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LONG-TERM ACUTE CARE HOSPITALS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

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SECOND SESSION

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LONG-TERM ACUTE CARE HOSPITALS

WEDNESDAY, MARCH 15, 2006

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 3:15 p.m., in Room 1100, Longworth House Office Building, Hon. Nancy L. Johnson (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
March 8, 2006
No. HL–13

CONTACT: (202) 225–3943

Johnson Announces Hearing on Long-Term Acute Care Hospitals

Congresswoman Nancy L. Johnson (R–CT), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on long-term acute care hospitals (LTCHs). **The hearing will take place on Wednesday, March 15, 2006, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 3:00 p.m. or immediately following the Subcommittee on Human Resources hearing on unemployment, whichever time is later.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

Medicare patients currently account for more than 70 percent of discharges from LTCH facilities. Long-term acute care hospitals are required to meet all the conditions of participation for short-term acute care hospitals, and they must have an average length of stay for their patients greater than 25 days. Medicare currently does not require LTCHs to use assessment tools or patient criteria to evaluate whether beneficiaries being treated in these facilities specifically need the level of care that LTCHs provide.

Spending for LTCH services has increased significantly in recent years. According to the Medicare Payment Advisory Commission (MedPAC), between 2001 and 2004 the number of LTCHs increased by 9 percent per year, while the volume of services increased by 12 percent annually. Medicare spending on LTCHs during 2001 to 2004 increased 25 percent per year during that period, and in 2004 alone Medicare spending for services in this setting increased by 38 percent. Long-term acute care hospitals, however, do not exist nationwide; patients who reside inareas without LTCHs often receive long-term care services in other hospitals or skilled nursing facilities.

The Centers for Medicare and Medicaid Services (CMS) have proposed a payment rule for 2007 that would make several changes to the LTCH payment system. The rule would provide a zero update to the LTCH base rate of $38,086 for the 2007 rate year (for discharges occurring on or after July 1, 2006). The Medicare Payment Advisory Commission also recommended a zero update for LTCHs in its March 2006 payment policy report.

The CMS also proposes a change in the short-stay outlier payment methodology. Currently, LTCHs are paid a reduced short-stay amount for patients whose length of stay in the facility is five-sixths or less of the average length of stay for that patient's long-term care-diagnosis related group (LTC–DRG). The CMS notes that 37 percent of LTCH cases are short-stays in institutions where the average length of stay must be more than 25 days. Under current rules, there is a special adjustment for short-stay cases so that payment is the lesser of 120 percent of costs, 120 percent of the per diem amount multiplied by the length of stay for that discharge, or the full LTC–DRG payment amount. The CMS proposed rule would change the 120 per-

cent of costs to 100 percent of costs. The rule also adds a fourth option of paying the short-term acute care payment for that diagnosis related group.

In announcing the hearing, Chairman Johnson stated, "This hearing will provide Committee Members valuable insight into the changing reimbursement world for long-term care hospitals. The Center for Medicare and Medicaid Services has proposed a seismic change in how these facilities are paid, so it is important to understand the current payment environment and the rationale for these reforms."

FOCUS OF THE HEARING:

Medicare payment policy as it relates to LTCHs, including the CMS proposed rule and MedPAC's March recommendations.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "*109th Congress*" from the menu entitled, "*Hearing Archives*" (*http://waysandmeans.house.gov/Hearings.asp?congress=17*). Select the hearing for which you would like to submit, and click on the link entitled, "*Click here to provide a submission for the record*." Once you have followed the online instructions, completing all informational forms and clicking "submit" on the final page, an email will be sent to the address which you supply confirming your interest in providing a submission for the record. You ***MUST REPLY*** to the email and ***ATTACH*** your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business Wednesday, March 29, 2006. **Finally**, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word or WordPerfect format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://waysandmeans.house.gov*.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman JOHNSON. The hearing will come to order. Mr. Stark is on his way, and he advises that we should begin, so we will do so.

Welcome, Mr. Kuhn and Mr. Miller. I am pleased to chair this hearing on long-term care hospitals in the Medicare Program. Medicare patients currently account for more than 70 percent of the discharges from long-term acute care hospitals, and Long-Term Care Hospitals (LTCH) are required to meet all the conditions of participation for short-term acute care hospitals, but also must have an average length of stay for their patients of greater than 25 days.

Medicare currently does not require LTCHs to use assessment tools or patient criteria to evaluate whether beneficiaries being treated in these facilities specifically need the level of care that LTCHs provide. Furthermore, spending on LTCH services has increased significantly in recent years, although the total payments to LTCHs is less than 1 percent of total Medicare spending, and these hospitals are, as we know, returning people to life and independence that not very many years ago would have died or been permanently disabled.

Between 2001 and 2004, the number of LTCH facilities increased 9 percent a year while the volume of services increased 12 percent annually. Medicare spending on LTCHs during 2001 to 2004 increased 25 percent per year during that period, and in 2004 alone Medicare spending for services in this setting increased by 38 percent. Needless to say, it is clear why this sector has caught our attention. Long-term acute care hospitals, however, do not exist nationwide, and patients who reside in areas without LTCHs often receive long-term care services in Intensive Care Units (ICU), as outliers in acute care hospitals, in other rehabilitation type hospitals, or in skilled nursing facilities; or they simply do not receive the care they need and die or are permanently disabled.

The Medicare payment Advisory Commission recommended a zero update for LTCHs in its March 2006 payment report. In the past, it has proposed and I support establishing criteria for facilities and patients so that both have the comfort to know they are providing and receiving appropriate care at the right time and in the right place.

This hearing will provide us with valuable insights into the changing reimbursement world for long-term care hospitals. Centers for Medicare and Medicaid Services (CMS) has proposed a significant change in how thee facilities are paid in its 2007 payment rule, so it is important to understand the current payment environment and the rationale for these reforms.

I am pleased to have with us today two distinguished panels of witnesses to help us explore the issues facing our long-term care hospitals. On our first panel, we will hear Mr. Herb Kuhn, the Director of the Center for Medicare Management at the CMS. Mr. Kuhn will describe for us the thinking behind CMS' proposed payment rule for long-term care hospitals, along with the ongoing work the agency is doing on developing patient criteria for LTCHs.

We will also hear from Dr. Mark Miller, Executive Director of the Medicare Payment Advisory Commission. Dr. Miller will discuss the work of MedPAC done recently in evaluating the growth of

long-term care hospitals in Medicare and their recommendations for the use of patient and facility criteria to ensure that beneficiaries are being admitted to these facilities appropriately.

On our second panel, we will hear from William Altman, Senior Vice President of Kindred Healthcare, a nationwide provider of long-term care services. Mr. Altman will provide us with an industry response to the proposed CMS rule from the perspective of a diversified, for-profit provider of post-acute services ranging from skilled nursing facilities to LTCHs in 40 States.

We will then hear from Laura Moore, Vice President of Strategy and Operations at MassPRO, the QIO for the State of Massachusetts. MedPAC has recommended that Quality Improvement Organizations (QIO) be more involved in evaluating LTCH admissions for medical necessity, and Ms. Moore will discuss with us the process MassPRO uses for evaluating LTCH admissions.

Finally, I am pleased to welcome to our second panel Dr. John Votto, President and Chief Executive Officer of the Hospital for Special Care, which is in my hometown of New Britain. Dr. Votto will provide us with an industry reaction to the CMS proposed rule from the perspective of a localized nonprofit long-term care facility, and also will comment on the issue of criteria-based admissions, an issue he has worked hard on as the chairman of a Committee of physician and other specialists from across the country looking at this issue.

Long-term care hospitals provide critical services to medically complex patients, and it is essential that we preserve beneficiary access to these services while also protecting the interests of taxpayers and of the Medicare Program as a whole.

I look forward to hearing from all of our witnesses on this issue, and Mr. Stark will submit his comments for the record and will be along shortly. Mr. Kuhn?

[The prepared statement of Mr. Stark follows:]

Opening Statement of The Honorable Pete Stark, a Representative in Congress from the State of California

Madam Chair, the topic of today's hearing is one of those that can rightfully be described as being in the underbelly of Medicare payment policy. We've seen tremendous growth in long-term care hospitals and associated spending, and it's an area that deserves attention. Indeed, while I have generally supported past CMS efforts to reign in this burgeoning industry, I do think that the proposed rule needs to be revisited, and I look forward to today's testimony and discussion.

However, I can't help but note, again, that we are fiddling while Rome burns. We have been asking for hearings, in writing, in private, and on the dais, on Part D for well over a year, yet the Committee on Ways and Means refuses to move forward. Every other authorizing committee and a few others have held hearings. Not us. We are apparently too busy.

Let's put this in perspective. In 2004, Medicare paid for about 122,000 cases in long-term care hospitals out of a Medicare population of almost 42 million Medicare beneficiaries. Iif every case were unique, which it might be for LTCHs, that would be less than 3/10ths of a percent. This rule was proposed January 27. My staff was first lobbied on this a week or two ago. The comment period closes at the end of this month. And here we are in a hearing on this very narrow issue.

In contrast, the MMA was enacted in December, 2003. Medicare spending for the new private prescription drug program is projected to run between $23–37 billion this year (CBO versus Actuaries), and the program may affect up to 37 million beneficiaries. Regardless of the precise number, it's a lot of money and a lot of people. And no matter how optimistic Wall Street is about the potential for profit in the long-term care hospital industry, this sector is a long way from competing with Part D.

I speak from experience when I say that it can be uncomfortable to review your own party's—much less your own—activities. But we are abrogating our Congressional and Constitutional responsibilities when we fail to do so. That said, I look forward to today's discussion, and hope we can get closer to a sensible approach that ensures appropriate access to care while minimizing the conditions that are clearly driving industry growth.

STATEMENT OF HERB B. KUHN, DIRECTOR, CENTER FOR MEDICARE MANAGEMENT, CENTERS FOR MEDICARE AND MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. KUHN. Thank you, Madam Chairman Johnson, Congressman McCrery. I appreciate the time you have taken to invite me to testify about long-term care hospitals. Long-term care hospitals, also known as LTCHs, typically provide post-acute medical and rehabilitative care for clinically complex patients including comprehensive rehabilitation and respiratory services. To be classified as an LTCH, a hospital must have an average Medicare inpatient length of stay of greater than 25 days. Despite the fact that their availability varies widely across the Nation, the number of LTCHs has increased exponentially over the last 10 years. In addition, LTCHs are the highest paid hospitals in the Medicare Program, with average Medicare margins of nearly 12 percent.

CMS published the long-term care hospital prospective payment system proposed rule on January 27, 2006. The rule is intended to assure appropriate payment for services to severely ill or medically complex patients, while providing incentives for more efficient care of Medicare beneficiaries.

The proposed rule provides for no increase in Medicare payment for LTCHs in 2007. MedPAC similarly, as you suggested in your opening statement, made this recommendation in their March 2006 report to Congress that Medicare payments to LTCHs are more than adequate, recommending a zero update for 2007. Again, their recommendation focused on efficiency without affecting the ability to furnish high-quality care to Medicare beneficiaries.

The proposed rule also would revise the payment adjustment formula for short-stay outlier cases. Short-stay outliers are cases where the patient may be discharged early, and often the hospital's costs are significantly below average. The most recent available data show that short-stay outlier cases comprise approximately 37 percent of LTCH discharges, and CMS believes that is an inappropriately high number of patients treated in LTCHs. Existing payment policy may unintentionally provide a financial incentive for LTCHs to admit a large number of short-stay cases, including premature and even inappropriate patient shifting from the referring acute care hospitals. The proposed rule would ensure that payments for short-stay outliers do not exceed costs. It would also add a fourth component to the current formula that would allow payment based on an amount comparable to what would be paid under the inpatient prospective payment system. We estimate that these revisions would result in approximately $440 million in savings to the Medicare Program.

CMS also discusses in the proposed regulation additional considerations of the hospital within a hospital criteria. As of October 2005, there were 376 LTCHs in the CMS database, of which 176 were hospitals within hospitals, and these facilities have been growing at a rate of 35 percent per year from 1993 to 2003. CMS recognizes that collocation of an acute care hospital and LTCH services may be an efficient way to deliver care and may be less disruptive for patients at the same time. However, collocation also leads to patient shifting from one part of a hospital to another, resulting in two Medicare payments for what is essentially one episode of patient care.

To ensure that Medicare avoids making two payments, CMS implemented a payment adjustment for fiscal year 2004 relating to the percentage of patients discharged from a hospital within a hospital or satellite that were admitted from its collocated host hospital before receiving a full episode of treatment at the host hospital. This payment adjustment is commonly called the 25-percent payment threshold policy. It is CMS' obligation to ensure that beneficiaries receive the right care in the appropriate setting at the appropriate payment for the services. Thus, CMS will continue to monitor the admission patterns of LTCHs to determine if further rulemaking is warranted.

Finally, CMS wants to ensure that the criteria used to determine placement in an LTCH are appropriate. In June 2004, MedPAC did release a report providing recommendations that urged us to establish facility and patient criteria for LTCHs and provide an expanded role for quality improvement organizations (QIO) in monitoring compliance with the newly established criteria. Currently, CMS is pursuing MedPAC's recommendations. We have awarded a contract with Research International, Inc. (RTI) in 2004 for this purpose, and a final report is expected this spring.

Since parts of the country lack LTCHs, LTCH-type patients may receive hospital-level treatment at acute care hospitals as outlier patients, or, for example, at an inpatient facility with significantly lower payments per beneficiary discharge than at LTCHs. RTI's research attempts to determine whether patient outcomes are equivalent across these sites. One specific area of evaluation will be whether there is a correlation between the higher payments of LTCHs and improved patient outcomes for the same types of patients in different treatment settings.

The goal of the Medicare Program is to assure cost-effective delivery of the highest quality of medical services to beneficiaries. CMS looks forward to receiving comments on the proposed rule—the comment period closes next Monday, March 20—in order for us to be able to develop the final policy and guide the future of LTCHs appropriately. I look forward to your questions.

Thank you.

[The prepared statement of Mr. Kuhn follows:]

Statement of Herb B. Kuhn, Director, Center for Medicare Management, Centers for Medicare and Medicaid Services, U.S. Department of Health & Human Services

Madam Chairman Johnson, Congressman Stark, distinguished Subcommittee members, thank you for inviting me to testify about long-term care hospitals (LTCHs). Long term care hospitals (LTCHs) typically provide post-acute medical

and rehabilitative care for clinically complex patients including comprehensive rehabilitation, respiratory therapy, head trauma treatment and pain management. Despite the fact that their availability varies widely across the nation, the number of LTCHs has increased exponentially over the last 10 years. The number of LTCHs more than tripled between 1993 and March 2005. Although the two States with the largest number of LTCHs are Texas and Louisiana, substantial growth is also occurring in States with large numbers of elderly populations including Pennsylvania, Ohio, Michigan, Georgia, Indiana, and Oklahoma. LTCHs are the highest paid hospitals in the Medicare program; preliminary cost report data for FY 2004 indicate average Medicare margins of almost 12 percent.

CMS published the long-term care hospital prospective payment system (LTCH PPS) proposed rule on January 27, 2006. The rule is intended to assure appropriate payment for services to severely ill or medically complex patients, while providing incentives to LTCHs for more efficient care of Medicare beneficiaries. CMS believes the proposed rule promotes appropriate payment, efficient care, and the Agency is looking forward to receiving your feedback as well as comments from the public. I do want to note that the FY 2007 President's Budget proposal assumes a zero percent update for Rate Year (RY) 2007 and a modified LTCH PPS short stay outlier policy.

Background

Most patients in LTCHs are clinically complex and have multiple co-morbidities—that is, they have secondary health conditions that can interact with and lead to an intensification of the primary diagnosis requiring hospital-level medical treatment. Medicare beneficiaries comprise, on average,83 percent of LTCH patients and the distributions vary from 68 percent to 90 percent at the 25th and 75th percentiles. LTCHs also provide care to a disproportionately large number of beneficiaries who are Medicare eligible because of disability. To be classified as an LTCH, a hospital must have an average Medicare inpatient length of stay that is greater than 25 days. CMS is considering payment adjustments for LTCHs that are tied to specific patient classification criteria based recommendations from the Medicare Payment Advisory Commission (MedPAC) and the results from the research currently underway by RTI International (RTI).

The LTCH PPS was implemented October 1, 2002 to assure appropriate payment for services to the medically complex patients treated in LTCHs. The LTCH PPS currently sets payments for approximately 376 LTCHs, and payments under the LTCH PPS are updated annually.

CMS issued the LTCH Proposed Rule for Rate Year 2007

Public comments on the LTCH PPS Proposed Rule for Rate Year (RY) 2007 will be accepted until March 20, 2006. The proposed rule provides for no increase in Medicare payment rates to LTCHs for RY 2007, which means the LTCH PPS standard Federal rate would remain at $38,086.04. The standard Federal rate for RY 2007 would apply to LTCH patient discharges taking place on or after July 1, 2006, through June 30, 2007. Similarly, MedPAC stated in its March 2006 Report to Congress that Medicare payments to LTCHs are more than adequate, recommending a zero update for LTCHs in 2007. MedPAC determined that keeping payments at the same level as 2006 would increase program efficiency without affecting the ability of LTCHs to furnish high quality care to Medicare beneficiaries.

The CMS update proposal is based on analysis of the LTCH case-mix index before and after implementation of the LTCH PPS, analysis of LTCH margins based on the latest available cost report data, and recent update recommendations for the LTCH PPS from MedPAC in the Commission's March 2006 Report to the Congress. In analyzing LTCH data, CMS found that the case-mix index increased by 6.75 percent between fiscal years (FYs) 2003 and 2004, which is believed to be due in large part to changes in coding practices and documentation rather than the treatment of more resource intensive patients. This belief is based on an analysis of LTCH cost report data that shows LTCH payments are increasing without a commensurate increase in average case costs. The LTCH PPS Federal rate for RY 2007, which would be the same as the Federal rate for RY 2006, would reflect an adjustment to the market basket update to account for the increase in case mix due to changes in coding practices. In addition, cost report data show increasing Medicare margins among LTCHs since the implementation of the LTCH PPS. Specifically, in an analysis of LTCH cost report data, CMS found that LTCH Medicare payments for FY 2003 (the first year of the LTCH PPS) were 8.8 percent higher than LTCHs' Medicare costs. Preliminary cost report data for FY 2004 data reveal an even higher Medicare margin of 11.7 percent.

Currently CMS uses the excluded hospital with capital market basket as the measure of inflation for calculating the annual update to the LTCH PPS Federal rate. CMS is proposing to adopt the Rehabilitation, Psychiatric and Long-Term Care (RPL) market basket to calculate the annual update to the LTCH PPS Federal Rate. The RPL market basket is based on the operating and capital costs of Inpatient Rehabilitation Facilities (IRFs), Inpatient Psychiatric Facilities (IPFs), and LTCHs. CMS would also revise the labor-related share of the Federal rate based on the RPL market basket. The revised labor-related share would increase from 72.855 percent (based on the excluded hospital with capital market basket) to 75.923 percent. Increasing the labor share will have a positive impact on payments to LTCHs in areas with a wage index of greater than 1.0.

The proposed rule also presents for comment a preliminary model of an update framework for possible future use under the LTCH PPS. The framework would account for other appropriate factors affecting the efficient delivery of services and care provided in LTCHs when determining future Federal rate update proposals. CMS intends to consider comments in refining the framework and would propose a refined framework in a future regulation before using it to determine an update proposal.

CMS's Proposed Ruke Would Revise the Payment Adjustment Formula for Short-Stay Outlier Cases

The proposed rule would revise the payment adjustment formula for short-stay outlier (SSO) cases (i.e., cases with a length of stay less than or equal to 5/6 of the average length of stay of the LTC–DRG). SSOs are cases where the patient is discharged early and often the hospital's costs are significantly below average. Currently, under the LTCH PPS, SSO cases are paid the lesser of 120 percent of the estimated cost of the case; 120 percent of the LTC–DRG per diem amount; or the full LTC–DRG payment. Since the implementation of the LTCH PPS in FY 2003, CMS has continued to monitor the SSO policy. The most recent available LTCH data reveal that SSO cases comprise approximately 37 percent of LTCH PPS discharges (as compared to 48.4 percent based on the LTCH data used to develop the LTCH PPS prior to its implementation in FY 2003).

CMS believes that 37 percent of LTCH discharges that are SSO cases is an inappropriate number of patients being treated in LTCHs. The Agency is concerned that these patients may be more appropriately served in acute care hospitals and that the existing SSO payment policy may unintentionally provide a financial incentive for LTCHs to admit a large number of short stay cases.

The proposed rule would reduce the part of the current payment formula that is based on costs to ensure that payments for SSOs do not exceed costs. It would also add a fourth component to the current formula that would allow payment based on an amount comparable to what would be paid under the inpatient prospective payment system (IPPS) for acute care hospitals for patients that group to that DRG. CMS proposes that payments for SSO cases would be the lesser of 100 percent of the estimated cost of the case, 120 percent of the LTC–DRG per diem amount, the full LTC–DRG payment, or an amount comparable to what would be paid under the IPPS. CMS estimates that revising the current SSO policy by reducing the percentage of costs in the formula and including a fourth part of the formula would result in approximately $440 million in savings to the Medicare program in RY 2007. Under this proposed payment alternative, LTCHs, which are certified as acute care hospitals, would be paid by Medicare under the LTCH PPS at a rate that is more consistent with the rate paid to acute care hospitals when they treat shorter stay patients. Additionally, the proposed reduction in the percentage of costs to 100 percent would reduce what CMS perceives to be a financial incentive under the current policy for LTCHs to treat short stay cases.

Adding an amount comparable to what would be paid under the IPPS to the SSO payment formula is appropriate since the vast majority of LTCH patients are admitted directly from acute care hospitals. Thus, CMS believes that short stay patients at LTCHs may indicate premature and even inappropriate patient shifting from the referring acute care hospitals. CMS perceives that LTCHs are acting more like short-term acute care hospitals by admitting such a large percentage of short-stay patients. Therefore, CMS believes that a patient admitted to an acute care hospital for a short stay and a patient admitted to a LTCH (which is certified as an acute care hospital) for the same number of days, should be paid a comparable amount.

CMS Proposes Increasing the Outlier-Fixed Amount

Medicare will pay a hospital an amount in addition to the Federal rate payment under the LTCH PPS for the LTC–DRG for unusually costly cases. To be eligible for this additional high cost outlier payment, the hospital's estimated costs in treat-

ing the case must exceed the LTC–DRG payment by an outlier fixed-loss amount. Aggregate estimated outlier case payments are limited to 8 percent of total estimated LTCH payments. For RY 2006, the outlier fixed-loss amount is $10,501. The proposed rule would increase the outlier fixed-loss amount for RY 2007 to $18,489. Since the proposed changes to the short stay outlier policy would result in reduced total LTCH payments, it is necessary to increase the outlier fixed loss amount in order to maintain the 8 percent limit on total LTCH outlier payments. CMS established the outlier target at 8 percent of estimated total LTCH PPS payments when the Agency implemented the LTCH PPS to allow CMS to achieve a balance between the conflicting considerations of the need to protect hospitals with costly cases, while maintaining incentives to improve overall efficiency.

CMS Notes Continuing Issue of Hospital within Hospitals

The IPPS for acute care hospitals was designed to provide one appropriate payment for hospitalized patients. The Standard Federal payment rate under the IPPS for FY 2005 is $4,555 whereas the Standard Federal payment rate under the LTCH PPS for RY 2005 was $38,086. Since LTCHs are certified by Medicare as acute care hospitals and in many parts of the country patients who could otherwise fit the typical profile of LTCH patients are treated in acute care hospitals as high cost outliers, CMS wants to ensure that the significantly higher Medicare payments made to LTCH facilities reflect treatment for patients who most need and can benefit from the specialized care they offer.

As of October 2005, there were 376 LTCHs in the CMS database, of which 176 were hospitals within hospitals (HwHs). In recent years, MedPAC as well as CMS, has been conducting a careful study of the rapid growth in LTCHs, particularly LTCH HwHs (which have been growing at a rate of 35 percent per year from 1993 to 2003—three times the overall rate of LTCH growth. Medicare regulations specify that an LTCH is an HwH when it is co-located with another Medicare hospital-level provider, its "host", generally an acute care hospital. Under present regulations, for an LTCH that occupies space in a building also used by another hospital, or in one or more separate buildings located on the same campus as buildings used by another hospital, to be considered a HwH, the entity must meet separateness and control criteria that demonstrate organizational and functional separateness from its host hospital. An LTCH may establish a satellite facility in another hospital, which must also demonstrate compliance with similar separateness and control criteria regarding its relationship to its host hospital.

These requirements are in place to ensure that host hospitals and HwHs or satellites are separate in medical and administrative governance and that a given LTCH HwH or satellite is not merely serving as a "step-down" unit of the acute care hospital. In such a case, Medicare would be paying under two payment systems, the IPPS and the LTCH PPS for what is essentially one episode of care. CMS recognizes that co-location of an acute care hospital and LTCH services may be an efficient way to deliver care and may be less disruptive for patients at the same time; however, co-location also leads to patient shifting from one part of a hospital to another, resulting in two Medicare payments for what is essentially one episode of patient care. Therefore, CMS believes that co-location creates incentives that can lead to patient admission, treatment, and discharge decisions that reflect maximization of Medicare payments, rather than provision of the most effective and efficient care based on patient need.

In order to ensure that Medicare avoids making two payments (one to the acute care and one to the onsite LTCH HwH or LTCH satellite) for a single episode of care, in addition to the "separateness and control" requirements, CMS implemented a payment adjustment for FY 2004 relating to the percentage of patients discharged from an HwH or satellite that were admitted from its co-located host hospital prior to receiving a full episode of treatment at the host hospital. This payment adjustment is commonly called the 25 percent payment threshold policy. Presently, CMS is monitoring and evaluating several identified behaviors that may be attempts to circumvent specifics of the implementation of this 25 percent threshold payment adjustment such as "patient-swapping," (that is hosts cross-discharging to one another's HwH or satellite).

CMS is aware that, following the implementation of the 25 percent threshold payment adjustment for co-located LTCHs, the significant growth in the LTCH industry has been in the development of free-standing LTCHs. CMS data indicate that many free-standing LTCHs are receiving high percentages of their patients from specific acute care hospitals (often a sole acute care hospital) and therefore are, in effect, acting as units of the acute care hospital, thereby replicating the concerns CMS has with LTCH HwHs or LTCH satellites.

As stewards of the Medicare trust fund, it is CMS' obligation to ensure that beneficiaries receive the right care, in the appropriate setting, at the appropriate payment for the services. Thus, CMS is concerned about the developments in LTCH HwHs and satellites and will continue to monitor the admission patterns of LTCHs to determine if further rulemaking is warranted.

CMS is Evaluating the Criteria Used to Define LTCHs

Since 1994, CMS has been studying the relationships between treatment at acute care hospitals and LTCHs, as well as the linkage between payment policies and substitution of services, especially among acute care hospitals, LTCHs, IRFs, and some skilled nursing facilities (SNFs). Many similar services are provided in an LTCH as are provided in an acute care hospital. In both cases, patients need a high level of care from nurses, technicians, and other health professionals. There are many existing acute care hospitals that treat as patients with the same profile as those typical of LTCHs. These acute care hospitals, paid under the IPPS, treat many, if not more, outlier (i.e., long length of stay) cases than do most LTCH HwHs. Furthermore, given that many acute care hospitals, IRFs, IPFs, and SNFs may serve as settings for potential LTCH patients, CMS wants to ensure that the criteria used to determine placement in an LTCH are appropriate. For example, CMS data reveal that one of the most frequent LTC–DRGs found in LTCHs is 462—Rehabilitation, a diagnosis that could receive appropriate treatment at IRFs. Another of the most common LTC–DRGs is 430, Psychoses, a diagnosis which could also be treated at IRFs. Many SNFs also offer a high-level of post-acute care including access to rehabilitation services and therapies.

In June of 2004, MedPAC released a report providing recommendations urging CMS to establish facility and patient criteria for LTCHs and provide an expanded role for Quality Improvement Organizations (QIOs) in monitoring compliance with the newly-established criteria. Currently, CMS is pursuing MedPAC's recommendations to develop patient and facility-level criteria and to determine the feasibility of developing a more clinically sophisticated admissions policy in order to distinguish Medicare patients who could most benefit from LTCH treatment. CMS awarded a contract to Research Triangle Institute, International (RTI) in 2004 for this purpose and a final report is expected in late Spring.

Since in parts of the country that lack LTCHs, LTCH-type patients may receive hospital-level treatment at acute hospitals as outlier patients, at IRFs, or in some cases, IPFs with significantly lower payments per beneficiary discharge than at LTCHs. RTI's research attempts to determine whether patient outcomes are equivalent across these sites. One specific area of evaluation will be whether there is a correlation between the higher payments at LTCHs and improved patient outcomes for the same types of patients in different treatment settings. Since there is wide variation in the range of post-acute care facilities available throughout the country, if payments are equivalent per case and patient outcomes are generally equal in different areas of the country, the variations may be explained as a reflection of variations in regional practices. However, if outcomes differ substantially for certain types of patients, indicating that LTCH patients have better outcomes, the recent growth of the LTCH industry could result in the availability of a better level of care for Medicare beneficiaries nationwide. Alternatively, if payments differ among provider types but patient outcomes are equivalent, one could question whether higher cost LTCH services are needed for all types of cases currently treated, or more specifically, which types of patients benefit from the higher cost LTCH services.

Conclusion

Madam Chairman Johnson, Congressman Stark, distinguished Subcommittee members, thank you for inviting me to testify about long-term care hospitals today. The goal of the Medicare program is to ensure the cost-effective delivery of the highest quality of medical services to beneficiaries. CMS looks forward to receiving comments on the proposed rule in order to develop final policy and guide the future of LTCHs appropriately. I will be happy to answer your questions.

Chairman JOHNSON. Thank you, Mr. Kuhn. Mr. Miller?

STATEMENT OF MARK E. MILLER, PH.D., EXECUTIVE DIRECTOR, MEDICARE PAYMENT ADVISORY COMMISSION

Mr. MILLER. Chairman Johnson, Congressman McCrery, I am Mark Miller, Executive Director of the Medicare Payment Advisory

Commission. The facts that Chairman Johnson went through are the same facts that got the attention of the Commission and drove us to look more intensively at long-term care hospitals. As you noted, these are very rapidly growing facilities, 9 percent per year, expenditures in the 25 and 35 percent growth rate. A decade ago, we spent about $400 million on long-term care hospitals, and in 2007 we are expected to spend about $5 billion on long-term care hospitals.

The other points that you made which also drew our attention is that they are not uniformly distributed across the country, and so Medicare beneficiaries receive post-acute care services in certain communities without using long-term care hospitals. All of these facts at least raise questions in the mind of the Commission.

Before I talk about the studies, you both know that there is a prospective payment system that started in 2003. The payment rates for long-term care hospitals are very high relative to inpatient hospitals and relative to skilled nursing facilities, and I will make a point about that in just a second. Under Prospective Payment System (PPS), both the payments and the costs of care have been increasing rapidly since the implementation. However, payments have grown faster than costs; hence, long-term care hospitals are a profitable Medicare service, and we are estimating margins in 2006 of about 8 percent for this industry.

As I mentioned, about a year and a half ago, we did intensive analysis of long-term care hospitals. We did our usual very intensive analysis of data—claims, costs, that type of thing. We did structured interviews of providers in communities to see what role long-term care hospitals played. We also made site visits to the long-term care hospitals and met with the medical staffs of the long-term care hospitals. We took our own physicians along for these discussions so we could have clinically meaningful conversation.

There are a couple of things from that study that I want you both to understand. The first is that in markets where long-term care hospitals are present, you have a shorter hospital length of stay and less use of skilled nursing facilities. Long-term care hospitals substitute for part of the hospital stay and for skilled nursing facility services.

The second thing I want you to get is that if you look at the episode of care, the acute care hospital stay and the post-acute care associated with that for the beneficiary. Just look at expenditures for the Medicare Program, you find that when long-term care hospitals are present, it costs the Medicare Program more. This is an important caveat; if you instead focus on the patients who are most likely to need those services, select a diagnosis and the most severe patients in that diagnosis, you find that long-term care hospitals for that episode of care, when you include long-term care hospitals, it is not significantly different than alternative settings of care.

That fact, coupled with some of the things that we learned in the site visits, the long-term care hospitals told us how they conducted their business, how they conducted the care of the patient. They said things like they have more intensive nursing services, higher presence of physicians on the floor, multidisciplinary teams, things like that. With that information, coupled with what we felt was the

need to target the services to the patients who most need that level of care—we made the recommendations that you are referring, the patient-level characteristics and the facility-level characteristics. The objective is to define the patients who most need this care and to improve the value of the long-term care hospital services to the Medicare Program.

I am not going to go through those criteria in detail, but I am willing to do it in questions if you are interested.

In closing, I just want to say a couple of things. One is that you should not take these recommendations as a blanket endorsement of long-term care hospitals. We see rapid growth in a setting where there are high payments and poorly defined criteria, and any policy analyst is going to look at that and it is going to raise questions in their mind.

The Commission is concerned that the long-term care hospitals not be used solely to reduce the inpatient length of stay, and then, as I have tried to stress throughout all my comments, with these payment rates, to assure that the patient who arrives there truly needs that level of care, and that is the objective of the criteria.

I look forward to your questions.

[The prepared statement of Mr. Miller follows:]

Statement of Mark E. Miller, Ph.D., Executive Director, Medicare Payment Advisory Commission

Chairman Johnson, Ranking Member Stark, distinguished Subcommittee members. I am Mark Miller, executive director of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this afternoon to discuss Medicare payment policy for long-term care hospitals.

Medicare beneficiaries can seek care after a hospitalization in four different post-acute settings: skilled nursing facilities (SNFs), home health agencies (HHAs), long-term care hospitals (LTCHs), and inpatient rehabilitation facilities (IRFs). In addition, in three of these settings patients can be referred directly from the community. Use and spending for these services have grown rapidly since the introduction of new prospective payment systems for them. About 3.7 million beneficiaries used post acute care in 2002. In 2004 Medicare spending for these settings was about $36 billion, accounting for more than 12 percent of total Medicare spending.

The overarching issue in Medicare post-acute care (PAC) is that there are no clear and comprehensive criteria for which of these settings are best for patients with particular characteristics or needs. The recuperation and rehabilitation services provided are important for Medicare beneficiaries. Yet, these settings and their payment systems have developed separately over the years, and it is not clear that together they form an integrated whole that provides the highest quality, most appropriate care for beneficiaries or the best value for the Medicare program and the taxpayers who support it. There is a need for comprehensive payment system reform across all PAC settings. Aligning Medicare payment systems with the patient's needs and characteristics and the quality of the care provided, rather than by type of facility, remains a challenge that will have to be met to get the best value for the Medicare program.

The Commission maintains that in the post-acute care sector, just as for the other sectors of Medicare, the services provided should meet the needs of the beneficiaries, Medicare payments should cover the costs of an efficient provider of those services, and higher quality services should be rewarded. Currently in post-acute care, none of these conditions is fully satisfied.

Long-term care hospitals, the subject of this hearing, illustrate the larger problem in the Medicare post acute care payment systems. Medicare payments to LTCHs have increased rapidly—from $398 million in 1993 to about $3.3 billion in 2004—and continue to rise. CMS estimates LTCH payments will be $5.2 billion in 2007. As shown in Table 1, along with the increase in Medicare spending there has been an increase in the number of LTCHs, the number of cases, and the payment per case. The average length of stay has fallen. Growth has been particularly rapid since the start of the new LTCH prospective payment system (PPS) in 2003. From 2002 to 2004, 71 new facilities entered the program and Medicare payments in-

creased 38 percent in 2004 alone. Medicare is very important to these hospitals, accounting for 73 percent of discharges, on average, in 2004.

TABLE 1 **Growth in number of LTCHs, volume of cases, and Medicare spending**

	2001	2003	2004	Average annual change 2001–2004
Number of LTCHs	273	319	357	9%
Number of cases	86,049	110,509	122,320	12
Medicare spending	$1.7 billion	$2.4 billion	$3.3 billion	25
Payment per case	$22,452	$25,076	$30,180	10
Length of stay (in days)	32.1	29.2	28.7	–4

Note: LTCH (long-term care hospital).

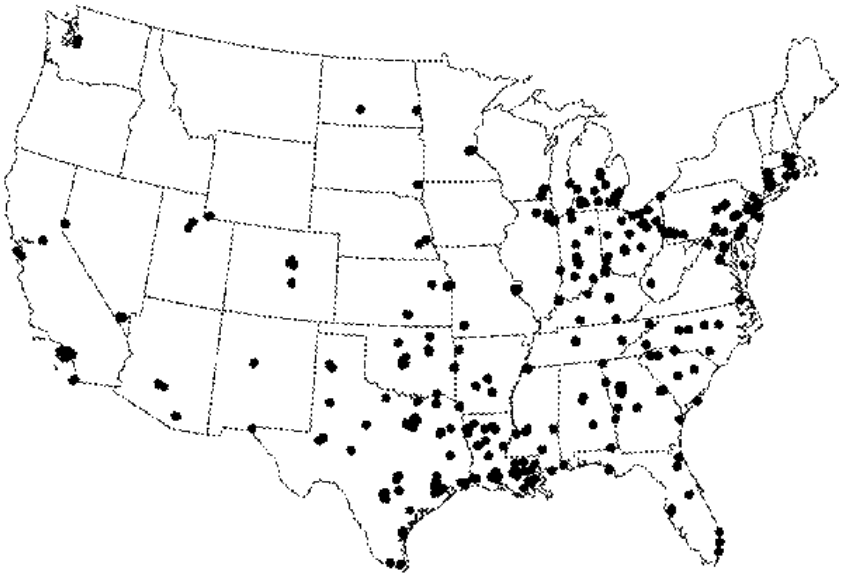
Source: MedPAC analysis of MedPAR data from CMS.

What are long-term care hospitals?

The characteristics of long-term care hospitals vary. Some are converted from former public health hospitals; these tend to be the largest and are concentrated in New England. Others are freestanding but have entered the program more recently. The newest entrants, called "hospitals within hospitals," are collocated with an acute care hospital but have separate ownership and financial arrangements. Hospitals within hospitals (HWHs) are smaller than the older LTCHs. The numbers of HWHs and freestanding LTCHs both increased following implementation of the LTCH PPS in 2003, but the rate of growth in HWHs was more than twice the rate for freestanding LTCHs. Both nonprofit and for-profit long-term care hospitals increased from 2001 to 2004, but nonprofits grew more slowly than for profits. Almost 60 percent of LTCHs are for profit, two-thirds of which are owned by just two chains.

LTCHs are unevenly distributed across the country (Figure 1). Some areas have many LTCHs; other areas have none. As shown in Table 2, the 5 states with the greatest number of LTCH beds per thousand Medicare beneficiaries account for 39 percent of the available beds but only 12 percent of the Medicare beneficiary population. Long-term care hospitals serve a wide mix of patients including ventilator patients, those requiring wound care, and those with respiratory and other infections.

FIGURE 1 **Location of long-term care hospitals**



Source: Online Survey, Certification, and Reporting System from CMS

The regulatory distinction between long-term care hospitals and acute care inpatient hospitals is the length of stay. Long-term care hospitals are certified as hospitals and are intended to treat medically complex patients with long lengths of stay. Medicare requires that the average Medicare length of stay be more than 25 days (the average length of stay in hospitals under the acute care inpatient PPS is approximately 5 days). Cost sharing and coverage follow the acute care hospital rules.

TABLE 2 **LTCH beds are concentrated in a few states in 2004**

	Share of LTCH beds	Share of beneficiaries	Beds per 10,000 FFS beneficiaries
Rhode Island	2.5%	0.3%	56.1
Massachusetts	14.1	2.3	44.5
Louisiana	7.5	1.5	37.0
Texas	11.7	6.4	14.7
Connecticut	2.8	1.4	14.3
Total	38.6	11.9	27.7
Nationwide	100	100	6.7

Note: LTCH (long-term care hospital), FFS (fee-for-service)

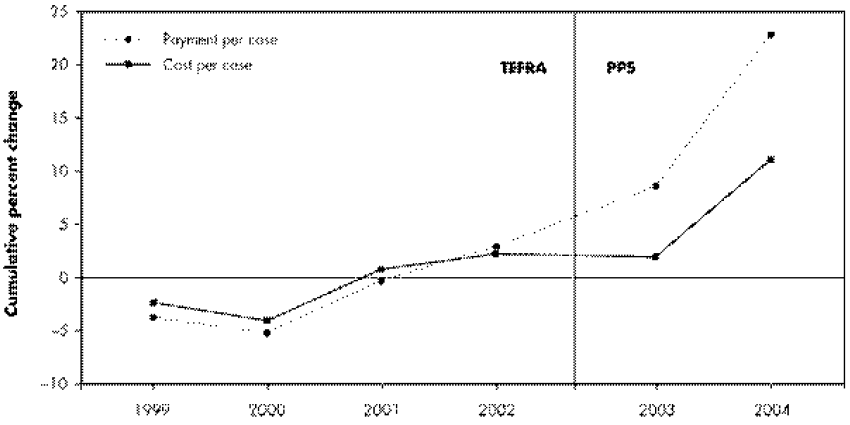
Source: MedPAC analysis of MedPAR data from CMS

Medicare payments to LTCHs

Before October 2002, long-term care hospitals were paid on the basis of their average costs per discharge, subject to an annually adjusted limit calculated for each facility. Since then, under the new PPS, Medicare has paid LTCHs under a prospective payment system based primarily on the patient's diagnosis. Payment rates range from $15,665 to $121,376 for a LTCH in an average wage area. These rates are higher than those hospitals receive under the inpatient PPS and they are also higher than rates for SNFs. In fiscal year 2004, for patients with the most common LTCH diagnoses, Medicare rates for LTCHs ranged from about 3 to almost 12 times as much as estimated rates for SNFs.

Under the previous payment system, the change in payment per case was at or below the change in cost per case (Figure 2). After PPS implementation, payment per case rose rapidly: it increased 5.5 percent in 2003 and 13.2 percent in 2004. The case-mix index (CMI) also appears to be increasing for LTCH patients, but CMS points out that CMI increases are at least partially due to coding improvement with a comparatively larger number of cases being assigned to LTC—DRGs with higher relative weights.

FIGURE 2 Comparison of changes in LTCH payment and cost per case, 1999–2004



Note: LTCH (long-term care hospital), TEFRA (Tax Equity and Fiscal Responsibility Act of 1982), PPS (prospective payment system). Data are from consistent two-year cohorts of LTCHs.

Source: MedPAC analysis of cost reports from CMS.

There was little change (less than—0.1 percent) in the reported cost per case from 2001 to 2003, the first year of PPS. It then increased substantially in the second year of the PPS (by 8.9 percent). More complicated LTCH patients could account for at least part of this increase in cost per case. However, the average length of stay decreased in 2004, which generally would decrease costs. The rapid rate of growth in costs could also be attributable to the rapid rate of increase in payments under the PPS which would have allowed LTCHs to spend more than under the old system.

Even though cost rose after the PPS started, payments outstripped them. Margins rose rapidly as suggested by the increasing difference between payments and costs in Figure 2. Margins reached 9.0 percent in 2004 and we project a margin of 7.8 percent in 2006. The Medicare margin is the difference between Medicare payments and providers' costs, as a percentage of Medicare payments.

In our March 2006 report to the Congress, the Commission assessed the adequacy of payment for long-term care hospitals. We found Medicare payments for LTCH services are more than adequate. The supply of LTCHs, the volume of services, and the number of beneficiaries admitted to LTCHs have all increased rapidly since 2001and access to capital is good. Moreover, Medicare spending for these facilities increased twice as fast as volume. As mentioned, margins are high.

The Commission concluded that long-term care hospitals should be able to accommodate increases in the cost of care in 2007 and recommended that the Congress eliminate the update to payment rates for LTCH services for 2007.

CMS actions

CMS has reacted to the growth in LTCHs and Medicare spending with several regulatory changes. First, CMS established a new policy, the 25 percent rule, which CMS intended to protect the integrity of the inpatient PPS by attempting to ensure that HWHs do not function as hospital-based units of host hospitals. Second, CMS made other changes to increase the accuracy of payments under the new PPS.

LTCHS can substitute for other settings

The Commission undertook extensive quantitative analysis, interviews, and site visits to understand which beneficiaries use LTCH services, what services they otherwise would have used, and what are the costs to Medicare. We found that LTCHs provide post-acute care to a small number of medically complex patients who are more stable than patients in an intensive care unit (ICU) but may still have unresolved underlying complex medical conditions. Many of these patients require ventilator support for respiratory problems, have failure of two or more major organ systems, neuromuscular damage, contagious infections, or complex wounds needing extended care.

Using quantitative analysis, we found that the tendency to use LTCHs is associated with certain diagnoses, severity levels, and the proximity of the facility. Having a diagnosis of tracheostomy is the single strongest predictor of LTCH use. Diagnoses other than tracheostomy also predict long-term care hospital use—respiratory system diagnosis with ventilator support, acute and subacute endocarditis, amputation, skin graft and wound debridement, and osteomyelitis. When we divided each diagnosis into four levels by how severely ill the patient was, those with the highest severity level, regardless of diagnosis, had almost quadruple the probability of LTCH use. Beneficiaries living near an LTCH were more likely to use them, and being in an acute hospital with a HWH quadrupled a beneficiary's probability of using an LTCH.

LTCHs can substitute for both hospital care and post-acute care. LTCHs can substitute for the end of an acute hospital stay. About 80 percent of LTCH Medicare patients are transferred from acute hospitals and patients who use LTCHs have shorter acute hospital lengths of stay than similar patients who do not use these facilities. Freestanding SNFs are the principal post acute alternative to LTCHs. Patients who would be most likely to use LTCHs often use SNFs and when patents use LTCHs the probability of using SNF care declines—suggesting that SNFs and LTCHs are used as substitutes.

In general, patients who use long-term care hospitals are more costly to Medicare than similar patients using alternative settings when we account for payments over an entire episode—that is, including payments in both the acute and post acute settings. However, the cost differences narrow considerably when LTCH care is targeted to very ill patients who are most likely to need and benefit from this level of care.

To better understand which patients most need and can most benefit from the particular capabilities of LTCHs, we undertook site visits and held discussions with LTCH representatives. According to LTCH clinicians, long-term care hospitals:

- frequently use admission criteria to determine whether patients require an LTCH level of care and have sicker patients who are more likely to improve
- have active daily physician involvement with patients
- have licensed nurse staffing of 6 to 10 hours per day per patient (much higher than other post-acute care settings)
- frequently employ specialist registered nurses and employ physical, occupational, speech, and respiratory therapists the latter of whom are available 24 hours per day; and
- have multidisciplinary teams that prepare and carry out treatment plans.

We drew on these observations to help tailor our recommendations.

Commission recommendations

In its June 2004 *Report to the Congress: New Approaches in Medicare*, the Commission recommended that Congress and the Secretary define long-term care hospitals by patient and facility criteria that ensure that patients admitted to these facilities are medically complex and have a good chance of improvement.

- Patient-level criteria should identify specific clinical characteristics and treatment modalities.

- Facility-level criteria should characterize this level of care by features such as staffing, patient evaluation and review processes, and mix of patients.

Medicare should use more precise criteria to ensure that LTCHs treat only appropriate patients. Criteria should describe the level of care required by LTCH patients so that their needs are clearly distinguishable from those of less resource-intensive patients who should be treated in other less costly settings. LTCH criteria should focus, to the extent possible, on patients and their care needs, rather than on facility characteristics.

Patient-level criteria would identify specific clinical characteristics and treatments required by patients cared for in LTCHs. All of these criteria would be intended to ensure that the patients admitted to LTCHs require an intensive level of resources and have a good chance of improvement.

National criteria could be required for both admission and discharge for each of the major categories of patients treated in LTCHs, including respiratory, infectious disease, other medically complex, wound care, ventilator-weaning, and cardiovascular or peripheral vascular patients. Because these criteria would be specific to each of the most common case types, they would need to be as detailed and clinically relevant as possible. Discharge criteria would ensure that patients are medically ready for discharge to less intensive and medically appropriate alternative care settings.

Patient mix and severity criteria are directed toward ensuring that LTCHs treat only medically complex cases. For example, one requirement could be that a high share (e.g., 85 percent) of a facility's patients must be classified into broad diagnosis categories—such as complex medical, complex respiratory, cardiovascular, ventilator-dependent, or extensive wound care—and that a large share (e.g., 85 percent) of an LTCH's patients demonstrate a high level of severity of illness at admission.

Facility-level criteria should delineate features of the care provided in LTCHs. Some examples include a patient evaluation and review process, a patient assessment tool, and the availability of physicians. A standard patient assessment tool would ensure consistency in the assessment process. Though most LTCHs already use assessment tools all facilities should use the same tool that emphasizes clinical and functional assessments of patients. The level of physician availability should be specified. Physicians' presence and their active involvement with patients are key aspects of the care that differentiates long-term care hospitals from SNFs. Also, requiring multidisciplinary teams of professionals, including physicians, to prepare and carry out treatment plans would encourage a team-based focus on patient care.

The 25 day length of stay criterion, the only criterion currently in place for LTCHs, is intended to ensure that patients require a high level of resources. Without other criteria, however, the length of stay criterion does not prevent SNF-level patients from being treated in LTCHs at much higher costs to Medicare. Over time, as patient criteria clearly delineate the types of patients appropriate for treatment in LTCHs, CMS could reevaluate use of this criterion.

A minimum staffing requirement would ensure that LTCHs provide an intensive level of care that is comparable to a step-down unit (from ICU-level care) in a hospital and would be consistent with long-term care hospitals treating medically complex patients who cannot be treated in SNFs.

The Secretary will need to monitor the compliance of LTCHs with facility—and patient-level criteria. Therefore, the Commission also recommended that the Secretary should require the Quality Improvement Organizations (QIOs) to review long-term care hospital admissions for medical necessity and monitor that these facilities are in compliance with defining criteria. A recent QIO medical record review found that 29 percent of 1,400 randomly selected LTCH Medicare admissions in 2004 did not need hospital-level care.

The Commission's recommendation to better target the patients treated in long-term care hospitals should not be taken as a blanket endorsement of LTCHs and their role in the post-acute care continuum. The rapid growth in long-term care hospitals, the opportunities for excess profit, and the fact that patients get care in other settings in markets where LTCHs do not exist all raise concerns for the Commission. The growth and incentives of the HWHs are of particular concern.

Quality

Refinements to the LTCH payment policies should be consistent with Medicare's longer-term goals for payment policy. These goals include improving quality and promoting patient care in the most appropriate and cost-effective setting. Better measures of quality for long-term care hospitals are needed. Additional measures of quality at the hospital-specific level, probably not available from administrative data, may come from the LTCH industry. One association and a large chain report independent efforts to develop quality indicators. If the data for these indicators

were available, CMS might use them to monitor LTCH care. For example, both organizations plan to measure rates of weaning from ventilators, pneumonia contracted while on a ventilator, decubitus ulcers acquired in the LTCH, blood stream inflections, falls, and use of restraints. However, the specific measures for these indicators differ widely between the two organizations. It is a positive step that the industry is starting to develop new quality indicators. However, the next steps that should be taken are CMS involvement, greater validation of the measures, and decisions on a data collection strategy.

Chairman JOHNSON. Do you both agree that we should be moving to a criteria-based system, both patient and facility criteria?

Mr. KUHN. Yes, we do agree with the recommendations MedPAC made in 2004 and agree with your statement, that, yes, I think better classification, better criteria for both facility as well as patients are long overdue here.

Chairman JOHNSON. Dr. Miller, do you agree with that?

Mr. MILLER. Right, it is a recommendation.

Chairman JOHNSON. Well, it seems to me that if you have a criteria-based system that is correct, then that addresses the short-stay issue; that addresses the possibility of an acute care transfer to a long-term care facility that is inappropriate, does it not?

Mr. KUHN. I think it would certainly help us. I don't know whether that gets us to the end game, because, you know, having the classification system is absolutely key, but also payment policy can drive behavior as well. Synching of both the payment policy as well as the classification system are going to be absolutely important components as we go forward.

Chairman JOHNSON. Dr. Miller?

Mr. MILLER. From our point of view, and we said at the end of our report that we think patient and facility criteria were important to define this benefit. Still at the end of the report, and as I tried to do in my opening comments, we think there are still potential concerns and that you might want, even within the payment system, some kinds of adjustments to capture inappropriate behavior. We do think that the criteria are the way to go and should be pushed forward.

Chairman JOHNSON. I would hope that if we had good criteria, we wouldn't have to have artificial additional structures. I see your short-stay policy as the parallel in the long-term care arena to the transfer policy in the acute care. Is that unreasonable?

Mr. KUHN. I think the tools that we have are—or I should say the strongest tool that we have is really payment, and so to deal with the post-acute care policy we had last year and last year's Inpatient Prospective Payment System (IPPS) rule was really designed to make sure that when we had an episode of care and we were paying for an episode of care in the acute care side, we wanted to make sure that we got those full services, and that was to try to prevent premature transfer to some post-acute care facility.

The same holds true here, that we really want to pay accurately for the care that is provided, and so, that is what is driving the proposal that we have before us now with the short-stay outlier policy.

Mr. MILLER. What I would say about that is that if you think about, and I am not sure this is a lot different than what Herb is

saying—If you think about payment systems and you are trying to build these on the basis of average and you build your payment per case around what is happening in the field, in the delivery at that time, just like in IPPS, you still might want to deal with the extreme cases differently in the payment system. You have outlier payments when a case becomes extremely expensive, and similarly, in a system of averages, you might want to address the other end of the distribution when a case is extremely different than what you expected the average to be.

Chairman JOHNSON. Yes, and we did do that in the acute care setting. We addressed both the transfer payment and the outlier issue at the same time, hoping that that would balance out.

This, I see a little differently, because when you define short stay as five-sixths of the mean and you begin to drop off those short stays, you put in place a mathematical system that is sort of inexorable. After you deal with the first set of short-stay patients, and, remember, you can deal with them in a number of ways—You can deal with them in keeping them in the acute care setting or sending them to a nursing home, and those are the ones you are sort of after. You can also deal with them by not accepting certain diagnoses because of the tremendous unpredictability of that patient, and we are going to hear more of that in the next panel. How much do we know about short stays? How predictable is it, how long a patient with this kind of complexity will need to be in the hospital? If you look at the comparison by diagnostic group, between the length of stay in an acute care hospital and the length of stay in a long-term care hospital, it is about 3 days to 1.

There is substantial difference between these patients, and if you lop off the bottom, then the next five-sixths is just going to include more complex patients and so and so up the ladder because it is five-sixths in every diagnostic group. You are going to have five-sixths of the ventilator patients and five-sixths of this and five-sixths of that. Every year you are going to get more and more complex patients. You are going to be moving up the complexity ladder through this automatic system. That is not quite exactly what happened in the acute care sector. This seems to be a far less balanced approach, a far more dangerous approach, and when you look at just the Lewin Study and its prediction in terms of the hospitals that will go from positive to negative margins, almost all of the institutions have positive margins now. One could say the margins are too high, but one could also be very concerned about essentially most of the hospitals going to a negative margin under the new payment method—in fact, all but the category of hospitals of 300 beds or more.

I am concerned not only about the tremendous shift that will take place under this proposal on average, all hospitals going from an average margin of 9.17 percent to an average negative margin of 4.9 percent. That is a huge swing. Institutionally, that is a huge swing. Then, when you look solely at the ones who end up with positive margins are the big institutions, I do not want payment policy to drive bigness. I am worried, terribly worried about the impact of this, and I think it is due to the definition of short stay as being almost all the patients, five-sixths.

What is your view, Mr. Kuhn, in proposing this of its ongoing impact on the existence of LTCHs?

Mr. KUHN. That is a good observation you make, and I think the observations you made there are what we have heard from a lot in the stakeholder community that we hope, we get comments during this open public comment period. I think——

Chairman JOHNSON. Excuse me. I should have asked that question. What did your analysis show before this?

Mr. KUHN. Yes, and I think your point is well taken. These are medically complex patients, and that is the whole point of what we are trying to drive here to make sure that we pay accurately for them.

Let me give you some information here that we have looked at and give you a sense of the ideas of why this proposal is out there. In the acute care setting, the average length of stay is about 5 days, and so if someone stays 4 days, the delta there is not that great in terms of the resources consumption, the activity that is there. If you are looking at these patients where the average length of stay for the facility and the only classification criteria is 25 days or more, and someone is there, presumably, for 30 days, but they are out in 12, that delta is very large, and I think that is something that we have to raise as a big concern about in terms of the order of magnitude here in terms of the dollars, the lengths of stay that we have, and how we are dealing with these short-stay outlier patients.

In LTCHs in 2004, we had about 118,000 cases. Of those cases, 44,000 were short stay. Let me give you a couple of facts about that. Sixty percent of those patients, about 26,000, 27,000, were out in 14 days or less. In fact, 23 percent of them were out in 7 days or less. the point here behind our policy is really trying to say if they are looking at—if they are taking acute care patients, maybe should we be thinking about paying at the acute care rate for these facilities.

Chairman JOHNSON. Well, see, what disturbs me about your policy is it does not focus on 14 days or less.

Mr. KUHN. No. That is right. It looks at the entire short-stay outlier threshold, and——

Chairman JOHNSON. The definition of short stay is not like in acute care, where you have an average Diagnosis-Related Group (DRG) and then short stay is something below average, a certain numbers of days below average. It is five-sixths of the mean.

Mr. KUHN. Right. Again, the point is that many of these are very, very short stay, and I think this is something that as the industry has come in and presented their information—and I will say that they have been very responsible in coming forward with good information. These are the kind of points that we need to have in the notice and comment period that we are in now so we can evaluate, we can analyze as we move forward to a final regulation.

Chairman JOHNSON. As you proposed this, did you make any runs of your information as to what the impact would be? If so, what was your estimate of the impact?

Mr. KUHN. The impact right now for the short-stay outlier policy is about savings of $440 million. It is about 11, 11.4 percent, I believe, reduction in payment.

Chairman JOHNSON. Have we ever proposed for any other provider an 11-percent reduction in a single year?

Mr. KUHN. For institutional providers, I am not aware.

Chairman JOHNSON. I don't remember any reduction of that magnitude. Mr. McCrery?

Mr. MCCRERY. Thank you, Madam Chair. You asked a lot of good questions, and you covered much of what I was going to get into, but let me just probe a little more. The LTCHs are paid on a PPS; is that right?

Mr. KUHN. That is correct.

Mr. MCCRERY. That PPS, I assume, is based on kind of an average length of stay?

Mr. KUHN. Yes, basically there is kind of a parallel system. We have the DRG system that is kind of a charge-based weight system in there, and the LTCH is basically—the LTC. DRGs is basically a very parallel system to that with the same kind of weighting process that goes on. It is based on averages determine the weights, the values for each and every DRG, and then, of course, that is multiplied times the standardized rate.

Mr. MCCRERY. That is why you talked about the delta between the short stays, the outliers, and the average stay in an LTCH.

Mr. KUHN. Yes, to give you a sense of the order of magnitude, right now, I think for the acute care side, the standardized rate is about $4,700; for LTCHs it is $38,000. It is a huge difference. If you have something that is a weight of 1.5 for each one, you can see the dollar differentiation that we have here, and that is why I think it raises a big question for us if we have folks that look like acute care patients. Should they really be treated as acute care patients and not in an LTCH facility?

Mr. MCCRERY. Okay. Well, you know, I think your concern is appropriate, but like the Chair, I would question the methodology of the five-sixths of the mean, because if you achieve the logical result, which would be LTCHs, if they are faced with only getting reimbursed—what the acute care hospital is going to get reimbursed— they are not going to take those patients. Those patients are going to stay in the acute care hospitals. you will reduce the population of the LTCHs, but you are still taking five-sixths of the remaining mean. you see, it just kind of gets smaller and smaller.

I understand what you are trying to get at, and I think it is a legitimate pursuit. Perhaps, the methodology needs to be scrubbed a little. You also made a point a couple times, maybe both of you, about in areas where LTCHs are present, acute care hospital stays are longer. Is that right?

Mr. MILLER. Shorter. Where long-term care hospitals are present, acute care hospital lengths of stay are shorter.

Mr. MCCRERY. Acute care hospital stays are shorter?

Mr. MILLER. Yes, so that, in other words, the presumption here is that someone leaves the hospital earlier and goes to a long-term care hospital.

Mr. MCCRERY. Okay, yes. The opposite is true as well. In areas where LTCHs are not present, the acute care hospital stays are longer. That is what I was trying to get at.

Mr. MILLER. Right, right.

Mr. MCCRERY. Well, duh. I mean, if you don't have an LTCH to send them to and they have these complex problems, I mean, they are going to keep them. They may not be able to treat them as effectively as a LTCH, but there is nowhere else for them to go. I don't see the point of that data, really.

Mr. MILLER. Well, I think what we were driving at, if I understand your question—at least let me get a couple of distinctions in.

Mr. MCCRERY. I may not understand my question either.

Mr. MILLER. No, it is quite all right.

Mr. MCCRERY. We will talk, though.

[Laughter.]

Mr. MILLER. Okay. It is complicated. I mean, what we were going at was, okay, you have markets with and without. When these things present in a market, what happens? Relative to what the average is and what is going on, you know, the secular trends in the data, when these enter the market—what happens is—and it is not just hospitals—skilled nursing facility services go down, and the length of stay in the hospital goes down. What these things seem to be doing is taking the place of a person staying in a hospital for a longer period of time, say in a step-down unit or something like that, or in some communities these people go to skilled nursing facilities; although, I would like to stress there that the ability for a skilled nursing facility to deal with these kind of patients varies, you know, from facility to facility and market to market.

We are just trying to say if these didn't exist, the patient would likely stay in the hospital longer or head to a skilled nursing facility. When they present, that is where you see the changes. Then the reason we were doing all of that was to figure out whether it cost Medicare more or less than if they had just stayed in those settings. That is what we are all driving at.

Mr. MCCRERY. Okay. Well, I think it is clear that if the patient stayed in those settings, it would cost Medicare less because you pay those treatment facilities less than you pay the LTCHs.

Mr. MILLER. If I could just get one—that is what we found, but just one subtlety past that. If you focus on a certain group of patients, patients with certain diagnosis—ventilator dependency, need for wound care, infectious disease, that type of thing, and the most severe of those patients, and then you ask the same set of questions again, the difference in cost is not as great.

Mr. MCCRERY. Yes.

Mr. MILLER. If you focus it on certain patients, then the long-term care hospitals, because you are looking over an episode of care, do not appear to be as expensive relative to other settings.

Mr. KUHN. I would just add the point you are making is kind of part of this overall larger debate of what we are trying to do here in the entire post-acute care. I know that Chairwoman Johnson had a terrific hearing on this last year where we really began to look at thoughtfully, the patient care needs instead of the name of the facility on the door, because right now we pay one rate at one facility, another rate at another facility, but it does not really logically follow what does the patient need and what is the appropriate payment for that patient. So——

Mr. MCCRERY. There is a study underway right now to get at that.

Mr. KUHN. Part of our effort, in fact, in the Deficit Reduction Act (P.L.109–171), you gave us additional authority to go out and do a demonstration in this area and do even more work in this area, and part of these changes that we are talking about here are a logical extension of that and incremental movement in that direction.

Mr. MCCRERY. You are not—my time has expired.

Chairman JOHNSON. That is okay.

Mr. MCCRERY. You are not suggesting then, as an uninformed observer might conclude based on some of your statements, that LTCHs are just not needed?

Mr. KUHN. No, I wouldn't make that statement at all. I think they have a good role, and for those very medically complex patients, they do very good work.

Mr. MCCRERY. If they are needed. If they have a place in our health care system, then it seems to me that this study is going to tell us a lot about who should go to these LTCHs and how much they should be paid. I echo the Chairwoman's comments that maybe we are putting the cart before the horse here in adjusting the payment rates before we complete this study, to get a more complete picture of the appropriate place in our system for these settings.

Mr. KUHN. I think that is a good observation, and we have heard that in comments from the stakeholders in the industry about this. Our thoughts are this: As I indicated earlier, with the short-stay outlier policy that is about $440 million. We will have this RTI study this spring. There is going to be some analysis, discussion with the industry. It may raise additional questions that we have to answer. It could be several years before we are ready to move forward on this, and I think as stewards of the trust fund, the opportunity from things that we have seen in terms of these short-stay patients, we think it is appropriate to go ahead and move forward with this policy. That is why we have proposed it. Again, we are in the comment period, but that is why we proposed it.

I hear what you are saying, and I think that others have raised that as well. From our aspect, it could be a few years before we get to that stage. Meanwhile, we think there is an opportunity, because the only lever that we have is the payment changes to go ahead and make some incremental adjustments here to move forward, and that was the basis of our proposal.

Mr. MCCRERY. Okay, but I would just urge you to scrub your payment proposal a little bit more.

Mr. MILLER. Could I say one thing about that, too? I am also aware of that study, and I think Herb said it here right at the end of his comments, you know, several years. I think there are two ways to think about it. Fortunately, or unfortunately, we have a bunch of silos in our post-acute care systems, and I think the way we think about it is let's try and get that as right as possible while we are trying to get above it and get it right across everything. we would urge that the criteria be thought through here, too, so that you are defining what is happening inside this box. You know, even

though, maybe, we do not want all these separate boxes, but in the short run, that is what we are living with.

Mr. MCCRERY. Okay. Thank you, Madam Chair.

Chairman JOHNSON. Thank you. I am very concerned by your answer, Mr. Kuhn, to Mr. McCrery's inquiry. First of all, the RTI study, which we all look forward to, was actually due January 1, 2005. We had this series of hearings planned, we have others in this series, to look at the criteria in the whole post-acute care arena, not just long-term care hospitals—rehabilitation hospitals, nursing homes, home care—because it isn't just LTCHs that need to have clearer criteria. The whole system needs to have clearer criteria so that you can get over the sort of placement between the different settings, but also guarantee that Medicare patients will have access to the advanced care that they need, depending on their illness and state of physical well-being.

We are behind the wheel on this, but I am very disturbed that you think that it might take you several years to do criteria-based, and that you would be willing to go ahead with this short-stay proposal before that, because I see this as absolutely the old world, blunt instrument. You are going to hear in the panel or your people will hear in the panel, and you saw yesterday the industry is far ahead of you. There are criteria based proposals that we would be better off starting with. If we do a criteria-based proposal, then we will see what portion of this problem of under 14 days is criteria-based and just that you cannot estimate who is going to die or who is going to get well fast and how much of it is actually the patient is in too expensive a setting for that patient's medical needs.

I certainly—if that is what you are thinking, then I do want to have your staff provide me with copies of the runs that your staff did to see what would be the impact of a short-stay proposal you are making, because I want to see if they knew at the time when they came to the 11 percent, because the 11 percent is about what Lewin comes to, too. I want to see did they realize that everybody was going to be negative margins? Did they realize that the average margin in the South was going to go from plus 7 to minus 7 and that 78 percent of the providers were going to have negative margins? That is just in the South.

In the Midwest and in the North, 55 percent, 56 percent would have negative margins; 52 percent would have negative margins. I am not interested in a system that treats people as complex and sick as these people are, needing as many services and as many physicians available to them.

I want to see those runs because I want to see exactly what your people thought you were doing, not just in terms of how much money you were going to save, but what was going to be the impact on the provider community.

The last comment. This mechanistic issue is a big issue because the five-sixths 1 year is going to be five-sixths—somebody whose normal DRG is 65 days, and they got 55, or whatever five-sixths is. That is a lot of time. If you pay them at an acute care rate, you don't even pay short stays in an acute care hospital, an acute care day rate. You pay them double the first day. To go from the acute care setting to a long-term care setting and propose that you pay an acute care rate, I mean, that worries me. It worries me that this

project is not only a very blunt instrument, but the lowest ball on the totem pole. I can't tell you any comparable experience that I have had, and I have been serving on this Committee since, I don't know,1979 or something.

I do want to see the work sheets and know how you got here because this isn't where I am interested in going myself. I am interested in going to a criteria-based system, and you will hear both sides, both the big national chains and the smaller nonprofits, have done an enormous amount of work and are ready to hand you a criteria-based system. With a year's experience with that, then we could see what is the real honest short-stay problem.

Mr. KUHN. We would be happy to give you all the impacts that we have in the regulation and any others that would help you understand kind of our analysis and what we did.

Chairman JOHNSON. It is the analysis that I am interested in understanding.

Mr. KUHN. You bet.

Chairman JOHNSON. Thank you. Thank you very much. Anything else?

Mr. MCCRERY. No.

Chairman JOHNSON. Thank you very much. We will start with the next panel.

Chairman JOHNSON. Welcome, Mr. Altman. Will you proceed, please?

STATEMENT OF WILLIAM M. ALTMAN, SENIOR VICE PRESIDENT, KINDRED HEALTHCARE, LOUISVILLE, KENTUCKY

Mr. ALTMAN. Good afternoon, Chairman Johnson, Mr. McCrery. Thank you for the opportunity to address the Subcommittee on the role of long-term care hospitals in the health care continuum.

My name is Bill Altman, and I serve as senior VP of Compliance and Government Programs for Kindred Healthcare. As you noted in your introductory remarks, Kindred has a diverse set of post-acute services ranging from long-term acute care hospitals, nursing facilities, rehabilitation services, and pharmacy services, and we operate in over 40 States. I am also here on behalf of the Acute Long Term Hospital Association, ALTHA, which is the trade association for LTCHs. It represents over 60 percent of LTCHs nationwide.

In the time that I have, I want to basically address three issues. First of all, I want to talk about the role of LTCHs in the health care continuum, but in the broader context of the deliberations of the Subcommittee and MedPAC about the entire post-acute space in an attempt to rationalize it. Then, I want to amplify a little bit on your comments about the impact of this proposed CMS policy on LTCHs. Then, I want to talk specifically about why the CMS policy proposal is flawed.

With respect to the role of LTCHs, let me be clear. Kindred and ALTHA support the Committee's initiatives to make sure that Medicare beneficiaries are placed in the most appropriate setting and that the payments are designed first and foremost based on the clinical needs of the patients and the intensity of the services they provide. Simply put, the proper role for LTCHs, as we have consistently told this Committee, MedPAC, and CMS, is to treat

the small number of medically complex, severely ill patients that require the intense unique services that LTCHs provide. As you noted, we have put proposals forth that would specifically be designed to ensure that that is the proper role of LTCHs.

Now, unfortunately, as you pointed out, CMS has not reciprocated our overtures to them in terms of pursuing this shared policy goal, and they have resorted to the blunt payment approach that you talked about. I applaud you for asking for the data that they relied on and the impact analysis. We have asked for the same data. We have also asked for data on severity of illness of the patients, both among the short-stay outliers and the rest of the LTCH patients, and, frankly, we have not received that. We have done our own analysis, and I want to talk a little bit about that.

Before I do, I do want to talk a little bit more about the impact and put it in the context of total Medicare spending. As you noted, despite growth, LTCH spending from Medicare amounts to around 1 percent, and it has been consistent over time, and that is an important contextual piece to understand the increase in LTCH spending.

I would also note, to digress for a moment here, that since the implementation of the Hospitals In Hospitals (HIH) rule, we have seen a significant decline in the number of new LTCHs opening. This is based on CMS' own data, and I am not quite sure where CMS gets its information from to assert that we are seeing continued growth in LTCHs, particularly among free-standing LTCHs, which is primarily what Kindred does, because in 2005, according to CMS's own data, we saw a dramatic decline in the number of HIHs that were started, and that is when the HIH rule really hasn't gone fully into effect. It is phased in over a number of years. We saw one fewer—ten—new free-standing LTCHs that achieved provider numbers in 2005, and that is compared with eleven the year prior. I am not quite sure where CMS gets its information to suggest that we are continuing to see rapid growth.

I think the HIH rule has begun to take hold, and we support rational growth limited to LTCHs treating medically complex, severely ill patients, and I think we are beginning to see that. Certification criteria will achieve that in a much more direct way. We don't think it should take 2 to 3 years. MedPAC made their recommendation in 2004, and we are ready to go, and we want to work with this Committee and CMS to see proper certification criteria put in place.

The other thing I want to emphasize is that as a percentage of what the Administration has proposed in terms of Medicare savings; although LTCHs only represent 1 percent of total Medicare spending, in fiscal year 2000 this rule alone accounts for 10 percent of the savings proposed by the Administration. We think that is disproportionate.

Let me jump right to the short-stay outlier policy. It has been described and you have pointed out some of the logical flaws and the actual flaws in it and questioned some of the data. Let me just walk very quickly through four assumptions that CMS has made in justifying their policy and point out through their own data why it is flawed.

First of all, CMS makes the assumption that LTCH short-stay patients—and as you pointed out, many of these patients are not short-stay. They have a very long length of stay relative to other patients. They make the assumption that those patients are clinically similar to patients in the short-term acute care hospital and that is the rate that they want to pay. That is not accurate.

We took their same data, the MedPAR data, and assigned severity of illness ratings to all LTCH patients, short-stay LTCH patients, and compared them with the short-term acute care hospital patients. What we see is two things: First of all, there is really no difference between the short-stay LTCH patients and the regular LTCH patients in terms of their severity of illness. The second thing we see is that almost twice as many short-stay LTCH patients are in the highest severity of illness categories as compared to the short-term hospital world.

Now, that has significant implications not only for payment. It is easy to see why the payment shortfall exists that you pointed out and the negative margins that Kindred, too, will experience as a result of this rule. It is also important to know that when the patient comes to us, they look basically the same. We do not know whether they are going to be short stay or long stay or very long stay. Many are very long stay, high-cost outliers. that is the first assumption that is actually false based on the data from MedPAR database, Medicare's own data, with respect to severity of illness.

The second assumption that CMS makes is that the short-stay patients, just by virtue of their label of short stay, as you pointed out, Mrs. Johnson, they have a similar length of stay to the short-term acute care hospital patient. We also know that that isn't true. Even the short-stay patients have an average length of stay of almost 13 days, and that is based on the five-sixths threshold. That compares with an average length of stay in the short-term hospital world of just over 5 days.

It is easy to see when you put those two pieces of information together—the high severity of illness and the long length of stay—why there is such a significant payment shortfall and why it is inappropriate to use the short-term hospital rate.

The third assumption that you pointed out, Mrs. Johnson, is that LTCHs can predict in advance who is going to be short stay, who is going to be normal stay, who is going to be long stay, and, more importantly, what the clinical outcome is going to be of those patients when they come to us. With this medically complex population, it is impossible to predict, particularly who is going to be successfully treated and live or die. Many of these patients, as it has been pointed out, are dependent on ventilators for breathing, and the science is not there in terms of being able to predict who is going to successfully wean from that ventilator. That is a big assumption made in this proposed rule, that we can actually change our behavior. We will just not admit short-stay patients. The physicians who make the discharge decisions and the admission decisions are unable to predict in advance, and I would argue should not predict before the full course of care is attempted and completed in the LTCH.

Finally, the last assumption, as you pointed out, is that the 37 percent of cases that happen to fall in by CMS' own definition as

short-stay outliers is too high and that we can do something about it. Mrs. Johnson, you have pointed out the mathematical inevitability of that statistic, but I would add one thing to that, and that is, there is a built-in disincentive for LTCHs to knowingly admit patients who are going to be short-stay. If we do that on a routine basis, we are no longer going to qualify as an LTCH under the current criteria, the 25-day length of stay. You will notice from our proposal for certification criteria, we are actually recommending that we retain the 25-day length of stay as a requirement and put on top of that patient and facility criteria. That is one of the reasons, because we do think LTCHs are appropriate for the longer-stay patient on average, as you have pointed out.

I would just conclude by saying that I think that the—we do believe that the policy proposal is excessive. It results in negative margins. We have not been able to find the data to support it based on their own data or what we have asked for, which they have not given it to us, and I think that that is a very problematic. Again, we think that certification criteria would address the legitimate policy issues that have been raised and would address patient placement, growth, and margin, and I have to end by saying that the thing that is most disturbing to me about the rule is the lack of discussion about quality. We have provided a lot of data about the quality outcomes we achieve, and the New York Times article that referenced the critical shortage of ventilators in this country in the event of a bird flu epidemic is more proof of the needed role of LTCHs in our health care continuum.

Thank you very much.

[The prepared statement of Mr. Altman follows:]

Statement of William M. Altman, Senior Vice President, Kindred Healthcare, Louisville, KY

Good afternoon Chairman Johnson, Ranking Member Stark and members of this Subcommittee. Thank you for the opportunity to comment on the role of Long Term Acute Care Hospitals (LTCHs) in the health care continuum.

My name is Bill Altman and I serve as Senior Vice President of Compliance and Government Programs for Kindred Healthcare, which is based in Louisville, Kentucky. Kindred is a leading provider of diversified long term care services, with 78 Long Term Acute Care Hospitals, 248 skilled nursing facilities, and several assisted living facilities providing services in 40 states. We also provide contract rehabilitation and pharmacy services to hospitals, nursing centers, outpatient centers and assisted living facilities nationwide. I am also testifying as Chair of the Public Policy Committee for the Acute Long Term Hospital Association (ALTHA), the association representing over two-thirds of LTCHs nationwide.

We are grateful for the opportunity to testify about a recent rule proposed by CMS that reduces payments to LTCHs to a point where care is jeopardized for the critically ill Medicare patients LTCHs serve. But first I would like to make a few comments on the broader context of the Subcommittee's discussions about the role of LTCHs in the health care continuum and your efforts to promote a rational policy for the post-acute sector.

Kindred is uniquely situated to assist policymakers to define the proper role of LTCHs in relation to other providers such as SNFs, Inpatient Rehabilitation Facilities, Hospice and Home Health because of the diversity of our service lines. Let me be clear from the start—Kindred and ALTHA support the Subcommittee's initiatives to make sure that Medicare beneficiaries are placed in the most appropriate setting and that Medicare payments are based first and foremost on the needs of patients. Simply put, the proper role for LTCHs is to treat the small number of medically complex, severely ill Medicare beneficiaries who can benefit from the unique set of intensive services that only LTCHs are equipped to provide. To support this policy goal, ALTHA testified before this Subcommittee in June of 2005 and expressed our support for a range of policies related to post-acute care. Specifically, we rec-

ommended four guiding principles we believe policymakers should follow in this area:

1. First, policy should seek clearer definitions of the distinct role of each post-acute provider, while recognizing that a certain amount of overlap is inevitable and necessary to ensure continuity of care across settings;
2. Second, policy should explore development of a unified post-acute assessment instrument. Development of such an instrument is an important prerequisite to deciding appropriate patient placement, coordinating care, and possibly determining appropriate payment;
3. Third, consistent with MedPAC's recommendations, patients should be cared and paid for in the most appropriate setting, based on an objective evaluation of clinical characteristics, needs and resource intensity. Patients who can be safely and effectively cared for in SNFs should not be treated and paid for in LTCHs or IRFs. Likewise, severely ill, medically complex patients should have access to the intensive set of services only available in LTCHs;
4. Fourth, also consistent with MedPAC's recommendations, policy should require not only that patients be placed in the appropriate setting, but that providers have the capacity to meet the needs of patients, in terms of staffing levels, staff skill mix, availability of diagnostic tests, sophistication of technology and intensity of service.

Chairman Johnson, as we have discussed with you and your staff, Kindred has begun our own work in developing tools to evaluate patients for the purposes of making appropriate decisions about placement and care planning. And ALTHA has put forth specific policy proposals to refine the current LTCH certification criteria to help ensure that LTCHs admit, treat and get paid for medically complex Medicare beneficiaries. These are critical steps towards rationalizing the entire post-acute sector and we stand ready to work with policymakers through demonstration projects or joint research studies to advance policy in this area.

Unfortunately, all of our attempts to work with CMS toward these shared policy goals have not been reciprocated. Instead, CMS has resorted to the bluntest of policy approaches—draconian payment cuts at unprecedented levels—with little to no transparent data and without even considering other mechanisms that this Subcommittee and MedPAC have consistently endorsed. More troubling, CMS has taken these actions without even discussing their proposals with other branches of government or the LTCH provider community. Nor has CMS analyzed the mass of data readily available to it showing the defects in its policy. Our repeated requests for the data they did rely on have gone unanswered.

Impact of CMS Proposal

As you heard from earlier testimony, CMS proposes not only to freeze LTCH rates by holding the LTCH market basket update to zero, they propose cutting rates an additional 11.1% by applying a policy that assumes, wrongly, that some 40% of LTCH patients whose length of stay is shorter than the average for all LTCH patients should have never been admitted to the LTCH in the first place. Last Friday, ALTHA submitted comments to CMS detailing why this policy is flawed, and we have provided these comments to the Subcommittee as part of our written testimony.

Before summarizing why CMS's policy proposal is wrong, I urge the Subcommittee to evaluate it in the context of total Medicare spending and the recent deliberations in Congress about Medicare savings. Despite recent growth in the number of LTCHs, LTCHs still represent only about 1% of total Medicare spending. Specifically, in 2005, Medicare spending on LTCHs represented just 1.3% of total Medicare spending. Yet, in the Administration's budget, which proposes an addition $36 billion in Medicare savings over the next 5 years, over 7% of proposed Medicare savings comes from the LTCH rule we are discussing today. In fiscal year 2007 alone, over 10% of the proposed savings comes from LTCHs. This level of cuts is disproportionate to the share of Medicare attributable to LTCHs. It is important for the Subcommittee to understand that these LTCH cuts would be imposed by regulation—unlike other parts of the proposed Budget, no Congressional action is needed or requested for these cuts to take effect on July 1st of this year.

It is not surprising therefore that CMS's proposal violates the threshold principle that Medicare payment systems should at least attempt to cover costs. On the contrary, CMS's proposal fails to cover the costs that LTCHs incur in caring for Medicare's most medically complex beneficiaries. For Kindred, CMS proposes to pay rates in the upcoming rate year that fall short of our actual costs by 6.2%. Revenue shortfalls of this magnitude cannot help but call into question our ability to continue to provide the level and intensity of service our patients expect and deserve.

CMS Policy on "Short Stay Outlier" Patients is Flawed

The major reason that CMS's proposal cuts rates so significantly is the way it proposes to pay for so-called "short stay outlier" patients. As you know, LTCH payments are divided into 3 categories: 1) Normal DRG payment for patients whose length of stay is about average; 2) High Cost Outlier payments for patients with usually high and unpredictable costs of care—those whose length of stay is longer than average; and 3) Short Stay Outlier payments for patients whose length of stay is shorter than average.

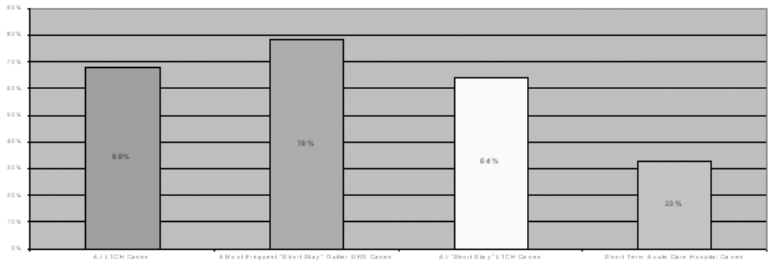
It is important to understand what a short stay outlier patient is, and what it is not, to understand why CMS's policy is flawed. CMS defines "short stay outliers" as those patients with lengths of stay less than 5/6ths of the mean length of stay for all patients in the same diagnostic category (i.e., DRG). Each DRG has its own length of stay and, not surprisingly, patients in those DRGs have different lengths of stay resulting in an average length of stay for all patients. For example, the average length of stay for the most common LTCH patient, those dependent on mechanical ventilators for breathing, is about 34 days. The threshold for defining these patients as "short stay" is 5/6ths of the mean, or 28.5 days. So an LTCH could successfully wean a patient from the ventilator in 26 days, send the patient home, and that patient would be defined as a "short stay outlier." Likewise, weaning attempts could fail and the patient, with family support, could decide to terminate life support before reaching the average length of stay. The average length of stay for all "short stay" patients is just under 13 days, almost 3 times as long as the 5-day average length of stay for all patients in a short-term acute care hospital.

CMS now proposes to pay for these "short stay" outlier patients at rates that are equivalent to what short-term community hospitals are paid for patients in the same diagnostic categories. CMS assumes—wrongly— that the patients in these two settings are clinically similar and therefore require the same level of resources and cost the same to treat. In fact, CMS's own data, which it failed to consider in formulating the policy, shows the opposite—LTCH patients in the same diagnostic categories are much sicker and have much longer lengths of stay than patients in short-term acute care hospitals. This is true even for so-called "short stay outlier" patients in LTCHs. In fact, short stay outlier patients in LTCHs are really no different from other LTCH patients in terms of how sick they are, their risk of mortality and their major diagnostic categories.

The following graph shows the percentage of patients that are classified in the highest severity of illness categories for all LTCH patients, "short stay" LTCH patients, and short-term acute care hospital patients. I want to re-emphasize that these data come from CMS's own database—MedPAR—and CMS could have done the same analysis to evaluate the appropriateness of its proposed policy. The graph shows that LTCH patients are much sicker than equivalent short-term acute care hospital patients in the same diagnostic categories. Even "short-stay" outlier LTCH patients are sicker—in fact, nearly twice as many short stay LTCH patients are in the highest severity of illness categories. Equally important, shorter stay LTCH patients are really no different than other LTCH patients in terms of how severely ill they are.

Figure 1: LTCH Patients are Much Sicker than Average Short Term Hospital Patients

Percentage of Patients in the highest APR-DRG "Severity of Illness" Categories



*Source: MedPAR 2004
*Severity of Illness from APR-DRG Methodology

Likewise, LTCH patients—even so-called "short stay" patients—have much longer lengths of stay than do equivalent short-term acute care hospital patients. Table One shows that, on average, LTCH patients have a length of stay of about 27 days, "short stay" patients have a length of stay just under 13 days, and Short-Term Acute Care Hospital patients have lengths of stay of just over 5 days.

TABLE 1

LTCH DRG	Description	LTCH Short Stay Average Length of Stay	Short-Term Hospital Length of Stay
475	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	13.0	8.0
87	PULMONARY EDEMA & RESPIRATORY FAILURE	13.0	4.9
88	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	9.8	4.1
271	SKIN ULCERS	13.0	5.5
89	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	10.1	4.8
	All DRGs (weighted by case frequency)	12.7	5.6

The combined effects of higher severity of illness and longer lengths of stay explains why CMS's policy is flawed and results in such significant payment shortfalls. Simply put, patients who are, on average, more severely ill and have longer lengths of stay are more costly to care for. Prospective payment systems produce rates based on these averages. Use of a prospective payment system for short term hospitals, based on one set of averages, will never produce rates that are adequate for the LTCH prospective payment system, which is based on another set of averages.

Consider the example I mentioned above regarding patients dependent on ventilators. The payment rate for LTCHs for a ventilator dependent patient assumes that the patient will stay in the LTCH 34 days, on average. Even "short stay" patients stay, on average, 13 days. Under CMS's proposed rule the LTCH would receive the short term hospital payment rate for all patients who stay less than 28 days—the threshold for defining "short stay"—when the average ventilator dependent patient in the short term acute care hospital stays only 8 days. The perverse effect of CMS's policy is to penalize LTCHs who admit and treat the most medically complex patients who happen to be defined as "short stay" under CMS's own rules.

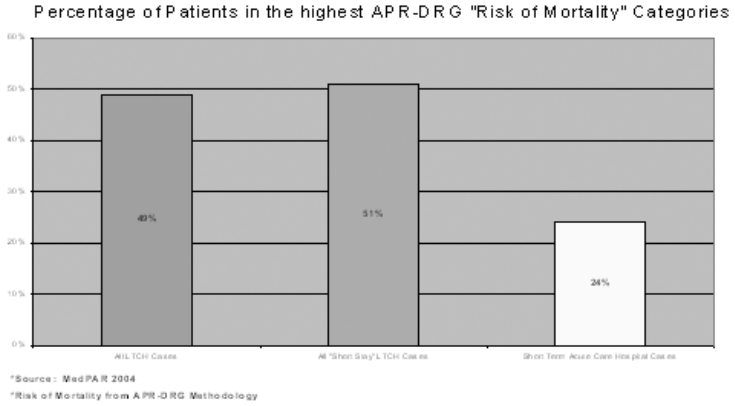
HHS had it right in 1982 when it told this Subcommittee that paying LTCHs (and other exempt hospitals) under a short-term hospital DRG system would be inappropriate because the system "was not designed to account for [the] types of treatment" found in these hospitals and therefore "would be inaccurate and unfair" (August 31, 2002 Federal Register, Vol. 67, No. 169, p. 55957). Congress had it right in 1983 when it exempted LTCHs because "the DRG system was developed for short-term acute care hospitals and as currently constructed does not adequately take into account special circumstances of diagnoses requiring longer stays." Report of the Committee on Ways and Means, U.S. House of Representatives, to Accompany HR 1900, H.R. Rept. No. 98–25, at 141 (1983). And CMS had it right in 2002 when it first developed the LTCH-specific DRG system at Congress' direction and stated that the short-term hospital system could "systematically underpay" LTCHs "if the same DRG system were applied to them." (August 31, 2002 Federal Register).

Without any data analysis, CMS justifies its proposed policy by making a number of assumptions, each of which is without substance. First, CMS asserts that LTCH patients who stay shorter than the average did not complete their course of care in the short-term acute care hospital and have been discharged too early. Yet, CMS's own data shows that patients discharged to an LTCH had prior lengths of stay in a short-term acute care hospital of over 13 days, nearly 3 times the average length of stay of just over 5 days for all other patients. So there is no evidence that short-term hospitals are discharging medically complex patients to LTCHs earlier than is clinically appropriate.

CMS next assumes that LTCHs can predict—in advance—how long patients will stay and what the clinical outcome of their care will be. This assumption is particularly troubling because it is very difficult to predict length of stay or clinical outcome with the medically complex patient population that LTCHs typically treat. As I noted above, shorter stay LTCH patients are no different than the average LTCH patient in terms of severity of illness, making it even more difficult for LTCH physicians to distinguish between patients whose length of stay may be shorter than average. I would also note that a certain percentage of these medically complex patients expire during their LTCH stay, some shortly after admission. Here again,

LTCH physicians cannot predict in advance with any accuracy whether or when patients may expire. In fact, the "risk of mortality" for short stay patients is virtually identical to the average LTCH patient.

Figure 2: LTCH Patients Have a Higher "Risk of Mortality" than Average Short Term Hospital Patients



Finally, CMS asserts that because 37% of LTCH cases are defined as "short stay" outliers, then LTCHs somehow must be engaged in admission practices that are inappropriate. But the percentage of short stay cases is determined by CMS's own rules and it is not surprising that about half of all patients have lengths of stay below the mean of all patients—it's simply proving the law of averages. When the same definition is applied to short-term acute care hospitals, over 40% of cases are likewise defined as "short stay," a statistic that is understandable given the definitions used by CMS. And even assuming LTCHs could predict length of stay or clinical outcome in advance, there is a built-in disincentive against LTCHs admitting patients whose length of stay might be short. If they routinely admit short stay patients, LTCHs risk losing LTCH certification status because they will no longer be able to meet the 25-day length of stay threshold for qualifying as an LTCH.

Conclusion and Recommendations

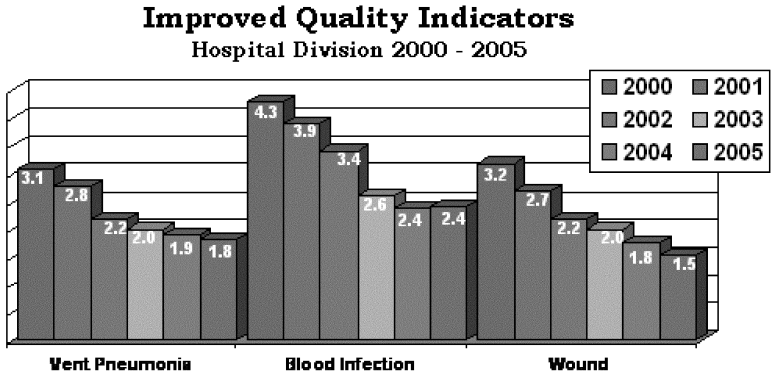
As I noted at the outset, this Subcommittee and MedPAC have raised legitimate issues regarding the proper role of LTCHs in the health care continuum, appropriate patient placement and recent LTCH growth. Kindred, in partnership with other ALTHA members, have developed specific policy alternatives designed to define an appropriate role for LTCHs. An inevitable byproduct of this work will be to ensure appropriate patient placement and limit growth. Specifically, we fundamentally agree with MedPAC's recommendation and this Subcommittee's endorsement that LTCH certification criteria should be refined to ensure that medically complex, severely ill patients are admitted to LTCHs. We have provided MedPAC and this Subcommittee the details of this proposal. We also provided a copy to CMS months ago, but have yet to receive any kind of response. Certification criteria, not draconian payment cuts, are the appropriate policy response to the LTCH policy issues we've been discussing today.

We also recommended to CMS in our comments a variety of non-payment approaches to address the policy issues they perceive to exist with shorter stay patients. For example, pre-admission physician certification of the need for LTCH services, coupled with post-hoc reviews of medical necessity as called for by MedPAC, would address the concerns raised by CMS. Similarly, ALTHA has long-encouraged CMS, as has MedPAC, to adopt uniform admission screening criteria to ensure the appropriateness of LTCH admissions. Many LTCH providers and Quality Improvement Organizations (QIOs) use such screening tools, but CMS has yet to standardize their use.

Finally, in our comment letter we have also encouraged CMS to adopt a more targeted approach to addressing its concerns about shorter stay patients, rather than

resorting to across the board dramatic payment cuts. While we generally oppose use of the payment system to address the issues raised, CMS could easily target payment reform to "very short stay" patients and avoid the damage caused by the proposed rule.

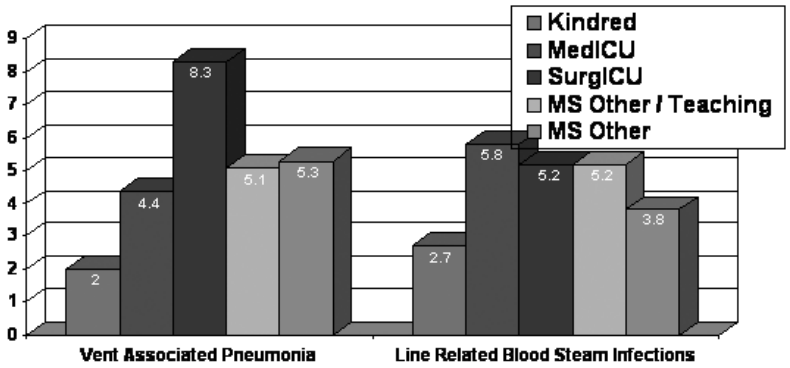
I would be remiss if I did not close today by sharing with the Subcommittee the importance of what LTCHs do in terms of quality outcomes. Perhaps most disappointing about CMS's proposed rule is the lack of any discussion about quality or any analysis about the impact of the payment reforms on access or quality. Kindred is very proud of the quality outcomes we have been able to achieve over the last several years in key areas of importance to the medically complex patients we treat. These outcomes were not achieved by chance—our strategic quality plan has systematically improved outcomes in key clinical areas such as ventilator associated pneumonia rates, blood stream infection rates, customer satisfaction, and ventilator weaning ratios.



* Internal Kindred Data, Rates Per 1,000 Patient Days

Based on available data, our clinical outcomes exceed those in other settings.

*Kindred Complication Rates are Less than Other Health Care Settings**



* National Nosocomial Infection Surveillance (NNIS) (2003)

Internal Kindred Data, Rates Per 1,000 Patient Days

Just this last Sunday the New York Times reported a critical shortage of available ventilators should the bird flu pandemic reach the United States. LTCHs are a vital part of our nation's already fragile infrastructure for complex respiratory care. CMS's proposed rule would deal a significant blow to this infrastructure. We look forward to working with the Subcommittee, MedPAC, CMS and others to implement policy reforms for LTCHs and other post-acute providers that balance fiscal responsibility with access to critical care.

Thank you again for the opportunity to testify and I would be happy to answer any questions you have.

Chairman JOHNSON. Thank you. Ms. Moore?

STATEMENT OF LAURA N. MOORE, VICE PRESIDENT, STRATEGY AND OPERATIONS, MASSPRO, WALTHAM, MASSACHUSETTS

Ms. MOORE. Chairwoman Johnson, Congressman McCrery, and Congressman Pomeroy, I would first like to thank you for allowing me to address you today. My name is Laura Moore, and I am the Vice President of Strategy and Operations for MassPRO, the quality improvement organization, also known as the QIO, for Massachusetts. I am here today to provide some information related to the use of patient criteria for long-term hospital patients. My discussion will center on screening criteria to evaluate whether beneficiaries being treated in the long-term care hospitals specifically need the level of care that these hospitals provide. As a representative of the QIO community, my role and the basis of expertise that I can provide to this Committee is related to the patient-centered and evidence-based assessment that we practice in our case review efforts, rather than the financial aspects of the process, since QIOs are quality/performance improvement, not payment, organizations.

As a QIO, MassPRO has significant experience with assessing the importance of employing the right criteria to ensure the appropriateness of both the admission and the continued stay. More particular to our testimony today, our nurse reviewers perform case review under contracts with the Centers for Medicare and Medicaid Services—CMS—one of the statutory requirements for federally designated QIOs, as well as our State Office of Medicaid.

In addition to the case review role, MassPRO has significant experience with long-term care hospitals because of several targeted projects we have worked on. For example, MassPRO was contracted by CMS to develop the written manual of policies and procedures that the QIOs use to ensure consistency and standardization in the review process. In addition, CMS used MassPRO's technical expertise in this arena to train other QIOs on several fronts, including: what the overall environment in the long-term care hospital setting encompasses; how to conduct outreach and educate long-term care hospitals on the QIO case review process; and how to explain the expectations within the—and at the time that we were doing this the new—prospective payment system, PPS, to long-term care hospital providers.

By introducing this new program with consistent materials, CMS promoted consistent and standard review practices. The only aspect of the program that was—and still is today—not standardized is the use of screening criteria. As with criteria for all case reviews, CMS neither requires not promotes the use of a single set.

In addition, MassPRO is currently working with the National Association of Long Term Care Hospitals, NALTH, in its effort to modernize patient-level screening criteria for the long-term care hospital industry. We are assessing NALTH's five sets of screening criteria to ensure that severity of illness and intensity of treatment

are appropriate and valid. Although the effort is still in process, 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.

An example of our experience with long-term care hospital providers in Massachusetts is as follows: since August 2005, MassPRO has reviewed 75 long-term care hospital cases, including 12 each from two different facilities and 11 cases involving respiratory DRGs. Our review process enables case reviewers to begin to see patterns of practice and perhaps trends, even in the relatively small number referenced above. When a patient is discharged in fewer days than the SSO threshold, it will be for one of three reasons, other than the death of the patient: one, the expertise of the hospital, therefore, the patient improves and gets better; circumvention of the rules by the providers, for example, multiple transfers; or, three, the reality that the patient should not have been admitted to the hospital in the first place.

In its report to Congress in June 2004, MedPAC reported, "In general beneficiaries treated in long-term care hospitals cost Medicare more than patients treated in alternative settings; however, if long-term care hospital care is better targeted to those patients who appear to be most suitable for long-term care hospital care, the costs to Medicare are more comparable." MedPAC, therefore, recommended "patient-level criteria should identify specific clinical characteristics and treatment modalities."

We believe and are in agreement with the MedPAC report that many problems with PPS for long-term care hospitals can be reduced through efforts to develop screening criteria that will improve the appropriateness of admissions and continued stay.

By having a standard criteria set, long-term care hospitals will reduce the number of inappropriate admissions. In its June 2003 report, MedPAC asserted, and MassPRO agrees, that "if care shifts among settings, it should occur for clinical reasons and not because of different payment rates or the profitability of specific settings of care." By having specific criteria in place, only those patients who should be admitted to long-term care hospital will be.

Thank you again for letting me talk with you today, and I would be happy to answer any questions.

[The prepared statement of Ms. Moore follows:]

Statement of Laura N. Moore, Vice President, Strategy and Operations, MassPRO, Waltham, MA

Chairwoman Johnson, Ranking member Stark and the members of the Subcommittee, I would like to thank you for allowing me to address your committee today. My name is Laura Moore, and I am Vice President of Strategy and Operations at MassPRO, the Quality Improvement Organization (QIO) for the Commonwealth of Massachusetts. I am here today to provide some information related to the use of patient level criteria for Long Term Care Hospital (LTCH) patients. My discussion will center on screening criteria to evaluate whether beneficiaries being treated in LTCHs specifically need the level of care that these hospitals provide. As a representative of the QIO community, my role and the basis of expertise that I can provide to this committee is related to the patient-centered and evidence-based assessment we practice in our case review efforts, rather than the financial aspects

of the process, since QIOs are quality/performance improvement, not payment, organizations.

As a QIO, MassPRO has significant experience with assessing the importance of employing the right criteria to ensure the appropriateness of both the admission and the continued stay. More particular to our testimony today, our nurse reviewers perform case review under contracts with the Centers for Medicare and Medicaid Services (CMS), one of the statutory requirements for federally designated QIOs, as well as our state Office of Medicaid.

In addition to the case review role, MassPRO has significant experience with LTCHs because of several targeted projects. For example, MassPRO was contracted by CMS to develop the written manual of policies and procedures that the QIOs use to ensure consistency and standardization in the review process. In addition, CMS used MassPRO's technical expertise in this arena to train other QIOs on several fronts including: what the overall environment in the LTCH setting encompasses; how to conduct outreach and educate LTCHs on the QIO case review process; and how to explain the expectations within the (then new) Prospective Payment System (PPS) to LTCH providers. PPS was established in regulation in 2002, training and outreach to providers occurred in 2003 and the new QIO review process was instituted as directed by CMS in January 2004.

By introducing this new program with consistent materials, CMS promoted consistent and standard review practices. The only aspect of the program that was (and is) not standardized is the use of screening criteria. As with criteria for all case review, CMS neither requires nor promotes the use of a single set.

In addition, MassPRO is currently working with the National Association of Long Term Care Hospitals (NALTH) in its effort to modernize patient-level screening criteria for the LTCH industry. We are assessing NALTH's five sets of screening criteria to ensure that severity of illness and intensity of treatment are appropriate and valid. Although the effort is still in process, 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.

An example of our experience with LTCH providers in Massachusetts is as follows: that since August 2005, MassPRO has reviewed 75 LTCH cases, including 12 each from 2 different facilities and 11 cases involving respiratory DRGs. Our review process enables case reviewers to begin to see patterns of practice and perhaps trends, even in the relatively small number referenced above. When a patient is discharged in fewer days than the SSO threshold, it will be for one of three reasons (other than the death of the patient): (1) due to the expertise of the hospital, the patient improves and gets better, (2) circumvention of the rules by the providers (e.g. multiple transfers), or (3) the reality that the patient should not have been admitted to the hospital in the first place.

In its report to Congress in June 2004, MedPAC reported, "In general, beneficiaries treated in long-term care hospitals cost Medicare more than patients treated in alternative settings; however, if LTCH care is better targeted to those patients who appear to be most suitable for LTCH care, the costs to Medicare are more comparable." MedPAC therefore recommended, *"patient-level criteria should identify specific clinical characteristics and treatment modalities."*

We believe, and are in agreement with the MedPAC report, that many problems with PPS for LTCHs can be reduced through the use of standardized screening criteria that will improve the appropriateness of admissions and continued stay.

By having a standard criteria set, LTCHs will reduce the number of inappropriate admissions. In its June 2003 report, MedPAC asserted, and MassPRO agrees, that "if care shifts among settings, it should occur for clinical reasons and not because of different payment rates or the profitability of specific settings of care." By having specific criteria in place, only those patients who should be admitted to LTCHs will be.

MedPAC also recommended that QIOs, given the requisite additional funding, could review LTCHs for medial necessity and monitor that these facilities are in compliance with defining criteria. By implementing both of these recommendations, costs will be reduced and patient care improved by providing the necessary tools for LTCHs to select appropriate patients and for QIOs to ensure that they do.

Thank you.

Background Information

Case Review Process

The case review process may need some explanation. On a monthly basis, CMS assigns a random sample of LTCH cases for full case review. CMS uses an average

of 1,400 per year (116 per month). In January 2006, this review was incorporated under the Hospital Payment Monitoring Program (HPMP), whose purpose is to measure, monitor, and reduce the incidence of improper fee-for-service inpatient payments, including errors in DRG coding; provision of medically necessary services; and appropriateness of setting, billing, and prepayment denials. The long-term goal of HPMP is to help inpatient prospective payment system hospitals monitor payment patterns by analyzing data, conducting focused audits, and implementing system changes to prevent payment errors.

Once the file is selected, the process begins with a request of the medical record. When the record is received, the nurse reviewer (called a review case manager, or RCM) uses screening criteria appropriate to the admission to determine whether or not the

- services or items provided to a patient were medically necessary, reasonable and provided in an appropriate care setting *(Utilization Review),*
- quality of the services/items was adequate *(Quality Review), and/or*
- hospital and patient record accurately reflects the services/items provided and billed *(Diagnosis Related Groups (DRG) Validation Review).*

If the case "passes" screening criteria, the paperwork is finalized and the case is closed.

If the RCM identifies any concerns, he/she refers the case to the physician reviewer (PR). Regulations specify the type of reviewer to ensure the applicability of **peer review**. The PR uses his/her medical experience and judgment to render a decision. PRs do **not** use screening criteria in rendering their decisions. The PR may resolve the concerns of the RCM, in which case the paperwork is finalized and the case closed. If, instead, he/she agrees with the concerns identified by the RCM, or identifies additional concerns, the provider is given an opportunity to discuss the concerns before a final determination is made. If appropriate, the QIO notifies the Fiscal Intermediary it should adjust the payment to the facility. In 2004, $2.2M in net dollars were identified through QIO review as having been made in error.

The QIO's RCM uses the screening criteria selected by that QIO. CMS does not require nor even promote the use of any specific screening criteria (although, for short-term acute care hospitals, QIOs have use of InterQual criteria as a pass-through cost in their contract). MassPRO strongly supports NALTH's development of standard screening criteria for LTCHs.

Chairman JOHNSON. You have to pull the microphone a little closer. Thank you.

STATEMENT OF JOHN VOTTO, D.O., PRESIDENT AND CHIEF EXECUTIVE OFFICER, HOSPITAL FOR SPECIAL CARE, NEW BRITAIN, CONNECTICUT

Dr. VOTTO. Thank you for inviting me here today to speak. My name is John Votto. I am a pulmonary physician. I practice at the Hospital for Special——

Chairman JOHNSON. Can you pull it closer to you? Try that.

Dr. VOTTO. Can you hear me now?

Chairman JOHNSON. Not very well.

[Pause.]

Dr. VOTTO. My name is John Votto. I am a pulmonary physician. I practice at the Hospital for Special Care in New Britain, Connecticut, and at the VA Hospital in Connecticut. I am President of the Hospital for Special Care. I am on the Board of Directors of the National Association of Long Term Hospitals, which I will refer to as NALTH throughout this testimony. I also chair the Physician Committee and the Criteria Development Committee, which you just heard about. The hospitals in NALTH organization care for approximately a third of all Medicare beneficiaries who receive care at long-term hospitals. My hospital, the Hospital for Special Care,

is a 228-bed long-term acute care hospitals, with a special emphasis on ventilator and wound programs, and we do act as a safety valve hospital for the State of Connecticut.

I will refer frequently throughout this testimony to the analysis of the proposed rule done by the Lewin Group at the request of NALTH. I know that you have heard a lot of numbers, but there are a few more important numbers. According to this report, 66 percent of all short-stay outliers and 28 percent of all admissions would be paid under the acute inpatient prospective payment system rate. This policy would obviously have a negative financial and patient care effect. CMS estimated 11.3 percent reduction in revenues, and at my hospital that would represent about $1.1 million. What is clear is that CMS sees all short-stay outlier cases as patients who should not be admitted to LTCHs but are instead premature discharges from acute care hospitals.

The payment penalty is formidable, as you have heard. Payments for short-stay outliers fall from an average of $14,500 to approximately $8,000 overall. LTCH margins for treating these cases will be 81 percent less than cost from what we hear. As Mrs. Johnson said, many of the LTCHs will have negative margins on the average of 5 percent. Additionally, a perverse consequence of the short-stay outlier policy is that so much money would be taken out of the long-term care payment system that more costly patients, those that are high-cost outliers, this threshold would be increased from $10,500 to $18,500. Therefore, a long-term hospital would be penalized for patients that are defined as short stay and patients that are long stay. These patients, as Mr. Altman mentioned, are more severely ill. According to Lewin's data, the case mix index for short-stay outliers in LTCHs is approximately 2.05, while the case mix index for the same DRG in acute care hospitals is 0.9, a 109-percent difference. The length of stay, according to Lewin, is 71 percent longer for the long-stay patients.

The proposed rule contains an explicit instruction which may preclude admission of very ill patients requiring a long stay. At my hospital we admit long-stay or very ill patients who have a very limited number of Medicare days left. If they have days left less than the five-sixths of the geometric mean, and even if they stayed for a very long time, they would be considered short-stay outliers and would be paid as a short-stay outlier, which would substantially under pay for this necessary care.

The major problem of the policy, as it has been stated, is that it destroys the fundamental premise of every prospective payment system, which is that the losses from the high-cost cases will be offset by the shorter-term low-cost cases. In other words, the proposal destroys the principle of averaging. We have heard about the 37 percent of cases being too short. We have heard the issue of the arithmetic, and the five-sixths does define, as Lewin states in their report, will always identify 35 to 40 percent of the patients, and thus, 37 percent is inevitable.

There are clear benefits to the patients cared for in LTCHs. MedPAC's 2004 report found that patients treated in LTCHs were readmitted to an acute care hospital 26 percent less often than those to other settings. In Nalth's ventilator outcome study, looking at 1,419 patients discharged from acute care hospitals, after failing

multiple weaning attempts—and they were defined to have to have failed multiple weaning attempts—over 400 had stays of less than 29 days, thus qualified as short-stay outliers. Ninety-four percent of these patients came directly from ICUs and despite advanced age, multiple complications, and multiple co-morbidities, 54 percent of these patients were weaned from the ventilator, and 75 percent of these patients survived to discharge.

NALTH has developed LTCH-specific criteria, as you have heard. I did lead that Committee, and we did spend a solid 2 years, and I am now on the 31st draft of the admission criteria. I believe that we are in the final-final-final draft of these criteria, and I believe that these criteria clearly constitute a more patient-centered approach to identify patients who qualify for admission to LTCHs. These criteria will very shortly be ready for implementation by the appropriate Medicare review organizations.

I also wish to note, in the March 2006 report to Congress, MedPAC reported a 29-percent denial rate when they reviewed a small, 1,400-case sample of LTCH cases. A 29-percent denial rate is a huge number of cases, and I would suggest that these criteria might lower that rate of denials.

I would also like to comment just shortly on the 25-percent rule because when it is phased in, it will be another example of a payment system driving admissions instead of good clinical evaluation. When this rule is in effect and under the scenario of this rule, any patient above the 25-percent threshold will be paid at the IPPS rate, whether they are a short-stay outlier or a high-cost outlier, if they are in a collocated hospital. This is another financially driven disincentive to admit clinically appropriate patients.

If the Committee would indulge me, I just would like to comment on the LTCH satellite that we developed in the State of Connecticut. The State of Connecticut came to us and said that they were having problems with back-up in the intensive care units throughout the State. They asked us if we could increase our number of bed as we are usually full. We researched the possibility of adding 25 beds to our main campus; however, the cost was untenable at $25 million.

The Office of Health Care Access then authorized a demonstration project allowing an LTCH satellite to be established in an acute care hospital. We then partnered with the acute care hospital in the State of Connecticut that happens to be the busiest cardiac surgery hospital in New England, for obvious reasons, because we thought that would be the most likely patients.

They identified a unit that they were not using, and at the cost of $2.1 million we together developed a 28-bed unit in an acute care hospital. We opened this hospital or this unit in September of 2004, and under the present 25-percent rule, we would have to begin dismantling it in September of 2006.

Thank you for your attention, and I will be happy to take questions.

[The prepared statement of Dr. Votto follows:]

Statement of John Votto, President and Chief Executive Officer, Hospital for Special Care, New Britain, CT

Chairman Johnson and members of the Subcommittee, thank you for inviting me to speak before you today on the important issues which are the focus of this hear-

ing: CMS' proposed changes to the payment system for long-term care hospitals and, more specifically, the proposed rules regarding short-stay outliers, the 25% rule and the 0% update. My name is John Votto. I am a physician with a specialty in pulmonary medicine. For the past eighteen years, I have practiced medicine at the Hospital for Special Care in New Britain, Connecticut. Currently, I am the President of the Hospital for Special Care and also maintain an active practice caring for patients at the Hospital. Additionally, I care for pulmonary patients at the Veterans Hospital located in Newington, Connecticut. I am a Director of the National Association of Long Term Hospitals and serve as the Chairman of the Association's Physician Committee, as well as its Committee on Criteria Development. The hospitals which constitute the National Association of Long Term Hospitals account for approximately one-third of all Medicare beneficiaries who receive services in long-term care hospitals. While many of my remarks today are made on behalf of the National Association of Long Term Hospitals, they also relate to the Hospital for Special Care. The Hospital for Special Care is a relatively large, long-term care hospital with 228 beds and an active outpatient department. The hospital provides a wide range of clinical services, including ventilator weaning services, to patients who have complex medical care needs. The hospital provides rehabilitation services and maintains the only certified spinal cord injury unit in the State of Connecticut. The Hospital for Special Care also operates a freestanding, 282-bed skilled nursing facility. Accordingly, I am keenly aware of the issues related to the appropriateness of services provided to inpatients in the long-term care hospital setting as compared to other settings.

At several points during my testimony, I will refer to an extensive analysis of CMS' January 27, 2006 proposed rule which the National Association of Long Term Hospitals asked The Lewin Group to prepare. This report is entitled "Final Report: Analysis of Long Term Care Hospitals RY 2007 Prospective Payment System Notice of Proposed Rulemaking" and has been made available, in its entirety, to the Committee's professional staff.

The focus of this hearing is to explore issues related to CMS' proposed changes to the payment system for long-term care hospitals. The proposal of these rules, in and of itself, has created an *emergency* situation for long-term care hospitals which, if not abated, will affect Medicare beneficiaries' access to patient care at the Hospital for Special Care and other long-term care hospitals throughout the nation in the next month or two, prior to the rule's July 1, 2006 proposed effective date. The situation I am referring to is created by the proposal of changes to the current short-stay outlier payment policy.

Effect of Proposed Rule

Currently, short-stay outliers are paid the lower of 120% of patient costs, 120% of the *per diem* of the LTCH–DRG or the full LTCH–DRG payment. CMS proposes to change this to the lower of 100% of patient costs, 120% of the *per diem* of the LTCH–DRG, the full LTCH–DRG or an amount comparable to what would be paid under the acute inpatient hospital prospective payment system. According to the Lewin Report, 77% of all short-stay outlier cases, and 28% of all cases, would be paid at acute inpatient hospital prospective payment system rates under the proposed rule. CMS' proposed short-stay outlier policy will have a negative impact on both patient care and the financial viability of long-term care hospitals. **CMS estimates that the effect of this policy will be an 11.3% reduction in reimbursement.** When combined with the estimated 3.6% reduction resulting from CMS' proposed 0% update, the aggregate reduction of about 15% would, for example, cost the Hospital for Special Care $1,100,000 out of approximately $11,500,000 in annual Medicare revenues.

It is clear that CMS views all short-stay outlier cases as patients who should not be admitted to long-term care hospitals. This is seen in the straightforward assertion, contained in the preamble to the proposed rule, that short-stay outlier cases "may be inappropriate admissions of patients who are prematurely discharged from acute care hospitals." 71 *Fed. Reg*. 4688. The preamble to the rule also explicitly states that the objective of the short-stay outlier proposal is to "discourage LTCHs from admitting patients that could be premature discharges from acute care hospitals." 71 *Fed. Reg.* 4687. CMS assumes patients identified as short-stay outlier cases in long-term care hospitals have lengths of stay more typical of an acute care hospital and that the long-term care hospitals which admit these patients may be behaving like acute care hospitals. 71 *Fed. Reg.* 4687.

CMS clearly and admittedly is proposing the new short-stay outlier policy as a way, effectively, to preclude Medicare beneficiaries who would become short-stay outlier patients from being admitted to long-term care hospitals. The payment penalty which is proposed as a deterrent for admission of the beneficiaries is indeed

formidable. According to the Lewin Group, the following financial consequences would accrue as a result of the short-stay outlier policies.

- Payments for short-stay outliers would fall from $14,582 per case in 2006 to $8,042 per case in 2007.
- Long-term care hospitals' margins for treating short-stay outlier cases would be a negative 81.2%. That is, hospitals would be paid 81.2% less than costs for treating a short-stay outlier patient.
- On a national basis, 68.6% of all long-term care hospitals would have negative margins of, on average, negative 4.93%. Not-for-profit hospitals' negative margins would be double the national average, at negative 8.80%.
- The rural areas and the south would have the worst negative margins.

Additionally, a perverse consequence of the short-stay outlier policy is that so much money would be taken out of the long-term care hospital payment that the cost threshold for treating longer-term, cost-outlier patients (those whose costs exceed 80% of full LTCH–DRG payments) would be increased from $10,501 to $18,489. Long-term care hospitals, therefore, would be penalized for patients CMS defines as short-stay patients *and* as high-cost (long-stay) patients.

The underlying policy premises for the short-stay outlier proposal also are clearly erroneous. Moreover these erroneous assumptions, as a real matter, drain all validity from the long-term care hospital prospective payment system.

Short-stay outlier cases in long-term care hospitals are not comparable, in terms of length of stay or medical resource use, to patients assigned to the same diagnosis-related groups in acute hospitals. In fact, the patients CMS identifies as short-stay outlier cases in long-term care hospitals would be extraordinary long-stay, costly cases in acute hospitals.

Using the 2004 MedPAR data which CMS used for its impact file in the proposed rule, the Lewin Group determined that the weighted average length of stay ("ALOS") for short-stay outlier cases admitted to long-term care hospitals is 12.7 days, which is 72% longer than the ALOS of patients assigned to the same diagnosis-related groups ("DRGs") in acute hospitals. The point is made best by comparing the ALOS of patients in long-term care hospitals with the ALOS of patients in acute hospitals, for the top three DRGs, as illustrated in the following chart.

DRG	DRG Name	SSO ALOS	Acute Care Hospital ALOS
475	Respiratory System DX with Ventilator Support	28.8	14.5
87	Pulmonary Edema & Respiratory Failure	21.2	11.7
271	Skin Ulcers	23.1	13.1

According to the Lewin Group, only 14% of the short-stay outlier cases in long-term care hospitals have a length of stay which is below the geometric mean length of stay of patients assigned the same DRG in the acute hospitals. It is beyond dispute that short-stay outlier cases in long-term care hospitals would be very long-stay, high-cost cases in acute hospitals. I have appended, as *Attachment A* to my testimony, all of the average case comparative length of stay data for DRGs which are in common in both long-term care hospitals and acute hospitals. An ironic consequence of the short-stay outlier policy is that it would penalize the Hospital for Special Care when it admits very ill patients who have a long length of stay and exhaust their Medicare day benefit prior to reaching 5/6 of the average length of stay for their DRG. CMS labels these long-stay patients as short-stay patients for billing purposes and will drastically underpay the cost of their care. These patients are usually medically indigent. The Medicare program should not establish financial disincentives for these patients to access care in long-term care hospitals. A payment system neither should be a substitution for a physician's clinical decision-making nor should it impinge on a beneficiary's freedom of choice, as secured by Section 1802 of the Social Security Act.

Short-stay outlier cases also are different in terms of their use of medical resources and, hence, cost of care, than the acute hospital patients who are assigned the same DRGs. The Lewin Group has determined that the case mix index of short-stay outlier cases is 2.0592, which is 109% greater than the 0.9873 case mix index of cases assigned to the same DRGs in acute hospitals. The difference in DRG weights for all DRGs which are common to long-term care hospitals and acute hospitals are contained in *Attachment B* to my written statements.

Where the average length of stay and case mix of short-stay outlier cases is dramatically different, it is clear that the proposed short-stay outlier policy will not make payments which reflect the difference in patient resource use and cost, which was required by Congress when it enacted Section 123(a)(1) of the Balanced Budget Refinement Act of 1999. Adherence to this statutory standard is fundamental to the establishment of a valid prospective payment system. The short-stay outlier policy, however, destroys the fundamental premise of every prospective payment system, that standard payments allow losses from high-cost cases to be offset by shorter-term, low-cost cases. This fundamental tenet for payment under prospective payment systems was established by HHS Secretary Schweiker in a 1982 report to Congress[1] as the base for the then-proposed acute inpatient hospital PPS. The Lewin Group has concluded that the proposed short-stay outlier policy destroys the averaging of profit and losses which is essential to a viable PPS because:

Under the currently proposed rule, averaging is not only taken away—it is reversed. The very cases required to balance the system as averages would be widely underpaid ($14,500 in costs vs. $8,000 in payments), and account for about 40 percent of all LPPS cases. To have 40 percent of cases paid at a 81.2 percent margin, and the other 60 percent paid to barely cover or paid slightly less than costs, is an untenable situation, should CMS intend to ensure the stability of care delivery in the LTCH setting."

CMS states that short-stay outliers currently account for approximately 37% of all long-term care hospital patients. CMS is wrong when it states that this percentage reflects "an inappropriate number of patients being treated in LTCHs who most likely do not require the full measure of resources available in [an LTCH]." *Id.* CMS' logic is flawed, as explained by the Lewin report.

CMS defines an SSO case in such a way that it is essentially impossible for LTCHs to admit a smaller percentage of SSOs in any given year. CMS uses a relative measure of "short stay" that guarantees that approximately 30 to 40 percent of cases will always be considered "short." A short stay is defined as a "stay shorter than 5/6 of the geometric mean length of stay." . . . Stays less than 5/6 of the geometric mean will *always* account for about 30 to 40 percent of cases, regardless of the expected-stay threshold the LTCHs require for an admission. . . . To object that this is "too many" is like objecting to the fact that LTCHs have 50 percent of cases that are below the median.

If long-term care hospitals were able, somehow, to eliminate all short-stay outlier cases, then when CMS engaged in its annual re-weighting of DRGs, it would re-calculate average lengths of stay, including calculation of the 5/6 geometric mean lengths of stay of DRGs, thereby identifying *new* short-stay outliers. In other words, cases which were not short-stay outliers last year would be deemed to be short-stay outliers next year.

Not only is the number of short-stay outliers essentially inevitable, CMS also is incorrect in its assertion that these patients most likely do not require the full measure of resources available in a long-term care hospital. The Lewin Report found that long-term care hospital short-stay outlier cases, as compared to acute hospital cases within the same diagnosis-related group, have a 70% higher length of stay, are about 70% more intense and are more severe. The Lewin Report also found that both types of hospitals have a similar percentage of short-stay cases.

In Chapter 5 of its June 2004 ("New Approaches in Medicare") Report to Congress, MedPAC found that "[p]atients treated in LTCHs tend to have fewer acute hospital readmissions—a measure of outcomes—than patients treated in other settings. Patients using LTCHs were readmitted 26 percent less frequently than similar patients in alternative settings." Therefore, proper admission of a patient to a long-term care hospital can save the Medicare program the costs of readmission to another hospital.

I can provide you with empirical evidence about the sorts of cases which CMS is suggesting long-term care hospitals should not admit. A significant segment of patients admitted to long-term care hospitals are in respiratory failure with ventilator support. The National Association of Long Term Hospitals sponsored a study of the characteristics of these patients, including ventilator weaning rates, and provided CMS and MedPAC with reports and study outcome data. This multi-site study, conducted by the Barlow Respiratory Hospital Research Center, included data on 1,419 patients who were admitted to 23 long-term care hospitals located throughout the country, which had active ventilator weaning programs. Most, if not all of the long-term care hospitals embrace the multidisciplinary, rehabilitative model of care for weaning patients from prolonged mechanical ventilation.

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[1] Schweiker, R.S., "Report to Congress: Hospital Prospective Payment for Medicare," Secretary of the Department of Health and Human Services, December, 1982.

Of all the patients studied, 32% had stays of less than 29 days, which means they would qualify as short-stay outliers because they were admitted under DRG 475 (respiratory system failure with ventilator support), which has a 5/6 geometric mean length of stay threshold of 28.8 days. Prior to transfer to the long-term care hospital, 93.9% of patients were in an ICU, with an additional 4.2% transferred from "step-down" or monitored units. Patients transferred to long-term care hospitals for weaning from prolonged mechanical ventilation are elderly with severe acute illness superimposed on chronic disease. This population requires extensive continued treatments and interventions at the long-term care hospital, not only for respiratory failure but for numerous pre-existing conditions, co-morbidities and complications, the latter predominantly being infections. In short, these patients were failing at the acute hospitals and were admitted to the long-term care hospitals for ventilation weaning, which could not be done as successfully at the acute care hospital. Despite advanced age and numerous co-morbidities and complications, and despite the fact that all of these patients already had failed multiple weaning attempts at the acute hospitals, more than 50% of all patients enrolled in the study were weaned successfully from mechanical ventilation at the long-term care hospitals. The rate of survival to discharge was 74.8%, illustrating that long-term care hospitals, with their specialized programs of care, safely can wean a population with exceptional medical challenges. Nearly 30% of patients returned directly home or to assisted living following discharge from the long-term care hospital. This percentage was not comparable to their status prior to their catastrophic illness. Furthermore, at 12-months post-admission to the long-term care hospital, nearly two-thirds of survivors reported good functional status.

Medicare beneficiaries such as those treated in this study have a right to access long-term care hospitals, which would be defeated by the short-stay outlier policy.

I understand that CMS and the Committee are concerned that the Medicare program makes inappropriate payments where patients who require the same or similar medical resources receive care in different Medicare provider settings at different rates of payment. An appropriate response to this concern was recommended by MedPAC in its June 2004 Report to Congress. MedPAC recommended, and the National Association of Long Term Hospitals strongly supports, that the Secretary: (i) develop facility and patient criteria to ensure patients admitted to long-term care hospitals are medically complex and have a good chance of improvement; and, (ii) increase medical necessity review of long-term care hospital admissions by Quality Improvement Organizations ("QIOs"), which also can monitor whether hospitals comply with the criteria. Implementation of MedPAC's recommendations would ensure that Medicare beneficiaries receive care in the most appropriate, cost-effective and safe setting. CMS' recent proposed rules effectively ignore MedPAC's recommendations. Rather than addressing its concerns through a reassessment of the proper placement of patients, CMS is proposing drastic changes to the long-term care prospective payment system, which both violate the fundamental logic of averaging which underlies prospective payments systems and fail to consider the potential crippling impact on the long-term care hospital sector and the resultant, negative effect on the treatment of Medicare beneficiaries.

As part of implementation of the long-term care hospital prospective payment system, the Secretary included review responsibilities for the appropriateness of admission to a long-term care hospital for a small sample of 1,400 Medicare cases in the QIO scope of work for 2004. The reported denial rate from this review process was 29%, as reported in MedPAC's March 2006 Report. The Secretary has retained this small sample size for the 2005 QIO scope of work. The denial of a patient admission by a QIO means there has been a finding that the patient could have been treated in a lower-cost, more appropriate Medicare provider setting, such as at a skilled nursing facility or at home with care from a home health agency. In every case where there is a final denial by a QIO, the long-term care hospital receives zero payment for the case at issue. The National Association of Long Term Hospitals has followed closely the review of Medicare cases by QIOs and believes that QIOs effectively and efficiently can distinguish between cases that require the medical resources and programs provided by long-term care hospitals and those provided by, for example, skilled nursing facilities. The Secretary properly may consider expanding QIO review responsibilities to include the appropriateness of continued stay and discharge. This would result in review for medical necessity and length of stay, the two factors which affect payment under the long-term care hospital prospective payment system.

Similar issues exist with CMS' proposed changes to the 25% rule. This rule, once it becomes fully phased-in, will apply when more than 25% of a long-term care hospital-within-hospital's or satellite facility's Medicare inpatient population (excluding outlier patients) are admitted from a hospital which is co-located on the same cam-

pus. Payments for the patients who are admitted from the co-located hospital and who cause the long-term care hospital-within-hospital or satellite facility to exceed the 25% threshold are the lesser of the amount otherwise payable under the long-term care hospital prospective payment system or an amount equivalent to what would be paid under the acute inpatient hospital prospective payment system. Payment equivalent to what would be paid under the acute system blatantly ignores the different resources used by long-term care hospitals and the statutory requirement, in Section 123 of the Balanced Budget Refinement Act of 1999, that payments should reflect differences in patient resource use and cost.

In the preamble to the proposed rules (at 71 *Fed. Reg.* 4697), CMS acknowledges that it was informed of a study commissioned from the Lewin Group, which found that 71.2% of freestanding long-term care hospitals admit more than 25% of their patients from a single source acute-care hospital. Therefore, long-term care hospitals-within-hospitals and satellite facilities which do the same are punished merely because of their co-location.

The State of Connecticut has ICUs which frequently have insufficient bed capacity to meet patients' needs. To address this need, the Hospital for Special Care initially decided it would add 25 beds to its facility. This proved to be infeasible because building an addition to the hospital would have cost $25,000,000. Therefore, to address the need in a more fiscally responsible way, the State of Connecticut approved a demonstration project that allowed the creation of a long-term care hospital within an acute hospital. The cost of renovating a floor at St. Francis Hospital, to create a 28-bed long-term care hospital-within-hospital, was only $2,000,000. This long-term care hospital-within-hospital currently provides much needed services. However, the proposed changes to the 25% rule, if implemented, would destroy the long-term care hospital-within-hospital, harm the patient population it otherwise would serve and strain the capacity of the State of Connecticut's precious ICU beds.

CMS' proposed rule provides for a 0% update in Rate Year 2007. It freezes the long-term care hospital prospective payment system standard amount at the RY 2006 level of $38,086.04. Experts in the LTCH industry estimate that the effect of this 0% update policy will be a 3.6% reduction in reimbursement. While most long-term care hospitals could deal with the effect of this proposal if all other aspects of the payment system remained unchanged, the cumulative effect of the 0% update and the proposed changes to the short-stay outlier policy—an untenable 15% reduction in reimbursement—could mean the destruction of the long-term care hospital industry. This is an emergency situation which cannot be ignored.

Requested Relief

The proposed rules, if implemented, would come into force on July 1, 2006. The proposed short-stay outlier rule would apply to patients admitted to long-term care hospitals in the next few months. The National Association of Long Term Hospitals and the Hospital for Special Care suggest the following steps be taken by CMS itself or under Congressional direction.

1. The proposed changes to the short-stay outlier policy should be withdrawn immediately because they have a present, adverse effect on beneficiary access to patient care.
2. CMS should halt the phase-in of the 25% rule for long-term care hospitals-within-hospitals and satellite facilities which currently exist (thereby allowing them to admit up to 75% of their patients from co-located hospitals).
3. CMS should address the issue of appropriate admissions through the use of more intensive Quality Improvement Organization review (i.e. to increase the small sample which they currently review).
4. Congress should require CMS to report to Congress on the development of facility and patient criteria for admission to long-term care hospitals by January 1, 2008 and to advise whether the implementation of such criteria would require Congressional authority.
5. If such criteria are not implemented by January 1, 2009, CMS automatically should implement criteria established by the National Association of Long Term Hospitals and validated by MassPRO.[2]

I wish to thank you and the Committee's staff again for inviting me here today and for your courtesy and your attention to these important questions.

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[2] The National Association of Long Term Hospitals has developed long-term care hospital screening criteria, including cardiovascular, complex medical, respiratory, ventilator weaning, wound care and rehabilitation criteria sets. The criteria are in the final stage of validation by MassPRO and will be ready for use within a month. The Association has shared drafts of these criteria with the Subcommittee staff, CMS and MedPAC.

Attachment A to Testimony of John Votto, D.O.

Appendix B

Short Stays and Mean Length of Stays by DRG based on 2004 MedPAR Data

		All LTC Hospitals				CMS Nominal			
			Short	Short Stays Only		Short-Stay	LTH	Acute	
DRG	DRG Name	Cases	Stays	ALOS	GMLOS	Threshold*	GMLOS	GMLOS	ALOS
1	Craniotomy Age >17 W CC	2	0			32.1	38.5	7.6	10.1
7	Periph & Cranial Nerve & Other Nerv Syst	330	114	23.3	22.3	31.4	37.7	6.7	9.7
8	Periph & Cranial Nerve & Other Nerv Syst	4	1	4.0	4.0	20.7	24.8	2	3
9	Spinal Dis & Injuries	168	59	17.3	14.4	28.1	33.7	4.5	6.4
10	Nervous System Neoplasms W CC	242	101	11.5	9.8	20.4	24.5	4.6	6.2
11	Nervous System Neoplasms w/o CC	17	7	11.1	9.0	17.8	21.3	2.9	3.8
12	Degenerative Nervous System Dis	5843	1811	12.8	10.9	21.3	25.5	4.3	5.5
13	Multiple Sclerosis & Cerebellar Ataxia	111	42	11.3	10.1	19.3	23.1	4	5
14	Intracranial Hemorrhage or Cerebral Infarc	433	151	12.7	10.2	21.7	26	4.5	5.8
15	Nonspecific Cva & Precerebral Occlusion	156	64	10.6	7.8	22.3	26.8	3.7	4.6
16	Nonspecific Cerebrovascular Dis W CC	261	95	10.1	8.3	19.6	23.5	5	6.5
17	Nonspecific Cerebrovascular Dis w/o CC	10	5	7.2	5.7	15.8	19	2.5	3.2
18	Cranial & Peripheral Nerve Dis W CC	327	122	11.2	9.7	19.7	23.6	4.1	5.3
19	Cranial & Peripheral Nerve Dis w/o CC	31	12	11.3	9.9	17.7	21.2	2.7	3.5
20	Nervous System Infection Ex Viral Mening	408	159	14.1	12.4	22.7	27.2	8	10.4
21	Viral Meningitis	9	2	17.5	17.3	20.7	24.8	4.9	6.3
22	Hypertensive Encephalopathy	6	3	10.0	9.7	24.7	29.6	4	5.2
23	Nontraumatic Stupor & Coma	49	17	10.6	9.7	21.2	25.4	3	3.9
24	Seizure & Headache Age >17 W CC	194	78	10.9	9.6	18.8	22.6	3.6	4.8
25	Seizure & Headache Age >17 w/o CC	22	12	7.5	5.6	15.8	19	2.5	3.1
27	Traumatic Stupor & Coma, Coma >1 Hr	32	12	15.4	14.6	22.6	27.1	3.2	5.2
28	Traumatic Stupor & Coma, Coma <1 Hr A	158	64	14.9	12.1	25.2	30.2	4.4	5.9
29	Traumatic Stupor & Coma, Coma <1 Hr A	16	10	9.2	7.9	17.8	21.3	2.6	3.4
31	Concussion Age >17 W CC	3	1	15.0	15.0	20.7	24.8	3	4
34	Other Dis Of Nervous System W CC	606	239	12.2	9.9	21.1	25.3	3.7	4.8
35	Other Dis Of Nervous System w/o CC	59	20	11.1	8.8	20.2	24.2	2.4	3
40	Extraocular Proc Ex Orbit Age >17	3	0			24.7	29.6	3	4.1
44	Acute Major Eye Infections	9	3	10.7	9.9	17.8	21.3	3.9	4.8
46	Other Dis Of The Eye Age >17 W CC	14	10	8.2	7.2	17.8	21.3	3.2	4.2
61	Myringotomy w/Tube Insertion Age >17	1	0			20.7	24.8	3.3	5.4
63	Other Ear, Nose, Mouth & Throat OR Proc	7	2	11.5	4.7	24.7	29.6	3	4.5
64	Ear, Nose, Mouth & Throat Malignancy	140	61	9.9	7.7	21.8	26.2	4.1	6.1
65	Dysequilibrium	11	5	10.4	9.2	15.8	19	2.3	2.8
67	Epiglottitis	1	1	17.0	17.0	20.7	24.8	2.9	3.7
68	Otitis Media & Uri Age >17 W CC	58	23	10.3	9.7	15	18	3.2	4
69	Otitis Media & Uri Age >17 w/o CC	13	5	8.4	7.7	15.8	19	2.5	3
73	Other Ear, Nose, Mouth & Throat Dx Age	54	26	12.2	11.4	18.3	21.9	3.3	4.4
75	Major Chest Proc	21	9	16.3	14.4	32.1	38.5	7.6	9.9
76	Other Resp System OR Proc W CC	1763	628	23.8	21.8	36.6	43.9	8.4	11.1
77	Other Resp System OR Proc w/o CC	2	1	32.0	32.0	32.1	38.5	3.3	4.7
78	Pulmonary Embolism	301	118	11.0	9.8	18.3	21.9	5.4	6.4
79	Respiratory Infections & Inflammations Ag	4494	1747	11.5	9.8	19.1	22.9	6.7	8.5
80	Respiratory Infections & Inflammations Ag	115	53	8.9	6.9	18.1	21.7	4.4	5.5
82	Respiratory Neoplasms	641	334	7.4	5.7	16.8	20.1	5.1	6.8
83	Major Chest Trauma W CC	12	3	11.0	10.3	17.8	21.3	4.2	5.3
84	Major Chest Trauma w/o CC	1	1	4.0	4.0	17.8	21.3	2.6	3.2
85	Pleural Effusion W CC	216	97	10.7	8.8	17.7	21.2	4.8	6.3
86	Pleural Effusion w/o CC	5	2	9.5	8.4	15.8	19	2.8	3.6
87	Pulmonary Edema & Respiratory Failure	5065	2257	11.7	9.4	21.2	25.4	4.9	6.4
88	Chronic Obstructive Pulmonary Disease	5020	2049	9.8	8.5	16.3	19.6	4	4.9
89	Simple Pneumonia & Pleurisy Age >17 W	4861	1924	10.1	8.6	17.3	20.8	4.7	5.7
90	Simple Pneumonia & Pleurisy Age >17 w/o	127	59	8.0	6.9	14.8	17.8	3.2	3.8

Short Stays and Mean Length of Stays by DRG based on 2004 MedPAR Data (continued)

		All LTC Hospitals				CMS Nominal			
			Short	Short Stays Only		Short-Stay	LTH	Acute	
DRG	DRG Name	Cases	Stays	ALOS	GMLOS	Threshold*	GMLOS	GMLOS	ALOS
92	Interstitial Lung Disease W CC	268	116	8.7	7.1	16.8	20.2	4.8	6.1
93	Interstitial Lung Disease w/o CC	7	4	13.3	12.3	17.8	21.3	3.1	3.9
94	Pneumothorax W CC	55	25	8.7	8.1	14.2	17	4.6	6.2
95	Pneumothorax w/o CC	3	2	10.0	8.7	15.8	19	2.9	3.6
96	Bronchitis & Asthma Age >17 W CC	140	65	10.0	8.7	16.2	19.4	3.6	4.4
97	Bronchitis & Asthma Age >17 w/o CC	25	19	7.8	6.3	17.8	21.3	2.8	3.4
99	Respiratory Signs & Symptoms W CC	333	146	10.5	8.4	19.3	23.2	2.4	3.1
100	Respiratory Signs & Symptoms w/o CC	8	2	7.5	3.7	20.7	24.8	1.7	2.1
101	Other Respiratory System Dx W CC	367	137	10.1	8.5	17.6	21.1	3.3	4.3
102	Other Respiratory System Dx w/o CC	3	2	13.5	13.5	15.8	19	2	2.5
110	Major Cardiovascular Proc W CC	3	1	20.0	20.0	20.7	24.8	5.7	8.4
113	Amputation For Circ System Dis Ex Upper	201	65	23.7	22.8	32.8	39.3	10.8	13.7
114	Upper Limb & Toe Amputation For Circ Sy	62	18	18.4	17.3	27.7	33.2	6.7	8.9
115	No Longer Valid	13	0					15.8	15.8
116	No Longer Valid	19	0					9.3	9.3
117	Cardiac Pacemaker Revision Ex Device R	5	3	18.7	18.6	24.7	29.6	2.6	4.2
118	Cardiac Pacemaker Device Replacement	4	2	17.5	17.3	24.7	29.6	2.1	3
119	Vein Ligation & Stripping	1	0			20.7	24.8	3.3	5.5
120	Other Circulatory System OR Proc	606	188	18.2	17.0	26.4	31.7	5.9	9.2
121	Circ Dis w/Ami & Major Comp, Discharged	95	49	11.4	9.4	19.3	23.2	5.3	6.6
122	Circ Dis w/Ami w/o Major Comp, Discharg	10	2	5.0	4.0	17.8	21.3	2.8	3.5
123	Circ Dis w/Ami, Expired	42	23	8.1	7.3	17	20.4	2.9	4.8
124	Circ Dis Ex Ami, w/Card Cath & Complex	24	13	16.1	12.8	24.7	29.6	3.3	4.4
125	Circ Dis Ex Ami, w/Card Cath w/o Comple	2	1	2.0	2.0	20.7	24.8	2.1	2.7
126	Acute & Subacute Endocarditis	596	210	12.1	10.1	21.1	25.3	9.4	12
127	Heart Failure & Shock	3735	1439	9.7	8.0	17.7	21.2	4.1	5.2
128	Deep Vein Thrombophlebitis	16	4	10.3	8.1	17.8	21.3	4.4	5.2
129	Cardiac Arrest, Unexplained	1	1	5.0	5.0	20.7	24.8	1.7	2.6
130	Peripheral Vascular Dis W CC	1438	507	11.1	9.4	19.3	23.2	4.4	5.5
131	Peripheral Vascular Dis w/o CC	66	23	10.3	9.0	17	20.4	3.2	3.9
132	Atherosclerosis W CC	428	163	10.9	9.1	18.2	21.8	2.2	2.8
133	Atherosclerosis w/o CC	67	43	9.3	8.1	15.8	19	1.8	2.2
134	Hypertension	106	36	11.8	9.7	20.7	24.8	2.4	3.1
135	Cardiac Congenital & Valvular Dis Age >1	152	52	9.7	7.5	19.8	23.7	3.2	4.3
136	Cardiac Congenital & Valvular Dis Age >1	4	2	3.0	2.2	17.8	21.3	2.2	2.8
138	Cardiac Arrhythmia & Conduction Dis W C	300	130	9.7	7.8	17.1	20.5	3	3.9
139	Cardiac Arrhythmia & Conduction Dis w/o	26	13	7.1	5.0	17.8	21.3	2	2.4
140	Angina Pectoris	10	4	6.3	5.3	15.8	19	2	2.4
141	Syncope & Collapse W CC	68	27	9.3	7.7	15.3	18.3	2.7	3.5
142	Syncope & Collapse w/o CC	20	9	9.1	8.6	15.3	18.3	2	2.5
143	Chest Pain	15	8	3.5	2.7	15.8	19	1.7	2.1
144	Other Circulatory System Dx W CC	1552	635	10.6	9.0	18.1	21.7	4.1	5.8
145	Other Circulatory System Dx w/o CC	31	12	7.6	5.6	15.2	18.2	2.1	2.6
148	Major Small & Large Bowel Proc W CC	35	12	25.1	24.3	34.1	40.9	10	12.3
150	Peritoneal Adhesiolysis W CC	2	1	22.0	22.0	24.7	29.6	8.9	11
151	Peritoneal Adhesiolysis w/o CC	1	1	17.0	17.0	17.8	21.3	4	5.1
152	Minor Small & Large Bowel Proc W CC	1	0			20.7	24.8	6.7	8
154	Stomach, Esophageal & Duodenal Proc A	19	7	23.0	21.9	32.1	38.5	9.9	13.3
157	Anal & Stomal Proc W CC	9	3	10.3	10.0	24.7	29.6	4.1	5.8
161	Inguinal & Femoral Hernia Proc Age >17 V	1	0			32.1	38.5	3.1	4.4
168	Mouth Proc W CC	2	1	16.0	16.0	24.7	29.6	3.3	4.9
170	Other Digestive System OR Proc W CC	149	49	20.4	18.3	29.9	35.9	7.8	11

Short Stays and Mean Length of Stays by DRG based on 2004 MedPAR Data (continued)

		All LTC Hospitals				CMS Nominal			
			Short	Short Stays Only		Short-Stay	LTH	Acute	
DRG	DRG Name	Cases	Stays	ALOS	GMLOS	Threshold*	GMLOS	GMLOS	ALOS
171	Other Digestive System OR Proc w/o CC	2	1	15.0	15.0	15.8	19	3.1	4.1
172	Digestive Malignancy W CC	477	242	9.0	7.2	18.2	21.8	5.1	7
173	Digestive Malignancy w/o CC	7	5	10.4	7.2	17.8	21.3	2.7	3.6
174	G.i. Hemorrhage W CC	229	95	10.0	8.0	18.5	22.2	3.8	4.7
175	G.i. Hemorrhage w/o CC	12	8	4.9	2.9	15.8	19	2.4	2.9
176	Complicated Peptic Ulcer	32	15	9.4	8.2	17.9	21.5	4.1	5.2
177	Uncomplicated Peptic Ulcer W CC	15	4	8.5	8.3	20.7	24.8	3.6	4.4
178	Uncomplicated Peptic Ulcer w/o CC	1	0			20.7	24.8	2.6	3.1
179	Inflammatory Bowel Disease	83	30	11.5	9.6	20	24	4.5	5.9
180	G.i. Obstruction W CC	224	88	10.4	8.7	19.6	23.5	4.2	5.4
181	G.i. Obstruction w/o CC	13	6	9.2	6.5	20.7	24.8	2.8	3.3
182	Esophagitis, Gastroent & Misc Digest Dis A	951	337	10.7	9.1	18.8	22.6	3.4	4.4
183	Esophagitis, Gastroent & Misc Digest Dis A	37	16	6.7	6.0	14	16.8	2.3	2.9
185	Dental & Oral Dis Ex Extractions & Restor	25	7	10.1	8.2	20.7	24.8	3.2	4.5
188	Other Digestive System Dx Age >17 W CC	1274	478	11.2	9.6	20	24	4.2	5.6
189	Other Digestive System Dx Age >17 w/o C	39	14	8.9	7.5	15.2	18.2	2.4	3.1
191	Pancreas, Liver & Shunt Proc W CC	17	8	17.4	16.9	24.7	29.6	9	12.9
193	Biliary Tract Proc Ex Only Cholecyst W or	1	0			20.7	24.8	9.9	12.1
195	Cholecystectomy W C.d.e. W CC	1	0			20.7	24.8	8.8	10.6
197	Cholecystectomy Ex By Laparoscope w/o	4	3	11.7	10.0	20.7	24.8	7.5	9.2
200	Hepatobiliary Dxnostic Proc For Non-Malig	2	0			32.1	38.5	6.5	9.8
201	Other Hepatobiliary or Pancreas OR Proc	28	13	24.5	23.9	30.1	36.1	9.9	13.7
202	Cirrhosis & Alcoholic Hepatitis	153	74	8.5	7.0	17.2	20.6	4.7	6.2
203	Malignancy Of Hepatobiliary System or Pa	272	154	7.4	5.6	16.3	19.5	4.9	6.5
204	Dis Of Pancreas Ex Malignancy	426	167	10.6	9.2	18.9	22.7	4.2	5.6
205	Dis Of Liver Ex Malig,Cirr,Alc Hepa W CC	190	77	9.3	7.6	17.1	20.5	4.4	6
206	Dis Of Liver Ex Malig,Cirr,Alc Hepa w/o C	9	5	10.0	9.1	17.8	21.3	3	3.9
207	Dis Of The Biliary Tract W CC	80	36	9.9	8.3	17.9	21.5	4.1	5.3
208	Dis Of The Biliary Tract w/o CC	1	0			17.8	21.3	2.3	2.9
210	Hip & Femur Proc Ex Major Joint Age >17	21	6	21.5	20.5	32.1	38.5	6.1	6.9
211	Hip & Femur Proc Ex Major Joint Age >17	2	1	2.0	2.0	24.7	29.6	4.4	4.7
213	Amputation For Musculoskeletal System &	170	53	20.3	19.0	28.3	34	7.2	9.7
216	Biopsies Of Musculoskeletal System & Co	18	5	18.2	17.8	24.7	29.6	3.3	5.8
217	Wnd Debrid & Skn Grft Ex Hand,For Musc	962	292	22.6	21.1	31.7	38	9.3	13.2
218	Lower Extrem & Humer Proc Ex Hip,Foot,	17	10	24.7	24.0	32.1	38.5	4.4	5.6
219	Lower Extrem & Humer Proc Ex Hip,Foot,	1	0			15.8	19	2.6	3.1
223	Major Shoulder/elbow Proc, or Other Uppe	3	0			20.7	24.8	2.3	3.2
225	Foot Proc	34	14	16.8	14.3	23.7	28.4	3.7	5.2
226	Soft Tissue Proc W CC	43	15	17.9	17.3	24.6	29.5	4.5	6.5
227	Soft Tissue Proc w/o CC	3	2	10.0	4.4	20.7	24.8	2.1	2.6
228	Major Thumb or Joint Proc,or Oth Hand or	10	3	11.7	11.5	24.7	29.6	2.8	4.1
230	Local Excision & Removal Of Int Fix Devic	5	2	29.5	29.5	32.1	38.5	3.7	5.6
233	Other Musculoskelet Sys & Conn Tiss OR	59	24	21.3	19.9	28.8	34.6	4.6	6.8
235	Fractures Of Femur	20	5	14.2	14.1	20.7	24.8	3.8	4.8
236	Fractures Of Hip & Pelvis	123	37	11.1	9.0	21	25.2	3.8	4.6
237	Sprains, Strains, & Dislocations Of Hip, Pe	6	2	12.5	12.2	15.8	19	3	3.7
238	Osteomyelitis	1820	576	14.7	12.8	23.6	28.3	6.7	8.7
239	Pathological Fractures & Musculoskeletal	262	104	10.6	8.7	19.7	23.6	5	6.2
240	Connective Tissue Dis W CC	122	45	10.7	8.8	20.7	24.8	5	6.7

Short Stays and Mean Length of Stays by DRG based on 2004 MedPAR Data (continued)

		All LTC Hospitals				CMS Nominal			
			Short	Short Stays Only		Short-Stay	LTH	Acute	
DRG	DRG Name	Cases	Stays	ALOS	GMLOS	Threshold*	GMLOS	GMLOS	ALOS
241	Connective Tissue Dis w/o CC	13	3	10.7	10.3	15.8	19	3	3.7
242	Septic Arthritis	364	127	14.5	12.5	22.1	26.5	5.1	6.7
243	Medical Back Problems	620	191	11.8	10.1	19.5	23.4	3.6	4.5
244	Bone Diseases & Specific Arthropathies W	151	45	12.9	12.0	18.5	22.2	3.6	4.5
245	Bone Diseases & Specific Arthropathies w	54	14	10.5	9.7	17	20.4	2.5	3.1
246	Non-Specific Arthropathies	25	8	9.9	8.8	15.8	19	2.8	3.6
247	Signs & Symptoms Of Musculoskeletal Sy	70	28	10.5	9.5	18.3	21.9	2.6	3.3
248	Tendonitis, Myositis & Bursitis	364	158	10.7	9.5	18.8	22.6	3.8	4.8
249	Aftercare, Musculoskeletal System & Conn	6290	1967	12.8	11.3	20.6	24.7	2.7	3.9
250	Fx, Sprn, Strn & Disl Of Forearm, Hand, F	11	4	8.8	6.1	17.8	21.3	3.2	3.9
251	Fx, Sprn, Strn & Disl Of Forearm, Hand, F	4	2	14.5	14.5	15.8	19	2.3	2.8
253	Fx, Sprn, Strn & Disl Of Uparm,Lowleg Ex	66	21	11.7	10.1	21.9	26.3	3.8	4.6
254	Fx, Sprn, Strn & Disl Of Uparm,Lowleg Ex	13	4	7.0	4.7	17.8	21.3	2.6	3.1
256	Other Musculoskeletal System & Connecti	495	178	12.9	11.2	21.1	25.3	3.9	5.1
259	Subtotal Mastectomy For Malignancy W C	1	0			17.8	21.3	1.8	2.8
261	Breast Proc For Non-Malignancy Ex Biops	2	2	1.0	1.0	20.7	24.8	1.6	2.2
262	Breast Biopsy & Local Excision For Non-M	1	1	15.0	15.0	15.8	19	3.3	4.8
263	Skin Graft &/or Debrid For Skn Ulcer or Ce	3781	1100	21.4	19.5	32.9	39.5	8.6	11.4
264	Skin Graft &/or Debrid For Skn Ulcer or Ce	175	60	16.6	14.7	26.7	32	5	6.5
265	Skin Graft &/or Debrid Ex For Skin Ulcer o	88	26	20.5	19.9	27.6	33.1	4.4	6.8
266	Skin Graft &/or Debrid Ex For Skin Ulcer o	7	3	8.3	4.8	20.7	24.8	2.3	3.2
268	Skin, Subcutaneous Tissue & Breast Plast	6	4	10.3	4.1	32.1	38.5	2.4	3.5
269	Other Skin, Subcut Tiss & Breast Proc W	445	142	20.6	19.2	30.1	36.1	6.2	8.6
270	Other Skin, Subcut Tiss & Breast Proc w/o	12	3	8.7	6.6	20.7	24.8	2.7	3.9
271	Skin Ulcers	5697	2054	13.1	10.9	23.1	27.7	5.6	7.1
272	Major Skin Dis W CC	78	33	10.2	7.8	18.8	22.6	4.5	5.9
273	Major Skin Dis w/o CC	5	3	10.7	10.5	15.8	19	2.9	3.7
274	Malignant Breast Dis W CC	81	42	10.8	8.2	20.7	24.8	4.7	6.3
276	Non-Malignant Breast Dis	13	9	11.7	10.2	17.8	21.3	3.5	4.5
277	Cellulitis Age >17 W CC	1921	724	10.7	9.4	17.5	21	4.6	5.6
278	Cellulitis Age >17 w/o CC	201	82	8.9	7.4	14.8	17.8	3.4	4.1
280	Trauma To The Skin, Subcut Tiss & Breas	185	62	11.5	9.4	20.3	24.3	3.2	4.1
281	Trauma To The Skin, Subcut Tiss & Breas	19	4	3.3	2.7	15.8	19	2.3	2.9
283	Minor Skin Dis W CC	74	25	12.9	11.2	19.9	23.9	3.5	4.6
284	Minor Skin Dis w/o CC	8	6	6.3	5.1	15.8	19	2.4	3
285	Amputat Of Lower Limb For Endocrine,Nu	102	27	19.8	18.7	29.7	35.6	8.2	10.5
287	Skin Grafts & Wound Debrid For Endoc, N	402	123	19.2	17.8	28.3	33.9	7.8	10.4
288	OR Proc For Obesity	12	4	11.0	8.1	24.7	29.6	3.2	4.1
290	Thyroid Proc	1	0			32.1	38.5	1.6	2.1
292	Other Endocrine, Nutrit & Metab OR Proc	36	12	13.4	11.3	26.4	31.7	7.3	10.3
293	Other Endocrine, Nutrit & Metab OR Proc	1	0			17.8	21.3	3.2	4.5
294	Diabetes Age >35	814	252	12.1	10.6	20.8	25	3.3	4.3
295	Diabetes Age 0-35	16	8	9.1	6.6	20.7	24.8	2.8	3.7
296	Nutritional & Misc Metabolic Dis Age >17	1203	433	10.9	9.2	19.3	23.1	3.7	4.8
297	Nutritional & Misc Metabolic Dis Age >17	54	30	7.5	5.6	15.3	18.4	2.5	3.1
299	Inborn Errors Of Metabolism	22	17	11.2	8.7	24.7	29.6	3.7	5.2
300	Endocrine Dis W CC	76	30	10.1	9.0	17.7	21.2	4.6	6

Short Stays and Mean Length of Stays by DRG based on 2004 MedPAR Data (continued)

		All LTC Hospitals				CMS Nominal			
			Short	Short Stays Only		Short-Stay	LTH	Acute	
DRG	DRG Name	Cases	Stays	ALOS	GMLOS	Threshold*	GMLOS	GMLOS	ALOS
301	Endocrine Dis w/o CC	13	5	10.6	9.7	15.8	19	2.7	3.4
303	Kidney, Ureter & Major Bladder Proc For N	2	1	21.0	21.0	24.7	29.6	5.8	7.4
304	Kidney, Ureter & Major Bladder Proc For N	9	4	18.5	16.5	32.1	38.5	6.1	8.6
305	Kidney, Ureter & Major Bladder Proc For N	1	1	9.0	9.0	15.8	19	2.6	3.2
306	Prostatectomy W CC	3	0			17.8	21.3	3.6	5.5
308	Minor Bladder Proc W CC	9	2	13.0	12.0	20.7	24.8	3.9	6.1
310	Transurethral Proc W CC	9	2	16.5	16.3	24.7	29.6	3	4.5
312	Urethral Proc, Age >17 W CC	2	1	15.0	15.0	15.8	19	3.2	4.8
315	Other Kidney & Urinary Tract OR Proc	364	137	18.0	16.7	26.3	31.6	3.6	6.8
316	Renal Failure	2384	886	10.0	8.3	18.9	22.7	4.9	6.4
317	Admit For Renal Dialysis	77	24	10.3	7.6	21	25.2	2.4	3.5
318	Kidney & Urinary Tract Neoplasms W CC	100	47	8.2	6.4	16.8	20.2	4.2	5.8
319	Kidney & Urinary Tract Neoplasms w/o CC	1	0			15.8	19	2.1	2.8
320	Kidney & Urinary Tract Infections Age >17	1353	467	11.0	9.7	18.5	22.2	4.2	5.2
321	Kidney & Urinary Tract Infections Age >17	116	53	9.9	8.6	15.8	19	3	3.6
323	Urinary Stones W CC, &/or Esw Lithotripsy	13	8	18.0	16.6	24.7	29.6	2.3	3.1
325	Kidney & Urinary Tract Signs & Symptoms	20	8	9.5	8.6	17.8	21.3	2.9	3.7
326	Kidney & Urinary Tract Signs & Symptoms	3	2	11.5	11.4	15.8	19	2.1	2.6
328	Urethral Stricture Age >17 W CC	1	0			15.8	19	2.6	3.5
331	Other Kidney & Urinary Tract Dx Age >17	415	162	10.7	9.1	19.3	23.1	4.1	5.5
332	Other Kidney & Urinary Tract Dx Age >17	17	6	9.0	8.1	17.8	21.3	2.4	3.1
334	Major Male Pelvic Proc W CC	1	1	15.0	15.0	17.8	21.3	3.5	4.3
336	Transurethral Prostatectomy W CC	2	0			17.8	21.3	2.5	3.3
339	Testes Proc, Non-Malignancy Age >17	8	2	15.5	15.4	24.7	29.6	3.2	5.1
341	Penis Proc	3	0			24.7	29.6	1.9	3.2
344	Other Male Reproductive System OR Proc	2	2	12.5	12.4	15.8	19	1.7	2.7
345	Other Male Reproductive System OR Proc	17	6	15.8	12.7	32.1	38.5	3.1	4.8
346	Malignancy, Male Reproductive System, W	97	50	8.0	6.2	17.2	20.6	4.2	5.7
347	Malignancy, Male Reproductive System, w	1	0			17.8	21.3	2.2	3.1
348	Benign Prostatic Hypertrophy W CC	4	0			17.8	21.3	3.2	4.1
350	Inflammation Of The Male Reproductive S	74	32	11.3	9.7	18.3	21.9	3.5	4.5
352	Other Male Reproductive System Dx	28	10	11.0	9.2	19.5	23.4	2.9	4
357	Uterine & Adnexa Proc For Ovarian or Adn	1	1	7.0	7.0	24.7	29.6	6.5	8.1
360	Vagina, Cervix & Vulva Proc	2	0			24.7	29.6	2	2.6
364	D&C, Conization Ex For Malignancy	1	0			32.1	38.5	3	4.2
365	Other Female Reproductive System OR P	9	2	29.0	28.8	32.1	38.5	5.3	7.7
366	Malignancy, Female Reproductive System	95	44	7.9	6.1	16.9	20.3	4.8	6.6
367	Malignancy, Female Reproductive System	1	1	2.0	2.0	20.7	24.8	2.3	3
368	Infections, Female Reproductive System	50	21	12.4	11.9	17.3	20.7	5.2	6.7
369	Menstrual & Other Female Reproductive S	14	3	10.0	8.3	20.7	24.8	2.4	3.3
394	Other OR Proc Of The Blood And Blood F	9	6	21.3	20.6	32.1	38.5	4.5	7.4
395	Red Blood Cell Dis Age >17	185	74	10.5	8.4	18.3	22	3.2	4.3
397	Coagulation Dis	87	39	10.4	9.0	19.1	22.9	3.7	5.1
398	Reticuloendothelial & Immunity Dis W CC	72	31	11.9	10.6	19.8	23.7	4.4	5.7
399	Reticuloendothelial & Immunity Dis w/o CC	4	1	13.0	13.0	17.8	21.3	2.7	3.3
401	Lymphoma & Non-Acute Leukemia W Oth	11	3	9.0	8.4	32.1	38.5	8	11.3

Short Stays and Mean Length of Stays by DRG based on 2004 MedPAR Data (continued)

		All LTC Hospitals				CMS Nominal			
			Short	Short Stays Only		Short-Stay	LTH	Acute	
DRG	DRG Name	Cases	Stays	ALOS	GMLOS	Threshold*	GMLOS	GMLOS	ALOS
403	Lymphoma & Non-Acute Leukemia W CC	345	159	8.6	7.0	17.8	21.3	5.8	8.1
404	Lymphoma & Non-Acute Leukemia w/o C(	13	9	5.0	4.1	17.8	21.3	3	4.2
406	Myeloprolif Disord or Poorly Diff Neopl w/M	2	1	20.0	20.0	24.7	29.6	7	9.9
408	Myeloprolif Disord or Poorly Diff Neopl w/C	6	2	16.5	15.6	24.7	29.6	4.8	8.2
409	Radiotherapy	160	66	12.5	11.1	19.6	23.5	4.3	5.8
410	Chemotherapy w/o Acute Leukemia As Se	40	18	15.9	15.2	22	26.4	3	3.8
413	Other Myeloprolif Dis or Poorly Diff Neopl [	137	71	8.8	6.6	17.1	20.5	5	6.8
415	OR Proc For Infectious & Parasitic Diseas	984	338	20.0	18.6	29.7	35.6	11	14.8
416	Septicemia Age >17	4195	1602	10.7	8.8	19.6	23.5	5.6	7.5
418	Postoperative & Post-Traumatic Infections	1906	666	12.1	10.5	20.6	24.7	4.8	6.2
419	Fever Of Unknown Origin Age >17 W CC	20	11	12.5	10.1	24.7	29.6	3.4	4.4
420	Fever Of Unknown Origin Age >17 w/o CC	1	1	5.0	5.0	24.7	29.6	2.7	3.4
421	Viral Illness Age >17	61	26	15.6	13.4	22.8	27.3	3.1	4.1
423	Other Infectious & Parasitic Diseases Dx	322	135	10.7	9.1	18.2	21.8	6	8.4
424	OR Proc w/Principal Dx Of Mental Illness	9	1	13.0	13.0	20.7	24.8	7.3	12.4
425	Acute Adjustment Reaction & Psychosocia	36	17	8.6	7.3	17.8	21.3	2.6	3.5
426	Depressive Neuroses	70	24	7.0	5.2	17.3	20.7	3	4.1
427	Neuroses Ex Depressive	35	15	10.1	7.7	19.8	23.8	3.2	4.7
428	Dis Of Personality & Impulse Control	15	4	9.3	8.7	15.8	19	4.6	7.3
429	Organic Disturbances & Mental Retardatio	422	143	14.7	12.9	22.3	26.8	4.3	5.6
430	Psychoses	2401	1025	12.8	10.8	20.2	24.2	5.8	7.9
431	Childhood Mental Dis	20	8	11.0	10.4	15.8	19	4	5.9
432	Other Mental Dis Dx	4	1	3.0	3.0	17.8	21.3	2.9	4.3
433	Alcohol/drug Abuse or Dependence, Left A	3	2	4.0	3.5	17.8	21.3	2.2	3
439	Skin Grafts For Injuries	50	16	19.4	18.3	29.7	35.6	5.4	8.9
440	Wound Debridements For Injuries	370	124	20.0	17.8	30.1	36.1	5.9	9.2
441	Hand Proc For Injuries	3	3	8.7	8.2	15.8	19	2.3	3.4
442	Other OR Proc For Injuries W CC	103	37	20.0	18.8	27.8	33.4	6	8.9
443	Other OR Proc For Injuries w/o CC	5	2	1.0	1.0	20.7	24.8	2.6	3.4
444	Traumatic Injury Age >17 W CC	124	40	13.5	11.8	21.9	26.3	3.2	4.1
445	Traumatic Injury Age >17 w/o CC	17	4	10.8	10.3	15.8	19	2.2	2.8
447	Allergic Reactions Age >17	3	1	9.0	9.0	17.8	21.3	1.9	2.6
449	Poisoning & Toxic Effects Of Drugs Age >1	28	10	9.4	5.8	20.7	24.8	2.6	3.7
452	Complications Of Treatment W CC	1495	585	13.3	11.4	21.1	25.3	3.5	4.9
453	Complications Of Treatment w/o CC	60	22	10.8	9.2	19.8	23.8	2.2	2.8
454	Other Injury, Poisoning & Toxic Effect Dx W	10	3	14.3	13.5	20.7	24.8	2.9	4.1
455	Other Injury, Poisoning & Toxic Effect Dx w	1	1	5.0	5.0	20.7	24.8	1.7	2.2
461	OR Proc w/Dx Of Other Contact w/Health	689	239	20.0	18.0	28.3	34	3	5.1
462	Rehabilitation	5174	1748	11.2	9.7	18.7	22.4	8.9	10.8
463	Signs & Symptoms W CC	899	251	10.9	9.3	19.8	23.8	3.1	3.9
464	Signs & Symptoms w/o CC	114	34	9.0	6.7	20.1	24.1	2.4	2.9
465	Aftercare w/History Of Malignancy As Sec	870	336	10.9	9.5	18.3	21.9	2.4	3.8
466	Aftercare w/o History Of Malignancy As Se	4531	1680	10.8	9.3	18.3	21.9	2.8	5.3
467	Other Factors Influencing Health Status	9	6	8.3	5.9	20.7	24.8	2	2.7
468	Extensive OR Proc Unrelated To Principal	945	338	22.6	21.1	33.5	40.2	9.7	13.2
471	Bilateral or Multiple Major Joint Procs Of L	2	0			32.1	38.5	4.5	5.1
473	Acute Leukemia w/o Major OR Proc Age >	74	42	7.3	5.2	16.7	20	7.4	12.7
475	Respiratory System Dx With Ventilator Su	13171	5182	14.5	11.4	28.8	34.6	8.1	11.3
476	Prostatic OR Proc Unrelated To Principal [	26	8	18.9	16.9	24.7	29.6	7.4	10.5
477	Non-Extensive OR Proc Unrelated To Prin	361	123	19.8	17.8	29.4	35.3	5.8	8.7
478	No Longer Valid	122	0					0	0

Short Stays and Mean Length of Stays by DRG based on 2004 MedPAR Data (continued)

		All LTC Hospitals				CMS Nominal			
			Short	Short Stays Only		Short-Stay	LTH	Acute	
DRG	DRG Name	Cases	Stays	ALOS	GMLOS	Threshold*	GMLOS	GMLOS	ALOS
482	Tracheostomy For Face,Mouth & Neck Dx	1	1	21.0	21.0	32.1	38.5	9.6	12.1
484	Craniotomy For Multiple Significant Traum	1	1	11.0	11.0	17.8	21.3	9.3	12.8
486	Other OR Proc For Multiple Significant Tra	3	1	18.0	18.0	32.1	38.5	8.5	12.5
487	Other Multiple Significant Trauma	34	11	11.8	9.6	21.7	26	5.3	7.3
488	Hiv w/Extensive OR Proc	5	2	23.0	21.6	32.1	38.5	11.8	16.4
489	Hiv w/Major Related Condition	283	116	9.9	8.3	17.8	21.4	5.9	8.4
490	Hiv w/ or w/o Other Related Condition	68	29	8.2	7.4	13.8	16.6	3.8	5.4
491	Major Joint & Limb Reattach Proc Of Uppe	1	0			32.1	38.5	2.6	3.1
493	Laparoscopic Cholecystectomy w/o C.d.e.	9	5	14.8	14.1	32.1	38.5	4.5	6.1
497	Spinal Fusion Ex Cervical W CC	5	3	15.3	15.3	24.7	29.6	5	5.9
499	Back & Neck Proc Ex Spinal Fusion W CC	12	4	24.0	22.8	32.1	38.5	3.1	4.3
500	Back & Neck Proc Ex Spinal Fusion w/o C	1	0			24.7	29.6	1.8	2.2
501	Knee Proc W Pdx Of Infection W CC	19	3	24.3	23.7	32.1	38.5	8.5	10.4
502	Knee Proc W Pdx Of Infection w/o CC	3	0			24.7	29.6	4.9	5.9
503	Knee Proc w/o Pdx Of Infection	3	1	10.0	10.0	17.8	21.3	2.9	3.8
505	Exten. Burns or Full Burn w/mv 96+Hrs w/	5	0			24.7	29.6	2.4	4.6
506	Full Burn W Skin Graft or Inhal Inj W CC o	10	2	14.0	12.6	24.7	29.6	11.2	15.9
507	Full Burn W Skin Grft or Inhal Inj w/o CC o	2	0			20.7	24.8	5.8	8.5
508	Full Burn w/o Skin Grft or Inhal Inj W CC o	30	10	15.7	13.7	24.5	29.4	5.1	7.4
509	Full Burn w/o Skin Grft or Inh Inj w/o CC o	7	3	7.3	4.7	15.8	19	3.6	5.2
510	Non-Extensive Burns W CC or Significant	35	14	13.0	11.3	20.5	24.6	4.4	6.4
511	Non-Extensive Burns w/o CC or Significan	4	1	15.0	15.0	15.8	19	2.6	4.1
515	Cardiac Defibrillator Implant w/o Cardiac C	16	6	19.5	18.2	32.1	38.5	2.6	4.3
517	No Longer Valid	4	0					0	0
518	Perc Cardio Proc w/o Coronary Artery Ster	2	1	13.0	13.0	20.7	24.8	1.8	2.5
519	Cervical Spinal Fusion W CC	1	1	32.0	32.0	32.1	38.5	3	4.8
521	Alcohol/drug Abuse or Dependence W CC	38	15	11.3	10.8	16.2	19.4	4.2	5.6
523	Alc/drug Abuse or Depend w/o Rehabi The	9	5	4.6	2.6	15.8	19	3.2	3.9
524	Transient Ischemia	31	11	10.1	9.3	17.6	21.1	2.6	3.2
527	No Longer Valid	1	0					0	0
529	Ventricular Shunt Proc W CC	2	0			32.1	38.5	5.3	8.3
531	Spinal Proc W CC	15	10	12.0	11.0	20.7	24.8	6.5	9.6
532	Spinal Proc w/o CC	2	1	13.0	13.0	20.7	24.8	2.8	3.7
533	Extracranial Proc W CC	19	7	26.0	25.4	32.1	38.5	2.4	3.8
537	Local Excis & Remov Of Int Fix Dev Ex Hip	43	11	19.2	17.8	28.9	34.7	4.8	6.9
539	Lymphoma & Leukemia W Major or Proc W	4	1	11.0	11.0	24.7	29.6	7	10.8
541	Ecmo or Trach W Mv 96+Hrs or Pdx Exc F	175	60	36.9	34.4	54.7	65.6	38.1	45.7
542	Trach W Mv 96+Hrs or Pdx Exc Face, Mou	714	247	25.1	22.5	40.2	48.2	29.1	35.1
543	Craniotomy w/implant Of Chemo Agent or	3	0			32.1	38.5	8.5	12.3
544	Major Joint Replacement or Reattachment	7	2	31.0	31.0	32.1	38.5	4.1	4.5
545	Revision Of Hip or Knee Replacement	18	3	25.3	24.3	32.1	38.5	4.5	5.2
N/A	N/A	37	0	0.0	1.0				

* The short-stay threshold is 5/6 of the nominal LTH GMLOS

Source: Lewin Group analysis of the 2004 Medicare Provider Analysis and Review (MedPAR) data. The CMS nominal values from the IPPS Final Rule for FY 2006.

Attachment B to Testimony of John Votto, D.O.

Appendix A

Comparison of LTCH and ACH DRG Weights by DRG for All SSO Cases

Diagnosis Related Group (DRG)	Number of LTCH Cases	LTCH DRG Weight	Number of ACH Cases	LTCH DRG Weight	Diff Between LTCH and ACH DRG Weight
7	113	3.0390	14,782	1.8486	1.1904
9	58	1.6313	1,724	0.9803	0.6510
10	66	1.4084	18,551	0.8634	0.5450
12	1,750	1.2480	52,059	0.6364	0.6116
13	41	0.9573	7,063	0.5701	0.3872
14	144	1.3218	235,629	0.8744	0.4474
15	57	0.9657	92,689	0.6734	0.2923
16	92	1.2891	9,895	0.8785	0.4105
18	121	1.1752	29,545	0.6990	0.4762
19	11	0.9560	8,485	0.4911	0.4649
20	154	1.7316	6,179	1.8929	(0.1613)
23	15	1.1852	11,165	0.5737	0.6114
24	72	1.2414	58,700	0.7014	0.5400
27	11	1.4511	4,447	0.9317	0.5195
28	60	1.4822	13,952	0.9304	0.5518
34	234	1.3440	23,699	0.6916	0.6524
35	19	0.7638	7,411	0.4428	0.3211
64	43	1.5637	3,109	0.9113	0.6524
65	5	0.7358	39,944	0.4010	0.3348
67	1	3.7672	383	0.5427	3.2245
68	20	1.2358	11,465	0.4555	0.7804
73	26	1.4268	7,654	0.5703	0.8565
75	9	2.6586	43,245	2.1226	0.5360
76	608	4.7632	44,348	1.9640	2.7992
78	111	1.3039	39,220	0.8856	0.4184
79	1,710	1.6891	167,196	1.1133	0.5758
80	47	0.9747	7,929	0.5853	0.3894
82	158	1.2138	63,922	0.9560	0.2578
85	95	1.3759	22,136	0.8299	0.5460
86	2	0.7097	2,226	0.4783	0.2315
87	2,163	1.8007	60,498	0.9348	0.8659
88	2,008	1.2142	398,325	0.6271	0.5871
89	1,864	1.3499	525,617	0.7244	0.6255
90	49	0.8806	47,542	0.4276	0.4530
92	109	1.1902	15,657	0.8374	0.3528
94	25	1.0823	12,763	0.7895	0.2928
96	61	1.2468	56,023	0.5205	0.7263
97	15	0.9493	28,360	0.3840	0.5652
99	143	1.5350	21,198	0.4901	1.0448
100	2	0.5292	8,182	0.3643	0.1648

Comparison of LTCH and ACH DRG Weights by DRG for All SSO Cases (continued)

Diagnosis Related Group (DRG)	Number of LTCH Cases	LTCH DRG Weight	Number of ACH Cases	ACH DRG Weight	Diff Between LTCH and ACH DRG Weight
101	136	1.3668	22,194	0.6030	0.7638
102	2	1.0346	5,584	0.3793	0.6553
113	60	3.8085	39,525	2.0303	1.7783
114	18	2.5241	8,280	1.1460	1.3781
120	185	2.4948	38,097	1.6150	0.8797
121	48	1.3892	162,443	1.0968	0.2924
123	23	1.5470	38,308	1.0915	0.4555
126	208	1.6560	5,371	1.7552	(0.0991)
127	1,400	1.2546	667,674	0.7117	0.5430
130	498	1.3147	88,024	0.6558	0.6589
131	21	0.9300	26,812	0.3926	0.5374
132	161	1.2110	141,313	0.4458	0.7652
133	13	0.8132	8,584	0.3879	0.4253
134	32	1.0708	40,950	0.4152	0.6556
135	50	1.0918	7,749	0.6441	0.4478
138	127	1.0221	206,600	0.5812	0.4409
139	11	0.6227	86,760	0.3600	0.2627
141	24	1.0640	108,038	0.5210	0.5430
142	7	0.6541	52,222	0.4019	0.2522
144	615	1.2835	94,294	0.8529	0.4306
145	11	0.6396	7,277	0.4036	0.2359
148	11	4.3224	133,149	2.3720	1.9504
151	1	2.6289	5,108	0.9111	1.7177
170	46	3.4173	15,615	1.9687	1.4486
171	1	1.9987	1,508	0.8305	1.1682
172	136	1.5401	31,193	0.9517	0.5884
173	5	0.9743	2,456	0.5246	0.4497
174	92	1.2301	249,690	0.6982	0.5320
175	6	0.4560	34,572	0.3895	0.0665
176	15	1.3985	13,384	0.7665	0.6320
179	30	1.5018	13,115	0.7589	0.7429
180	86	1.4414	89,518	0.6716	0.7698
182	323	1.4524	270,142	0.5733	0.8791
183	11	0.7272	90,281	0.4017	0.3255
185	6	1.3115	5,350	0.6053	0.7062
188	470	1.7765	83,496	0.7722	1.0042
189	13	0.8060	13,002	0.4173	0.3887

Comparison of LTCH and ACH DRG Weights by DRG for AllSSO Cases (continued)

Diagnosis Related Group (DRG)	Number of LTCH Cases	LTCH DRG Weight	Number of ACH Cases	ACH DRG Weight	Diff Between LTCH and ACH DRG Weight
202	72	1.0629	26,597	0.9130	0.1499
203	51	1.2459	29,851	0.9390	0.3069
204	161	1.6195	65,032	0.8124	0.8070
205	74	1.1771	27,308	0.8414	0.3357
207	35	1.2914	32,486	0.8000	0.4914
211	1	0.1411	29,910	0.8679	(0.7268)
213	50	2.8658	9,941	1.3179	1.5479
217	283	2.8227	17,302	2.0906	0.7321
225	14	2.0605	6,458	0.8165	1.2440
233	24	3.2714	9,955	1.3963	1.8751
235	4	1.1596	5,077	0.5240	0.6356
236	28	1.2198	39,734	0.5049	0.7149
238	565	1.7180	8,853	0.9431	0.7749
239	82	1.1457	45,836	0.7293	0.4164
240	44	1.0881	11,991	0.9164	0.1717
242	122	1.7388	2,575	0.8116	0.9273
243	188	1.0084	95,842	0.5242	0.4841
244	41	1.1881	14,536	0.4989	0.6891
245	14	0.9037	5,794	0.3338	0.5699
246	7	1.1017	1,483	0.4229	0.6788
247	27	0.8153	20,262	0.3991	0.4162
248	71	1.1231	13,801	0.5982	0.5249
249	1,922	1.1332	12,889	0.4698	0.6634
253	17	1.0099	21,978	0.5279	0.4820
254	3	0.5843	10,705	0.3110	0.2733
256	174	1.5773	6,679	0.5704	1.0070
263	1,079	2.8294	23,018	1.4324	1.3970
264	58	1.6955	3,859	0.7394	0.9561
265	26	2.2588	4,097	1.1148	1.1441
269	140	3.0307	9,800	1.2373	1.7933
271	2,001	1.6761	19,129	0.7163	0.9599
272	22	1.1947	5,696	0.7094	0.4852
274	9	1.7102	2,283	0.8063	0.9039
277	701	1.2173	99,585	0.6089	0.6085
278	8	0.7974	31,973	0.3775	0.4199
280	59	1.0462	17,758	0.4956	0.5506
281	3	0.2868	7,518	0.3393	(0.0526)
283	23	1.3608	6,010	0.5101	0.8507
285	27	3.2003	6,942	1.4518	1.7485
287	121	2.3060	6,223	1.3171	0.9888
294	244	1.4007	97,377	0.5410	0.8596
296	411	1.3599	277,113	0.5988	0.7611
297	25	0.7324	47,860	0.3537	0.3787

Comparison of LTCH and ACH DRG Weights by DRG for All SSO Cases (continued)

Diagnosis Related Group (DRG)	Number of LTCH Cases	LTCH DRG Weight	Number of ACH Cases	ACH DRG Weight	Diff Between LTCH and ACH DRG Weight
300	25	1.0277	18,635	0.7665	0.2612
301	3	0.8190	3,592	0.4293	0.3897
315	135	2.8792	34,014	1.4505	1.4287
316	853	1.4338	118,639	0.9037	0.5301
317	24	1.4998	2,029	0.5932	0.9066
318	16	1.5144	5,737	0.8261	0.6883
320	438	1.3191	185,666	0.6115	0.7076
321	47	0.9245	30,824	0.3951	0.5295
331	155	1.4582	51,130	0.7395	0.7188
332	6	0.6851	4,964	0.4171	0.2680
334	1	2.3165	10,503	1.0330	1.2834
346	14	1.1964	4,823	0.7118	0.4846
350	30	1.2172	6,669	0.5139	0.7033
357	1	1.4275	5,609	1.5861	(0.1586)
366	22	1.3991	4,555	0.8907	0.5084
368	21	1.5966	3,547	0.8121	0.7845
395	71	1.4058	106,920	0.5770	0.8288
397	38	1.4092	18,865	0.8811	0.5280
398	27	1.2725	18,054	0.8609	0.4117
403	113	1.3262	31,718	1.2678	0.0584
409	65	1.7428	2,155	0.8678	0.8750
413	28	1.4028	5,303	0.9209	0.4820
415	333	2.9569	43,248	2.5272	0.4297
416	1,551	1.5416	190,961	1.1082	0.4335
418	652	1.5435	25,757	0.7420	0.8015
421	26	1.6616	10,646	0.5206	1.1409
423	130	1.6837	8,039	1.2646	0.4192
425	11	0.5728	16,028	0.4726	0.1001
426	12	0.4620	4,549	0.3544	0.1076
428	3	0.7784	793	0.5080	0.2705
429	96	1.2124	27,000	0.5679	0.6445
430	724	0.8735	64,921	0.4732	0.4003
431	8	0.6812	316	0.4605	0.2207
432	1	0.1442	448	0.4542	(0.3099)
439	16	2.6165	1,516	1.2242	1.3924
440	123	2.5308	5,775	1.3162	1.2145
442	37	3.1882	17,534	1.6867	1.5015
443	2	0.4440	3,910	0.6826	(0.2386)
444	40	1.5246	5,723	0.5211	1.0035
445	3	0.8830	2,544	0.3498	0.5332

Comparison of LTCH ans ACH DRG Weights by DRG for All SSO Cases (continued)

Diagnosis Related Group (DRG)	Number of LTCH Cases	TCH DRG Weight	Number of ACH Cases	ACH DRG Weight	Diff Between LTCH and ACH DRG Weight
452	573	1.7898	25,608	0.7280	1.0618
453	22	1.1296	5,670	0.3566	0.7730
461	231	2.6655	4,964	0.8157	1.8498
462	1,528	1.1667	9,653	0.6749	0.4918
463	248	0.9982	26,785	0.4779	0.5203
464	34	0.7624	7,137	0.3473	0.4151
465	335	1.0854	197	0.6196	0.4658
466	1,629	1.1684	1,716	0.5641	0.6044
468	325	4.2355	51,309	2.6472	1.5884
473	22	1.5193	8,064	2.4235	(0.9042)
475	4,959	3.4036	109,073	2.5009	0.9027
477	119	2.9505	26,262	1.3152	1.6353
482	1	3.6175	5,284	2.4243	1.1932
484	1	2.3226	345	3.7689	(1.4463)
487	10	1.3611	3,885	1.3904	(0.0293)
489	113	1.7921	13,365	1.2968	0.4953
490	27	1.1293	5,439	0.7331	0.3962
508	10	1.4059	622	0.9554	0.4505
510	4	1.3835	1,634	0.8220	0.5615
521	13	0.5523	30,580	0.4956	0.0567
523	2	0.4695	15,190	0.2756	0.1939
524	10	0.8570	131,223	0.5104	0.3466
537	11	3.1824	6,861	1.2683	1.9142

Chairman JOHNSON. My first question is going to be to Dr. Votto and Mr. Altman, and also Ms. Moore if she cares to answer it. There seems to be a contradiction in your testimony. On the one hand, you say you cannot predict who is going to be a short stay and, on the other hand, you say you will have to not accept short stays if this proposal goes through. Discuss that issue. Those two comments were at different points in different statements, and so, please clarify that.

Mr. ALTMAN. I will start, if that is okay. I think that what I testified was that we cannot predict and, therefore, I don't think there is any way that we would be able to not admit people that would be short stay. that would be what our position would be, and that is what I am told by our physicians. I don't think there is any way we can respond to this rule in the way that CMS assumes by taking fewer patients that would be short-stay outliers because I don't think we can predict that.

Chairman JOHNSON. Dr. Votto?

Dr. VOTTO. I will comment on that. I agree that there is no way and there is no evidence or publication that suggest that there is any way to predict a short-stay outlier, just like there is really not a lot of evidence that predicts who can get off a ventilator and who cannot and the way you do your weaning, because there is just not a lot of evidence.

I think that one of the problems with long-term acute care hospitals is in the definition. We are acute care hospitals; thus, we

have to take theoretically acutely ill patients. If you say—you take acutely ill patients but they have to have a long length of stay and they have to look similar to acute care patients, but you have to predict that they are going to stay a long time, this makes it a little bit tough. That is why it took us so long to develop the admission criteria. We believe that we have criteria that can distinguish these groups of patients, but as was stated, there is no way to predict. I believe that we can reduce the numbers of very short stay, possibly, with very good review by QIOs or whoever, if they audited the admission criteria and the use of the admission criteria.

Chairman JOHNSON. This leads me to my next question. Dr. Votto, you have talked about spending 2 years developing criteria. Mr. Altman, you have talked about developing criteria. Ms. Moore, you have been very directly involved in it. How close are you three to being able to sit down and come together on a set of criteria that we could put in place?

Dr. VOTTO. Well, it is March 15th, and I believe our criteria will be ready on March 31st. I don't know—but if we then looked at trying to collaborate with others, I think that would be reasonable. I think we could put out criteria at this time and adjust them over time. As most places do that develop criteria, you usually bring them out, try them out. We have had them validated, as Laura said, by MassPRO. We believe that they are good criteria. We believe that they are useful. We have no problem, though, revisiting them at certain intervals, and we have to do that, anyway.

Mr. ALTMAN. I think ours will be available March 30th.

[Laughter.]

Mr. ALTMAN. I think what would be helpful perhaps is some direction from Congress to CMS—and, by extension, the provider community—to sit down and work this through in an open, transparent, public way. We at ALTHA and Kindred are more than happy to sit down, we have been trying to sit down with various folks in the government to move this thing along.

I think one thing that might be helpful is some direction from Congress to CMS and to us to engage in an open public process to come up with criteria that meets the policy goals that we all seem to share. I think that can be done very quickly.

Chairman JOHNSON. Well, I hope you will take this hearing as giving you that direction. You cannot beat something with nothing. We have something that I think is not only not workable but positively negative and will have a damaging impact on the system. I think the answer is to go forward with what we have said we wanted to do for several years now and that MedPAC recommended—I don't remember whether it was 2 or 3 years ago—that we need a criteria-based system, because it is best to start with that with you folks. Then we can back down on that for the other facilities. We need to get greater clarity about what kinds of patients you treat, recognizing that, of course, two people can come in the same state and one does remarkably well and one does very badly.

The system is supposed to account for that already. The arbitrariness of short-stay policies in my estimation conflict with the underlying logic of a DRG system. I am not anxious to start down that path with facilities that deal with such extremely complex and ill patients. I would like to get some idea of whether you can begin

working together in your criteria to see whether you can merge your opinions. I am more familiar with Dr. Votto's efforts since he is a neighbor, but I know his Committee has been nationwide. The experience cannot be all that different. The nature of for-profits and nonprofits in this arena I do not believe is all that significant. I think, Mr. Altman, with your experience of not only LTCHs but nursing homes who do this kind of—you know, do the stepdown, that could be very useful. Ms. Moore, are you optimistic that we could move forward on a criteria-based system in a reasonable period of time?

Ms. MOORE. Like I said, our efforts are with NALTH, and I echo Dr. Votto's statement, that we really do intend on having criteria for a long-term care hospital setting completed by the end of the month. As a quality improvement, performance improvement organization, we believe in and foster collaboration, and we would be more than happy to assist in the effort in any way. It helps us and the Medicare trust fund as well in terms of——

Chairman JOHNSON. One vastly overlooked strength of the QIOs is that you are actually on the ground in every single State and do see the care issues patient by patient and provider by provider.

Ms. MOORE. Absolutely.

Chairman JOHNSON. All right. Mr. Pomeroy? It is a pleasure to have Mr. Pomeroy with us. He has taken a great interest in a number of the issue areas before this Committee, and this is one of them.

Mr. POMEROY. Madam Chairman, thank you very much, and although I am not a member of this Subcommittee, I follow your hearings with the greatest of interest, and this one involves a segment in the continuum of care that I really was not very familiar with. I found out, in response to the CMS rule change, North Dakota has two of these facilities. There are now 122 nationally?

Mr. ALTMAN. More like 380.

Mr. POMEROY. Three hundred and eighty? Oh, that is more than I thought. Is that a rapidly growing number?

Mr. ALTMAN. It has grown by number of facilities in the last few years at a pretty good rate. I think it is important to put that into context, as we discussed before. Number one, many of these facilities are small. You can have a 40-, 50-, 60-bed hospital.

Mr. POMEROY. Right.

Mr. ALTMAN. It is not like especially the newer ones are very large. Number two, the interesting thing about the recent growth and your experience in particular is that there has been historic geographic mal-distribution of LTCHs concentrated in a small number of States. The growth has occurred in areas where there were not formerly LTCH services, including North Dakota and some other areas.

Then, the last thing that we discussed about growth before you were able to join us is that the growth has really slowed down, particularly in the last year, with the implementation of the 25-percent HIH rule that Dr. Votto referenced, which has not even really fully gone into effect, so that growth really hasn't even taken into effect those HIHs that are going to have to close as a result of this rule. The growth we do see is slowing down a little bit. The growth

that is occurring, is evening out the distribution and making this service available to a larger, a more diverse set of—-geographic set of beneficiaries.

Then the last thing that we discussed and probably the most important, is that the best way to get at growth, because there is growth that is inappropriate, and then, there is growth that would arguably be appropriate because it is providing an expanded service to the people we want that service to be available to, and that is the medically complex, severely ill people, and that is the certification criteria. That will also address growth. The last thing I would say in terms of growth is that we at Kindred have seen a significant——

Mr. POMEROY. What is the status—so, there is a certification of what is a legitimate LTCH for purposes of Medicare reimbursement?

Mr. ALTMAN. Right now, the only certification criteria for an LTCH is if you have a 25-day length of stay for your Medicare patients. We are part of a number of people, including policymakers, who say, you know what, that is not a targeted enough definition. We really ought to make it based on the patients more.

Mr. POMEROY. It strikes me that this issue really brings to the fore the fact that we spend an awful lot of money on very ill people at the end of life who are struggling to hang on to life, frankly. Obviously, that is an essential function of the health care system, provide for people at that time, but it really does get extremely expensive. I was very interested in your testimony, Ms. Moore. You talk about noting, yes, these are expensive, but compared to what? If you look at treatment of those that are legitimately in these facilities, it really is not necessarily, more expensive. They are going to be an extremely expensive patient no matter where they are. They are very, very ill. Is that correct?

Ms. MOORE. I am sorry. We really cannot comment on the payment system. We do not have experience with that. The evidence and data we collect do not talk to that. What we can say is that the screening criteria really help us direct the patient to the appropriate setting.

Mr. POMEROY. Okay. On that point, so the industry is basically saying, look, develop an admission criteria. You have concerns here; develop an admit criteria. Don't just whack rates, because you are going to what people that need to be in these facilities. The institutions in North Dakota that I visited with on Monday in preparation for this hearing told me that they believe these rates will dramatically shrink services and affect the willingness of hospitals to take transfers, and you are going to have ICUs stacking up all across the country. Do you have a comment on that?

Ms. MOORE. What I can say, again, in developing the criteria with NALTH, one of the criterion we look at is weaning of mechanical ventilation, and what the criteria tells us is that when the patient fails weaning on a regular basis or repeatedly, that is a patient appropriate for the long-term care hospital setting. What that does do, is it frees up a short-term ICU bed in the acute care hospital setting and gives the patient the right expertise that they need. I can speak to that in terms of an example for the Committee.

Mr. POMEROY. Right. If that referral source is not available, what do you do? You have got—it looks like a long-term case here, weaning was not successful. Do you pull the plug on the ventilator because you have got nowhere to send them? Of course, you cannot do that. They stay in the ICU even though it is over indicated lengths of stay. That gets very expensive as well. This whole business is—it needs more of a holistic approach than just watch the rates and see what happens. We are talking about lives in the balance. I thank the Chairman. I yield back.

Chairman JOHNSON. Thank you, Mr. Pomeroy. I do want to clarify a couple of things while you are before us just for the record. One is we look at the growth of both the long-term care hospitals and the hospitals within a hospital, satellites. What has driven that growth?

Mr. ALTMAN. I am sorry. What has driven the growth——

Chairman JOHNSON. Why has there been a really dramatic increase in patients needing that level of care? This is not a hard question. I just want it on the record. It is so obvious to you that I see you staggering. I do not want some mysterious answer. I want to put on the record what kinds of treatment capability have we developed in the last decade that has allowed this expansion, because Dr. Votto's hospital has been there a long, long time. When I was first elected to the State Senate 30 years ago, it was basically a residential facility. When you went there, you did not leave. I have seen the evolution. In the last, I do not know, 10 or 12 years, there have been some advances in medicine because you are a different operation now than you were even when you moved from a residential facility to an actual hospital. I think we need to put on the record what are some of the diagnoses that are, what are some of the treatment capabilities that are different, and why are people able to go home from these institutions and become independent when they are unlikely to be able to go home from either an acute care hospital or a nursing home.

Dr. VOTTO. Okay. I will try to answer that question. First of all, technology has prolonged the lives of many people. I would like to answer Mr. Pomeroy's question maybe before he leaves, real quick.

Chairman JOHNSON. Do that first, yes.

Dr. VOTTO. Or try to answer it, anyway, because I have to answer it anecdotally, not with side-by-side data. In our study looking at ventilator outcomes, our average patient costs approximately $68,000 from 23 different centers, so the average is pretty good and that is 1,400 patients.

When we looked at a side-by-side population that was published in the Critical Care Journal, it looked at the length of stay of patients that were difficult to wean, not dissimilar to our patients, and the cost average, if you extrapolated the costs in an acute care hospital, which is about 2 to 3 times more per day than a long-term hospital, the cost comparison we came up with was about $210,000 versus $68,000.

Mrs. Johnson's question gets to the issue of possibly why do we have more of these patients. The answer is that there is better technology. Patients who had septic shock 15 years ago probably died most of the time. Patients with septic shock nowadays, certainly many of them live. They end up on a ventilator. They end

up pretty sick, but they will live. They are very sick when they get out, and it takes them a long time to recover.

The reason, I think, LTCHs in general have better outcomes is because we have a more programmatic rehabilitative approach with a team approach. In my hospital, we have a team that, as soon as you come in and you are a ventilator-weaning patient, just like NASA's job was to get somebody on the Moon and everybody understood that was their job, get somebody on the Moon, for all those years and they got somebody on the Moon, our job is to get people off ventilators, so we spend all of our time, energy, and staff getting them off the ventilator. That is the job, so that physical therapy and occupational therapy see them the day they come in. Nutrition sees them the day they come in.

It is an approach that you have to use with critically ill patients, or you don't get good outcomes. Critical masses are the important issue in LTCHs. If you have a critical mass of patients who are ventilator dependent, then you know how to do it. You have a whole team that can do it. If you have patients who are ventilator dependent scattered throughout a big acute care hospital, you cannot have the team approach. The same with wounds, the same with head injury, lots of specific diagnostic categories that relate to LTCH care. I would think that that would be the answer that I would give for those questions.

Chairman JOHNSON. Would you like to add anything?

Mr. ALTMAN. The only thing I would add is the notion of interdisciplinary versus multidisciplinary care, and the interdisciplinary care approach that Dr. Votto has described, where you have a team captain and all the disciplines working toward a common goal is really not the way short-term acute care hospitals are set up. They are set up to stabilize and treat, and they do a very good job of that. They are not set up to do the extended course of care that is what we do in LTCHs.

Chairman JOHNSON. If you come in for knee replacement and you have heart problems, you go down to the cardiac floor.

Dr. VOTTO. Right.

Mr. ALTMAN. Right.

Chairman JOHNSON. It is a very different concept, and I think we need to recognize that.

The last thing I want to get on the record is your experience, Dr. Votto—in the cost of a new bed, building a free-standing institution versus the cost of building a bed in a hospital that has space.

Dr. VOTTO. Well, the example that I used, when we looked at 25 beds costing $25 million, I found out that the industry—this is not unusual in the industry. A million dollars a bed for a hospital is pretty much fairly standard, at least in New England. When we realized that we could afford to do that, we looked to partner, and there are certainly many older hospitals in New England with lots of new attachments, new buildings to them, and so they have units that they have not used. What we found was that we could renovate a very large unit, as we said, 28 beds, at a price 10 percent of the cost of building a new building. It seemed like a very logical approach.

I believe that we have the same—we do have the same programs there as we have at the base hospital. One advantage that we have

at the satellite is that we can actually take even sicker patients because we can get surgeons to come over more quickly, and if there are diagnostic tests that you absolutely need, you can get them a little bit easier. There are advantages to the satellite.

Chairman JOHNSON. All right. Thank you very much for your testimony. It has been very helpful. We are expecting that the RTI study will be done in a couple of months or so. I know some of you have been interviewed by their researchers and have had input into it, and we certainly will encourage them to move along rapidly. I encourage you to move along rapidly so that we can get some sense of what is the consensus from the care giver community and what impact you think it will have. That way we will be able to compare your analysis, your information with the administration's analysis and information, which has not yet been made public and should be made public, and what RTI is doing. Because, clearly, we need to move to a criteria-based system, and we need to figure out how we make that transition, and that is number one. Then after that is done, we will know whether there is or is not a legitimate problem with people being in the high-cost setting of an LTCH versus a more appropriate setting for that particular patient of a nursing home or an acute care facility.

That is our goal. We must pursue it, and you will just have to accelerate your time to do this and come to some conclusion so you can provide guidance. You know, the real answer is, in a democracy, for the real world to provide guidance to the government. The government should only come in to do what the real world cannot on their own, and you cannot individually assure that the criteria is the same for all institutions. We can do that. The criteria should come from the patient-physician level, and I am pleased that you are so far along, and we look forward to working with you, and thank you, Ms. Moore, for the role of the Massachusetts QIO in not only developing this approach and teaching other QIOs and doing some basic work over the last few years, but also for working with NALTH to review their proposal.

Thank you very much.

[Whereupon, at 4:45 p.m., the hearing was adjourned.]

[Question submitted from Mr. Sam Johnson to Mr. Kuhn and his response follow:]

Question: In your testimony, you mentioned that CMS estimates the margins of Long-term Care Hospitals (LTCHs) to be around 12 percent. Do those margins take into account changes in regulation that have taken place over the last couple years, such as the so-called "25-percent rule," or the re-weighting of the DRGs? Do you think that those changes have taken full effect? If not, do you think there is any wisdom in letting those policies run their course?

Answer: In the long-term care hospital prospective payment system (LTCH PPS) final rule for rate year (RY) 2007, the Centers for Medicare & Medicaid Services (CMS) calculated "revenue-weighted" Medicare margins to evaluate the overall financial status of LTCHs. CMS' analysis of the latest available LTCH data found that LTCH Medicare margins for fiscal year (FY) 2003—the first year of the LTCH PPS—were 7.8 percent, and preliminary data for FY 2004 based on the most recent data revealed a Medicare margin of 12.7 percent. These estimates do not take into account changes in the regulations that have taken place over the last few years, including the impact of the "25-percent rule" or the re-weighting of the long-term care diagnosis related groups (LTC–DRGs).

The "25-percent rule" is a special payment provision for long-term care hospitals-within-hospitals (HwHs) and satellites, which comprise approximately 39.5 percent of all LTCHs. Under this policy, CMS adjusts payments for patients admitted from

the host hospital to the co-located LTCH that exceed a specified threshold percentage (in most cases, 25 percent). For cost reporting periods beginning on or after October 1, 2003, which was the effective date of the rule, the only affected facilities were those co-located LTCHs that had their first cost reporting period as a LTCH after the effective date. Existing co-located LTCHs were held-harmless for their first cost reporting period following the effective date of the regulation. Therefore, CMS did not have the data to evaluate the impact of this policy, and could not factor in the anticipated behavioral changes by both the host hospital and the co-located LTCHs.

CMS determines LTC–DRG relative weights to account for differences in resource use by LTCH patients who typically have complex cases and multiple medical problems. For payments for discharges occurring in FY 2006, CMS recalibrated the LTC–DRG relative weights based on an analysis of LTCH claims data from FY 2004. The recalibration of LTC–DRG weights only corrects for coding improvement for the purpose of making accurate LTCH PPS payments in FY 2006. Annual recalibration does not serve to account for payments that were made based on improved coding (rather than patient severity) in prior years.

Based on the information available to us, we do not believe that it would be appropriate to "postpone implementation" of the policies finalized for FY 2007, including the zero percent update to the standard Federal rate, the payment adjustment for short-stay outlier cases, and the case mix adjustment to the market basket, pending an analysis of other impacts on LTCH payment adequacy.