MEDPAC Medicare Payment Advisory Commission

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July 21, 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-1493-IFC2

Dear Mr. Weems:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS') interim final rule entitled *Medicare Program; Changes for Long-Term Care Hospitals Required by Certain Provisions of the Medicare, Medicaid, SCHIP Extension Act of 2007; 3-Year Moratorium on the Establishment of New Long-Term Care Hospitals and Long-Term Care Satellite Facilities and Increases in Beds in Existing Long-Term Care Hospitals and Long-Term Care Hospital Satellite Facilities; and 3-Year Delay in the Application of Certain Payment Adjustments.* We appreciate your staff's work on this prospective payment system (PPS), particularly given the competing demands on the agency.

The interim final rule implements certain provisions of section 114 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) related to long-term care hospitals (LTCHs). One provision delays for three years the application of the so-called 25-percent rule, which reduces payments for LTCHs that exceed established percentage thresholds for patients admitted from certain referring hospitals during a cost-reporting period.

The 25-percent rule is intended to help ensure that LTCHs do not function as units of acute care hospitals and that decisions about admission, treatment, and discharge in both acute care hospitals and LTCHs are made for clinical rather than financial reasons. When first implemented, it applied only to LTCH hospitals-within-hospitals (HWHs) and satellites, limiting the proportion of Medicare patients who could be admitted from a HWH's or satellite's host hospital during a cost reporting period. The policy was phased in over three years, with the threshold for most HWHs and satellites set at 75 percent for fiscal year 2006, 50 percent for fiscal year 2007, and 25 percent for fiscal year 2008 and beyond. In July 2007, CMS began to phase-in the 25-percent rule for all freestanding LTCHs, as well as for HWHs and satellite LTCHs that had previously been excluded from the rule, limiting the proportion of patients who could be admitted to an LTCH from any one acute care hospital during a cost reporting period.

Some LTCHs—both freestanding and those with formal ties to other hospitals—may function as de facto step-down units of acute care hospitals. Research by MedPAC and others has found that patients who use LTCHs have shorter acute care hospital lengths of stay than similar patients who do not use these facilities, suggesting that LTCHs substitute for at least part of the acute care hospital stay. The Commission has long been concerned about the nature of the services furnished by LTCHs and how patient outcomes compare with those of other, less costly, providers. MedPAC favors using criteria to define the level of care typically furnished in LTCHs (as well as in step-down units of many acute-care hospitals, and some specialized skilled nursing and inpatient rehabilitation facilities) and to help ensure that beneficiaries receive appropriate, high-quality care in the least costly setting consistent with their clinical conditions.

Until criteria can be developed, the 25 percent rule may be a useful, if blunt, tool. But it is a flawed one. Under the 25-percent rule, an LTCH's decision on whether to admit a patient may be based not only on the patient's clinical condition but also on how close the facility is to exceeding its threshold.

In addition, MedPAC noted previously that setting different thresholds for different types of LTCHs is inequitable (see July 9, 2004 comment letter). Prior to passage of the MMSEA, CMS attempted to remedy this inequity by phasing in the 25 percent rule for all LTCHs. The agency's interpretation of section 114 of the MMSEA creates this problem anew. As described in the interim final rule, "grandfathered" satellite facilities (those that were operating as of September 30, 1999) will be treated differently from grandfathered HWHs. Grandfathered satellites will continue to operate under the 75-percent threshold established for RY 2008, transitioning to a 50 percent threshold in 2009, and a 25 percent threshold in 2010; grandfathered HWHs will have no threshold applied at all for the next three years. The interim final rule will also establish a 50 percent threshold for nongrandfathered HWHs and satellites that were paid under the LTCH PPS prior to October 1, 2004, and a 25 percent threshold for nongrandfathered HWHs and satellites that were not paid under the LTCH PPS prior to October 1, 2004, even though all these facilities were operating at a 25-percent threshold prior to passage of the MMSEA.

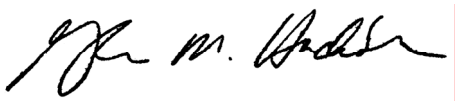
It is not clear to us that CMS will be able to accurately track these various categories of LTCHs for purposes of administering this rule. In the past CMS has had difficulty identifying HWHs and satellites. These facilities are now required by CMS to report their status to their fiscal intermediaries (FIs), but it remains to be seen whether FIs will be able to accurately make these precise distinctions among LTCHs.

MedPAC believes that the policy articulated here is inequitable in its treatment of various LTCHs and creates additional administrative burden for the agency. If CMS believes it has no latitude in interpreting the statute, then the Secretary should attempt to remedy these problems by submitting a legislative proposal to the Congress.

MedPAC appreciates the opportunity to comment on the rule. 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

GMH/dk/wc