The Commission is concerned, however, that the 1.0 percent estimate of real case-mix increase proposed by CMS is based on a RAND review of acute care hospital medical records from two decades ago. It is difficult to know whether this finding reflects the current growth in real case mix in LTCHs. The Commission urges CMS to reassess case-mix growth in LTCHs in order to have more up-to-date information for future

adjustments. This will be especially important in estimating the impact on case-mix change of the move to MS-LTC-DRGs.

Facility and patient criteria

In MedPAC's June 2004 Report to the Congress, we recommended that the Congress and the Secretary define LTCHs using facility and patient criteria, to ensure that the patients admitted to these facilities are medically complex. We specified that facility-level criteria should characterize the level of LTCH care by features such as staffing, patient evaluation, review processes, and mix of patients; while patient-level criteria should identify specific clinical characteristics and treatment modalities. We made this recommendation because our qualitative and quantitative research found that beneficiaries treated in LTCHs cost Medicare more than those treated in alternative settings; however, the cost differences narrowed considerably if LTCH care was targeted to patients who appeared most suitable for this level of care. That lead us to conclude that Medicare should ensure that LTCHs treat only appropriate patients.

The types of cases treated by LTCHs can be (and are) treated in other settings, particularly in step-down units of many acute-care hospitals. Therefore, it is not possible (nor desirable) to develop criteria defining patients who can be cared for exclusively in LTCHs. Rather, CMS should seek to define the *level of care* typically furnished in LTCHs, step-down units of many acute-care hospitals, and some specialized skilled nursing facilities (SNFs) and inpatient rehabilitation facilities (IRFs). This is an important distinction because Medicare's goal is to ensure that beneficiaries receive appropriate, high-quality care in the least costly setting consistent with their clinical conditions. Further, the Commission has long held that payment for the same set of services should be the same regardless of where the services are provided.

CMS has contracted with RTI International to study the feasibility of implementing MedPAC's recommendations. With the support of RTI, CMS has convened two technical expert panels (TEPs) to discuss differences and similarities in the populations admitted to different high-acuity settings and begin to identify critical differences in populations and facilities that might be associated with inappropriate admissions. TEP participants included clinicians from LTCHs, acute care hospitals with ventilator units, and specialized IRFs and SNFs, such as those that manage the care of ventilator patients. Representatives from hospitals, IRFs, and SNFs offering specialized services were included with the acknowledgment that their patient populations were likely more acute than those of the average provider. Including these representatives should help RTI and CMS gauge similarities and differences across facilities that care for the sickest patient populations.

TEP participants agreed that LTCHs treat patients that are also appropriately cared for in other settings, making it difficult to develop criteria for LTCHs only. However, TEP participants were able to determine some services that distinguish between facilities that treat patients of higher versus lower acuity levels, such as the ability to provide intravenous insulin therapy, continuous cardiac monitoring, and ventilator weaning.

There was agreement among TEP participants that, for many conditions, a critical mass of patients is required to ensure that providers have adequate experience treating the conditions. If this is the case, as we noted in our March Report to the Congress, then the proliferation of LTCHs in some markets might be cause for concern. To gain an adequate level of experience caring for medically complex patients, LTCHs (and other providers of medically complex care)

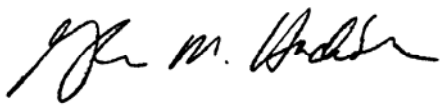
might most appropriately be viewed as regional referral centers, serving wider catchment areas. Providers with this level of experience may be able to provide more value for the Medicare program by achieving better outcomes with greater efficiency. With this in mind, CMS should consider policies that encourage this model of care for medically complex patients, such as volume criteria and staff credentialing. MedPAC will also be exploring this issue.

TEP participants also agreed on the need for structure and process standards, measurement of quality and outcomes, and established treatment protocols for medically complex patients. The Commission has stated that the individual "silos" of post-acute care do not function as an integrated system—in which a common patient instrument is used to assess patient care needs and guide placement decisions, payments reflect the resource needs of the patients and not the setting, and outcomes gauge the value of the care furnished. MedPAC has identified several barriers that inhibit the integration of the separate post-acute care settings into a united system and undermine the program's ability to purchase high-quality care in the least costly PAC setting consistent with the care needs of the beneficiary. Those barriers include incomparable (or, in the case of LTCHs, nonexistent) data on the quality and outcomes of care and lack of evidence-based standards. More research and better data are needed to compare types of patients, payments and costs, quality of care, and outcomes across acute and post-acute care settings to determine whether care is appropriate and of high-quality and whether payments are sufficient. In addition, better information about the effectiveness of treatment alternatives would help providers make value-based decisions and might also inform CMS determinations about care criteria and payment policy for medically complex and other post-acute care patients.

MedPAC appreciates the opportunity to comment on the important policy proposals crafted by CMS. The Commission also values the ongoing cooperation and collaboration between CMS and MedPAC staff on technical policy issues. We look forward to continuing this productive relationship.

If you have any questions or require clarification of our comments, please feel free to contact Mark Miller, MedPAC's Executive Director.

Sincerely,



Glenn M. Hackbarth, J.D.
Chairman