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Advancing Health in America

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March 19, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
The Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Room 445-G
Washington, DC 20201

Submitted Electronically

Re: Protecting Critically Ill Medicare Beneficiaries Through Reforms to the Long-term Care Hospital Prospective Payment System High-Cost Outlier Policy

Dear Administrator Brooks-LaSure:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including approximately 250 long-term care hospitals (LTCH), and our clinician partners — more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) is writing regarding a pressing issue with the potential to impact thousands of critically ill Medicare beneficiaries. The AHA is recommending that the Centers for Medicare & Medicaid Services (CMS) make changes to its high-cost outlier (HCO) policy that is part of the LTCH prospective payment system (PPS) to help avoid significant financial hardship on LTCHs and loss of access to care for Medicare beneficiaries.

The current HCO policy is incompatible with the modern LTCH PPS, which has changed substantially since it underwent significant reforms eight years ago. As such, it should be reconfigured to match the current and future realities of the patient care that LTCHs provide. Therefore, as discussed in AHA's December 2023 white paper on this policy, we recommend that the agency:

- revert to a market-basket based methodology for calculating the HCO fixed-loss amount, which would help ensure the fixed-loss amount grows consistent with payment;
- include all LTCH cases in its methodology when calculating annual updates to the fixed-loss amount, which would provide more stability from year to year,

allowing providers to better predict both HCO losses and the partial relief provided by the HCO policy; and

- initiate an analysis of LTCH cases' cost variation within payment groups to determine whether refinements to improve overall payment accuracy are needed.

BACKGROUND

As CMS is aware, LTCHs play highly specialized roles in the care continuum by focusing on caring for critically ill, medically complex patients that require extended hospital stays. Less than 1% of Medicare beneficiaries discharged from short-term acute-care hospitals (STACHs) are sent to an LTCH, but these are the most highly acute patients.

In recognition of the unique patients served by LTCHs, Congress in 1999 and 2000 directed CMS to establish the LTCH PPS. Then, in 2016, CMS implemented substantial reforms to the LTCH PPS. This included a dual-rate payment policy, which made full payment (the "standard rate") only for beneficiaries who were admitted following STACH stays with at least three days in the ICU, or if the patient received ventilator services for at least 96 hours during their stay in the LTCH. If beneficiaries do not meet this criteria, LTCHs are paid a rate equivalent to what a STACH would be paid through the inpatient PPS (IPPS) (the "IPPS-equivalent rate").

This policy has had far-reaching implications for the LTCH field. Most notably, the number of standard rate cases has fallen by more than 40%, from approximately 74,000 in 2016, to only 42,000 in 2022. In addition, the number of Medicare-participating LTCHs has also decreased by 20% in that same period. As explained more below, 2016 reforms and other market dynamics have yielded a significantly altered, more acute patient mix in LTCHs. However, the reforms left untouched certain components of the LTCH PPS, including its HCO policy. Under this policy, LTCHs must incur a set amount of loss before they are eligible for additional reimbursement (the "fixed-loss amount"). Prior to fiscal year (FY) 2018, CMS used its regulatory authority to set the fixed-loss amount for LTCH standard rate cases so that outlier payments would be equal to 8% of total payments. However, beginning in FY 2018, Congress required CMS to set the fixed-loss amount such that estimated outlier payments would equal only 7.975% of total LTCH payments. CMS sets the fixed-loss amount prospectively based on historical claims data to target paying out 7.975% of total payments as HCO payments.

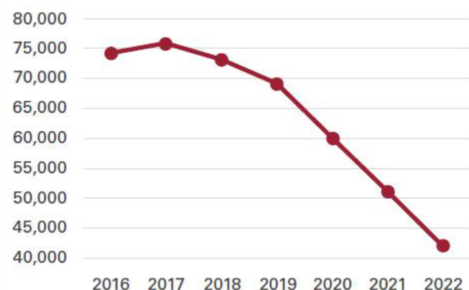
In addition, since FY 2022, CMS has utilized a methodology that examines recent claims data to forecast growth in charges for the coming FY (known as the "charge-inflation factor"). Prior to that, CMS utilized a different methodology, which tied the charge-inflation factor to the market basket update for LTCHs. When CMS made the change, the field warned it would lead to volatility, and indeed, these concerns have borne out; there have since been sharp increases in the fixed-loss amount.

THE NEW REALITY FOR LTCH FACILITIES

Dual-Rate Payment System

Reforms to the LTCH PPS and other market dynamics have resulted in a significantly altered, more acute patient mix in LTCHs compared to prior to the implementation of the dual-rate payment system. The number of LTCH cases has fallen dramatically, while beneficiaries' acuity has climbed. **These trends, along with the increasing fixed-loss amount, have led to the current HCO policy becoming inadequate in meeting its goal of reasonably reducing the financial losses that would otherwise be incurred by hospitals when treating beneficiaries in need of the costliest care.** Further, this inadequacy is being exacerbated by other market dynamics, including inadequate payment updates, sharply increased costs, and growth in Medicare Advantage, resulting in payments that fall short of the cost of care and an uncertain future for the LTCH field.

Indeed, from FY 2011 through FY 2013, LTCHs' aggregate average Medicare margin ranged from 6.6% to 7.4%.[1] However, from FY 2017 through FY 2019, that margin fell substantially into the negative, ranging from -0.5% to -2.2%.[2] AHA estimates that FY 2022 margins remained negative.[3] While the years during the COVID-19 pandemic saw a return to positive margins, this can be entirely attributable to the temporary suspension of the dual-rate payment system by Congress, which has since expired.



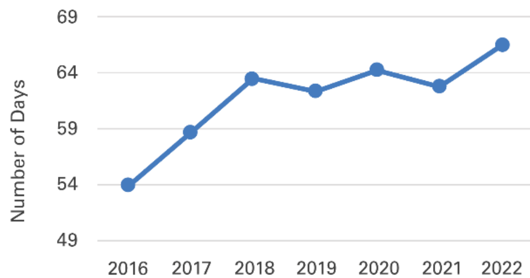
HCO Policy is Inadequate. Since implementation of the dual-rate payment system in FY 2016, the volume of standard rate LTCH cases has fallen by over 40%, from 74,294 in FY 2016 to 42,132 in FY 2022 (see Figure 1). Further, the total number of cases has fallen by approximately 70% from its peak under the legacy payment system. The number of LTCH providers also decreased by 20% in that same period. The decreasing number of LTCH cases has led to their significant consolidation into a relatively small number of LTCH PPS diagnosis-related groups (DRGs). Ten DRGs now account for more than half of all LTCH cases.[4] However,

[1] MedPAC, March 2015 Report to Congress, Ch. 11, pg. 275 (https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/chapter-11-long-term-care-hospital-services-march-2015-report-.pdf).
[2] MedPAC March 2022 Report to Congress Chapter 11, pg. 351 (https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch10_SEC.pdf).
[3] AHA analysis of FY 2021-FY2023 Medicare cost reports.
[4] Medicare Payment Advisory Commission, Health Care Spending and the Medicare Program, July 2023 (https://www.medpac.gov/wp-content/uploads/2023/07/July2023_MedPAC_DataBook_SEC.pdf).

within these cases, there is great variation in patient severity, and therefore in actual cost. The lack of precision in payment for these cases has led to a notable number of them qualifying for HCO payments because the DRG payment is not sufficient.

With the shrinking patient pool, the remaining patients are markedly more acute on average than before. The acuity of HCO cases (as measured by their "outlier-adjusted" case-mix index (CMI)) has increased by 23%, from 2.18 in FY 2016 to 2.69 in FY 2022.[5] By comparison, the average outlier-adjusted CMI of all standard-rate cases in FY 2022 was 1.44.[6] The average length of stay (ALOS) for these cases has also increased, by 23%, from 53.9 days in FY 2016 to 66.47 days in FY 2022 (see Figure 2). By comparison, the ALOS for all standard rate cases in FY 2022 was 29 days.[7]

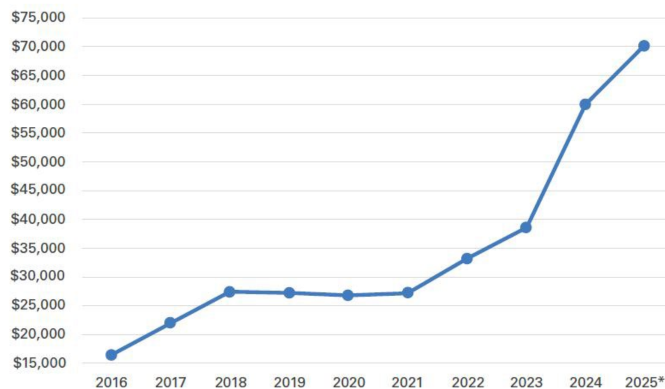
Figure 2: ALOS, LTCH PPS Standard Rate HCO Cases, FY 2016 through FY 2022



Source: *FY 2015-2022 LTCH Medicare Provider Analysis and Review (MedPAR) files; CMS LTCH PPS public use files.*

Rapid inflation in the fixed-loss amount has proven that the current methodology for calculating the amount is incompatible with the reformed LTCH PPS. Specifically, due to the changes encountered by LTCHs, the fixed-loss amount has risen by a staggering 265% since 2016, from $15,000 to $75,000, requiring LTCHs to incur tens of millions of losses per year when treating Medicare's most acutely ill patients (see Figure 3).

Figure 3: LTCH PPS Fixed-loss Amounts, FY 2016 through FY 2025



Source: *FY 2016-2024 LTCH PPS Final Rules*
**Projected fixed-loss amount based upon analysis of FY 2022 to FY 2023 claims.*

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[5] To calculate the outlier-adjusted CMI, we use the same concept as what CMS presents in the LTCH impact files. We multiply the MS-LTC-DRG service intensity weights by an adjustment factor calculated as the total estimated LTCH PPS payment amount (including the outlier amount), divided by the estimated "inlier" payment amount (the payment amount excluding the outlier payment). An HCO case would then have a higher adjusted weight than a non-HCO case since its adjustment factor would be greater than 1, reflecting the higher service intensity not captured in base DRG payments. The outlier-adjusted CMI is then calculated as the average of the adjusted MS-LTC-DRG weights.
[6] FY 2015-2022 LTCH MedPAR files; CMS LTCH PPS public use files.
[7] FY 2015-2022 LTCH MedPAR files; CMS LTCH PPS public use files.

Additional Market Dynamics Exacerbating Inadequacy of the Outlier Policy. In addition to caring for sicker patients at greater financial loss, numerous other pressures on LTCHs have emerged over the last several years. First, CMS' annual market basket updates, which rely on forecasts, have underestimated inflation for several years. From FY 2021 through 2023, CMS' updated figures and estimates show that annual updates fell short of actual inflation by a total of 4.2% (see Table 1). These underpayments are permanent and compound, as payment updates in subsequent years are based upon the prior year's rates.

Table 1: LTCH Market Basket Updates, FY 2021 through FY 2023

Year	FY 2021	FY 2022	FY 2023	Total
Market Basket Update in Final Rule	2.3%	2.6%	4.1%	9.0%
Actual/Updated Market Basket Forecast*	2.8%	5.5%	4.9%**	13.2%
Difference	(0.5%)	(2.9%)	(0.8%)	(4.2%)

**Based on the Four-quarter Moving Average Percent Change from Q3 of the Fiscal Year.*
***Most recent forecast as published by CMS OACT.*

As such, by FY 2028, these forecast errors will have resulted in an underpayment to LTCHs of at least $375 million over the prior four years.[8] Further, these underpayments also drive increases in the fixed-loss amount. Specifically, as payment fails to keep up with cost, more cases will have costs above the threshold; to maintain the 7.975% outlier payment pool, CMS must keep raising the fixed-loss amount.

The missed market basket forecasts are not the only way in which Medicare LTCH reimbursement is lagging. Approximately one-third of all Medicare LTCH discharges nationally are paid the IPPS-equivalent rate, but these reimbursements fall well short of the cost of care. Specifically, AHA analysis shows that as of FY 2020, reimbursement for these cases totaled only 46% of the cost of care.[9] This is largely driven by the fact that these cases are not actually comparable to those treated in STACHs. For example, AHA's analysis showed that of STACH claims with three days or more in the ICU, the ALOS was approximately *four* days. However, the ALOS for LTCH IPPS-equivalent cases was 23 days. Further, only 16% of STACH claims had patients with five or more complication or comorbidities or a major complication or comorbidity (MCC), while 41% fell in that category for LTCH IPPS-equivalent cases.

The growth of Medicare Advantage has also contributed to financial instability in the LTCH field. The share of Medicare beneficiaries enrolled in Medicare Advantage has grown by 54% since 2016. As of 2023, more than half of all Medicare beneficiaries are now enrolled in the program, and projections estimate it will continue to grow. These Medicare Advantage plans often inappropriately deny beneficiaries access to LTCH

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[8] Based upon FFS claims data and projected statutory updates.
[9] https://www.aha.org/system/files/media/file/2019/06/aha-cms-long-term-care-proposed-rule-fy2020-6-21-2019_0.pdf

care, and those are that able to access LTCHs are of higher acuity.[10] Indeed, while about half of Medicare beneficiaries were enrolled in Medicare Advantage in 2022, only about 31% of LTCHs' Medicare discharges were for Medicare Advantage beneficiaries.[11] This has further shrunk the LTCH patient population pool, resulting in sicker and outlier patients making up a higher proportion of total patients.

Finally, LTCHs continue to face very real difficulties and uncertainties due to rising medical inflation and workforce shortages. An analysis of cost reports shows that in 2023 there was a 21.7% increase in total adjusted cost per day for LTCHs.[12] Further, Kaufman Hall's *National Hospital Flash Report* analysis indicates that from 2020 to present, overall expenses have risen by 20% for hospitals.[13] This has been driven in large part by labor costs, including contract labor costs, which have risen 258% since 2019.[14] Because LTCHs are in the middle of the continuum of care, they experience both upstream and downstream consequences of the crisis. For example, they are experiencing challenges placing patients in skilled-nursing facilities, home health agencies and outpatient dialysis treatment due to the critical workforce shortages those providers are facing. This leads to longer lengths of stay and capacity issues in LTCHs. However, these capacity issues then in turn mean that LTCHs may need to delay accepting patients from STACH.[15] As a result, these patients may arrive sicker and more debilitated than they would have been.

The Rising Fixed-Loss Amount and Patient Access to Care

The shrinking LTCH patient population and other market dynamics has led to a higher beneficiary acuity and more cases qualifying for HCO payments. This has led CMS to increase the fixed-loss amount in an attempt to hit its HCO target of 7.95%. As noted above, CMS has increased the fixed-loss amount by a staggering 265%, from $16,423 in FY 2016 to $59,873 in FY 2024. In addition, AHA projects that the fixed-loss amount will again substantially increase in FY 2025. An AHA analysis of FY 2022 to FY 2023 claims, AHA projects a fixed-loss amount of $70,117 for FY 2025.[16] This represents a

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[10] HHS, Office of Inspector General (OIG); Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care (April 2022) (https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf).
[11] Data from Strata Decision Technology, a health care technology and consulting firm (https://www.stratadecision.com/company/).
[12] Total adjusted costs includes the facility trail balance cost plus cost report adjustments required by Medicare.
[13] Kaufman Hall | *National Hospital Flash Report* (November 2023) https://www.kaufmanhall.com/sites/default/files/2023-11/November_NHFR-2023.pdf.
[14] Syntellis and AHA, *Hospital Vitals: Financial and Operational Trends* at 2 (last visited May 8, 2023), https://www.syntellis.com/sites/default/files/2023-03/AHA%20Q2_Feb%202023.pdf.
[15] American Hospital Association. Issue Brief: Patients and Providers Faced with Increasing Delays in Timely Discharges (December 2022) https://www.aha.org/issue-brief/2022-12-05-patients-and-providers-faced-increasing-delays-timely-discharges.
[16] Medicare fee-for-service claims, Centers for Medicare & Medicaid Services, Chronic Conditions Data Warehouse, ww2.ccwdata.org/web/guest/home.

further 17% increase over the FY 2024 amount and an 82% increase over the FY 2023 amount.

Due to this rising fixed-loss amount, the financial loss that LTCHs must take on before the outlier policy provides relief has more than tripled and is projected to quadruple without further action. Indeed, due to the rise in the fixed-lost amount, the total additional loss that the LTCH field must incur before seeing financial relief through additional HCO payments is approximately $250 million annually.[17] This is a staggering amount considering that payments under the entire LTCH PPS total less than $2.6 billion annually.

This phenomenon is not surprising to providers who cautioned the dual-rate payment system would have such an effect. In the FY 2016 and 2017 rulemakings, CMS noted increases in the fixed-loss amounts, and said it believed that it was due to the new dual-rate payment system. [18] However, it stated that it "expect[s] annual changes to the fixed-loss amount to generally stabilize as experience is gained under the new dual rate LTCH PPS payment structure."[19] The agency stated that it would continue to monitor the issue and would revisit if warranted.

If not halted by meaningful reform, this continued anticipated increase in the fixed-loss amount will lead to a loss of beneficiary access to care. The LTCH field will continue to contract due to unsustainable losses and other mounting financial pressures. To protect their ability to care for their communities at large, those LTCHs that remain will be forced to carefully consider whether they are able to admit the most critically ill beneficiaries. It is likely that the sickest of the sick, those beneficiaries for which LTCHs typically receive an HCO payment, will be unable to access LTCH care. In addition, historically marginalized Medicare beneficiaries may be disproportionately affected by this loss of access to care. More specifically, while dual-eligible Medicare/Medicaid beneficiaries represent 17% of all beneficiaries, they make up 44% of LTCH cases.[20] Further, Black beneficiaries also utilize LTCHs at a rate disproportionate to other Medicare beneficiaries.

Beyond just LTCHs, beneficiary care in other facilities may also be affected. For example, the most severely ill beneficiaries in IPPS ICUs typically go on to receive LTCH care. Specifically, of IPPS beneficiaries that spent three days or more in the ICU in FY 2022, the average outlier-adjusted case-mix index for those discharged to LTCHs was 7.07, compared to just 2.89 for all IPPS discharges. If LTCHs are not available to

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[17] Based upon FY 2022 outlier volume.
[18] FY 2016 IPPS/LTCH PPS Final Rule, 80 Fed. Reg. 49326, 49621 (Aug. 17, 2015).
[19] FY 2017 IPPS/LTCH PPS Final Rule, 81 Fed. Reg. 56762, 57305 (Aug. 22, 2016).
[20] MedPAC March 2022 Report to Congress; Chapter 10 Long-Term Care Hospital Services (https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch10_SEC.pdf).

care for these severely ill beneficiaries, the strain on STACHs, and particularly on their ICU capacity, would notably increase, creating ripple effects throughout the continuum.

RECOMMENDATIONS TO MODERNIZE THE LTCH PPS HCO SYSTEM

To ensure that the most severely ill Medicare beneficiaries retain access to LTCH care and to minimize strain on other parts of the health care continuum, AHA urges CMS to expeditiously take action. Below, AHA sets forth several possible actions for reforming the HCO policy so that it serves its intended purpose of ensuring adequate beneficiary access to care. **AHA urges CMS to consider these policy changes in its annual regulatory cycle to relieve the extreme pressures on LTCHs due to the inadequacies of current HCO policy.**

Revert to a Market Basket-based Methodology for Calculating the Fixed-loss Amount. Until FY 2022, CMS forecasted growth in charges using the market basket for LTCHs. It did this because indexing charge growth to market basket growth helped ensure the fixed-loss amount grew consistent with payment. However, in FY 2022, the agency began utilizing a methodology that examines recent claims data to forecast growth in charges for the coming FY. When CMS made the change, the field warned it would lead to volatility, and these concerns have borne out and there have since been sharp increases in the fixed-loss amount.

As such, AHA recommends CMS revert to its pre-FY 2022 methodology for updating its fixed-loss amount. That methodology has proven to provide more stability for both beneficiaries and providers alike. Specifically, AHA has forecast that under this methodology, the fixed-loss amount for FY 2025 would be approximately $54,590, very similar to the FY 2024 amount of $59,873, and substantially more reasonable than the $70,117 projected under the current methodology.

Analyze All LTCH Cases When Calculating the Fixed-loss Amount. Recent decreases in the number of LTCH cases means that each case has a larger financial impact on LTCH providers as well as on the PPS system. **As such, AHA recommends CMS consider utilizing both standard and IPPS-equivalent rate cases to calculate the fixed-loss amount.** Combining the two sets of cases would provide more stability from year to year as a higher number of cases would be less prone to volatility. Further, doing so would provide only one fixed-loss amount under the entire LTCH PPS, allowing providers to better predict both HCO losses and the partial relief provided under the PPS.

Initiate Analysis of LTCH DRG Cost Variation. As mentioned previously, the decreasing number of LTCH cases is leading to their significant consolidation into a small group of ten DRGs, which is lessening the accuracy of the payment system. **AHA recommends CMS consider analyzing these variations, including those driven by differences in beneficiaries' complications and comorbidities, and consider how the payment**

accuracy of DRGs can be improved to mitigate the negative effects to the LTCH payment system.

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We appreciate your consideration of these issues. Please contact me if you have questions or feel free to have a member of your team contact Jonathan Gold, AHA's senior associate director for policy, at (202) 626-2368 or jgold@aha.org.

Sincerely,

/s/

Stacey Hughes
Executive Vice President, Government Relations and Public Policy