



To: William Walters, CEO
ALTHA

From: Alexis Ahlstrom and Jon Blum

Date: June 20, 2007

Re: Cost Estimate for “Long-Term Care Patient Safety and Improvement Act of 2007”

Overview

This memorandum describes the underlying data, cost estimate model methodology, and results of the Avalere estimate of the budgetary effect of enacting H.R. ___ the “Long-Term Care Patient Safety and Improvement Act of 2007” as provided to us by ALTHA and dated June 14, 2007. Among other provisions, the bill would: establish patient and facility certification criteria for long-term acute care hospitals (LTACHs); freeze or eliminate the 25 Percent Rule thresholds; bar the Centers for Medicare and Medicaid Services (CMS) from implementing the changes to the short-stay outlier (SSO) policy finalized for rate year (RY) 2008; expand the number of medical necessity reviews of LTACH claims; and limit the certification of new LTACHs for three years.

Table 1: Summary of Budgetary Impact of Bill Provisions¹

Bill Section	Provision	Budgetary Impact FY 2008-2012, in billions
2, 3	Patient and Facility Certification Criteria	-0.280
4	Establishment of Rehabilitation Units	0.0
5	Expanded Review of Medical Necessity by QIOs*	-0.580
6	3-Year Moratorium on New LTACHs	-0.210
7	No Application of 25% Rule to Freestanding LTACHs	0.310
8	Freeze 25% Rule Thresholds for Co-Located LTACHs	0.380
9	No Change to the Short-Stay Outlier Policy	0.220
10	No One-Time Budget Neutrality Adjustment	0.0
11	Quality Initiative	0.0
	TOTAL ESTIMATED IMPACT	-0.160

* Includes effect from Section 2 provision requiring use of medical necessity screening tools

The memorandum summarizes the key bill provisions section by section, and describes Avalere’s methodology for assessing the budgetary impact of each provision. At the end of the document, we present a total year-by-year assessment of the bill’s budgetary effect.

¹ Estimates include LTACH spending in the fee-for-service program only and do not attempt to estimate the impact to the Medicare Advantage program.

Cost Estimating Approach. The estimated effect on Medicare spending of the legislation is derived from calculating the difference between expected payments for LTACH services under current law versus expected LTACH payments under the proposal. Current law spending, or baseline spending, is an estimate of Federal outlays for LTACHs under current rules and regulations. For the purposes of constructing our model, Avalere used the CMS Office of the Actuary (OACT) baseline, published in the final LTACH prospective payment system (PPS) rule for RY 2008 (Federal Register, May 14, 2007, pg. 26902) as the best available estimate of current and future expected payments to LTACHs.

The OACT baseline reflects current law spending for LTACH services in the Medicare fee-for-service (FFS) program only and therefore, does not include LTACH spending under the Medicare Advantage program. Because we use the OACT baseline in our model, we did not attempt to score the effect of the legislation on spending in the Medicare Advantage program. Avalere adjusted the OACT baseline, which was published on a rate year basis, to a fiscal year basis because we assume enactment of the statute by October 1, 2007.

Enactment of the bill would alter statute and change the rules under which LTACHs operate. Measuring spending under these new rules is done by creating a policy baseline. The policy baseline estimates spending changes from enacting each provision of the legislation, and includes estimates of the fiscal impact of provider behavior changes, such as changes that LTACHs make in the kinds of patients they admit and the shifting of patients to other care settings. The difference between spending projections under current law and under the proposed legislation is the estimate of the budgetary impact of the proposal. This impact is presented below in Table 2.

Bill Sections 2 and 3: Patient and Facility Certification Criteria

Section 2 of the bill would maintain current criteria LTACHs must meet in order to bill under Medicare, which are maintaining an average length of stay for Medicare patients greater than 25 days and meeting the hospital conditions of participation. The bill would require LTACHs to implement a patient assessment tool for the determination of medical necessity of admission and continued stay, and meet other staffing requirements. In addition, the bill directs the Secretary to implement patient certification criteria that would ensure a majority of LTACH patients are severely ill and can be classified into one of seven major diagnostic categories (MDCs).

Section 3 lays out the two-year timeline for the Secretary to implement the LTACH facility and patient criteria specified in Section 2. With an assumed enactment date of October 1, 2007 (FY 2008), LTACHs would have to meet the certification requirements that the Secretary develops beginning October 1, 2009 (FY 2010).

Avalere assumed that for LTACHs, using a patient review tool for medical necessity and meeting staffing requirements would not be a significant barrier to qualifying as an LTACH provider. Therefore, we did not score a budgetary effect for those provisions. However, Avalere assumed that some LTACHs would change admission behavior in order to meet the

patient mix requirement. This change in admission behavior is expected to impact Medicare payments to LTACHs.

To assess the budgetary effect of this provision, Avalere incorporated results from analyzing MedPAR 2005 data into the cost estimate model. The results of our analysis show that almost all LTACHs have current discharge patterns that would meet the requirement that LTACHs admit a majority of patients within the seven MDCs; in fact, over 70 percent of cases in 2005 were within those seven MDCs. However, the bill also instructs the Secretary to require a majority of patients meet a high severity of illness threshold, although the bill does not specify how the Secretary might measure high severity of illness. Avalere assumed that whatever measure the Secretary would choose, that some cases would not meet the threshold. This assumption is based on Avalere analysis of the current share of LTACH patients that are in high severity of illness categories as measured by the all-payer refined diagnosis-related group (APR-DRG) grouper software. While a vast majority of LTACHs in 2005 were classified by the APR-DRG grouper into high severity of illness categories, some LTACHs did not admit a majority of high severity cases. As a result, the model estimates that those LTACHs would change their admission behaviors, and there would be fewer LTACH cases paid by Medicare. Starting in 2010, the model shifts some of those cases to inpatient rehabilitation facilities (IRFs) and skilled nursing facilities (SNFs), and assumes longer stays for some STACH patients. In addition, the model assumes that some cases get redistributed from an LTACH that fails to meet the threshold to another LTACH which is able to meet the threshold even when accepting that type of case. The model redistributes the cases proportional to the share of cases each provider type makes up in the Medicare program, with a downward adjustment to the cases redistributed to STACHs to take into account the payment disincentives for hospitals to keep those patients.

Avalere estimates that the budgetary impact of implementing the facility and patient certification criteria described in Section 2 under the timeline in Section 3 would reduce Medicare spending by \$280 million over the 2008-2012 budget window. The \$280 million savings figure includes the offsetting costs of treating the patients at alternative post-acute care settings.

Bill Section 4: Establishment of Rehabilitation Units

The bill would establish separate rehabilitation units for LTACHs, under certain conditions. Only LTACHs having accreditation by the Commission on Accreditation of Rehabilitation Facilities in 2004 would be eligible under this provision to open a distinct rehabilitation unit. Avalere assumes that few LTACHs would be eligible to open separate rehabilitation units, and would choose to do so only if in taking rehabilitation patients they could not comply with the patient certification criteria described in Section 2. Therefore, the provision would most likely not have any effect until 2010 at the earliest. The budgetary effect would be the difference in expected payments under the IRF PPS versus expected payments under the LTACH PPS. Given the provision's limited applicability, Avalere assumes negligible budgetary impact over the five year budget window.

Bill Section 5: Expanded Review of Medical Necessity

Section 5 of the bill would require the Secretary to design a medical necessity review program that would capture 65 percent of overpayments to LTACHs using the quality improvement organizations (QIOs); the provision would require the Secretary to begin the program by January 1, 2008. Currently QIO's review only a small portion of all LTACH claims, and therefore this provision represents a significant change in current practice. CMS reported in the final rule for RY 2008 a summary of 2005 QIO reviews which found 7.9 percent of claims reviewed were inappropriate.²

Section 5 requires the Secretary to design a medical review system that would review a sample of claims submitted by every LTACH and would do a more targeted review of any LTACH's claims if the initial review produced a certain denial rate. The Secretary would have to recoup, under his system, 65 percent of overpayments.

Avalere expects implementation of this provision would reduce Medicare payments to LTACHs, on a retrospective basis, because the provision requires the QIOs to review enough claims to recoup 65 percent of overpayments.

Avalere expects that this provision will have an interaction with the requirement that LTACHs implement a patient assessment tool for the determination of the medical necessity of admission and continued stay. That is, as all LTACH patient admissions and continued stay decisions are deemed appropriate through the use of a patient screening tool, the number of improperly reimbursed claims is expected to diminish over time. Thus, the requirement that the QIOs recoup 65 percent of overpayments will be applicable to a smaller number of claims.

Avalere used the 7.9 percent estimate of current overpayments to LTACHs in Medicare as the basis for estimating the impact of this bill provision. We estimate that this provision would result in a reduction in payments of \$580 million over the 2008-2012 budget window.

Bill Section 6: Moratorium on New LTACHs

Section 6 would limit the certification of new LTACHs for three years after enactment unless the LTACH met one of two exceptions. After the moratorium expires, the Secretary would have the authority again to certify new LTACHs. The exceptions allow for the certification of an LTACH during the moratorium if that LTACH can prove it was under development before enactment, or if in an area without an LTACH, the Secretary deems it would be in the best interest of Medicare beneficiaries to provide access to LTACH services.

As stated previously, Avalere assumes an enactment date of October 1, 2007. This would mean an end to the moratorium by October 1, 2010 (FY 2011). Avalere expects that enactment of this provision would reduce Medicare spending during the years of the moratorium as fewer LTACHs would participate in Medicare than would have had the moratorium not been in effect.

² Federal Register, May 14, 2007, pg. 26946-26947.

In order to estimate the amount of the budgetary impact, Avalere assessed trends in the number of newly certified LTACHs. In 2006 there were 12 new certifications; in the first quarter of 2007 there were no new certifications. These data points are in alignment with the trend of fewer new LTACH certifications from 2003 to present. Avalere assumed that absent a moratorium, CMS would certify 6 new LTACHs each year over the budget window. We estimated that the first year effect of the moratorium would be limited as some LTACHs would be able to prove they were in development at time of enactment. Avalere also assumed that more LTACHs would be certified under the policy in 2011 than would have been certified under current law, due to the expiration of the moratorium. Over the 2008-2012 budget window, we estimate that the enactment of this provision would reduce Medicare spending by \$210 million.

Bill Sections 7 and 8: Changes to the 25 Percent Rule

Section 7 of the bill contains a provision that would not allow the Secretary to extend to freestanding LTACHs a policy that pays for a portion of LTACH cases under the inpatient PPS (IPPS) rather than under the LTACH PPS, when the portion of those cases coming from a single source exceeds a threshold set by the Secretary. In the final rule for RY 2008, CMS finalized a policy to extend the 25 Percent Rule to all LTACHs, and this provision would effectively bar CMS from implementing that regulatory change.

In making that policy final, CMS estimated a 0.4 percent reduction in LTACH payments in the first year of the policy (RY 2009) and a 3.1 percent effect when the 25 Percent Rule was fully implemented. CMS estimates the five year budget effect of this policy to be a reduction of \$460 million in LTACH payments. Avalere conducted its own analysis of the impact of the 25 Percent Rule thresholds on freestanding and previously grandfathered LTACHs and our results differ from CMS's estimate.

A reasonable methodology for predicting the effect of the 25 Percent Rule is to link current discharges from STACHs to LTACHs to determine typical referral areas and current referral patterns. This methodology requires a dataset that contains beneficiary data allowing us to track referrals across settings. All referrals in excess of the allowable thresholds could be assumed to result in reduced payments according to the 25 Percent Rule policies. Avalere does not have a dataset that links patients across settings. As a substitute, we used MedPAR 2005 case data and the Provider of Service file to compare STACH discharges with LTACH admissions by metropolitan statistical area (MSA). Using these files we can identify areas where it would be mathematically possible to meet the 25 Percent Rule thresholds. We assumed that in areas with four STACHs discharging roughly 25 percent each of all the cases discharged to LTACHs in that area, or in areas with six or more STACHs discharging patients to LTACHs, that LTACHs could meet the 25 percent threshold level and would therefore not experience a reduction in payments. We also identified LTACHs in areas with few STACHs that discharge patients to determine which LTACHs would have difficulty meeting the threshold levels. We then calculated the expected payment reduction for cases admitted by these LTACHs. Avalere estimates no budgetary effect of implementing this provision in 2008 because the transition to the 25 Percent Rule begins in RY 2009. We estimate that barring CMS from implementing the 25 Percent Rule would cost \$310 million over the 2008-2012 budget window.

Section 8 would alter the 25 Percent Rule thresholds for LTACHs co-located with other hospitals (hospitals-within-hospitals, or HwHs). Current regulations would implement a different payment system for HwH admissions beyond the threshold limit, which after the transition period would be Section 8 would freeze the current transition-level thresholds, which are 50 percent for urban HwHs and 75 percent for rural LTACHs and LTACHs located in a MSA-dominant hospital.

To assess the budgetary impact of Section 8, Avalere analyzed MedPAR 2005 discharge data for short-term care hospitals (STACHs and HwHs). Avalere found that for HwHs affected by the 25 Percent Rule, the provision freezing current thresholds would affect 17 percent of their cases on average. Avalere estimates the budgetary effect of implementing this provision to be the difference in payment for those cases under the reduced 25 Percent Rule rates and payment under the regular LTACH PPS rates. We expect implementing this policy would increase Medicare spending by \$380 million over the 2008-2012 budget window.

Section 9: No Application of Very Short-Stay Outlier Policy

In the bill, Section 9 would bar CMS from implementing a change in payment policy for certain short-stay outlier (SSO) cases that the agency finalized for RY 2008. The policy would affect LTACH SSO cases with lengths of stay below the IPPS average length of stay plus one standard deviation (the inpatient comparable threshold). CMS reported that the impact of this regulatory policy change would be a net reduction of LTACHs payments of 0.9 percent in RY 2008.

In order to assess the budgetary impact of implementing this provision of the bill, Avalere conducted analyses of the MedPAR 2005 file. Using this file, we were able to approximate CMS's result, and estimate that a provision barring CMS from implementing this policy change would increase Medicare spending by \$220 million over the budget window.

Section 10: No One-Time Budget Neutrality Adjustment

Section 10 contains a provision relating to transition to the LTACH PPS, which would prohibit the Secretary from making a one-time budget neutrality adjustment to ensure that payments under the PPS are not less than or more than payments would have been under the previous payment system. Avalere assumes that the baselines do not contain an assumption of a positive or negative one-time budget neutrality adjustment by the Secretary. This assumption is based on language in the most recent final regulation for RY 2008 which states that the Secretary has no plans to implement the adjustment at this time and has not included such an adjustment in its baseline. Therefore, Avalere does not expect the provision to have any budgetary impact against current law baseline assumptions.

Section 11: Quality Improvement Initiative

Section 11 of the bill would require the Secretary to study appropriate quality measures for LTACH patients. Once the study is completed, the bill directs the Secretary to choose three

measures to be reported by LTACHs, and allows the Secretary to augment the number of quality measures as appropriate. LTACHs which do not participate in the quality data reporting program would lose a percent of the market basket update. For the purposes of this estimate, Avalere assumes that LTACHs will comply with this requirement. Therefore, we do not estimate any reduction in Medicare spending from this provision.

Summary

This memorandum describes the policies contained in H.R. ___ the “Long-Term Care Patient Safety and Improvement Act of 2007”, and expected budgetary impact of enacting the bill’s provisions. Below, we provide our estimate the year-by-year impact of the bill.

Table 2: Year-by-Year Estimate of Bill Impact

Baseline, FY	2008	2009	2010	2011	2012	5-Year
<i>in billions</i>	4.700	4.900	5.090	5.310	5.570	25.570
Patient Cert Criteria	0.000	0.000	(0.060)	(0.060)	(0.170)	(0.280)
Rehab Units	0.000	0.000	0.000	0.000	0.000	0.000
QIO Review	(0.150)	(0.180)	(0.120)	(0.060)	(0.070)	(0.580)
Moratorium	(0.030)	(0.050)	(0.130)	0.000	0.000	(0.210)
Repeal 25% Rule FS	0.000	0.010	0.060	0.120	0.120	0.310
Freeze HwH						
50%/75%	0.070	0.070	0.080	0.080	0.080	0.380
No VSSO	0.040	0.040	0.040	0.050	0.050	0.220
No One-Time Budget						
Neutrality Adjustment	0.000	0.000	0.000	0.000	0.000	0.000
Quality Initiative	0.000	0.000	0.000	0.000	0.000	0.000
New Policy Spending	4.640	4.800	4.960	5.430	5.580	25.410
Budgetary Effect	(0.060)	(0.100)	(0.130)	0.120	0.010	(0.160)