

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Friday, March 19, 2004
9:05 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
AUTRY O.V. DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY E. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

1 **AGENDA ITEM:**
2 **Long-term care hospitals: continuing research and policy**
3 **analysis - Sally Kaplan**
4

5 MR. HACKBARTH: First up this morning is a
6 continuing discussion of long-term care hospitals. Sally?

7 DR. KAPLAN: Good morning. This presentation has two
8 purposes, first to use results from our qualitative and
9 quantitative research to answer a series of research
10 questions that we've been asking throughout our study of
11 long-term care hospitals.

12 The second purpose is to bring you results from a
13 policy analysis designed to answer the question how can we
14 better define long-term care hospitals and the patients
15 appropriate for them? At the end of the presentation we'll
16 ask you to discuss the results of the policy analysis and
17 the draft recommendation.

18 The research results I'm presenting today address the
19 three questions on the screen. As you remember in the last
20 June's report when we looked at long-term care hospitals
21 using descriptive statistics and controlling for DRGs and
22 severity level, we found that patients in market areas with
23 long-term care hospitals had similar acute hospital lengths
24 of stay whether they used long-term care hospitals or not.
25 We also found that long-term care hospital patients were
26 three to five times less likely to use skilled nursing
27 facilities, or SNFs, suggesting that SNFs and long-term care
28 hospitals may be substitutes.

29 We also found THAT long-term care hospital patients had
30 higher mortality rates and that Medicare pays the more for
31 their care. We concluded that more research was needed.

32 To better answer the research questions, we conducted
33 two qualitative and two quantitative studies. In the first
34 qualitative study, NORC and Georgetown conducted 34
35 interviews with physicians, hospital administrators, nurses
36 and discharge planners in market areas with and without
37 long-term care hospitals.

38 For the second qualitative study, physicians from 10
39 long-term care hospitals presented profiles of patients in a
40 grand rounds format. We talked about the two qualitative
41 studies at the January meeting.

42 The first quantitative study compared patient
43 characteristics on a market level. The second quantitative

1 study examined the impact of long-term care hospital use on
2 Medicare spending and outcomes.

3 I want to briefly tell you about our methods for the
4 quantitative studies. The unit of analysis is an episode.
5 Episodes begin with an acute hospitalization in the first
6 half of 2001 and end with death, readmission to an acute
7 hospital or 61 days without acute or post-acute services.
8 We had 4.3 million episodes in the full dataset. We also
9 created two subsamples to examine if the results differ for
10 patients who are more likely to be admitted to long-term
11 care hospitals. One subsample had patients with a high
12 probability of using a long-term care hospital in the top 5
13 percent probability, about 226,000 episodes. This subsample
14 is more likely to have severity level three or four,
15 mortality risk three or four, prior hospitalization, ICU
16 use, and to have certain APR-DRGs such as osteomyelitis,
17 endocarditis or tracheostomy.

18 The second subsample had patients with an acute
19 hospital diagnosis of tracheostomy and ventilator support
20 for 96 or more hours, about 20,000 episodes. There is some
21 overlap between these two subsamples. To control for
22 patients severity of illness we used every clinical variable
23 available from administrative data. We'll be presenting
24 results today for all patients and for patients with a high
25 probability of using a long-term care hospital. You should
26 know that even among patients with a high probability of
27 using a long-term care hospital, actual use is relatively
28 rare.

29 Last year, controlling for DRG and severity level, we
30 found that long-term care hospital patients had higher
31 mortality and Medicare spending compared with patients using
32 alternative settings. To be as conservative as possible,
33 this year we used three different methods to control for
34 severity of illness. We used ordinary Lee squares
35 regression and two methods that control for unmeasured
36 severity of illness, an instrumental variable approach and
37 the Heckman model.

38 Our first research question concerns the role long-term
39 care hospitals play. If long-term hospitals are present in
40 some areas and not others, this raises the question of their
41 role. You've seen a map similar to one on the screen
42 several times. This map is updated to include the new long-
43 term care hospitals established in 2003. The red triangles
44 represent the long-term care hospitals that have opened in

1 the last decade, since 1993. You can see that the long-term
2 care hospitals are concentrated in some areas. For example,
3 look at Louisiana where you see 35 long-term care hospitals.
4 Physicians and long-term care hospital administrators
5 told us that long-term care hospitals provide post-acute
6 care to a small number of medically complex patients. These
7 patients are more stable than ICU patients but may not have
8 all their underlying problems resolved at admission to the
9 long-term care hospital. Fewer than 1 percent of acute
10 hospital patients are admitted to long-term care hospitals.
11 A diagnosis of tracheostomy with ventilator support is the
12 single strongest predictor of long-term care hospital use.
13 Nevertheless, patients with tracheostomy represent only 3
14 percent of long-term care hospital cases.

15 As severity level increases, the probability of long-
16 term care hospital use increases. Regardless of diagnosis,
17 severity level four quadruples the probability of using a
18 long-term care hospital.

19 As the patient's proximity to a long-term care hospital
20 increases, the probability of using one also increases.
21 Being discharged from an acute hospital that has a hospital
22 within hospital quadruples the probability that a patient
23 uses a long-term care hospital.

24 In answer to our second research question, in areas
25 without long-term care hospitals we found that clinically
26 similar patients are principally treated in acute hospitals
27 or SNFs. In qualitative studies, physicians told us that
28 patients without access to long-term care hospitals stay in
29 the hospital longer and others go to the relatively few SNFs
30 who have the capacity to care for patients with multiple
31 complex conditions.

32 Our quantitative results support what physicians told
33 us. Our multivariate analyses, regardless of method,
34 support that clinically similar patients who use long-term
35 care hospitals have shorter lengths of stay in the acute
36 hospital compared with patients who don't use these
37 facilities. Among all patients, long-term care hospital
38 users have a six day shorter acute hospital length of stay.
39 Among patients with the highest probability of using a long-
40 term care hospital, long-term care hospital users have a
41 nine day shorter length of stay.

42 Short acute hospital lengths of stay for clinically
43 similar patients who use long-term care hospitals suggest
44 that acute hospitals and long-term care hospitals are

1 substitutes.

2 Our multivariate results also support that freestanding
3 SNFs are a principal alternative to long-term care hospitals
4 in areas with and without long-term care hospitals.
5 Overall, 24 percent of patients with the highest probability
6 of long-term care hospital use actually use freestanding
7 SNFs. For long-term care hospital users in this group,
8 however, SNF use drops 33 percent. Long-term care hospital
9 users' sharp decrease in SNF use suggest that SNFs and long-
10 term care hospitals are substitutes.

11 On average, long-term care hospital users are more
12 costly to Medicare compared to clinically similar patients
13 who use alternative settings. This is true when we use
14 multivariate models regardless of the method used. In 2001,
15 long-term care hospital patients saved Medicare money for
16 the acute hospital stay because of lower outlier payments.
17 But the same patients cost Medicare more money for post-
18 acute care and for the total episode.

19 For patients with the highest probability of using a
20 long-term care hospital, there was a positive but
21 statistically insignificant difference in Medicare spending
22 for the episode.

23 These findings are based on actual Medicare spending in
24 2001 before the long-term care hospital PPS was implemented.
25 It is possible that the combination of the PPS rates and
26 improvement in coding could result in patients with the
27 highest probability of long-term care hospital use having
28 higher Medicare spending under the PPS than in 2001.

29 Regardless of the method we used, we found that long-
30 term care hospital users had lower readmission rates than
31 similar patients treated in alternative settings. This is
32 what we would have expected considering that long-term care
33 hospitals must meet the acute hospital conditions of
34 participation. Comparison of mortality rates generally
35 raised statistical issues for all researchers and they did
36 for us. For each method we used to compare death in 120
37 days we got a different answer. Thus, the results are
38 inconclusive.

39 The main conclusions from our study are that when
40 admissions to long-term care hospitals are largely
41 unrestricted, long-term care hospitals tend to cost Medicare
42 more than patients treated in alternative settings.

43 DR. ROWE: [off microphone.] Let me interrupt for a
44 second. Does that include the effect of the reduction in

1 the readmission?

2 DR. KAPLAN: No.

3 DR. NEWHOUSE: No, if the readmission is in the same
4 episode?

5 DR. KAPLAN: No, the readmission ends the episode so
6 the money for the readmission is not in the episode.

7 DR. MILLER: [off microphone.] If you go from episode
8 to episode --

9 DR. ROWE: [off microphone.] Their point, of course,
10 is that they're preventing readmissions and so we should
11 just be clear what this includes.

12 DR. KAPLAN: One can conclude on the basis of logic
13 alone that long-term care hospitals need to be limited in
14 the types in patients they can admit so that these
15 facilities treat medically complex patients that cannot be
16 treated in less costly settings. Three issues make limits
17 even more logical under current policies, growth in number
18 of long-term care hospitals, payment rates for these
19 facilities and the financial incentives of the long-term
20 care hospital PPS.

21 Let's briefly take a look at the rapid growth in long-
22 term care hospitals. You've seen some of these numbers
23 before. In 1993 there were 105 of these facilities. That
24 number more than tripled by the end of 2003 to 318. From
25 1993 to 2001 Medicare spending quintupled from \$398 million
26 to \$1.9 billion.

27 CMS estimates spending to be \$2.8 billion this year but
28 that estimate does not take into consideration the number of
29 long-term care hospitals that have opened since 2001. As
30 the number of long-term care hospitals continue to grow,
31 these facilities may find it more difficult to fill their
32 beds with appropriate patients.

33 Long-term care hospitals are very expensive. On the
34 screen is a comparison of 2004 per discharge rates by
35 setting for five diagnoses common in and long-term care
36 hospitals.

37 In addition, the financial incentives of the PPS for
38 long-term care hospitals encourage these facilities to admit
39 patients with the least costly needs within a DRG.

40 Now Carol is going to talk to you about suggestions for
41 better defining long-term care hospitals and the patients
42 appropriate for them.

43 MS. CARTER: We had several goals in mind in developing
44 examples of criteria for long-term care hospitals. First

1 and foremost, we wanted to clearly distinguish long-term
2 care level of care from other settings. We wanted the
3 criteria to be feasible to administer and monitor, both for
4 the hospitals and for CMS. The criteria should establish
5 clear expectations and hold providers accountable for their
6 actions. The criteria should also reinforce provision of
7 high quality of care. And in the longer term, the criteria
8 should facilitate adoption of common patient assessment
9 tools and a classification system across all post-acute
10 care. Further, the criteria must be consistent with the
11 payment policies of other PPS's.

12 During our site visits and numerous interviews with
13 clinical and administrative folks from various long-term
14 care hospitals we were consistently told about the features
15 of long-term care hospitals that distinguish these
16 facilities from other settings, notably SNFs and rehab
17 facilities. They told us that they have sicker patients and
18 that the majority of their patients were likely to improve.
19 They frequently use admission criteria to screen patients
20 who need this level of care.

21 Many told us that they require daily physician
22 involvement with all of their patients. Active physician
23 involvement was a key distinguishing characteristic of this
24 level of care. The level of nursing care that they provided
25 was fairly intensive, ranging from six to 10 hours of
26 licensed nursing hours per day. They had respiratory
27 therapists available 24 hours a day. They had physical,
28 occupational, speech and respiratory therapists on staff.

29 Finally, they told us about how the care in their
30 facilities was organized, that they have multidisciplinary
31 teams who prepare and carry out treatment plans.

32 Building on these, we developed examples of facility
33 and patient criteria that could be used to ensure that long-
34 term care hospitals treat medically complex patients who
35 have a good chance of improvement.

36 You can see we've outlined the kinds of criteria we
37 think are reasonable for facilities to have to meet in order
38 to be paid as long-term care hospitals. Each hospital would
39 have to have a patient review process that screens patients
40 prior to admission, periodically assesses the patient
41 throughout the stay and assesses the available options when
42 the patient no longer meets the continued stay criteria.

43 The purpose of this is to ensure that each facility has
44 a clear and uniform process for evaluating patients.

1 Another criteria would state that all long-term care
2 hospitals move towards using a uniform patient assessment
3 tool that is valid and clinically reliable. Many facilities
4 already use an assessment tool. So what we're talking about
5 is moving the industry towards using the same tool that
6 emphasizes a clinical assessment of the patient.

7 The Secretary could evaluate these various assessment
8 tools and choose the best one that determines whether or not
9 the patient is appropriate for placement in a long-term care
10 hospital. The purpose of this criteria would be to the
11 extent possible to ensure consistency across facilities in
12 how patients are assessed.

13 Another criterion requires multidisciplinary care
14 treatment planning that establishes patient-specific care
15 plans. Given the patient population, these hospitals would
16 be expected to have would care experts, respiratory
17 therapists, end of life counseling and home ventilator
18 training depending on the mix of the patients that they
19 treat.

20 For the near term, we think that the current average
21 length of stay requirement should be retained. Over time
22 the patient criteria would clearly start to delineate the
23 patient population appropriately treated in these settings
24 and it would make sense to reevaluate this criterion.

25 Another criterion would state that there would need to
26 be daily physician presence in the care of patients. This
27 criterion would delineate the kinds of activities that would
28 be expected for physicians to play. For example, care
29 planning, daily patient assessments, and if needed,
30 performing medical interventions.

31 Another criterion notes that facilities should wean the
32 majority of their ventilator dependent patients. A
33 criterion should be developed regarding a weaning success
34 rate.

35 Facilities specializing in rehabilitation or
36 psychiatric care should not be long-term care hospitals and
37 we'll come back to this when I discuss the patient criteria.

38 Up on this slide you see examples of patient criteria.
39 National admission and discharge criteria would be developed
40 for each major category of patients. Examples of major
41 categories are medically complex patients and respiratory
42 patients. These criteria would specify clinical
43 characteristics such as blood pressure, respiratory
44 insufficiency or the presence and severity of open wounds.

1 They would also delineate the need for specific treatments
2 such as IV medications, fluid administration, telemetry,
3 pulmonary monitoring, ventilator support, TPN feeding or GI
4 suctioning, depending on the patient category. Patients who
5 do not meet the admission criteria should be admitted to a
6 different level of care.

7 Discharge criteria for each type of patient would be
8 specific to the discharge destination. Criteria for
9 patients headed to SNFs would be different for those
10 patients headed home. The purpose of this would be to
11 ensure appropriate patient placement.

12 Another patient criterion could be to require that a
13 high share of patients, for example 85 percent, must be
14 classified into major categories of patients. The major
15 categories could include things like respiratory, complex
16 medical, wound care, ventilator weaning, infectious disease
17 and cardiovascular patients. A long-term care hospital
18 could not have a high share of patients classified as
19 rehabilitation or psychiatric.

20 A severity criterion would ensure that long-term care
21 hospitals treat the most severely ill patients. For
22 example, a criterion could require that a high share, again
23 say 85 percent, of patients in each DRG should have a high
24 severity level, something like the APR-DRG level three or
25 four. Again, we're trying to make sure that patients are
26 treated in the most appropriate and cost-effective setting.
27 Patients who are less sick can be treated in other less
28 costly settings.

29 Our last example criterion has to do with the nursing
30 hours per patient day. This criterion is another way to
31 ensure patients require an intensive level of care. The
32 minimum should be comparable to a step-down unit in a
33 hospital, something like six-and-a-half hours of nursing
34 hours per patient day.

35 I should probably note that some of these criteria
36 would need to be updated over time as practice patterns
37 change.

38 On this slide you can see the draft recommendation.
39 Long-term care hospitals should be delineated by facility
40 and patient characteristics that ensure that patients
41 admitted to these facilities are medically complex and have
42 a good chance of improvement and cannot be treated in other
43 less costly settings.

44 Facility level criteria should characterize this level

1 of care by features such as staffing, patient evaluation and
2 review processes and the mix of patients. Patient level
3 criteria should identify specific clinical characteristics
4 and treatment modalities.

5 Before you begin discussing this material, I wanted to
6 make a couple of closing comments. First, we understand
7 that developing criteria is one way to ensure that long-term
8 care hospitals that are already out there treat the kinds of
9 patients who need this level of care. But we also want to
10 point out that it will be important in the longer term to
11 make refinements to existing PPS'S for acute care hospitals
12 and SNFs. As currently designed, these payment systems may
13 have had the unintended consequence of encouraging long-term
14 care hospital growth. Refinements to both acute care
15 hospital PPS and the SNF PPS are needed to more accurately
16 match payments to patient resource requirements. This will
17 help reinforce decisions about where patients are treated
18 being made on clinical factors and not financial
19 considerations.

20 On the inpatient side, there are three policies that
21 warrant further analysis. The single most important feature
22 of a payment system to ensure that payments match patient
23 resource requirements is the classification system. In the
24 hospital PPS, a classification system that reflects the
25 severity of patients would improve the accuracy of payments
26 and make hospitals financially neutral to treating the
27 complex cases that they currently may transfer to long-term
28 care hospitals. This is also likely to lower the number of
29 outlier cases that get transferred to long-term care
30 hospitals.

31 The second policy that warrants examination is the
32 current outlier policy. That is the threshold level and the
33 cost-sharing requirements. These may contribute to
34 hospitals unbundling care to long-term care hospitals.
35 Adjusting the outlier threshold and/or the cost-sharing
36 arrangements could make hospitals less prone to transfer
37 cases that they could treat themselves. These refinements
38 warrant further examination.

39 Third, strong rules regarding hospitals within
40 hospitals are needed to ensure that hospitals do not
41 discharge patients prematurely for financial gain. CMS has
42 expressed concern about hospitals within hospitals and we
43 look forward to seeing what they do to ensure that these
44 facilities facilitate appropriate clinically based

1 decisionmaking.

2 On the SNF side, we and others have noted the
3 shortcomings in the current RUGs classification system.
4 Refinements that better target payments to medically complex
5 patients and away from being driven by the provision of
6 therapy services may increased SNFs to admit certain types
7 of patients who could be more appropriately treated in a
8 lower cost setting.

9 This ends our presentation. I'd like to open it up for
10 discussion.

11 DR. NEWHOUSE: I had a number of technical comments
12 that I gave to Sally and I don't want to go into here, but I
13 do think the question Jack raised is important. And I think
14 that what it implies is that the data defining the episode
15 should be changed so that the episode ends with either death
16 or no institutional care for 60 days. That is, it would
17 conform to the Medicare spell of illness definition so it
18 would pick up the readmission expenses.

19 And I'm going to assume that this change won't affect
20 the results, at least the qualitative results, and what I
21 say next. But if it does, we'll go from there.

22 I'm fine with the draft recommendation. I think we
23 should say that it's similar in spirit to the regs on rehab
24 use where we've defined that the patient using the rehab has
25 to have three hours of active therapy a day. That's the one
26 I'm thinking of in particular. I don't know if we want to
27 go to 75 percent have to be in one of 10 diagnoses or not.
28 I think that some reference to that might be helpful.

29 Beyond the recommendations that you are proposing, I'd
30 like to see us be a little more aggressive what you're
31 calling the longer run agenda. I don't see any reason why
32 we shouldn't recommend a moratorium on the hospitals within
33 hospitals. That seems to me to be just a device to game the
34 system and I'm with CMS and the text here. I just would go
35 stronger on a recommendation.

36 And then finally, assuming that the finding that areas
37 with LTCHs have shorter acute lengths of stay is still there
38 once you account for the readmission, I think we should put
39 in a longer run agenda some consideration about both
40 bundling the post-acute care and about debasing the PPS,
41 which would be implied if care is shifting out of the
42 hospital by unbundling.

43 MR. MULLER: Sally, Carol, I find this a very helpful
44 elaboration about what we know about these populations. Yet

1 I'm still struck by what we discussed last year and what you
2 had in one of your earlier slides about the concentration in
3 a few states. So when you think about these criterion and
4 this population, you ask yourself why is this not happening
5 everywhere? So there's a variable here that we're not
6 getting at, which is why is it happening in Louisiana and
7 Indiana and a few other states like that?

8 Because if, in fact, these patients needed care -- I
9 think there were like two triangles in California in terms
10 of new facilities and I think you said 37 in Louisiana. So
11 there's obviously some overarching variable here in terms of
12 why they're going on in certain settings with I think
13 probably has to do with certain groupings. I'm trying to
14 remember what we knew about ownership and so forth but my
15 guess is there's a concerted thrust to go into certain
16 settings irrespective of patient needed.

17 So I'll ask you to comment on that because it is so
18 puzzling that essentially I think there's very few
19 triangles, to use the code for the new facilities, west of
20 the Mississippi aside from Louisiana. So what's going on
21 here that is kind of irrespective or not tied to patient
22 need at all?

23 DR. KAPLAN: I'm not 100 percent sure about what's
24 going on. I think that it's possible that the areas that
25 don't have long-term care hospitals either -- in some areas
26 it's an issue of population. One thing we heard when we
27 were out in the field was at least some of the long-term
28 care hospital major players required a density of Medicare
29 population, Medicare beneficiaries in an area before they
30 would set up a long-term care hospital there. So that may
31 be one factor.

32 These are predominately for-profit. The new ones, in
33 particular, are for-profit facilities. The most recent
34 growth has been in hospitals within hospitals which may
35 indicate that a certain type of acute hospital is opening
36 these facilities more frequently than others.

37 We haven't really looked at that yet.

38 MR. MULLER: [off microphone.] Obviously you have
39 density in LA, in San Francisco, in Chicago and New York.
40 And we can just go around the country.

41 MS. DePARLE: But I think the industry also says, in
42 some cases there are CON requirements in some states and not
43 in others and it kind of parallels -- for better or worse, I
44 think it kind of parallels the growth we've seen in other

1 newer providers or newer services. For better or worse.

2 But I don't think you can just assume based on -- I
3 agree the number in Louisiana is curious, but I don't think
4 you can assume based on where they've developed that there
5 are not appropriate patients. I think that one thing
6 they've said, as Sally said, is that they need to have a
7 certain density of the Medicare population in order to
8 ensure there are enough appropriate patients.

9 MR. MULLER: But there's more than five states with a
10 density of Medicare population --

11 DR. REISCHAUER: But they'd be all over the board if
12 that were the case.

13 MS. DePARLE: That has very difficult CON requirements.
14 I asked that specific question and that's the answer I got.

15 MR. MULLER: Half of the states have CON, half don't.
16 I just find it puzzling that five states have all this and
17 45 don't. So it strikes me the overarching variable here is
18 something else aside from characteristics of a patient and I
19 think we should -- whether it's Joe's recommendation on not
20 having a hospital within a hospital but basically there's
21 something else going on in 45 states that indicates they
22 don't see the patient need for this.

23 So I think we should keep trying to figure out what it
24 is. My guess is there's nothing in the patient
25 characteristics of those five state that explains why they
26 developed there versus not having developed in the other 45.
27 So there's something else going on here than patient need.

28 MR. DeBUSK: I certainly disagree with a moratorium on
29 the hospitals. I think they serve a special need for such a
30 group of people and I think we're in an evolutionary process
31 where the care for these sick patients is getting better.
32 That's probably what we're seeing. I think the certificate
33 of need states and that play is having an effect on it but I
34 think it's an evolving situation.

35 In the examples of facility level criteria, Sally could
36 you expand a little bit on the comment no specialization in
37 rehabilitation?

38 DR. KAPLAN: There are a few long-term care hospitals
39 that specialize in psychiatric care. They have more than 50
40 percent of their cases that are psychiatric. I believe it's
41 about five long-term care hospitals.

42 MR. DeBUSK: Psychiatric, I'm not --

43 DR. KAPLAN: Also, there are a few hospitals that also
44 -- or not also but that respectively specialize in rehab,

1 where 50 percent of their cases are rehabilitation cases.
2 Our thought is that those should be rehab hospitals rather
3 than long-term care hospitals.

4 If you look at the difference between major joint
5 replacement in a rehab hospital and a long-term care
6 hospital, the payment is \$50,000 a case. And there is
7 definitely an incentive with no restrictions to have these
8 people go to long-term care hospitals rather than rehab
9 hospitals. So we feel that not only is patient criterion
10 needed but that we need to basically say these should be
11 rehab hospitals. If that's what they primarily do is rehab,
12 they should be rehab hospitals.

13 MR. DeBUSK: Thank you. I understand.

14 DR. NELSON: One of the things that seems to
15 characterize these institutions is a greater level of
16 physician and nurse direct involvement on a daily basis. It
17 may be that if they have indeed better outcomes, that we
18 need more rather than fewer.

19 So my question is I know that you referenced outcomes
20 with respect to readmission rates and death rates. But are
21 there any data on the clinical outcomes such as success at
22 weaning from respirators, wound healing, endocarditis cure
23 rates, functional capability after treatment for joint
24 replacement? Do they have clinical outcomes that are
25 superior as a result of the increased professional
26 involvement?

27 DR. KAPLAN: None of that data is available that you're
28 talking about. There is no assessment instrument for these
29 facilities at this time. To get the kind of information
30 that you're talking about it you'd need either a patient
31 assessment instrument and/or a medical record abstract
32 basically, to see whether there was a cure rate or whatever.

33 The only outcomes that we really could measure from our
34 data that we had were readmission and death.

35 DR. NELSON: It seems to me that one of the
36 recommendations that we might consider is that there be,
37 without undue burden, that we try and have a few of those
38 measurement characteristics collected. We do for our other
39 delivery systems and it seems to me that if we're going to
40 make a case one way or another against these we have to
41 determine whether the increased investment results in
42 improved outcomes.

43 MR. DeBUSK: I like your approach where you ended up.

44 DR. KAPLAN: Thank you. That's really our intention

1 when we talk about having a standard patient assessment
2 instrument. Part of the assessment instrument would be to
3 determine whether these people were appropriate for
4 admission. But also if you assess them at admission and at
5 discharge, you then could measure quality.

6 One of the criteria that we did mention was a weaning
7 success rate so that they would be required to have a rate
8 above a certain level.

9 DR. NELSON: [off microphone.] I would make that very
10 explicit.

11 DR. MILLER: Could I say just one thing about that? It
12 may be early to say what the criteria should be on a weaning
13 rate. I think what we are more saying and to follow up on
14 these outcome measures is to say that they need to be
15 developed. But there's not actually a lot of standards out,
16 I don't think, on a lot of these specific outcomes. So you
17 would use this assessment instrument to try to get the
18 information and then drive the criteria, I think would be
19 the process.

20 DR. ROWE: I'm not a pulmonologist and maybe somebody
21 else can help here, but I'm a little concerned about the
22 weaning success rate requirement because it may be that that
23 will lead these institutions to select against certain
24 patients who, in fact, could get optimal care in this
25 setting because of the resources available in this setting
26 and the expertise of nurses to deal with patients on
27 ventilators with tracheotomies, et cetera. We don't want
28 those patients to have limited access to these resources
29 because they're judged to be chronically dependent on
30 ventilators and not to get weaned. Where are they going to
31 go? Where else are they going to go?

32 I don't know, Nick, if you have any thoughts about
33 this. You have more experience than I, but I'm a little
34 concerned about that and how we would deal with that.

35 DR. WOLTER: I do think it would be very hard up front
36 to categorize the patients to be compared because they're
37 chronically quick critically ill to start with. And so some
38 of them are weanable and others aren't. It would be almost
39 hard to do the compare group.

40 I would say in the institutions we visited, they have
41 wean rates. They track all of this stuff. They have their
42 own institution-specific information.

43 What we can't really do very well is to compare that
44 with a patient who might stay in an acute care setting and

1 has sort of the same approaches taken. We just don't have
2 databases to allow us to do that.

3 DR. MILLER: Could I just add one thing? From our
4 visits I think they are making these assessment on patients.
5 They will look at a patient and say I think this patient
6 does have a good chance and so we'll take one, and other
7 patients not. So I think we're trying to recognize what is
8 happening there and then bring a little more...

9 DR. ROWE: Thank you.

10 DR. REISCHAUER: But even if they're doing that, the
11 incentive that Jack raises isn't there now but would be
12 there after you set this criterion. That's the issue, not
13 that they have the capacity to do this evaluation.

14 DR. MILLER: Let me go back to the comment I was making
15 a second ago on the outcomes in general. It's very murky on
16 what the guidelines and standards are at this point. What I
17 think we're really try to say with this criteria is to begin
18 to collected it so that you can look at the outcomes of
19 patients and begin to ask whether there is a big difference
20 between this setting and somebody who goes to a different
21 post-acute setting or stays in the hospital. To Nick's
22 point, the ability to compare to a different setting.

23 I don't think we would say the criteria has to be a 60
24 percent wean rate. I don't think we would end up saying
25 something like that. We would say this is something that
26 the industry should drive towards, I think is what we're
27 thinking.

28 DR. KAPLAN: I think the concern is we don't want long-
29 term care hospitals, which are very expensive facilities, to
30 become warehouses for people who are on ventilators and have
31 no opportunity to be weaned. The long-term care hospitals
32 clearly told us in our site visits that they basically do
33 assess patients and only take patients who have a good
34 chance of being weaned. And they don't represent that they
35 always succeed, but they do represent that they -- at least
36 most of the facilities that we visited -- that they
37 succeeded more often that they failed.

38 DR. ROWE: Where would the patients go who are judged--

39 DR. KAPLAN: They go to the SNF. The patients who do
40 not wean go to SNF.

41 MS. RAPHAEL: Where we also think they're not being
42 paid for --

43 DR. KAPLAN: Basically we did say that that's why the
44 SNF PPS needs to be fixed. We don't think this is just one

1 little fix that we have to do. We think there are lots of
2 fixes that have to go on.

3 DR. NEWHOUSE: I want to come back to the reimbursement
4 issue and the moratorium issue. Let me remind people how we
5 got this category. It's not like a new category of hospital
6 came onto the scene. It's that when we started the PPS we
7 decided to use a per stay reimbursement method through the
8 DRG. And there was a group of very heterogeneous hospitals
9 out there that existed at the time that had very long
10 average length of stays. And they were going to get creamed
11 by paying them an average per case payment that was averaged
12 over all short term general hospitals. So we said all
13 right, we'll just kind of set them aside and try to deal
14 with them later. And later has been later and later and
15 later, and here we are. But in the meantime, this group has
16 seen some entry.

17 That's how we got there. Now the question is what
18 would happen to these patients or does happen to these
19 patient when there's not one of his hospitals available?
20 The answer is presumably they're treated in, Sally said, the
21 SNF. But also there's nothing that stops treatment in the
22 acute care hospital of these patients. And I would assume
23 that in an acute phase that's where they are in the white
24 areas that Ralph is talking about on the map. They are
25 therefore in the PPS in those areas.

26 And implicitly, the base rate for the PPS includes
27 these patients. And there's nothing that I can see that
28 precludes the same clinical care in the acute care hospital
29 that is going on in the long-term hospital.

30 So the reason I was asking for a moratorium would be
31 analogous to the specialty hospital moratorium is that I
32 don't see any economies, in fact I see costs, in paying for
33 this care in a separate facility, let alone a separate floor
34 that I relabel a long-term hospital within a hospital
35 instead of just calling it a unit of the acute care hospital
36 like the coronary care unit where we pay, in effect, as part
37 of the PPS.

38 MR. MULLER: Empirically, it's the ones in the acute
39 care hospital, in the two hospitals I'm very familiar with,
40 this was the DRG with the biggest loss by a factor of about
41 five. These obviously are the patients who stay there a
42 long, long time and it's at the far end of the distribution
43 of losses by a major factor.

44 DR. NEWHOUSE: So maybe we need to fix the PPS for that

1 reason because there is this loss in those other areas.

2 MS. DePARLE: When you say the biggest loss, is it the
3 ventilator patient? Is that the DRG you're talking about?

4 MR. MULLER: DRG, I think it's 483 or 283, I'm trying
5 to remember, but the losses are five or six times.

6 MR. DeBUSK: The hospitals are making plenty of money.
7 They can take some more loss then, can't they?

8 MR. HACKBARTH: Nick, is it on a specific point? If
9 not, I've got a number of other people in the cue and I'll
10 put you in. Can you wait?

11 Ray?

12 DR. STOWERS: My maybe reaching redundancy but I think
13 it kind of wraps up what Joe and the others are talking
14 about. I think we need not to lose track of this one
15 paragraph on page 16 that talks about the mandated fixed
16 loss that happens with these outlier patients and why that
17 might have brought about what we're talking about today.

18 And I think that loss goes way above what that fixed
19 loss is with the outlier on these respiratory patients may
20 be the three or four times that. I think maybe a policy
21 question for us here is are we better to have in the future
22 a continued proliferation of these in-hospital long-term
23 hospitals or to work towards fixing how we're going to take
24 care of these patients under the DRG system with the
25 outliers? Which is better in the long run for the patients?
26 Which is better cost to Medicare? That kind of thing.

27 Because I think our payment policy is what is brought
28 about these hospitals and maybe very justifiably so, because
29 we've induced this big loss on this group of very needy
30 patients.

31 So maybe that's where we ought to be going, which would
32 be better, to work on that or to work on continuing to
33 support these hospitals with all of the details that go with
34 that?

35 MR. FEEZOR: Ray just made some comments that I thought
36 were right on target. And then the other thing my namesake,
37 Dr. Nelson down there, in terms of focusing our standards on
38 the clinical outcomes and the patient is where we should --
39 even though we have to be mindful of the payment side.

40 I wonder if, following up on Ray's comments, I wonder
41 if we really aren't facing the ultimate intergovernmental
42 conundrum here, the fact that states whose monies are at
43 risk, significantly at risk in the availability of SNF beds
44 try to restrain. And on the Medicare side the only

1 alternative may be to develop these new capacities since
2 there is a shortage, I think, in many areas.

3 I think we're on the edge of a real boom. I think
4 Joe's comments and admissions about what is likely to be
5 facing us, given some lack of either restrictions or real
6 consideration. My point is I think not just for-profit, not
7 just in certain geographic areas, Ralph, but I think the
8 pressures among a lot of the hospital systems are to really
9 look very, very favorably on these.

10 I think in addition, particularly in those states where
11 there has been some excess capacity leftover from the late
12 '90s, I think those are tinder boxes waiting to be ignited.
13 And in fact, have seen a couple of sales promotions aimed at
14 hospitals that have some excess beds, particularly in
15 certificate of need states, that suggest this is a way to
16 help your existing hospital as well as use some unused
17 capacity.

18 So I think it certainly would be the recommendations of
19 staff, I think, to move for some standards, standards that
20 should though be focused more closely on the patient
21 outcomes are in order. I do think that we, in April, ought
22 to debate Joe's comments about some sort of restriction or
23 moratorium on growth very seriously.

24 MS. DePARLE: Thanks. I want to thank the staff for
25 all the work that you've put into this over the last year
26 and the visits that were made to the LTCHs because I think
27 that's important in developing our understanding of this.

28 I think the recommendations are good. I really liked
29 Alan Nelson's idea of doing everything we can to move more
30 in the direction of both collecting information and trying
31 to get to some sort of outcomes measures that would move us
32 in the direction of better quality of life and functional
33 capacity for these patients. So I think it's great.

34 We have to start somewhere. As Mark says, we have
35 nothing right now. We have a type of hospital that Joe has
36 described the genesis of, but where the only criteria --
37 it's where it's very expensive and the only criteria is a 25
38 day average length of stay for Medicare patients. So we
39 have to go somewhere. I think this is a very good start.

40 I'm not prepared at this point to say that I think
41 there should be a moratorium on this because I don't think I
42 have enough evidence that that's what needs to happen, but I
43 do think these recommendations are good.

44 I'm not clear and I guess I should be, Mark, on what --

1 does CMS have the authority to, if we were to make
2 recommendations, to just do these things? Or does this take
3 a change in the law?

4 DR. MILLER: We were thinking through that issue and I
5 guess I'll take a shot. I thought that there was probably
6 some mix here of both legislative and administrative
7 actions. I think lots of this can be done administratively
8 but there's probably pieces of it that cross over into
9 legislation. I'd take a nod or a shake of the head down
10 there if anybody wants to...

11 MS. DePARLE: It seems to me the assessment, they could
12 just say we're going to start doing this. It's not easy to
13 do that but you could develop that. New criteria, I'm not
14 so sure whether they could do that.

15 DR. MILLER: I think the criteria -- and I really don't
16 know the precise answer to your question. But I think if
17 you start getting into criteria on from these DRGs,
18 proportions of your patients, that kind of thing, I think we
19 may be then crossing over into legislation. Again I think
20 probably the best answer is we've raised this question for
21 ourselves. But we have not drilled through it.

22 MS. DePARLE: One more thing, this PPS was supposed to
23 be budget neutral; correct?

24 DR. KAPLAN: Yes, ma'am.

25 MS. DePARLE: So what does that mean? You made the
26 point, Sally that the 2004 projections did not take into
27 account the growth in the number of facilities. I thought I
28 understood what budget neutrality meant but then I started
29 thinking about it. Does it mean budget neutral versus those
30 projections?

31 DR. KAPLAN: It means budget neutral with what would
32 have been paid under TEFRA but it does not take into
33 consideration growth. It takes into consideration growth in
34 beneficiaries and the market basket. But it does not take
35 into consideration opening new facilities or more patients
36 and more beds.

37 DR. NEWHOUSE: [off microphone.] Or the unbundling of
38 the PPS.

39 DR. KAPLAN: Exactly.

40 MS. DePARLE: So if spending is, in fact, higher than
41 what was projected though, just like everything else there's
42 not a mechanism to go back and say oh, but wait a minute.

43 DR. KAPLAN: No.

44 MR. DURENBERGER: First, I would just like to add my

1 complements to the staff because I know how much work really
2 went into this, and Mark, you two.

3 I have two questions that I didn't hear addressed and
4 then I associate myself with the comments relative to the
5 moratorium by saying I do believe -- and I don't know what
6 the answer is either -- I do believe there's a distinction
7 between co-located and independent. I wouldn't be prepared
8 to vote on it today because I think we ought to have more
9 information on it, but I think it probably ought to be here
10 and we probably ought to have a specific recommendation to
11 make.

12 My two questions relate, one to patient safety and
13 employee safety issues. I don't recall hearing anything
14 about either of those. I don't know the degree to which in
15 a qualitative or a quantitative study those issues get
16 raised and whether you're comparing an LTCH with a regular
17 acute care hospital. But my experience tells me,
18 particularly with the nature of some of these patients -- I
19 recall on one of my visits seeing a 450 pound man, and the
20 challenge that just that particular issue presents.

21 So I say both employee and patient safety issues
22 because I'm making some assumptions about the more
23 specialized hospital perhaps having a much better record but
24 I don't know the answer to it.

25 The second one, which I recall from way back in the
26 mid-'80s when I piggybacked on Joe's explanation to sort of
27 expand a little bit the definition of an LTCH, at that time
28 the admissions were being reviewed by the PROs, as I recall,
29 in their scope of work. For whatever reason I don't think
30 it's any longer included. So I think we have fiscal
31 intermediaries doing the review? Could you comment on both
32 of those, please?

33 DR. KAPLAN: First of all, in the patient and employee
34 safety, I have no information on that at the moment.

35 As far as PRO or they are now called QIO review, they
36 really are not reviewing admissions. They are reviewing a
37 randomly selected, starting this past January, a randomly
38 selected sample of 116 claims to review because of coding
39 and a review of medical necessity. And that's basically it.

40 There's very little review by the FIs of these. In
41 fact, I was at a meeting of the FI Medical Directors and was
42 told by the medical director of one of the primary FIs that
43 has long-term care hospitals. And he said that they had
44 received a letter from CMS, double-signed, whatever that

1 means -- telling him not to review the claims. I don't know
2 what that means. It had two signatures on it instead of
3 one.

4 DR. REISCHAUER: Sally and Carol, I think this is both
5 an interesting and a sophisticated piece of analysis and I
6 would hope when a few adjustments were made to reflect both
7 Jack and Joe's concerns that you try and publish this into a
8 peer-reviewed journal because I think it has the elements of
9 an interesting contribution to the literature.

10 I just want to piggyback on what they were talking
11 about and ask a bit about how we should be judging costs
12 when we compare these hospitals with acute care hospitals
13 and wondering whether we should be looking at patients with
14 the same diagnoses who stay in acute care hospitals more
15 than 20 days versus this set before we jump to conclusions
16 about how expensive they are.

17 And then when we talk about the patients in these
18 hospitals are more expensive than they would be if they were
19 treated in acute care hospitals. When we reflect on the
20 fact that a large fraction of them would be outliers in the
21 acute care hospital and they might look a lot cheaper in
22 that form because somebody else is paying part of the cost
23 here and we should be really concerned about sort of total
24 resource use in the two settings, not the anomalies of a
25 payment system. And we've reflected on the fact that the
26 payment system really isn't "fair" maybe for these kinds of
27 patients in acute care settings. But we say all oh, but
28 they're cheaper than that unfair system and make a policy
29 recommendation on those grounds.

30 The other thing that I was interested, just a comment
31 on Ralph's, you know, where these things are. I don't know
32 if the little diamonds within states are located sort of
33 where the actual hospitals are, but there's a lot of the
34 these that are in nowheresville. So the notion that you
35 need sort of large population -- oh, excuse me, Mary. I
36 forgot Devil's Lake.

37 But they're out in the middle of the Plains in Texas
38 and things like that which sort of makes you think that this
39 isn't large concentrations of Medicare eligible folks.

40 But I was wondering, I might have missed it in the
41 chapter, but what's the average bed size of these things?
42 Particularly the hospitals within the hospitals? And are
43 there admissions from other hospitals to a hospital within a
44 hospital? Or is this just channeling all of the people from

1 that hospital on to another floor of that hospital?

2 Because you might judge these things very differently
3 if they're taking admissions from a catchment area of some
4 kind, and you might want to know sort of are there real
5 economies of scale here because you laid out a set of
6 services and competencies that many acute care hospitals
7 just can't have, particularly smaller ones. They might
8 serve a valuable function.

9 DR. NEWHOUSE: [off microphone.] How would they get to
10 20 days in the first hospital? Wouldn't they be transferred
11 right away?

12 DR. KAPLAN: Let me address a couple of Bob's questions
13 if I may. First of all, on the map the diamonds and the
14 squares and the dots are where the hospitals are located.
15 That's their ZIP code. So that's one question

16 Average bed size, I can tell you hospitals within
17 hospitals have fewer than 50 beds. And some of them have
18 considerably less than that. Some of them have only 10 or
19 20 beds. It varies quite a bit.

20 DR. REISCHAUER: Should one of the criteria be a
21 minimal bed size because it suggests that if it's 10 beds
22 then you are really using resources that are probably dual
23 functions and are operating within the other hospital as
24 well, I would think. It is just uneconomical to run
25 something like this at that small a level, I would think.

26 DR. KAPLAN: Let me answer your question on the primary
27 refer. With the work we did in the last year for the 2003
28 June report, we found that hospitals within hospitals
29 receive 61 percent on average of their cases from the
30 primary refer, which is the host hospital. The long-term
31 care hospitals have a relationship, even the freestanding
32 ones have a primary refer. On average they receive 40
33 percent of their cases from the primary refer. So there is
34 a stronger relationship with the hospitals within hospitals
35 but there is a relationship for the freestanding, as well.

36 MR. HACKBARTH: Sally, what proportion of the triangles
37 are hospitals within hospitals?

38 DR. KAPLAN: I don't have a percentage on the tip of my
39 tongue for you now. I will have that in April. But the
40 majority of the new hospitals are hospitals within
41 hospitals. Almost all of the hospitals established -- in
42 fact, CMS made a comment in this most recent proposed rule
43 that all of the long-term care hospitals established since
44 the PPS was implemented are hospitals within hospitals, but

1 I can't give you a firm percentage.

2 MR. MULLER: But go back to my previous point in the
3 questions that Glenn and Bob are now raising, if there were
4 that incentive to create them within the hospital, that
5 incentive should be nationwide, as a way of clustering those
6 patients that I referred to earlier. So again, I'm puzzled
7 as to why they're just here, because insofar these are the
8 expensive patients and the real outliers. And we know the
9 outliers basically pays 34 percent of the cost of outliers
10 cases. So there's a real incentive to go in that direction.

11 So why don't 50 states do that? Almost every acute
12 hospital in some sense, of any scale, would have this kind
13 of incentive.

14 DR. NEWHOUSE: But wouldn't it also have the
15 capability? That is, Bob seems to be an envisioning some
16 kind of specialized unit that what have an economy of scale.
17 But if that were the case, then I would have thought we
18 would have seen transfers very early in the stay of such a
19 patient like we might see a transfer of a patient to a
20 hospital they could do angioplasty from a hospital that
21 didn't have that capability.

22 But as I understand these patients, they are in the
23 hospital they're admitted to for quite a few days. And then
24 they're transferred to the long-term hospital within a
25 hospital or a separate hospital. I think some of the
26 hospitals since '93 are separate stand-alone hospitals.

27 And I agree with Bob that the issue should be the total
28 resource cost here. But just on the face of it it would
29 seem that if you have a separate bricks and mortar building,
30 separate from the acute care hospital, that that's going to
31 cost more in resources. And if you have just a separate
32 unit within the hospital, in principle the PPOs was set up
33 to encompass those resource costs in its reimbursement.

34 Now the incentives are screwed up as Ray said, but then
35 that goes to working on the PPS incentives rather than
36 trying to, in effect, give the hospitals incentive to game
37 the system by relabeling some floor as the long-term
38 hospital within the hospital, or even worse building another
39 building down the block.

40 MR. HACKBARTH: But Joe if the rapid growth of the
41 hospital within hospital is a byproduct of flaws in the
42 inpatient PPS system and/or an effort to unbundle, how do
43 you respond to Ralph's point that if that's what's driving
44 this you would expect it to be evenly distributed across the

1 U.S.?

2 DR. NELSON: Glenn, I think it's a mistake to consider
3 this as a homogenous group. There are almost certainly some
4 of these facilities that say that they provide a different
5 service, that fixing DRG for long-term stay in the
6 traditional hospital setting doesn't get at what they do,
7 which they may purport to be multidisciplinary teams of
8 experts in a relatively small number of tough kinds of
9 clinical conditions.

10 I'm not saying that that's the majority of them. But I
11 am saying that some of that will make that case, that they
12 are not providing the same service that a longer stay in an
13 acute hospital would provide.

14 MR. HACKBARTH: And I'm very open to that. Just
15 instinctively I'm open to the notion that there are new ways
16 to do things and some specialization. You may come up with
17 something that's better for patients. So I'm not
18 reflexively closed to it.

19 I am concerned about the set of issues that Joe raised
20 early on about whether, in fact, a lot of this is a function
21 of payment failures in inpatient PPS in an effort to get
22 around that. But then I think Ralph has made a very
23 compelling -- and about SNF.

24 But I think Ralph has made a very compelling point that
25 the geographic distribution doesn't seem to be consistent
26 with that.

27 MS. RAPHAEL: Glenn, has there been any change in
28 geographic distribution except for states that have CON in
29 the recent years? Have we seen any spread? Or are the
30 newer facilities concentrated in the same areas as the older
31 facilities?

32 MR. MULLER: Why would California have three and New
33 York have none? I mean, there's a big Medicare beneficiary
34 population in those two states. I think Joe's point has
35 some intellectual appeal but then you start seeing the
36 behavior and it's inconsistent with that because, in fact,
37 that should be -- and I agree with Alan's point, this
38 population -- and maybe Carol and Sally know what proportion
39 of this population really could also be in an acute facility
40 versus needing this kind of care. But the geography still
41 puzzles me.

42 DR. NEWHOUSE: Why is it inconsistent? Why is the
43 geographic concentration inconsistent with this?

44 MR. MULLER: Because then, if that incentive were

1 there, it would be an incentive around the country not just
2 in a few states.

3 DR. NEWHOUSE: But that's true of the clinical side,
4 also. If you want to say there's a specialized capability
5 that's better, then why is that concentrated?

6 MR. MULLER: I'm not following your point. There's
7 geographic concentration but you'd expect to see something
8 in Missouri and California and New York and other states, as
9 well, not just the ones we're listing here. If this
10 provides a special clinical need, then it should provide a
11 special clinical need around the country.

12 DR. NEWHOUSE: I agree with that. So that suggests
13 it's not providing that and that these other areas are
14 doing -

15 MR. HACKBARTH: But you could imagine that the
16 diffusion of the new clinical approach might take time and
17 it would sort of concentrate, but the PPS incentives have
18 been in place for a long time.

19 We are rapidly running out of time and we have Nick and
20 Alan Nelson, did you have another point to make? Okay, and
21 Dave Smith?

22 MR. SMITH: [off microphone.] No, my confusion has
23 largely been expressed.

24 MR. HACKBARTH: Okay Nick, you've got the last word.

25 DR. WOLTER: I would just say Montana is white on that
26 map. I have no experience with LTCHs and had not been in
27 one prior to these visits. I was interested to see that
28 North Dakota is an entrepreneurial state now, too.

29 A few comments. On the hospital within a hospital
30 thing, it might be worth clarifying that there are some
31 governance and ownership rules about what those actually
32 mean, if I remember right. It's not that they're operated
33 by the acute care hospital. And so that at least creates
34 some arms length relationship, although one might question
35 how really arms length is it. But it's probably worth
36 clarifying that.

37 It also would be interesting to see if data can suggest
38 that utilization of the hospitals within hospitals is
39 different in some way. Is the length of stay on the acute
40 care side less there than it is -- before we make judgments.
41 I think it might be worth getting that data.

42 And then a clinical comment. At the best places we
43 visited, and in visiting with my pulmonary critical care
44 colleagues, I was very impressed with the sincerity of their

1 belief that they were providing care that served patients
2 very well, that in many cases they didn't believe was as
3 well provided on the acute care side because of the
4 organization of the team around the chronically/critically
5 ill really wasn't as well put in place as it was in the
6 LTCH. Now that was in the best of the places that we
7 visited.

8 I also had not seen the quantitative analysis until
9 this report came out. And if I'm remembering what's in the
10 paper, if you look at the top 5 percent of patients most
11 likely to receive this care and compare the cost to those
12 who did go to LTCHs, it's a wash or maybe a slight advantage
13 to the LTCH. So we don't really have good information yet
14 that this is more costly care if you try to normalize it for
15 the types of patients being cared for.

16 When you add the readmission differences to that there
17 is at least one thing suggesting that maybe there's some
18 benefit being provided.

19 I also hadn't seen the draft recommendations until
20 today and I just think you guys did an outstanding job
21 coming up with a balance of trying to tighten up the
22 criteria so that indeed the right patients, if that's at all
23 possible, get into these settings. And that the patients
24 who really don't need this care, hopefully the criteria can
25 help us with that.

26 And clearly, the importance of adjusting PPS in the
27 other settings, the acute side and the SNF side, is really
28 critical. Unfortunately, the recommendations on revising
29 RUGs have been out there for how long. That hasn't happened
30 yet. But I think that is really critical as well.

31 I think you really did a nice job packaging those
32 recommendations.

33 MR. HACKBARTH: Thank you. I think that's a great
34 summary of where things stand. Nick, thank you for the time
35 that you spent going on those visits. It was very helpful.

36 And Pete, I'm reminded you also invested some time in
37 that. So thank you