

TESTIMONY

OF

MASSPRO

House Ways & Means Committee
Subcommittee on Health

Wednesday, March 15, 2006

Chairwoman Johnson, Ranking member Stark and the members of the Subcommittee, I would like to thank you for allowing me to address your committee today. My name is Laura Moore, and I am Vice President of Strategy and Operations at MassPRO, the Quality Improvement Organization (QIO) for the Commonwealth of Massachusetts. I am here today to provide some information related to the use of patient level criteria for Long Term Care Hospital (LTCH) patients. My discussion will center on screening criteria to evaluate whether beneficiaries being treated in LTCHs specifically need the level of care that these hospitals provide. As a representative of the QIO community, my role and the basis of expertise that I can provide to this committee is related to the patient-centered and evidence-based assessment we practice in our case review efforts, rather than the financial aspects of the process, since QIOs are quality/performance improvement, not payment, organizations.

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

In addition to the case review role, MassPRO has significant experience with LTCHs because of several targeted projects. For example, MassPRO was contracted by CMS to develop the written manual of policies and procedures that the QIOs use to ensure consistency and standardization in the review process. In addition, CMS used MassPRO's technical expertise in this arena to train other QIOs on several fronts including: what the overall environment in the LTCH setting

encompasses; how to conduct outreach and educate LTCHs on the QIO case review process; and how to explain the expectations within the (then new) Prospective Payment System (PPS) to LTCH providers. PPS was established in regulation in 2002, training and outreach to providers occurred in 2003 and the new QIO review process was instituted as directed by CMS in January 2004.

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

In addition, MassPRO is currently working with the National Association of Long Term Care Hospitals (NALTH) in its effort to modernize patient-level screening criteria for the LTCH industry. We are assessing NALTH's five sets of screening criteria to ensure that severity of illness and intensity of treatment are appropriate and valid. Although the effort is still in process, our assessment so far is that these criteria are on the right track – they address the complex medical conditions of long-term care hospital patients, and we believe that providing a standard, consistent measurement tool will not only improve quality of care but also help protect the Medicare Trust Fund by reducing inappropriate admissions.

An example of our experience with LTCH providers in Massachusetts is as follows: that since August 2005, MassPRO has reviewed 75 LTCH cases, including 12 each from 2 different facilities and 11 cases involving respiratory DRGs. Our review process enables case reviewers

to begin to see patterns of practice and perhaps trends, even in the relatively small number referenced above. When a patient is discharged in fewer days than the SSO threshold, it will be for one of three reasons (other than the death of the patient): (1) due to the expertise of the hospital, the patient improves and gets better, (2) circumvention of the rules by the providers (e.g. multiple transfers), or (3) the reality that the patient should not have been admitted to the hospital in the first place.

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

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

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

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

Thank you.

Background Information

Case Review Process

The case review process may need some explanation. On a monthly basis, CMS assigns a random sample of LTCH cases for full case review. CMS uses an average of 1,400 per year (116 per month). In January 2006, this review was incorporated under the Hospital Payment Monitoring Program (HPMP), whose purpose is to measure, monitor, and reduce the incidence of improper fee-for-service inpatient payments, including errors in DRG coding; provision of medically necessary services; and appropriateness of setting, billing, and prepayment denials. The long-term goal of HPMP is to help inpatient prospective payment system hospitals monitor payment patterns by analyzing data, conducting focused audits, and implementing system changes to prevent payment errors.

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

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

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

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

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