LOUISIANA HOSPITAL ASSOCIATION

9521 BROOKLINE AVENUE ◆ BATON ROUGE, LOUISIANA 70809-1431
(225) 928-0026 ◆ FAX (225) 923-1004 ◆ www.lhaonline.org

June 25, 2018

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Room 445-G
Washington, DC 20201

RE: CMS-1694-P. Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2019 Rates; Proposed Quality Reporting Requirements for Specific Providers; Proposed Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (Promoting Interoperability Programs) Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Medicare Cost Reporting Requirements; and Physician Certification and Recertification of Claims.

Dear Ms. Verma:

On behalf of our member hospitals, health systems the Louisiana Hospital Association (LHA) appreciates the opportunity to comment on the LTCH provisions in the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2019 proposed rule for the inpatient and LTCH prospective payment systems (PPS). This letter addresses the LTCH payment and quality-reporting provisions in the proposed rule. We are submitting a separate letter on the agency's inpatient PPS (IPPS) proposals and request for information related to price transparency.

The LHA supports several of the proposed rule's provisions**. In particular, we appreciate and endorse the agency's proposal to permanently withdraw the 25% Rule; however, we have substantial concerns with the associated budget neutrality adjustment (BNA) proposed by CMS.** We also support the proposed changes related to co-located facilities, and the streamlining of the LTCH quality reporting program (QRP). In addition, this letter reiterates our concerns related to underpayment for site-neutral cases.

PERMANENT WITHDRAWAL OF THE 25% RULE

The LHA is very supportive and appreciative of CMS's proposal to permanently withdraw the 25% Rule, and we encourage CMS to finalize this policy effective Oct. 1, 2018. However, we oppose this provision's application of a one-time, permanent BNA of -0.9 percent that CMS proposes to apply to the LTCH PPS standard federal payment rate for the proposed elimination of the 25% Rule.

The 25% Rule reduces LTCH payments to an "IPPS-equivalent" level for patients transferring from a general acute-care hospital to an LTCH and who exceed a particular referral threshold. The referral threshold varies by LTCH type. For example, rural LTCHs have a more lenient threshold of 50 percent. For many years, the policy was partially in effect due to multiple congressional interventions that each

temporarily blocked full implementation. For the current fiscal year, the 25% Rule is partially in effect due to the regulatory pause CMS authorized in the FY 2018 final rule.

Reduced Administrative Burden. While withdrawal of the 25% Rule would be beneficial for patient access to care, it also would improve LTCH operations by ending the substantial allocation of staff resources to oversee compliance with the policy. Typically, LTCHs have dedicated multiple personnel to monitor compliance with the policy, align compliance levels for each referring hospital with its admissions practices per hospital – often a daily exercise – and calculate impact and the associated refunds to CMS. We appreciate CMS's recognition of the LTCH field's need for this relief, especially in light of new operational pressures under LTCH site-neutral payment. In addition, the removal of the policy also would reduce burden for CMS and its contractors.

The 25% Rule Continues to be an Arbitrary Policy. Since its proposal and implementation, the 25% Rule lacked a policy rationale for its role in limiting admissions of cases that otherwise met LTCH admissions criteria. The Medicare Payment Advisory Commission (MedPAC) has opined on the policy's non-clinical and arbitrary nature, calling it "blunt" and "flawed" in a March 2011 report to Congress. Since its implementation, medically appropriate beneficiaries have faced reduced access to LTCHs for cases that would have been non-compliant with the 25% Rule. Likewise, retrospective 25% Rule refunds to CMS returned payments that were otherwise appropriate reimbursement for treating clinically appropriate LTCH patients. **This fundamentally flawed policy should neither have been used to limit LTCH access nor as the basis for refunds to CMS for otherwise appropriate care. Accordingly, it should not be used to further reduce payments through the proposed budget neutrality adjustment**.

The Proposed BNA Departs from Prior CMS Policies. We note that prior interventions by Congress and CMS to pause full implementation of the 25% Rule, including the 12-month pause in the FY 2018 final rule, were never paired with a BNA. Specifically, although these interventions were the same as CMS's proposed repeal, neither Congress nor CMS took the step of combining these changes with even a one-year adjustment, much less a multiple-year or permanent cut. Yet, despite the considerable history of congressional and CMS actions on this policy, this rule lacks an explanation regarding why this 25% Rule change is different and, unlike these prior changes, warrants an adjustment. **Therefore, to align this rule with prior CMS policy, the proposed BNA should be withdrawn.**

CONCERNS WITH NEW PAYMENT CUT FOR SITE-NEUTRAL CASES

In March 2018, CMS retrospectively implemented a 4.6 percent payment reduction for site-neutral cases authorized by the Bipartisan Budget Act of 2018 for FYs 2018 through 2026. Per "internal transmittal" 3986 from March 2018 and public transmittal 4046 issued in May 2018, the effective date of this cut is Oct. 1, 2017. While we understand the statutory reference implementing this cut in particular fiscal years, the cut is an offset for site-neutral relief authorized by the same legislation, which is being implemented on a cost reporting period schedule. **As such, we urge CMS to align the rollout of both of these policies on a cost reporting period schedule.** These two policies were designed as a pair and should be implemented as such. Moving forward, we urge CMS to raise its level of transparency for any cut that takes effect prior to notification to the field. In this case, CMS contractors received authorization from CMS via "internal transmittal" 3986 and began its implementation prior to any notification of stakeholders. Providers only learned of this implementation after CMS contractors began to recoup funds.

PROPOSED CHANGES FOR CO-LOCATED SATELLITES

The LHA thanks CMS for its proposed changes to the separateness and control criteria that apply to satellite hospitals that are excluded from the inpatient PPS and co-located with another excluded hospital. Specifically, we support CMS's proposal to exempt satellites from Medicare separateness and control requirements, in line with changes made in FY 2018 for hospitals-within-a-hospital (HwH). HwHs and satellites would still be held to these requirements when co-located with an inpatient PPS hospital. We support CMS's rationale for this proposed change, agreeing that the

definitions for HwHs and satellites are significantly similar and their co-location policies have been based on many of the same concerns, most notably that patients would be inappropriately transferred from the host hospital to the co-located provider to maximize Medicare payment, rather than to optimize patient care. We appreciate CMS noting that such concerns have been "sufficiently moderated" and no compelling reason exists to treat satellites differently than HwHs with regard to the rules on separateness and control. We also note CMS's clarification that those co-located satellites that were excluded from the inpatient PPS before Oct. 1, 1995 remain exempt from the separateness and control requirements.

We thank you for the opportunity to comment on this proposed rule. If you have any questions concerning our comments, please contact LHA Vice President of Healthcare Reimbursement Kevin Bridwell at kbridwell@lhaonline.org.

Sincerely,

Paul A. Salles
President & CEO