MEDPAC Medicare Payment Advisory Commission

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Thomas A. Scully, Administrator
Department of Health and Human Services
Centers for Medicare & Medicaid Services
Attention HCFA-1069-P
Hubert H. Humphrey Building, Room 443-G
200 Independence Avenue, SW
Washington, DC 20201

Re: File code CMS-1177-P

Dear Mr. Scully:

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 Implementation and FY 2003 Rates; Proposed Rule*, 67 Fed. Reg. 13416 (March 22, 2002). We appreciate your staff's careful design of this prospective payment system and recognize that designing such a complex system in a short amount of time is particularly difficult in the context of competing demands on the agency.

The Commission supports CMS's objectives to ensure that long-term care hospitals (LTCHs) serve Medicare beneficiaries who need acute long-term care and cannot be treated by acute care hospitals. We also support implementation of the prospective payment system (PPS) described in the rule. We recognize that many design decisions were based on the best data available; nevertheless, because the data are of poor quality, the Commission recommends that CMS revisit the design of the PPS for LTCHs in two years when the quality of the data has improved. Such review should include revisiting the classification system to determine whether using the long-term care all-patient refined diagnosis related groups (LTC-APR-DRGs) improves payment accuracy or increases policymakers' ability to determine whether LTCH patients truly require acute long-term care.

We have three concerns about the design of the proposed PPS. They regard the:

- treatment of short-stays,
- lack of an adjustment for differences in wages across geographic areas, and
- onsite transfer policies.

In addition, the Commission has several general concerns about LTCHs.

Concerns about the proposed prospective payment system

Treatment of short-stays: The new system will pay LTCHs on a per discharge basis, which raises the possibility that some LTCHs will admit patients who could reasonably be treated in acute care hospitals and do not require the longer-term or more costly care provided in LTCHs. To discourage admissions that could be cared for in acute care hospitals, CMS proposes to pay LTCHs on a per diem basis for patients who stay less than two-thirds the average length of stay. Two separate per diem policies are proposed.

(1) Under the very short-stay policy, CMS proposes to pay hospitals a per diem rate for patients with lengths of stay of seven or fewer days—including those who died within that period. LTCHs will be paid $327 per day for patients with psychiatric diagnoses and $611 per day for patients with non-psychiatric diagnoses.

(2) Under the short-stay outlier policy, for patients whose stays exceed seven days but are less than two-thirds of the average length of stay for the case-mix adjusted group, CMS proposes that LTCHs be paid the least of:

- 150 percent of total per diem payments for the specific case-mix adjusted group,
- 150 percent of the cost of the case, or
- the full, per discharge, case-mix adjusted payment.

We agree with the purpose of the very short-stay policy but note two issues with the method used. First, hospitals will be paid the very short-stay rates for individuals who exhaust their Medicare covered days within seven days of admission but remain in LTCHs. This policy will create financial incentives for LTCHs to avoid patients close to the end of Medicare coverage for hospital stays, but who need LTCH care. For these patients, we suggest paying hospitals the short-stay outlier rate, which is based on the patients'case-mix adjusted payment. Second, by establishing large differences between payments for the seventh and eighth day—from almost $5,000 to more than $16,000 per patient—this policy creates strong extremely strong financial incentives for LTCHs to keep patients until the eighth day regardless of clinical need.

No adjustment for wage differences: Most of Medicare's prospective payment systems adjust national average payment rates to reflect local market prices for labor and other inputs. The intent of such adjustments is to reflect differences across areas in the costs of providing services that are beyond the control of providers. CMS proposes not to make such an adjustment for the LTCH PPS because the agency found that differences in local input prices were not significant

predictors of costs for care in LTCHs. We examined two possible reasons for this result: (1) high correlation of patient need with local wages, and (2) lack of variation in wages for these locations.[1] We found the correlation of patient need and wages to be low (.12) and that wages for the counties where LTCHs are located did vary widely, from about 0.75 to about 1.50. We were unable to test a third possible reason—that limitations on increases in costs imposed for 20 years by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) have distorted costs.

If CMS does not adjust rates for local input prices, hospitals with low wages may be overpaid and those with high wages may be underpaid. If CMS does adjust to account for differences in wages, the opposite error may result. Given differences in labor costs for other services, it seems unlikely that local input prices do not have an effect on LTCH costs. The need for adjustment should be reexamined when better data are available.

Onsite transfer policies: To discourage LTCHs from transferring patients to and from onsite acute care hospitals, skilled nursing facilities, inpatient rehabilitation or inpatient psychiatric units, CMS proposes limiting payments for LTCHs who transfer more than 10 percent of their patients. MedPAC supports reducing incentives to transfer patients inappropriately, but because the proposed mechanism does not take into account the clinical needs of patients, we are concerned that it will discourage appropriate and inappropriate transfers alike. Therefore, we suggest review by the Quality Improvement Organizations (QIOs) to monitor appropriateness of patients for long-term care hospitals in general and onsite readmissions in particular.

Concerns about long-term care hospitals in general

The rapid growth in LTCHs, Medicare spending for them, their geographical distribution, and interaction between acute care and long-term care hospitals raise basic questions about LTCHs. The uneven distribution of these entities suggests that some Medicare patients who need acute long-term care are served in acute care hospitals instead of long-term facilities. This fact, in turn, suggests that these patients can be cared for in acute care hospitals and that LTCHs may not be necessary. Acute care hospitals that treat long-term patients presumably receive high-cost outlier payments for these patients. Payments for care in LTCHs should not be significantly different from payments for similar patients treated in acute care hospitals, without clear reasons for the difference.

In designing the PPS, CMS compared current costs versus payments under the new PPS, but these costs may be higher than necessary. It is impossible to say whether additional payments for care provided by LTCHs is or is not an appropriate expenditure of Medicare funds without more information about:

[1]Patient need was measured by the case-mix index (CMI) for long-term care hospitals and wages were measured by the wage index for the counties in which there are LTCHs.

- where patients who need acute long-term care are treated in areas where there are no LTCHs,
- how costs and outcomes compare for similar patients in long-term care hospitals and other settings in areas where LTCHs do not exist,
- how costs compare for hospitals with and without onsite LTCHs,
- how costs compare for onsite LTCHs and freestanding LTCHs, and
- how the presence or absence of LTCHs affects transfers to acute care hospitals and other post-acute care settings.

We recommend that CMS study these issues in concert with MedPAC.

Finally, none of the payment provisions for LTCHs address the transfer decisions of acute care hospitals from which 70 percent of LTCH patients come. Such information could provide a foundation for improving policies to help ensure that decisions about where beneficiaries are treated are made on the basis of clinical rather than financial considerations.

Sincerely,

Glenn M. Hackbarth, J.D.
Chairman

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