CMS-1485-P-2 **Prospective Payment System for Long-Term Care Hospitals FY 2007; Annual Payment Rate Updates***

Submitter : **Mr. Raymond Alvarez Alvarez** **Date & Time:** **03/10/2006**

Organization : **Regency Hospital of Central Georgia**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Our facility has maintained an average LOS consistent with the GMLOS per DRG. We have excellent outcomes and physicians have come to respect what we do. Our vent weaning rate is excellent. I have found that LTACs can provide cost effective care, provide excellent outcomes and have high degree of patient satisfaction as well as physician satisfaction. It is a great mistake to reduce funding. Medicare needs to consider a limit on physician inpatient billing--or put them under a DRG. There IS no incentive for a physician to discharge a patient from an acute setting. In an LTAC, we make sure our physicians know how long the patient should stay based on the GMLOS. Our care plans are agressive and physicians are more involved than they would be in an acute setting. Medicare needs to evaluate provider payment for services in acute settings as far as limitations on how long they will pay a physician for subsequent care (E&M codes 99231-233).

Long-Term Care Diagnosis-Related Group (LTC-DRG) Classifications and Relative Weights

Long-Term Care Diagnosis-Related Group (LTC-DRG) Classifications and Relative Weights

I would encourage no change in LTCH PPS. I have worked in acute hospitals for 30 years and recently became the CEO of a 34 bed LTCH in Macon, GA. This experience has been a relevation to me as far a PPS and outcomes. I have found that LTCHs uphold Interqual criteria for admissions and only admit appropriately.

Proposed Changes to the LTCH PPS Payment Rates for the 2007 LTCH PPS Rate Year

Proposed Changes to the LTCH PPS Payment Rates for the 2007 LTCH PPS Rate Year

There will be a detrimental impact on current LTCH's and without continued support and development, Medicare will be forced to deal with critically ill patients with a lengthy LOS in an acute setting. This creates financial burden on the acute hospital, keeps critical care beds full with patients in outlier status and consumes resources. Let me give you an example... I was Chief Operating Officer in an urban hospital in Northern New Jersey. Typically, each winter, our ICU would fill with nursing home patients on ventilators... we'd have to call in agency nurses, and then we

would be on divert for new admissions. These patients stayed about 2 months. We could not do agressive vent weaning because we did not have the depth of staff in respiratory (typically, most acute hospitals will not have more than 2 or 3 therapists to cover the entire hospital). We lost money and unfortunately, this hospital was in financial problems. There were no LTACs in the area... thus without a safe discharge plan, the acute hospitals had to keep the patients.

CMS-1485-P-3 Prospective Payment System for Long-Term Care Hospitals FY 2007; Annual Payment Rate Updates***

Submitter : **Date & Time:** **03/10/2006**

Organization : **Acute Long Term Hospital Association**

Category : **Health Care Provider/Association**

Issue Areas/Comments
GENERAL

GENERAL

See Attachment

CMS-1485-P-3-Attach-1.DOC

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March 10, 2006

BY ELECTRONIC FILING AND OVERNIGHT MAIL

Hon. Mark B. McClellan, M.D., Ph.D.
Administrator
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Re: ***Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule, 71 Fed. Reg. 4648 (January 27, 2006)***

Dear Dr. McClellan:

This letter presents comments and recommendations of the Acute Long Term Hospital Association ("ALTHA") to certain aspects of the proposed annual payment rate updates, policy changes, and clarifications under the prospective payment system for long-term care hospitals ("LTCH PPS") for rate year ("RY") 2007, which were published by the Centers for Medicare & Medicaid Services ("CMS") on January 27, 2006.

As we discuss more fully below, ALTHA opposes the severe and arbitrary reductions in long-term care hospital ("LTCH") payments that will result if these proposed changes to the LTCH PPS are implemented. ALTHA has analyzed the proposed rule and found that CMS used materially flawed and incomplete data in developing their proposed changes to LTCH payments for RY 2007. ALTHA's analysis shows that the assumptions CMS made in developing its proposed changes to LTCH payments for RY 2007 are incorrect due to the data errors discussed herein. CMS should (i) withdraw the proposed rule, (ii) revise the data it is using to develop final payment changes for LTCHs in RY 2007 to correct these data errors, and (iii) publish a new proposed rule that will allow for interested and affected parties to provide meaningful comments.

ALTHA recommends that CMS reconsider its proposed changes to the LTCH PPS in light of the Medicare Payment Advisory Commission ("MedPAC") recommendations in June 2004 that the certification criteria for the Medicare LTCH provider category be strengthened to ensure that LTCH payments are being made to only those providers that are administering medically complex care to severely ill patients. ALTHA supports this approach as a more defined method for limiting LTCH payments to hospitals that are truly caring for a medically complex patient population. Unfortunately, the proposals that CMS advances in this proposed rule use incomplete data and analyses to reach false assumptions about LTCHs and the patients these hospitals care for. The proposed payment changes will

have a severe impact on all LTCHs and will undoubtedly have a deleterious impact on the care that LTCH patients receive. Arbitrary payment reductions are the wrong approach if quality of care is to be encouraged.

Specifically, CMS should reconsider its proposed policy for short-stay outlier ("SSO") cases. CMS makes the erroneous assumption that all so-called "short stay" cases – even those whose stay exceeds the statutory threshold of 25 days to qualify as an LTCH – should never have been admitted to an LTCH and should have been paid at a rate that fails to cover costs. This will amount to a rationing of care through the payment system by establishing financial disincentives that deprive this subset of hospital patients from LTCH care. To the extent that CMS is concerned about "inappropriate" admissions to LTCHs, it should implement non-payment approaches such as pre-admission physician certifications, uniform admission screening criteria, and more extensive Quality Improvement Organization ("QIO") reviews. Alternatively, CMS should consider narrowly tailored payment reforms targeted specifically at "very short stay" LTCH patients (*e.g.*, patients with lengths of stay of less than 7 days). If the intent of the proposed rule is to rationalize what CMS views as one of the settings in the post-acute care space for Medicare beneficiaries, ALTHA supports that goal. But, for the reasons stated below, we firmly believe that the dramatic payment reductions in the proposed rule interfere with this goal because they are not based on solid data analysis and supportable conclusions.

ALTHA represents the nation's leading LTCHs and works to protect the rights of medically complex patients by educating federal and state regulators, Members of Congress and health care industry colleagues. ALTHA represents over three hundred LTCH hospitals across the United States, constituting over two-thirds of this provider community nationwide. The proposed reimbursement changes that are based upon the data and other information errors in the Proposed Rule will have a direct, adverse impact on the LTCHs operated by ALTHA members.

I. Proposed Changes to Short-Stay Outlier Payments

A. General Description

The proposed rule would revise the payment adjustment formula for SSO patients. SSO cases are defined as LTCH PPS cases with a length of stay of less than or equal to five-sixths of the geometric average length of stay for each Long Term Care Diagnosis Related Group (LTC-DRG). Currently, payment for SSO patients is based on the lesser of (1) 120 percent of estimated patient costs; (2) 120 percent of the per diem of the LTC-DRG multiplied by the length of stay of that discharge; or (3) the full LTC-DRG payment.

CMS proposes two specific changes to the SSO payment methodology in the proposed rule. First, CMS would reduce the first part of the current payment formula that is based on costs from 120 percent to 100 percent of the costs of the case. Second, CMS would add a fourth component to the current formula that would allow payment under the LTCH PPS based on an amount comparable to what would be paid to an acute care hospital under the inpatient prospective payment system ("IPPS"). That is, for SSO cases, the LTCH would be paid based upon the lesser of four amounts, one of which would be an amount equivalent to the IPPS payment for the patient stay. Both of these changes would be effective for discharges on or after July 1, 2006. CMS believes that, under this proposed policy, LTCHs could be paid by Medicare under the LTCH PPS at a rate that is more consistent with the rate paid to acute care hospitals when the LTCHs treat shorter stay patients.

B. Assessment

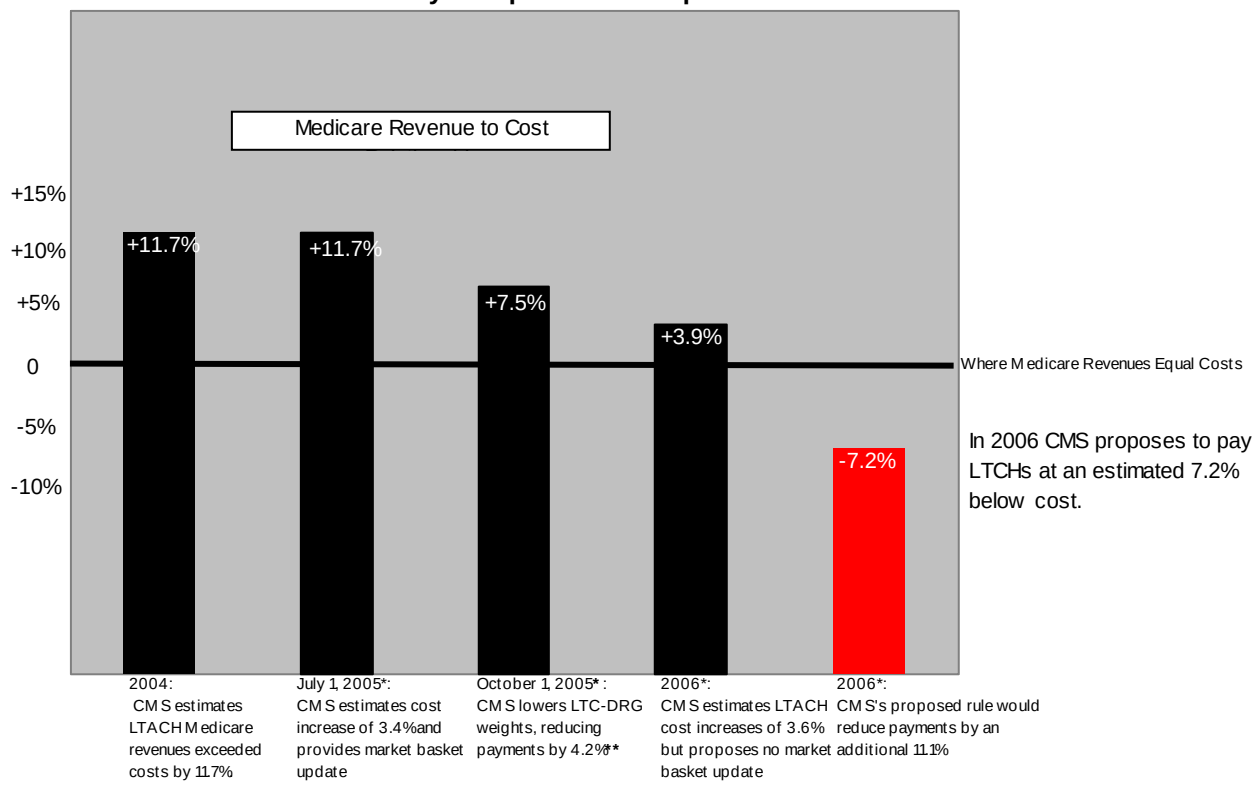
1. CMS's Proposal to Pay for SSO Patients at IPPS Rates Would Result In LTCHs Being Paid Amounts Significantly Below Their Costs of Providing Patient Care

CMS's proposal to limit the payment for SSO cases at the IPPS payment rate would cause LTCHs to be significantly underpaid. For SSO cases, which CMS acknowledges represent fully 37 percent of the patients served by LTCHs, the proposal would cause payment amounts to fall materially below the actual costs of providing care. Payment to LTCHs operated by one of our member organizations for SSO cases under the proposed policy would represent only 57 percent of the actual costs incurred in caring for those patients.

Overall, CMS's proposal would drastically cut payments to LTCHs by approximately 11 percent, as CMS has calculated. Combined with the proposal to deny the basic inflationary update to cover the rising costs of care, which CMS estimates to be 3.6 percent, and other recent changes to LTCH coding and LTC-DRG weighting, the impact of the proposed revisions to the SSO payment policy will be to pay LTCHs *significantly* less than it costs them to care for appropriately admitted patients. Patients with complex medical conditions will lose access to needed hospital care, and general acute care hospitals will incur additional costs since they will be unable to discharge these complex patients to a more appropriate setting.

Moreover, LTCHs will not be able to make up these costs from other patients. Our analysis shows that, after giving effect to the proposed SSO payment policy and the lack of any inflationary update, the total payments to LTCHs will fall short of LTCH costs by 7.2 percent (see Figure 1 below).

FIGURE 1: CMS Proposes Rates Well Below the Costs of Caring for the Medically Complex LTCH Population



*** Estimates; Assumes no changes in volume or intensity of services, which could affect total costs.**
**** Note: CMS rebases LTCH DRG weights annually, with an effective date of Oct. 1 of each rate year. This rebasing is not budget neutral.**

CMS assumes that LTCHs can change their behavior so as to accommodate this dramatic reduction in payments. In particular, CMS claims that LTCHs will decline to admit SSO patients, since the costs of treating such patients will exceed the proposed payment amounts. In fact, as discussed below, LTCHs are not able to predict a patient's length of stay at the time of admission. Therefore, LTCHs cannot change their behavior to accommodate these payment cuts. Instead, LTCHs will simply be forced to absorb payment rates that bear no reasonable relationship to the costs of furnishing patient care.

The magnitude of the proposed cuts in payments for treating SSO patients is so dramatic that the proposal appears to be nothing short of punitive. Certainly, CMS is well aware that the rate of payment for these cases will be insufficient to cover LTCHs' reasonable and necessary costs in providing care to SSO patients. Although apparently intended to punish LTCHs for allegedly inappropriately admitting patients not in need of LTCH care, CMS has produced no study or analysis showing that inappropriate admissions constitute a material portion of SSO cases. To the contrary, the data presented below demonstrates that SSO cases are, in fact, appropriate for admission to LTCHs.

Further, the proposed material shift in LTCH payment policy after the conclusion of the initial LTCH PPS rate setting process, the initial budget neutrality adjustment, and subsequent annual updates, calls into question the continued appropriateness of overall LTCH payment rates. When CMS established the various features of LTCH PPS (*e.g.*, the standard federal rate and the various facility- and patient-level adjustments) and engaged in annual updates, the agency's calculations took into account the existence of an SSO patient population comparable (if not larger) than the one described in the January 2006 Proposed Rule and, thus, payments for care furnished to that population based upon the SSO methodology in effect since the initial implementation of LTCH PPS. Given the budget neutrality principles followed by CMS in the rate setting process, anticipated payments for SSO cases under the existing SSO formula necessarily had an offsetting effect on other elements of LTCH PPS, such as the standard federal rate. Therefore, to cut SSO payments radically at this juncture in the implementation of LTCH PPS, without a material increase in payment rates for inlier cases, casts doubt on the ongoing fairness of the overall payment system. It also shows that CMS failed to do any analysis to demonstrate that the proposed 11.1 percent payment cut and zero market basket update maintains a budget neutral LTCH PPS, as required by statute.

The impact of the proposed policy changes by CMS in this rule, of which the SSO policy is the largest contributor, is estimated in the President's Budget to equal $280 million in 2007 and to total $2.48 billion over the next 5 years. The President's Budget proposes an additional $2.452 billion reduction to the Medicare program in 2007 (in total, a $35.891 billion decrease over the next five years). Spending on the beneficiaries receiving care in LTCHs represents just 1.4% of all Medicare spending, yet the CMS policies in this proposed rule equal 11% of all the proposed cuts to the Medicare program in 2007 and 7.8% of all cuts over the next 5 years. Thus, the SSO policy represents a disproportionately severe payment cut to a relatively small provider category in Medicare, and can be expected to harm beneficiary access to the unique care LTCHs provide.[1]

2. The SSO Thresholds Are Not, And Were Never Meant To Be, a Measure of the Appropriateness of an LTCH Admission

In the January 2006 Proposed Rule, CMS asserts that SSO cases (*i.e.*, patients whose length of stay is less than the SSO threshold) "most likely do not require the full measure of resources available in a hospital that has been established to treat patients requiring long-stay hospital level services." In this assertion, CMS demonstrates its fundamental misunderstanding and misuse of the SSO thresholds.

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[1] LTCH baseline numbers from Table 9 of the proposed rule, pgs. 4,681-82. Medicare baseline and policy proposal numbers from *Analytical Perspectives, Budget of the United States Government, Fiscal Year 2007,* pgs. 211, 360, and 363.

The SSO thresholds have nothing at all to do with the appropriateness of an LTCH admission. Rather, the SSO thresholds are simply the mathematical result of the per diem rates that CMS established for cases whose lengths of stay are less than the average for a particular LTC-DRG. As CMS explained in the August 2002 Final Rule, the SSO threshold "corresponds to the day where the full LTC-DRG payment would be reached by paying the specified percentage of the per diem amount for the LTC-DRG." By providing for per diem payments until this point, CMS accomplished its objective of "a gradual increase in payment as the length of stay increases, without producing a 'payment cliff,' which will provide an incentive to discharge a patient one day later because there will be a significant increase in the payment." 67 Fed. Reg. 55,996. By setting the per diem rates at 120 percent of the average LTC-DRG specific per diem amount, the SSO threshold necessarily became fixed at 5/6 of the average length of stay for the LTC-DRG. This relationship between the per diem rate and the SSO threshold is illustrated in the preamble to the March 2002 Proposed Rule, where CMS discussed three alternative per diem payment rates: 100 percent of the LTC-DRG specific per diem amount, yielding an SSO threshold equal to the average length of stay for the LTC-DRG; 150 percent of the LTC-DRG specific per diem amount, yielding an SSO threshold equal to 2/3 of the average length of stay for the LTC-DRG; and 200 percent of the LTC-DRG specific per diem amount, yielding an SSO threshold equal to 1/2 of the average length of stay for the LTC-DRG. 67 Fed. Reg. 13,454-55. It is plain that the SSO threshold was simply derived from the per diem payment amounts and had nothing to do with the appropriateness or inappropriateness of admissions of SSO cases for LTCH care.

Furthermore, CMS's objective in establishing the SSO per diem payment amounts was wholly unrelated to any consideration of the appropriateness of LTCH admissions. As CMS explained, the per diem amounts were set so that the payment-to-cost ratio for SSO cases would to be at (or close to) 1.0. According to CMS, this approach "would ensure appropriate payments to both short-stay and inlier cases within a LTC-DRG because, on average, payments closely match costs for these cases under this prospective payment system." 67 Fed. Reg. 55996. In the August 2002 Final Rule, after reevaluating its data to take into account the elimination of the proposed very short-stay outlier policy, CMS "determined that the most appropriate percentage that maintains a payment-to-cost ratio of approximately 1 for 7 days or less is 120 percent." Thus, the SSO per diem amount selected by CMS, which determines the SSO threshold, was based on maintaining this payment-to-cost ratio during the early days of a patient's hospital stay, and was not based on any consideration of the appropriateness or inappropriateness of admissions of SSO cases for LTCH care.

An example illustrates that CMS's proposed changes to the SSO payment policy bear no relationship to the appropriateness of a patient's admission to an LTCH. Ventilator-dependent patients assigned to LTC-DRG 475 have an average length of stay of 34 days, which results in an SSO threshold of 28 days for these patients. The statutory qualification criteria for LTCHs require that LTCHs have an average length of say of greater than 25 days, which is less that the SSO threshold for patients assigned to this LTC-DRG. Obviously, therefore, the SSO thresholds do not measure the appropriateness of an admission for LTCH care.

In short, the SSO thresholds are not, and were never meant to be, a measure of the appropriateness of an LTCH admission. Rather, they were mathematically derived from the per diem payment amounts, which were based on a methodology that would produce a payment-to-cost ratio for SSO cases close to 1.0. Implementing a payment policy that assumes that all SSO cases were inappropriate for admission for LTCH care lacks any foundation in supportive data and reflects a misunderstanding and misuse of the SSO thresholds. In fact, by paying SSO cases at the equivalent of short-term care hospital rates, CMS's proposed policy on SSO cases would itself create a payment cliff. This would lead to a significant and unwarranted reduction in payments for patients appropriately admitted to, and receiving care in, LTCHs.

3. The CMS Analysis of Short-Stay Outlier Cases Is Premature and Ignores Variables that Render CMS's Conclusions Erroneous

CMS cites two sources of data for the first proposed change to SSO payments. CMS looked at LTCH claims data from the FY 2004 MedPAR files (using version 23 of the GROUPER software), which CMS says reveals that 37 percent of LTCH discharges are SSO patients. CMS states that it compared this percentage against the 48 percent of LTCH discharges that would have been SSO patients at the outset of LTCH PPS (*i.e.*, FY 2003). This pre-LTCH PPS data was derived from the same regression analyses and simulations based on prior years' LTCH claims data generated under the former reasonable cost-based (TEFRA) system that CMS used to develop many aspects of LTCH PPS for FY 2003. After comparing the number of SSO cases for FY 2003 (48 percent) against the number of SSO cases for FY 2004 (37 percent), CMS concludes that the drop in SSO cases is not sufficient enough and the changes it is proposing to make to the SSO payment methodology are warranted.

a. The Data In CMS's Analysis of a One-Year Change In Short-Stay Outlier Cases, At the Beginning of the Transition Period to LTCH PPS, Is Too Preliminary to Support the Proposed Payment Change

Even if one were to assume that this data is accurate, it is premature to use this data to make such a drastic change to SSO payments. CMS is only looking at a one-year change in SSO cases (data that it states is correct going into LTCH PPS in FY 2003, and data from FY 2004), not the three years that CMS improperly states in the proposed rule. In addition, FY 2004 is only the second year of the transition period to full prospective payment. The regulations provide that each LTCH payment was comprised of 40 percent of the federal prospective payment rate during FY 2004, with 60 percent of each LTCH payment still cost-based reimbursement for those LTCHs that chose to transition to LTCH PPS. Accordingly, the incentives that CMS states that it built into LTCH PPS to pay LTCHs for patients who could not be more appropriately treated in other types of facilities may not have taken hold in FY 2004, since LTCHs paid under the transition methodology continued to be paid 60 percent of their reimbursement based on their costs. For a credible analysis, CMS would need to examine the number of SSO cases in LTCH cost report data at the conclusion of the transition period, and certainly no earlier than FY 2005 (the first year that more than 50 percent of each LTCH PPS payment was comprised of the federal rate), before it can know whether SSO cases remain a material portion of LTCH discharges.

b. CMS's Analysis Is Defective For Not Examining the Types of Short-Stay Outlier Cases, Only a Portion of Which Could Bear Any Meaningful Relationship to CMS's Stated Policy Goals

CMS states in the proposed rule, there "continues to be an inappropriate number of patients being treated in LTCHs who most likely do not require the full measure of resources available in a hospital that has been established to treat patients requiring long-stay hospital-level care. Generally, if these patients required the type of care associated with LTCHs, the patients would most likely be in the LTCH for the duration of the LOS associated with the particular LTC-DRG to which the case is assigned. Therefore, we are concerned that the existing SSO payment adjustment at §412.529…may unintentionally provide a financial incentive for LTCHS to admit patients not requiring the level of care available in that setting." 71 Fed. Reg. at 4,686.

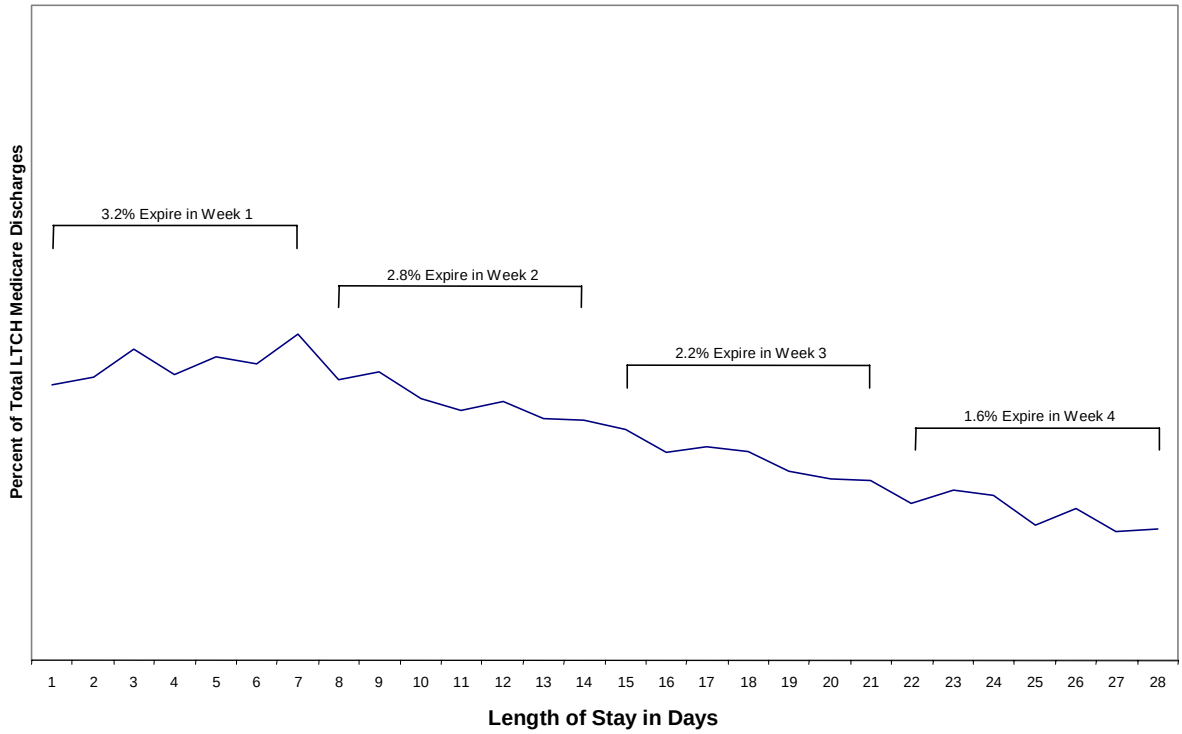
Even if CMS were to find a significant number of SSO cases after most LTCHs had begun to receive payments based in whole or in significant part on the federal rate, CMS would still need to determine from some reliable data source (1) the portion of SSO cases that are patients whose medical condition(s) made them appropriate for the resource-intensive care provided by LTCHs, but whose condition improved enough to warrant further treatment in an alternate care setting, (2) the portion of SSO cases that expired early in their LTCH stay, and (3) the portion of SSO cases that were admitted to the LTCH, but were later discharged after the patients' care providers determined after further examination and treatment that the patient would more appropriately be treated in an alternate care

setting. Only this last category of SSO cases bears any meaningful relationship to the policy that CMS presents in the proposed rule for ensuring that the majority of LTCH cases are appropriate for an LTCH level of care.

If all or most SSO patients did not require an LTCH level of care – that is, they required less intensive services – then the CMS statement above may suggest the need to bring payments more in line with the proper incentives. However, as shown in Table 4 in this section, there are no discernable differences in terms of patient acuity between SSO patients and full-stay LTCH patients, as measured by both severity of illness and by risk of mortality. These findings contradict the assertion by CMS that LTCHs are admitting patients that are "not requiring the level of care available in that setting" – rather they show that LTCHs admit a homogenous group of patients who for a variety of reasons have varying lengths of stays. Additionally, there are good explanations for why a patient may be LTCH-appropriate, even if that patient does not stay "for the duration of the LOS associated with the particular LTC-DRG to which the case is assigned." One such example is patients that expire prior to reaching the 5/6th geometric mean LOS threshold.

The Figure below shows the distribution of LTCH expirations by length of stay for all LTCH discharges (see Figure 2). It shows that 3.2% of all LTCH discharges expire within the first week of admission, another 2.8% expire during week two, 2.2% during week three, and 1.6% expire in week four. Approximately 1.5% of long stay, high cost outlier patients expire. Overall, 13.8% of all LTCH Medicare patients expire. From a clinical perspective, this distribution is not surprising given the medical complexity of LTCH patients and the fact that patient expirations typically occur in the earlier stages of intervention in health care facilities.

FIGURE 2: LTCH Medicare Patient Expirations by Length of Stay as a Percent of Total LTCH Medicare Discharges



Note: 13.8% of all LTCH Medicare patients expire
Source: MedPAR 2004

It is unreasonable for CMS to expect admitting physicians to be able to predict a potential patient death 10 or even 20 days in the future and decline admittance based on that criterion alone in the face of the potential clinical benefits to the patient in the LTCH. Tools simply do not exist for physicians to predict death weeks in advance. The APACHE tool, which is commonly used in LTCHs and short-term general hospital intensive care units to measure patient acuity and resource use, lacks that specificity. Even if a physician could predict an individual patient's LOS and risk of mortality, CMS cannot reasonably assume that an LTCH patient that dies on the 20th day of his stay does not need "long-stay hospital-level care." Given the clinical difficulties in predicting a patient's length of stay and risk of death as well as the low number of very short-stay LTCH patients due to death, we do not believe this issue requires action in the unfounded and financially punitive manner CMS has proposed.

In addition, another portion of LTCH SSO patients are characterized as such because their Medicare *coverage* expires during their LTCH stay but before they reach the relevant SSO thresholds. Clearly, loss of Medicare coverage bears no relevance whatsoever to whether the patient was appropriate for admission to an LTCH. CMS, itself, recognized this fact in the initial implementation of LTCH PPS, when it decided to count total patient days rather than Medicare-covered days to determine whether an LTCH meets the statutory average length of stay requirement for certification:

> We are adopting this policy because we believe that a criterion based on the total number of treatment days for Medicare patients is a better indication of the appropriateness of the patient's stay at an LTCH than the number of days covered by Medicare for payment purposes.

67 Fed. Reg. 55954, 55984 (Aug. 20, 2002). For such loss-of-coverage SSOs in particular, there is no relationship between the need for LTCH level care and the length of Medicare stay in the facility, and this patient population should be discounted from statistics used to evaluate current SSO payment policy.

On a related note, we suggest that CMS further consider MedPAC's proposal to establish patient and facility level criteria for LTCHs to better define the patient setting and medical conditions for LTCHs, rather than draw questionable assumptions about admission appropriateness from a limited set of data.

c. CMS Cited One QIO Review of an LTCH But Ignored Available Data On Numerous Other QIO Reviews of LTCHs In Which the Medical Necessity of LTCH Admissions Were Upheld

CMS cites one QIO review of one LTCH in the proposed rule and ignores readily available data concerning other QIO reviews of LTCHs in developing this proposed policy. The proposed policy rests on CMS's erroneous assumption that these shorter-than-average-stay patients were inappropriately admitted to the LTCH in the first place. LTCHs admit patients only after applying an objective and rigorous set of admissions screening criteria. To confirm this, Medicare QIOs conduct post-admission reviews of LTCH patients to ensure that the admission was medically necessary. At CMS's direction, QIOs have been reviewing a sample of LTCH cases for admission appropriateness.

For two of the largest LTCH organizations, the QIOs have determined that the vast majority of LTCH admissions were appropriate and medically necessary. Kindred Healthcare, Inc. ("Kindred") and Select Medical Corporation ("Select") had over 1,000 combined LTCH cases reviewed by QIOs since 2003. The denial rate for all of these reviews is 1.6%. Specifically, Kindred had 495 cases reviewed by QIOs between 2003 and 2005. Of this total, only 12 cases were denied on the basis of inappropriate admission or medical necessity. That is a denial rate of 2.4%. Select had 592 cases reviewed by QIOs between 2004 and 2005. Of this total, only 6 were denied, for a denial rate of 1.0%. Therefore, data available to CMS clearly show an immaterial number of LTCH claims denied as the result of QIO reviews. The QIO review data does not support CMS's assumption that SSO cases were inappropriately

admitted to LTCHs. On the contrary, QIOs are overwhelmingly finding that LTCH patients have appropriately been admitted and treated in LTCHs.

d. CMS Ignored Available Data On the Clinical Differences Between Short-Stay LTCH Patients and General Acute Care Hospital Patients

Most important is the clinically documented fact that LTCHs treat a substantially different patient population with virtually no other treatment options – one that is demonstrably sicker, with higher patient acuity and multiple medical complexities – than the typical short-term general hospital patient in similar diagnostic categories. That is precisely why Congress created this special class of hospitals in 1983. Available Medicare data demonstrate that LTCHs continue to occupy a special niche in post-acute care by serving the most medically complex patients. This data supports modernizing the classification criteria for LTCHs to distinguish and define the unique level of care that LTCHs provide.

"Short stay" LTCH patients are not clinically similar to short-term general hospital patients, simply because their length of stay is less than the average LTCH patient, as CMS assumes. Medicare data show that so-called "short stay" LTCH patients actually have a much longer length of stay than the average short-term general hospital patient with the same diagnosis. The length of stay is longer because the LTCH patient is, on average, much more medically complex. Table 1 below shows the five most common SSO LTC-DRGs, and compares the average length of stay for those stays with the average length of stay for the average general short-term care hospital patient.[2] The data clearly show that LTCH SSO patient lengths of stay, on average, greatly exceed that of patients treated in general short-term care hospitals. Therefore, these patient populations are not clinically similar. These differences reflect the more specialized needs, and more complex medical conditions, of LTCH patients, and are indicative of the fact that, even for SSO cases, LTCHs do not simply function as general acute care hospitals.

TABLE 1

LTCH DRG	Description	LTCH SSO ALOS	Short-Term Hospital GMLOS
475	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	13.0	8.0
87	PULMONARY EDEMA & RESPIRATORY FAILURE	13.0	4.9
88	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	9.8	4.1
271	SKIN ULCERS	13.0	5.5
89	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	10.1	4.8
	All DRGs (weighted by case frequency)	12.7	5.6

e. Short-Stay LTCH Patients Are Clinically No Different Than Other LTCH Patients

"Short stay" LTCH patients are not less medically complex than the general LTCH patient population. In fact, the diagnoses, medical complexity and severity of illness of "short stay" LTCH patients are generally no different from the general LTCH patient population. For example, the most common "short stay" LTCH patients are ventilator dependent (DRG 475) – the most vulnerable and medically complex patients. Overall for LTCHs, the average length of stay for these patients is about 34

[2] Data in table taken from the 2004 Medicare Provider Analysis and Review ("MedPAR") file, December and March updates. GMLOS refers to geometric mean length of stay.

days. However, under CMS' system, even ventilator-dependent patients with a length of stay of 28 days are classified as "short stay" and would be subject to payment penalties. The data for the five most common SSO LTC-DRGs are presented in Table 2.[3] In Table 2, we provide data from the 2004 MedPAR file which shows the geometric mean length of stay ("LOS") for all LTCH patients, with the SSO threshold stay (or 5/6ths of the geometric mean LOS). The MedPAR file, along with 3M APR DRG Software for the 3M All Patient Refined DRG ("APR-DRG") Classification System, allows us to categorize cases by severity of illness ("SOI"). The APR-DRG severity of illness scores range from 1 to 4, with scores of 3 and 4 considered severely ill. Our data show that SSO cases have similar SOI scores as cases that stay longer, demonstrating the clinical homogeneity of the two groups.

TABLE 2

LTCH DRG	Description	GMLOS for All LTCH Cases	LTCH 5/6 GM: SSO Threshold	All LTCH Cases: % in SOI 3,4	SSO Cases: % in SOI 3,4
475	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	34.2	28.5	94%	94%
87	PULMONARY EDEMA & RESPIRATORY FAILURE	30.4	25.3	90%	87%
88	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	20.1	16.8	60%	52%
271	SKIN ULCERS	28.4	23.7	72%	69%
89	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	21.2	17.7	74%	67%
	All LTCH DRGs (weighted by case frequency)	26.6	NA	68%	64%

To illustrate the extent to which CMS's proposals contradict the available data and established regulatory scheme, these so-called "short stay" patients have a length of stay that exceeds the 25-day threshold CMS uses to determine whether a hospital is eligible for classification as an LTCH and yet CMS would also now, in effect, classify these patients as short-term general hospital patients. This would penalize LTCHs who admit and treat the most medically complex patients when those patients happen to be defined as "short stay" under CMS's own rules.

f. The Data Do Not Support CMS's Assumption that LTCHs Can Predict In Advance an Individual Patient's Length of Stay

In developing these proposed changes to LTCH payments for SSO cases, CMS makes the false assumption that LTCHs can predict in advance the expected length of stay for medically complex LTCH patients. The data do not support this assumption. LTCH patients are a homogeneous group of medically complex patients, as shown in Table 2. From a clinical perspective, there are no discernable differences between "short-stay" LTCH patients and longer stay ("inlier") LTCH patients. Physicians who make admission decisions after applying objective and rigorous clinical screening criteria cannot, indeed *should* not, predict in advance – in effect, gamble on – the length of stay for this small subset of medically complex, severely ill patients.

Consistent with the fact that SSO patients require the same level of care as inlier patients, LTCHs are unable to distinguish between these two patient populations at the time of admission. (For

[3] Data in table taken from 2004 MedPAR file, December and March updates. The APR-DRG grouper software is proprietary software of 3M used to categorize cases by diagnoses and procedures at discharge. The SOI scores range from 1 "minor," 2 "moderate," 3 "major," and 4 "extreme."

the same reason, LTCHs are also unable to identify high cost outliers at the time of admission, and are unable to predict the patient's outcome, including death, at the time of admission.) Data show that patients who are ultimately characterized as SSO cases present similar diagnostic mix, similar levels of severity, and similar risk of mortality than inlier cases. In fact, the percentages of SSO cases falling into each of the most common LTC-DRGs is comparable to the percentages of inliers falling into such LTC-DRGs. DRG classification does not occur until after discharge, when the GROUPER software identifies the proper LTC-DRG for payment. Because the 5/6th geometric stay thresholds are different for each LTC-DRG, it is impossible to predict whether a patient will be a SSO upon admission.

Similarly, the proportion of SSO patients in LTCHs that fall within the highest severity of illness and risk of mortality categories is consistent with the proportion of inlier patients that fall within those categories (see Table 4). Given the high levels of severity of illness and risk of mortality within the SSO patient population, physicians making admissions decisions cannot and *should not be* required to predict the ultimate length of stay for this subset of medically-complex, severely ill patients. Rather, if LTCHs are successful in establishing and implementing a plan of care that achieves the best clinical outcome for the patient in a shorter-than-average timeframe, the result should be lauded, rather than penalized, as beneficial for all affected parties.

Many patients admitted to LTCHs already have had extended stays at acute care hospitals, making it even more difficult to predict how long they will stay. This is supported by the data presented in Table 3 below.[4] For example, Table 3 shows that the average DRG 475 short-term acute care hospital ("STCH") patient has a LOS of 8 days; but STCH patients who are admitted to LTCHs with DRG 475 had a LOS of 27 days, on average, in the STCH.

TABLE 3

			LTCH Patients	
LTCH DRG	**Description**	**Short-Term Hospital GMLOS**	**Prior Short-Term Hospital LOS**	**GMLOS for All LTCH Cases**
475	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	8.0	27	34.2
87	PULMONARY EDEMA & RESPIRATORY FAILURE	4.9	23	30.4
88	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	4.1	10	20.1
271	SKIN ULCERS	5.5	12	28.4
89	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	4.8	10	21.2
	All DRGs (weighted by case frequency)	5.6	NA	26.6

Overall, STCH patients sent to LTCHs had prior lengths of stay in the STCH of 13.2 days. This is far in excess of the 5.6 days geometric mean length of stay for all STCH patients. This rebuts any inference CMS may make that STCHs are systematically sending patients to LTCHs before completing their course of care in the STCH.

[4] "Prior Short-Term Hospital LOS" data are from RY 2007 proposed rule. Other columns from MedPAR 2004, December and March updates.

The SSO policy would penalize LTCHs for admitting LTCH-appropriate patients by paying providers below cost most of the time. Currently, most LTCHs use patient assessment tools, such as InterQual® Long-Term Acute Care Criteria (McKesson Health Solutions), to assess the appropriateness of patients' admissions, their continued stays and ultimate discharges from its facilities. Such criteria are among the patient-level standards that MedPAC has recommended be applied by CMS to define more precisely the level of care furnished by LTCHs ("Report to the Congress: New Approaches in Medicare," June 2004) and are used by many of Medicare's QIOs to evaluate the appropriateness of LTCH admissions. LTCH application of the InterQual® Criteria identifies and screens a significant number of patients from admission, thereby ensuring that only those patients who are appropriate for an LTCH stay are admitted.

In the January 2006 Proposed Rule, CMS hypothesizes that LTCHs seek to admit patients who are likely to be SSO cases because LTCHs financially benefit from treating SSO patients. In reality, however, LTCH clinical personnel, in conjunction with personnel from the referring facility, are applying the InterQual® Criteria – rigorous, objective standards – in order to determine whether patients are appropriate for LTCH admission. As discussed further below, these criteria do not identify (and no criteria would be able to identify) whether patients are likely to be SSO patients. The fact that some of the patients ultimately require a shorter LTCH stay than average for their diagnosis and clinical complexity does not change this initial clinical determination of appropriateness. Upon admission, a multidisciplinary team of clinicians establishes a comprehensive plan of care designed to achieve the best possible medical outcome in the most optimal timeframe consistent with the patient's condition. LTCHs should not be penalized for achieving clinical outcomes in shorter periods of time – the successful outcome everyone wants.

In addition, CMS's premise that LTCHs have an incentive to target SSO cases for admission is flawed. Even if LTCHs did not uniformly apply screening criteria to limit all admissions to appropriate patients, and even if SSO cases could be identified at the time of admission, in fact, LTCHs have a *disincentive*, not an incentive, to admit short-stay cases. This is because the admission of short-stay cases lowers an LTCH's average length of stay and puts the LTCH at risk losing its certification status due to a failure maintain the required average length of stay of greater than 25 days.

Our analysis of 2004 MedPAR data suggests that SSO cases are indistinguishable from full-stay cases on several important clinical measures. Therefore, we believe that LTCH admitting physicians will have a very difficult time distinguishing SSO patients from full-stay patients, and will not be able to change their behaviors, as CMS believes this policy will provide the incentive to do. Table 4 below shows the severity of illness ("SOI") and risk of mortality ("ROM") scores (derived from MedPAR 2004 using the APR-DRG grouper software) for LTCH and short-term general hospital patients.[5] As you can see, there is no indication that LTCHs are admitting less acute patients for a short-stay in order to maximize revenues, as CMS asserts; rather, we find that SSO patients are virtually identical to full-stay patients on several key clinical measures. There are many reasons why patients do not stay the same amount of time in an LTCH, including death or better care outcomes, which do not imply so-called "gaming."

[5] Data taken from MedPAR 2004, December and March updates.

TABLE 4

Comparison of Short-Term, SSO and All LTCH Patients

LTCH DRG	Short-Term Hospital GMLOS	Short-Term Hospital Cases: % in SOI 3,4	Short-Term Hospital Cases: % in ROM 3,4	LTCH SSO ALOS	SSO Cases: % in SOI 3,4	SSO Cases: % in ROM 3,4	GMLOS for All LTCH Cases	All LTCH Cases: % in SOI 3,4	All LTCH Cases: % in ROM 3,4
475	8.0	95%	92%	13.0	94%	88%	34.2	94%	81%
87	4.9	70%	90%	13.0	87%	90%	30.4	90%	93%
88	4.1	27%	18%	9.8	52%	38%	20.1	60%	44%
271	5.5	41%	22%	13.0	69%	49%	28.4	72%	41%
89	4.8	47%	23%	10.1	67%	40%	21.2	74%	42%
All DRGs	5.6	33%	24%	12.5	64%	51%	26.6	68%	49%

As the table above demonstrates, the average medical complexity (as measured by SOI and ROM) and length of stay of SSO cases are far higher than for short-term general hospital patients, and thus it is not surprising that the average costs for SSO patients are above the inpatient prospective payment system ("IPPS") DRG payment amounts. Since we find no evidence that SSOs are in any way similar to short-term general hospital patients, we therefore believe there is no basis for paying for them using the IPPS methodology.

g. CMS's Analysis of Short-Stay Outlier Data Fails to Consider the Fundamental "Law of Averages" of Every Prospective Payment System

Prospective payment systems by design are based on averages – where some patients have longer lengths of stay and some shorter. This is true for the IPPS and the LTCH PPS, among others. CMS's proposed policy looks at the SSO data out of context and in a way that violates the fundamental "law of averages" that is the backbone of every prospective payment system (i.e., that, by definition, many patients have hospital stays less than average and many have hospital stays longer than average, but the Medicare program is protected because the overall payments are relatively fixed). This violates the will of Congress and CMS's own understanding of the legislative intent behind the IPPS and LTCH PPS. In the August 2002 final rulemaking that established the LTCH PPS, CMS stated as follows:

> The acute care hospital inpatient prospective payment system is a system of average-based payments that assumes that some patient stays will consume more resources than the typical stay, while others will demand fewer resources. Therefore, an efficiently operated hospital should be able to deliver care to its Medicare patients for an overall cost that is at or below the amount paid under the acute care hospital inpatient prospective payment system. In a report to the Congress, "Hospital Prospective Payment for Medicare (1982)," the Department of Health and Human Services stated that the "467 DRGs were not designed to account for these types of treatment" found in the four classes of excluded hospitals [psychiatric hospitals and units, rehabilitation hospitals and units, LTCHs, and children's hospitals], and noted that "including these hospitals will result in criticism and their application to these hospitals would be inaccurate and unfair."
>
> The Congress excluded these hospitals from the acute care hospital inpatient prospective payment system because they typically treated cases that involved stays that were, on average, longer or more costly than would be predicted by the DRG system. The legislative history of the 1983 Social Security Amendments stated that the "DRG system

> was developed for short-term acute care general hospitals and as currently constructed does not adequately take into account special circumstances of diagnoses requiring long stays." (Report of the Committee on Ways and Means, U.S. House of Representatives, to Accompany HR 1900, H.R. Rept. No. 98-25, at 141 (1983)). Therefore, these hospitals could be systemically underpaid if the same DRG system were applied to them.

67 Fed. Reg. 55,954, 55,957 (August 20, 2002). By CMS's own admission, therefore, CMS cannot pay LTCHs at rates comparable to the IPPS rates for SSO patients. To do so would violate the law of averages upon which the LTCH PPS is based, and the clear will of Congress and previous statements by HHS and CMS that short-term care hospital reimbursement does not adequately compensate LTCHs.

CMS's logic flies in the face of the structure of LTCH PPS. LTCH PPS compensates providers based on a standard payment rate per case for each LTC-DRG. Implicit in the application of a standard case rate is the premise that, regardless of whether a patient's length of stay actually exceeds or falls short of the average, the payment to the provider remains the same. By setting payments based on averages, LTCH PPS is designed to create an incentive for LTCHs to furnish the most efficient care possible to each patient, and imposes on LTCHs the primary financial risk with respect to patients who exceed the average length of stay for their LTC-DRG.

It should be expected, therefore, that the lengths of stay of approximately half of LTCH patients will be below the average. Payment for these cases based on LTC-DRG rates is fully consistent with the underpinnings of LTCH PPS, since LTCHs will bear the cost of furnishing care to patients whose length of stay exceeds the average. On the other hand, dramatically reducing the payment levels for the vast majority of patients whose length of stay is less than average is inconsistent with the fundamental structure of LTCH PPS.

In fact, the percentage of LTCH cases that are paid under the SSO payment policy is a function of the SSO threshold and the dispersion of cases above and below the average lengths of stay for the LTC-DRGs. As indicated above, CMS fixed the SSO threshold mathematically at a number of days that approaches the average length of stay for each LTC-DRG (*i.e.*, 5/6 of such average). Thus, from a purely statistical perspective, the 5/6 standard can be expected to capture a significant fraction of the patients in a given LTC-DRG. (It is worth noting that, had CMS set the per diem rate at 100 percent of the average LTC-DRG specific per diem amount, as was discussed in the March 2002 Proposed Rule, about half of the LTCH cases would have been treated as SSO cases.) In addition, in an LTCH, where each case presents both complex and unique needs and may not fall within a standardized course of care, one may expect a high frequency of deviation from the average length of stay in a given LTC-DRG. Thus, the fact that a significant number of LTCH patients fall below 5/6 of the average length of stay for each LTC-DRG is entirely expected as a fundamental feature of LTCH PPS and provides no information whatsoever about the appropriateness of a given patient's admission to the LTCH in the first instance.

CMS states "[w]e believe that the 37 percent of LTCH discharges (that is, more than one-third of all LTCH patients) that the FY 2004 MedPAR identified as SSO cases continues to be an inappropriate number of patients…." 71 Fed. Reg. at 4,686. However, CMS measures SSO utilization using a methodology that will *always* produce results that are in the same range as the current 37 percent total. Assuming that the GMLOS is defined as the point at which the length of stay of 50 percent of patients are above and 50 percent are below, then taking 5/6th of the GMLOS will consistently produce a percent of patients that is around 42 percent. That is, 5/6th of 50 percent is always 42 percent. As the lengths of stay change each year and the GMLOS is recalibrated annually, the $5/6^{th}$ measurement factor will continue to produce the same percent of patients below that level. In light of this fact, it is apparent that the 37 percent SSO patient total that CMS is concerned with is actually quite reasonable, if not low. When examining the MedPAR 2004 discharges for short-term hospitals, it was determined – not to our surprise – that 41.7 percent of these cases fell below 5/6th of the short-term hospital GMLOS.

4. The Data On Patient Discharges from IPPS Acute Care Hospitals Does Not Support CMS's Conclusions

As the basis for the second proposed change to the SSO payment methodology, CMS states that it found that the majority of LTCH patients are admitted directly from IPPS acute care hospitals, after looking at its patient data files (National Claims History Files), a recent MedPAC Report (June 2003, pg. 79), and by research done by the Urban Institute at the outset of the LTCH PPS and RTI. CMS believes that this data "may indicate premature and even inappropriate discharges from the referring acute care hospitals." 71 Fed. Reg. 4,648, 4,687 (Jan. 27, 2006). To remove "what may be an inappropriate financial incentive for a LTCH to admit a short-stay case" CMS proposes to add a fourth payment amount to the SSO payment methodology. Id. This would, in effect, limit LTCH payments to *no more than* what a IPPS hospital would be paid for *every* SSO case. The result is to penalize LTCHs for admitting patients from any IPPS acute care hospital if the patient is not treated for a full LTCH stay. From CMS's own statements, the agency clearly does not have a firm understanding of the admissions data to which it refers.

In addition, the fact that LTCHs admit many patients who have already received some hospitalization at an IPPS hospital does not mean that those patients have been prematurely or inappropriately discharged from the IPPS hospital. Without more data on the patient's condition and a valid comparison of the respective resources of the LTCH and the IPPS hospital, the only inference that can be drawn solely from the number of patient admissions from IPPS hospitals is that those patients require hospitalization. CMS's logic fails to acknowledge and account for the simple fact that the very patients that are most appropriate for LTCH care – that is, the sickest patients with the most medically complex cases – would naturally have been initially admitted to a general acute care hospital prior to any determination of their appropriateness for LTCH care. Put differently, patients in nursing facilities or receiving care at home immediately prior to admission to an LTCH are least likely to have the complexities that make their admission to an LTCH necessary. In fact, rather than creating a basis for suspicion that such patients were inappropriate for LTCH care, the fact that most LTCH patients come from general acute care hospitals would tend to demonstrate that LTCH patients are being identified from among the patient population most likely to be appropriate for LTCH admission. ALTHA submits that the available data supports clear decisions by medical professionals determined that those patients would be better cared for in an LTCH setting, with its greater resources and better trained staff to treat the patients' conditions.

The data do not support the position espoused by CMS in the proposed rule that the IPPS hospital payment rate is sufficient to cover the costs of caring for this medically complex patient population. CMS's proposed rule will result in payment levels well below LTCHs' costs of caring for these short stay patients. In fact, the combined effect of CMS' proposed rule is to cut rates to an unprecedented level where LTCHs would actually experience negative Medicare margins. A simple example proves this point. The payment rate for LTCHs for a patient who is ventilator dependent (DRG 475) assumes that the patient will stay in the LTCH about 34 days, on average. An LTCH could provide excellent care and discharge such a patient after only 28 days. Under CMS's proposed rule, the LTCH would receive the IPPS hospital payment rate for this patient, which assumes the patient was only hospitalized for about 8 days. This proposal would result in payments far below the costs the LTCH actually incurred in treating the patient. In fact, a majority of DRG 475 SSO cases have stays above the typical 8 day short-term general hospital average, indicating that CMS proposes to pay less than cost most of the time – an unprecedented shift in policy, and one that would be unsustainable for many LTCHs. A full 11% of DRG 475 SSO cases are discharged within 5 days of the 28.5 day threshold, and likely have costs more similar to the full LTCH DRG payment than the IPPS payment based on an 8 day

stay.[6] Thus, this proposed policy would create a significant payment cliff for these and other SSO cases with stays close to the SSO threshold.

5. CMS's Proposal to Pay for SSO Patients at the IPPS Rate Is Inconsistent With the Statutory Standard for LTCH Certification

By proposing to pay for SSO cases at IPPS rates, CMS violates the clear will of Congress in establishing LTCHs as a distinct, IPPS-exempt hospital provider type. As the agency is well aware, Social Security Act § 1886(d)(1)(B)(iv)(I) defines an LTCH as "a hospital which has an *average* inpatient length of stay … of greater than 25 days" (emphasis added). Because it incorporates the term "average," this text permits no conclusion except that Congress fully understood and intended that a significant portion of LTCH patients would experience lengths of stay *below* the 25-day certification standard. Any other inference renders the concept of "average" within the statutory language meaningless. Thus, by concluding presumptively that SSO patients have been admitted to LTCHs inappropriately and paying these cases under IPPS methodology, CMS thwarts the clear intent of Congress to exempt LTCHs from IPPS.

Further, CMS does not avoid the fundamental conflict between its proposal and the statutory LTCH definition by virtue of the regulatory language it uses to implement the new reimbursement policy. The new SSO payment ceiling in 42 C.F.R. § 412.529(c)(2)(iv) is described as "an amount payable under [LTCH PPS] that is *comparable to* an amount that is otherwise paid under the hospital [IPPS] … (emphasis added)." Use of the construct "comparable to" does not negate the actual effect of the proposal – namely, to reimburse LTCH cases at rates developed for IPPS-reimbursed general acute care hospitals. CMS says as much itself when it justifies this policy on its opinion that LTCHs are "behaving like acute care hospitals," despite the absence of any evidence that such LTCHs are failing to meet the 25-day statutory certification standard. CMS's "comparable to" language does not change the fact that, contrary to Congressional mandate, LTCHs will be paid as IPPS-reimbursed general acute care hospital for a significant number of their cases.

Importantly, the statutory language of SSA § 1886(d)(1)(B)(iv)(I) demonstrates that the presumption underlying CMS's proposed change in SSO payment policy is fundamentally flawed. It follows necessarily from the statutory definition of LTCHs that, as long as the facility satisfies the statutory certification standard – *i.e.*, an average length of stay of greater than 25 days – any patient for whom continued acute care is medically necessary is, by definition, appropriate for LTCH admission. Until Congress adopts a different standard to define LTCHs, CMS lacks the authority to alter the methodology for reimbursing SSO cases on the basis of assumptions directly at odds with statutory principles.

6. CMS's Proposal on SSO Cases Is Contrary to the Agency's Prior Analyses of SSO and Very Short-Stay Outlier Cases

In March 2002, CMS first proposed, and later adopted in August 2002, a special payment policy for SSO cases under which an LTCH would not receive the full LTCH-DRG payment. In developing the SSO payment policy in 2002, CMS carefully analyzed the competing considerations (such as the need to balance appropriate payments for shorter stay and inlier cases, and the desire to avoid a "payment cliff" that could create inappropriate incentives), identified numerous available options, and simulated the impact of those options using actual data. When the August 2002 Final Rule was published, it provided that LTCHs would be paid for SSO cases the least of (i) 120 percent of the LTC-DRG specific per diem (determined by dividing the LTC-DRG payment by the average length of stay for that LTC-DRG) multiplied by the length of stay, (ii) 120 percent of the cost of the case, or (iii) the

[6] Twenty-nine percent of all SSO cases fall within 5 days of the 5/6th geometric mean threshold for their DRG.

Federal prospective payment for the LTC-DRG. Because the aggregate of the per diem payments for a particular SSO case should not exceed the full LTC-DRG payment for the case, the SSO payment policy applies only for patients whose lengths of stay do not exceed 5/6 of the average length of stay for the particular LTC-DRG. In other words, the aggregate of the per diem payments set at 120 percent of the LTC-DRG specific per diem would equal the full LTC-DRG payment once the patient's length of stay reaches 5/6 of the average length of stay for the particular LTC-DRG. This point, therefore, became the "SSO threshold" – cases with lengths of stay below the SSO threshold are paid under the SSO payment policy, and those above it are paid the full LTC-DRG rate.

The March 2002 Proposed Rule also included a separate payment policy for cases categorized as "very short-stay discharges." This payment policy was not included in the August 2002 Final Rule. Under the proposed policy, two LTC-DRGs (one psychiatric and one non-psychiatric) would have been created for cases that have lengths of stay of 7 days or fewer, and LTCHs would have been paid a per diem amount, determined by dividing the Federal payment rate for the applicable LTC-DRG category (that is, federal payment rate multiplied by the LTC-DRG weight) by seven. In proposing this policy, CMS sought to address its concern that "[a] very short-stay discharge often occurs when it is determined, following admission to a LTCH, that the beneficiary would receive more appropriate care in another setting" by making "an adjustment for very short-stay discharges in order to make appropriate payment to cases that may not necessarily require the type of services intended to be provided at a LTCH." 67 Fed. Reg. 13,453. The development of the LTC-DRGs for very short-stay discharges and their proposed relative payment weights, and the impact on the payment rates for non-short-stay patients, were carefully simulated and analyzed by CMS at that time. In the August 2002 Final Rule, CMS ultimately determined not to adopt the very short-stay discharge payment policy. Responding to comments, CMS decided that this policy would inappropriately penalize an LTCH "for those occasions when, in good faith, it admits a patient, who shortly after admission, expires or is transferred to a more appropriate setting," 67 Fed. Reg. 56,000, and would create a "'payment cliff,' which potentially could have provided a significant incentive for LTCHs to keep patients who would otherwise have been paid for as very short-stay discharges." 67 Fed. Reg. 56,001.

In the January 2006 Proposed Rule, among other things, CMS proposes to change radically the method for determining the payment amount for SSO cases. In particular, CMS proposes to change the percentage-of-cost-of-case limitation from 120 percent to 100 percent, and to add an additional payment limitation for SSO cases based on an amount comparable to what would have been paid to a general acute care hospital under IPPS. In marked contrast with CMS's development of SSO payment policy in the March 2002 Proposed Rule and the August 2002 Final Rule, and even though CMS claims insufficient data under the newly-implemented LTCH PPS to effect the budget neutrality adjustment under 42 C.F.R. § 412.523(d)(3), CMS's current proposed SSO payment policy changes are founded only on CMS's erroneous and unsubstantiated assumptions that all SSO patients have been inappropriately admitted to LTCHs and inappropriately discharged from general acute care hospitals. In developing this radical proposal, (1) CMS misuses the SSO thresholds, which are not, and were never meant to be, a measure of the appropriateness of an LTCH admission; (2) CMS erroneously assumes that patients below SSO thresholds have been inappropriately admitted to LTCHs; (3) CMS erroneously assumes that LTCHs function like general acute care hospitals when treating patients below SSO thresholds; (4) by proposing to pay for SSO patients at IPPS rate, CMS proposes a payment methodology that is inconsistent with the Congressionally-enacted standard for an LTCH's exemption from IPPS; and (5) CMS proposes to pay for SSO patients at rates that would result in LTCHs being paid amounts significantly below their actual costs of providing care.

C. Recommendations

ALTHA firmly believes that CMS should *not* revise the payment adjustment formula for short-stay outlier ("SSO") patients as proposed. These changes are not supported by the data presented in the proposed rule and herein. Only after CMS has more than one year of cost report data from the transition to LTCH PPS *and* CMS performs a valid analysis of the facility characteristics and resources of LTCHs

compared to general short-term care hospitals for the LTCH patient conditions treated can CMS understand whether the current SSO payment methodology is fair. ALTHA is confident that CMS *will* find the current SSO payment methodology to be fair because the overwhelming majority of SSO patients are appropriate for LTCH care, based upon clinical admission decisions after applying objective and rigorous clinical screening criteria and comprehensive patient plans of care. The available data supports effective LTCH care, and in certain cases patient mortality during an LTCH stay, rather than inappropriate patient admissions. Moreover, the LTCH PPS, like most prospective payment systems, is based on averages by design – some patients have longer lengths of stay and some shorter. Provided that LTCHs satisfy the statutory requirement of an *average* inpatient length of stay that exceeds 25 days, these hospitals have achieved the desired balance of short- and long-stay patients envisioned by LTCH PPS.

We strongly urge CMS to consider alternatives that more appropriately target any cases that, based on a meaningful analysis of current data, are likely the result of inappropriate admissions to LTCHs. We recommend that CMS consider the following alternatives to address the issues raised in the proposed rule regarding SSOs:

Option 1: CMS should adopt requirements for pre-admission, concurrent and post-hoc review of the appropriateness of LTCH admissions.

a. **Require physician certification of the need for LTCH services prior to or concurrent with admission to an LTCH.** This certification should be based on guidelines established by CMS through rulemaking and public comment. CMS requires physician certification of medical necessity for treatment for other Medicare providers to balance the goals of protecting the Medicare trust fund against abuse with the need to preserve access to medically necessary services. This approach directly addresses the issues CMS raised in the proposed rule regarding SSOs. Requiring physician certification of medical necessity for LTCH care would address CMS's concerns that LTCHs are admitting SSO patients for financial reasons.

b. **Adopt uniform admission and continuing stay screening criteria to ensure that only appropriate patients are admitted to LTCHs.** As noted above, some LTCHs already use InterQual, the screening instrument used by the majority of QIOs to evaluate the appropriateness of LTCH admissions and continued stays. Requiring the use of this or a related instrument would meet the goal of ensuring that only appropriate patients are admitted to LTCHs.

c. **Expand the sample of LTCH cases reviewed by QIOs for appropriateness of admission and continued stay.** In conjunction with recommendations (a) and (b) above, expanded QIO review would be the most direct way to address CMS concerns about inappropriate admission of short-stay patients raised in the CMS proposed rule. This is consistent with the recommendation made by MedPAC in their June 2004 report to Congress.

Option 2: CMS Could Implement Targeted Payment Reforms Directed at "Very Short Stay" Cases.

If CMS decides to use payment mechanisms to address SSOs, we recommend that CMS implement a much more targeted approach than the one contained in the Proposed Rule. As noted above, in CMS's March 2002 Proposed Rule, CMS articulated the same concern that has formed the basis for its current proposal – namely, the potential that some short-stay patients may not have been appropriate for LTCH admission. At that time, CMS proposed to address this concern with a more tailored alternate payment policy for very short-stay discharges. In the August 2002 Final Rule, CMS declined to adopt this policy because it concluded that its concerns were adequately addressed in the broader SSO payment policy. Nevertheless, the very short-stay discharge policy presented in the March 2002 Proposed Rule demonstrates that a more thoughtful and targeted approach to address CMS' concerns is possible.

We urge CMS to develop a more targeted alternative payment policy that is tailored to meet any legitimate concerns about inappropriate admissions. Any such alternative payment policy must be based on a rigorous and objective analysis of relevant and current data, and must result in payment amounts that bear a relationship with the LTCH's costs of providing care on average for the affected cases. As discussed above, LTCHs do not possess the ability to predict, in advance, the length of an LTCH patient's stay, nor do we believe that LTCHs should attempt to make such predictions. However, to remove any incentive that CMS believes LTCHs might have to admit patients for a brief LTCH stay, we propose the following alternatives for CMS to pay for "very short stay" cases:

a. **Define "very short stay" cases as those with a length of stay well below the mean for all LTCH cases (*e.g.*, 5-7 days) and reimburse those cases at cost.** The rest of LTCH cases that are between the "very short stay" and the 5/6th geometric mean threshold for their DRG would be defined as "short stay outlier" cases, and would be paid under the current "lesser of" payment methodology. Paying at cost for the "very short stay" cases removes any incentive that might arguably exist for LTCHs to admit patients who could be predicted to have very short lengths of stay.

b. **Reimburse "very short stay" cases (as defined above) at a percentage of cost (*e.g.*, 95% of cost) to remove any incentive whatsoever that LTCHs might have for admitting patients who could be predicted to have very short lengths of stay.** This option would be similar to the payment approach for high cost outliers, but we do not recommend a "stop loss" feature given the difficulty in predicting lengths of stay or clinical outcomes for those patients. All other SSO cases would be paid under the current SSO "lesser of" methodology. However, if this option is adopted, we encourage CMS to consider reallocating the 5% "payment penalty" imposed on very short stay cases to payment levels for other SSO cases.

ALTHA also considered three other recommendations, but rejected each on policy grounds for the following reasons:

<u>"Phase-In" of SSO Policy Proposed by CMS</u>. ALTHA generally supports the agency's use of phase-ins to ease the transition for LTCHs to new payment changes; however, ALTHA is opposed to a phase-in of the SSO policy proposed by CMS for two primary reasons. First, as demonstrated above, CMS's proposal to pay LTCHs for SSO cases at the IPPS rate is not supported by the data which indicate that LTCH SSO costs would not be covered by IPPS rates and is, therefore, a flawed policy. Second, LTCHs are unable to predict in advance length of stay or clinical outcome and therefore will not be able to adjust behavior in response to the policy, even if given more time. A phase-in will not cure these fundamental shortcomings with CMS's proposed approach.

<u>Specific Payment Adjustment for Very Short Stay Deaths</u>. ALTHA also considered but rejected a specific payment adjustment for short stay cases resulting in death. We did not make this recommendation because, as discussed above, physicians making admission decisions cannot predict in advance clinical outcomes, particularly death. In addition, as noted above, deaths occurring in short time periods represent a relatively small percentage of total LTCH discharges. Finally, the other options discussed above would apply to a broader array of "short stay" patients and more directly address CMS's articulated concerns about inappropriate admissions.

<u>Per Diem Amount for Very Short Stay Cases</u>. We also considered the option of per diem amounts paid for very short stay cases, consistent with CMS's March 2002 Proposed Rule, when it first proposed the LTCH PPS. We rejected this approach for basically the same reason CMS did, namely, it creates a payment cliff that could interfere with sound clinical decision making. We believe our recommended approaches described above, *i.e.*, paying cost for "very short stay" cases, minimizes the cliff issue.

It is noteworthy that, in the March 2002 Proposed Rule, CMS originally proposed to pay SSOs at 150% of cost to account for the fact that very short stay cases would be getting a per diem amount at a

much lower level. CMS then determined that higher SSO payments were required to produce an LTCH payment system that was, overall, adequate and met the statutory mandate to "maintain budget neutrality." Under any approach that CMS chooses, and any percentage of cost that CMS pays short stay cases, it is vitally important that CMS evaluate the overall adequacy of the LTCH payment system as a whole, with due consideration of how those decisions affect the ability of LTCHs to meet patient care needs.

II. Proposal to Not Update the RY 2007 Federal Rate

A. General Description

CMS is proposing that the LTCH PPS federal rate remain at $38,086.04 for the 2007 rate year. CMS stated that this proposal is based on an analysis of the LTCH case-mix index and margins before and after implementation of LTCH PPS and the latest available LTCH cost reports, which allegedly indicate that LTCH Medicare margins were 8.8 percent for FY 2003 and 11.7 percent for FY 2004. CMS added that the proposed federal rate for RY 2007 is also based upon and consistent with the recent recommendation by MedPAC that "Congress should eliminate the update to payment rates for long-term care hospital services for rate year 2007." December 8, 2005 MedPAC Meeting Transcript (the "MedPAC Meeting Transcript"), pg. 165. Each of these data sources fail to support the proposal to not update the LTCH PPS federal rate.

B. Assessment

1. The 3M Analysis of LTCH Claims Data Is Flawed

The case-mix index ("CMI") is defined as an LTCH's case weighted average LTC-DRG relative weight for all its discharges in a given period. CMS characterizes a change in CMI as either "real" or "apparent." A "real" CMI increase is an increase in the average LTC-DRG relative weights resulting from the hospital's treatment of more resource intensive patients. An "apparent" CMI increase is an increase in CMI due to changes in coding practices, according to CMS. CMS believes that freezing the federal rate for RY 2007 will eliminate the effect of coding or classification changes that do not reflect changes in LTCHs' case-mix (i.e., the federal rate will reflect only "real" CMI and not "apparent" CMI). CMS reaches this conclusion by looking at a data analysis performed by 3M. The 3M analysis compared FY 2003 LTCH claims data from the first year of implementation of LTCH PPS with the FY 2001 claims data generated prior to the implementation of LTCH PPS (the same LTCH claims data CMS used to develop LTCH PPS). 3M found that the average CMI increase from FY 2001 to FY 2003 was 2.75 percent. CMS then assumes that the observed 2.75 percent change in case-mix in the years prior to the implementation of LTCH PPS represents the value for the "real" CMI increase. CMS then makes a second assumption that the same 2.75 percent "real" CMI increase remained absolutely constant during the LTCH PPS transition period. Because the 3M data showed a 6.75 rise in CMI between FY 2003 and FY 2004, CMS concludes that 4.0 percent of that increase represents the "apparent" CMI increase due to improvements in LTCH documentation and coding.

The first error with the assumptions that CMS makes here is that there are a number of LTCHs that did not begin the transition to LTCH PPS until close to the start of FY 2004 – the second year of the LTCH PPS transition period. Significantly, all of Kindred Healthcare's 44 LTCH hospitals (out of a total 280 LTCHs operating in FY 2003) did not receive *any* portion of the LTCH PPS federal rate until September 1, 2003 – one month shy of the FY 2004 rate year. The evidence available to ALTHA suggests that there were other LTCHs that went onto LTCH PPS late in the FY 2003 rate year as well. So CMS's assumptions that 4.0 percent of the 6.75 rise in CMI between FY 2003 and FY 2004 can be attributed to better LTCH coding and documentation is simply false – at least with respect to Kindred Healthcare's LTCHs. Therefore, the proposed elimination of the update to the federal rate for RY 2007 is based on at least two false assumptions and a failure to use the proper data (in this case, the case-mix data from FY 2004, when all LTCHs in operation at the time LTCH PPS went into effect had begun the

transition to LTCH PPS). Moreover, to prove CMS's assumptions, it would need to compare the CMI increases for LTCHs that elected reimbursement at the full federal rate at the beginning or at some time during the transition period against the CMI increases for LTCHs that chose to go through the full five-year transition period to the federal rate. In addition, during the first year of the transition period, the federal rate only made up 20 percent of the LTCH's payment for those LTCHs that chose to transition to LTCH PPS. This relatively small portion of the overall payment makes it far less likely that LTCHs were aggressively coding LTCH stays during FY 2003 in a manner that would account for the *entire* differential between the pre-LTCH PPS average CMI increase and the post-LTCH PPS average CMI increase. In sum, CMS makes a number of false assumptions to explain a rise in CMI for LTCHs during the transition period to LTCH PPS, without considering other factors or data elements that suggest real CMI increases, due to real changes in LTCH treatment of more resource intensive patients, rather than deliberate coding efforts to enhance payments. On this basis alone, the LTCH PPS federal rate for RY 2007 should be updated.

2. The Medicare Program Safeguard Contractor Review of One LTCH is Not Representative Data

The second source of erroneous data that CMS used to propose a rate freeze for RY 2007 is a review by a Medicare program safeguard contractor working with a fiscal intermediary that examined a sample of LTCH claims with specific diagnoses in one LTCH and determined that the majority of those patients were not "hospital-level" patients, but were more suitably skilled nursing facility ("SNF") patients. CMS states that a Medicare QIO reviewed a sample of the claims that had been determined not to be hospital-level patients by the Medicare program safeguard contractor and concurred with its assessment of most of those cases. CMS adds that they have other anecdotal information about investigations of LTCHs treating patients that do not require hospital-level care. CMS concludes that these findings add further support for its assumptions that the increase in LTCHs' CMI is primarily due to factors other than "real" CMI. On its face, this is the worst kind of data for CMS to use when making an important policy decision such as a payment rate change. The conclusions reached by a Medicare program safeguard contractor after a *single* review using only a *sample* of claims from a *single* LTCH, where some of the contractor's conclusions were later disputed by a QIO, bears no meaningful relationship to the patients treated by the other 374 LTCHs that are currently paid under LTCH PPS. The same can be said for the anecdotal information about similar LTCH reviews that CMS mentions. CMS fails to show a relationship between one LTCH's behavior with regard to admitting what are disputably a few inappropriate cases and the case mix of any other hospitals or industry-wide case mix increases. CMS assumes that one LTCH's behavior is similar across all LTCHs without presenting data to show that this is in fact true. CMS did not analyze the individual cases of other LTCHs to determine if the one case it reviewed was more widespread.

Data available to CMS clearly show an immaterial number of LTCH claims denied as the result of QIO reviews. Two of the largest LTCH providers, Kindred and Select, had over 1,000 combined LTCH cases reviewed by QIOs since 2003. The denial rate for all of these reviews is 1.6%. Specifically, Kindred had 495 cases reviewed by QIOs between 2003 and 2005. Of this total, only 12 cases were denied on the basis of inappropriate admission or medical necessity. That is a denial rate of 2.4%. Select had 592 cases reviewed by QIOs between 2004 and 2005. Of this total, only 6 were denied, for a denial rate of 1.0%. Without question, then, QIOs are overwhelming finding that LTCH patients have appropriately been admitted and treated in LTCHs. Therefore, a broader examination of the data on QIO reviews contradicts CMS's use of this data as support for a rate freeze for RY 2007.

3. The CMS Analysis of LTCH Margins Is Flawed

The third source of erroneous data CMS discusses in the proposed rule as support for the rate freeze is an internal CMS analysis that basically retraces the steps MedPAC took to examine LTCH margins before and after implementation of LTCH PPS. CMS says full-year cost report data from FY 2003 indicates that LTCH Medicare margins were 8.8 percent in that year, and preliminary cost report

data for FY 2004 indicates LTCH Medicare margins of 11.7 percent for that year. CMS says that LTCH Medicare margins prior to LTCH PPS (going back to 1996) ranged from -2.2 percent in FY 2002 to 2.9 percent in FY 1997. However, upon a closer examination of the MedPAC data on LTCH margins, the data shows that almost a quarter of LTCHs (23% to be precise) had *negative* Medicare margins in 2004. In addition, MedPAC did not take into consideration the effect of the 25 percent rule on reimbursement to LTCH hospitals-within-hospitals for admissions from the host hospital when modeling LTCH Medicare margins. See MedPAC Meeting Transcript, pg. 164. Thus, it is clear that CMS has not properly interpreted the data and has drawn incorrect conclusions from the selected observations about LTCHs' Medicare margins to support its proposed freeze of the LTCH PPS federal rate in RY 2007.

In the proposed rule, CMS states that the LTCH cost report data does not show increases similar to the increases in CMI, and because reported costs did not increase as much as reported increases in CMI, LTCHs must be incorrectly coding cases. In making this assumption, CMS does not indicate that it is allowing for any increase in efficiency by LTCHs, which would lower costs and not affect CMI. In a different part of the proposed rule, CMS suggests that it may begin measuring efficiency and include that in the LTCH market basket methodology. This is inconsistent with the agency's position on the increase in CMI. On the one hand, CMS suggests that efficiency plays a part in LTCH payment adjustments, yet CMS does not concede that efficiency affects cost growth in CMI. In fact, when CMS discusses PPS transition periods, the agency states its expectation that providers will become more efficient under a PPS system. In is erroneous, therefore, for CMS to take a contrary position, and ignore its own stated expectations and the available data, to conclude that LTCHs transitioning to LTCH PPS do not become more efficient for purposes of measuring CMI growth.

4. CMS Failed to Consider the Reweighting of LTC-DRG Weights Earlier This Year

The discussion in the proposed rule regarding changes in CMI since the implementation of the LTCH PPS fails to address other recent changes that have had a material affect on LTCH coding and payment. Namely, CMS has already corrected any coding issues from 2004 by reweighting the LTC-DRG weights earlier this year. In fact, each year of the LTCH PPS, CMS has reweighted the LTC-DRGs in a non-budget neutral manner to realign LTCH payments with costs, and reserves the right to do so going forward. In the IPPS Final Rule for FY 2006, published August 1, 2005, CMS reduced the LTC-DRG weights (resulting in an agency-estimated 4.2% reduction in payments to LTCHs) for the exact same reason that CMS is now proposing no market basket update for RY2007 – because PPS reimbursements to LTCHs were higher than LTCH costs in 2004. In that rulemaking, CMS stated the following rationale for reducing the LTC-DRG weights for FY 2006:

> As we explained in the FY 2006 IPPS proposed rule (70 FR 23667), we continue to observe an increase of relatively lower charge cases being assigned to LTC–DRGs with higher relative weights in the prior year. The addition of these lower charge cases results in a decrease in many of the LTC–DRG relative weights from FY 2005 to FY 2006. This decrease in many of the LTC–DRG relative weights, in turn, will result in an estimated decrease in LTCH PPS payments. As we explained in that same proposed rule, contributing to this increased number of relatively lower charge cases being assigned to LTC–DRGs with higher relative weights in the prior year are improvements in coding practices, which are typically found when moving from a reasonable cost based payment system to a PPS.
>
> […]
>
> Specifically, two commenters stated that "the LTCH PPS, in its third year of implementation, is still in transition; the initial 5-year phase-in will end September 2006. During this time of transition, LTCH coding and data are still undergoing improvement." Therefore, it is not unreasonable to observe relatively significant changes (either higher

> or lower) in the average charge for many LTC–DRGs as LTCHs' behavior coding continues to change in response to the implementation of a PPS.
>
> […]
>
> As we discussed above, we believe that there are no systemic errors in the LTCH FY 2004 MedPAR data, and we believe that the increase of relatively lower charge cases being assigned to LTC–DRGs with higher relative weights that we observed in the FY 2004 LTCH claims data (which results in a decrease in the many of the LTC–DRG relative weights) accurately represents current LTCH costs. . . . Therefore, because we believe the FY 2004 LTCH claims data used to determine the FY 2006 LTC–DRG relative weights accurately reflect the resources used by LTCHs to treat their patients, and these data show either a decrease in the average charge of the LTC–DRG or an increase in the average charge of the LTC–DRG that is less than the overall increase in the average charge across all LTC–DRGs, we believe that the decrease in many of the LTC–DRG relative weights is appropriate. The LTC–DRG relative weights are designed to reflect the average of resources used to treat representative cases of the discharges within each LTC–DRG. As we discussed in greater detail above, after our extensive analysis of the FY 2004 MedPAR data, which we used to determine the FY 2006 LTC–DRG relative weights, we concluded that there are no systematic errors in that data. Therefore, we continue to believe it is appropriate to base the FY2006 LTC–DRG relative weights on LTCH claims data in the FY 2004 MedPAR file. Furthermore, we believe that the decrease in many of the LTC–DRG relative weights is appropriate and is reflective of the changing behaviors of LTCHs' response to a PPS environment."

70 Fed. Reg. 47,335 (August 1, 2005).

Through the CMI analysis in this proposed rule, CMS has basically documented the same purported phenomenon that it found a few months ago and documented in the IPPS final rule – that during the transition to the PPS, LTCH coding practices are resulting in patients being assigned to DRGs with reimbursements that are higher than the LTCH's costs for those patients. As stated above, CMS sought to eliminate any differences between reimbursements and costs in 2004 by reducing LTC-DRG weights in 2006 (and it did the same for 2003 differences in the 2005 LTC-DRG weights). If CMS eliminates the market basket update in RY 2007, CMS will be correcting the same alleged PPS coding transition problem that it previously corrected in the 2006 IPPS rule. As a result, LTCHs will be unfairly penalized twice for the same issue.

5. CMS Failed to Consider Recent Changes to Coding Clinic Logic

CMS also has failed to address another recent change that has had a material affect on LTCH coding and payment. Recent revisions to the guidelines for utilizing DRG 475 ("Respiratory System Diagnosis with Ventilator Support") have resulted in reduced payments to LTCHs. In particular, the AHA Coding Clinic revisions to DRG 475 now require that LTCHs use lower-weighted DRGs for principal diagnoses that previously fell within the parameters of DRG 475. As a result of this change, LTCHs are now receiving reduced payment for treating patients with certain types of respiratory distress, despite that the same resources are being expended on such patients. Nonetheless, CMS failed to consider this change in the applicability of DRG 475, which many LTCH patients are classified for payment, in proposing a zero percent update to the LTCH PPS federal rate for RY 2007.

C. Recommendations

CMS should allow a full update to the LTCH PPS federal rate for RY 2007. Projected or assumed "overpayments" in the LTCH system are effectively eliminated from the payment system on an annual basis as CMS recalibrates the LTC-DRG weights or makes similar adjustments to other aspects

of the LTCH PPS. CMS has achieved payment adequacy through the DRG reweighting. A zero market basket update would be a duplicative and unnecessary cut in LTCH payments to address the very same issue that CMS just addressed in the IPPS Final Rule for FY 2006. CMS also needs to account for other changes in LTCH coding, including the amended guidelines regarding classification of patients under DRG 475, when proposing changes to the update.

III. Monitoring/RTI International Study

A. General Description

The proposed rule summarizes the preliminary data analyses conducted by the Research Triangle Institute International ("RTI") under contract to CMS. The stated purpose of this research is to analyze the LTCH provider category and determine the feasibility of implementing MedPAC's recommendations (in the June 2004 Report to Congress) for creating new LTCH facility and patient criteria. This would ensure that patients admitted to LTCHs are medically complex and have a good chance of improvement. Specifically, the RTI research is designed to:

- Determine whether industry growth is attributable to attractive Medicare payments or increased patient demand;
- Measure patient outcomes across post-acute providers and assess the correlation between outcomes and payment levels; and
- Determine whether there are unique characteristics of LTCH facilities and patients to assess the feasibility of developing additional certification criteria.

CMS presents preliminary data results from the RTI study, which are primarily based on analyses of the 100% MedPAR 2003 file, other Medicare data, stakeholder interviews, and site visits to LTCHs.

B. Assessment

1. Insufficient Description of Methodology to Comment

As an overall comment, we do not believe that CMS presented in the proposed rule a sufficient description of the methodology that RTI is using to analyze LTCH data. Without an understanding of RTI's methodology, we cannot provide meaningful comments to the preliminary data analyses that are presented in the proposed rule. CMS needs to provide this methodology. The comments that follow are based upon our review of the limited information about RTI's work that CMS published in the proposed rule.

2. Causes of Industry Growth

CMS states that a goal of the "research is to determine whether this [increase in numbers] is due to growing patient demand or industry response to generous payment policies." However, no data are presented that indicate that RTI has studied this issue. Therefore, it is not possible for the industry to submit meaningful comments until such time as CMS publishes these results. The assertion that LTCHs have "increased in numbers exponentially" is not mathematically correct, nor is it meaningful without context. By RTI's own findings, there are many places in the country where Medicare beneficiaries do not have access to LTCHs. Finally, we note that despite LTCH numbers growth, CMS Medicare spending for LTCHs is estimated to be about 1% of total Medicare spending.[7]

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[7] In the proposed rule, CMS estimates RY 2007 spending for LTCHs to be $5.27 billion (see 71 Fed. Reg. at 4,681). This figure excludes an SSO policy effect of 11.1% and includes a market basket update

3. Patient Outcomes

CMS states in this proposed rule that the "central question" of the research by RTI is determining "whether there is a correlation between the higher payments at LTCHs and improved patient outcomes for the same types of patient is different treatment settings." Again, in the proposed rule, no data were presented that compared outcomes for clinically identical patients across the post-acute care providers, so the industry has not been provided an opportunity to submit meaningful comments on this section. The single outcomes data point that was published concerned mortality rates for LTCHs and short-term hospital outlier patients for a subset of patients (short-term hospital outlier mortality rates in that sample were about one-third higher than the rate for LTCH patients). Regardless, the RTI comparison of acute outlier patients with LTCH patients does not constitute a full analysis of outcomes across different settings for similar patients. Thus, the central question of RTI's research has not been answered. A more appropriate comparison of outcomes would contain a subset of clinically similar patients discharged from short-term hospitals to SNFs, IRFs, IPFs, home health, and LTCHs.

We reject the notion that a proper measure of outcomes is costs per case, which seems to be an implied outcomes measure in the RTI study methodology, *without controlling for patient acuity*. For example, on page 4,710 of the proposed rule, RTI finds that the cost per case for LTCH patients in DRG 462 was $20,311 while the IRF payment in a majority of cases is $11,741. RTI then acknowledges that "little is known about the differences in severity across the different settings." It is precisely because of patient acuity differences that the Medicare PPS payment methodologies adjust payment amounts both through DRG weights and through differences in Federal base rate amounts. Without a proper analysis that considers patient acuity, RTI's comparison of costs per case between different provider types has little to no value.

4. Descriptions of LTCH Patients

ALTHA has performed its own data analysis of MedPAR data using the 2004 data set. We agree with the RTI finding that LTCHs "treat a relatively small proportion of all types of cases compared to other settings." 71 Fed. Reg. at 4,707. Our analysis shows that approximately 75% of LTCH patients fall into 25 DRGs but that the DRG with the most cases, DRG 475, only accounted for 10% of LTCH patients.

According to the proposed rule, a primary focus of the RTI study is to identify any differences between LTCH patients and those seen in other post-acute settings. The acute outlier and LTCH assessments that RTI performed do not answer this study question. RTI does report that LTCH patients tend to have a higher number of co-morbidities relative to other types of post acute care providers. Additionally, RTI evaluated medical complexity by using Hierarchical Coexisting Condition ("HCC") scores, which are based on a patient's Medicare expenditures from the year preceding the index IPPS admission. Overall, "LTCH only" patients had the highest average HCC score of any post-acute care provider, according to the RTI data.

ALTHA, in collaboration with LTCH providers, conducted an evaluative study of the LTCH provider community with a focus on patient and facility level characteristics. This study builds on previous work we have done to identify appropriate LTCH certification criteria. The all patient refined-

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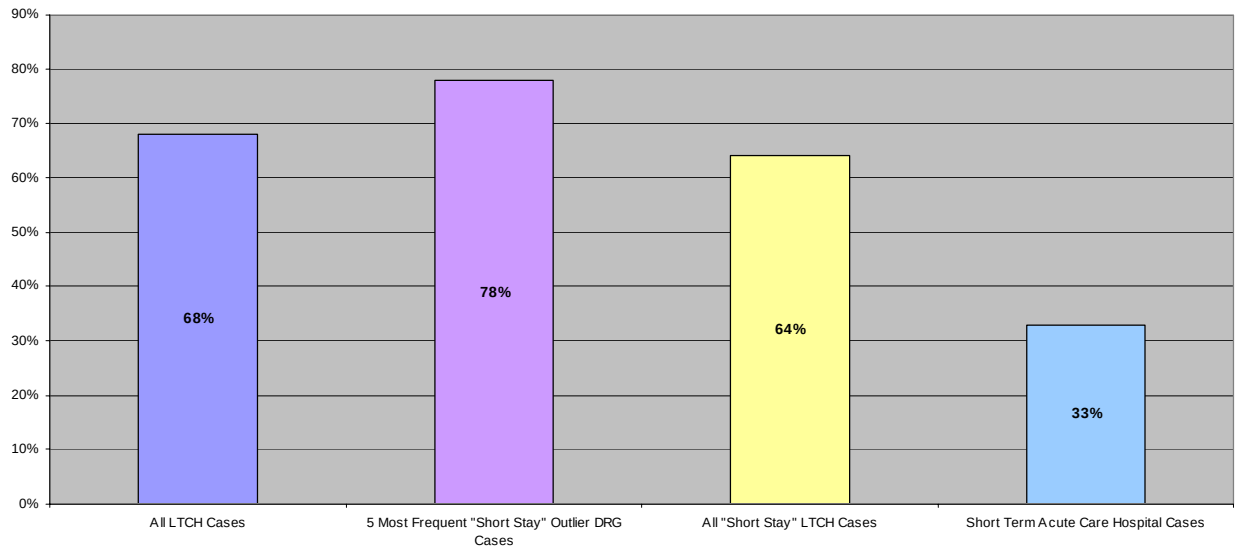
of 3.6%. By reducing the $5.27 billion by the CMS-estimated 11.1% SSO policy effect, and by eliminating the market basket update, spending under existing policies would be $4.5 billion in 2007. CBO estimates of net mandatory Medicare spending in RY 2007 is $383.4 billion, meaning that LTCH spending projections equal 1.2% of net mandatory Medicare spending. If you assume, as does CMS, that the 11.1% estimated reduction for the proposed changes to SSO payments does not occur, LTCH spending is projected to be just 1.3% of net mandatory Medicare spending in 2007.

diagnosis related groups ("APR-DRGs") system permits users to classify hospital patients not only by resource utilization, but also in terms of patient SOI and likelihood of mortality.[8] The Figure below shows that the vast majority of LTCH patients are classified in the highest APR-DRG SOI categories – whether one looks at all LTCH cases, just the five most frequent "short stay" outlier DRG cases, or all "short stay" LTCH cases – but that only a third of short term care hospital patients are classified in the highest SOI categories (see Figure 3). This supports the conclusion that LTCH patients are, in fact, much sicker than short term hospital patients.

FIGURE 3: LTCH Patients are Much Sicker than Average Short Term Hospital Patients

Percentage of Patients in the highest APR-DRG "Severity of Illness" Categories



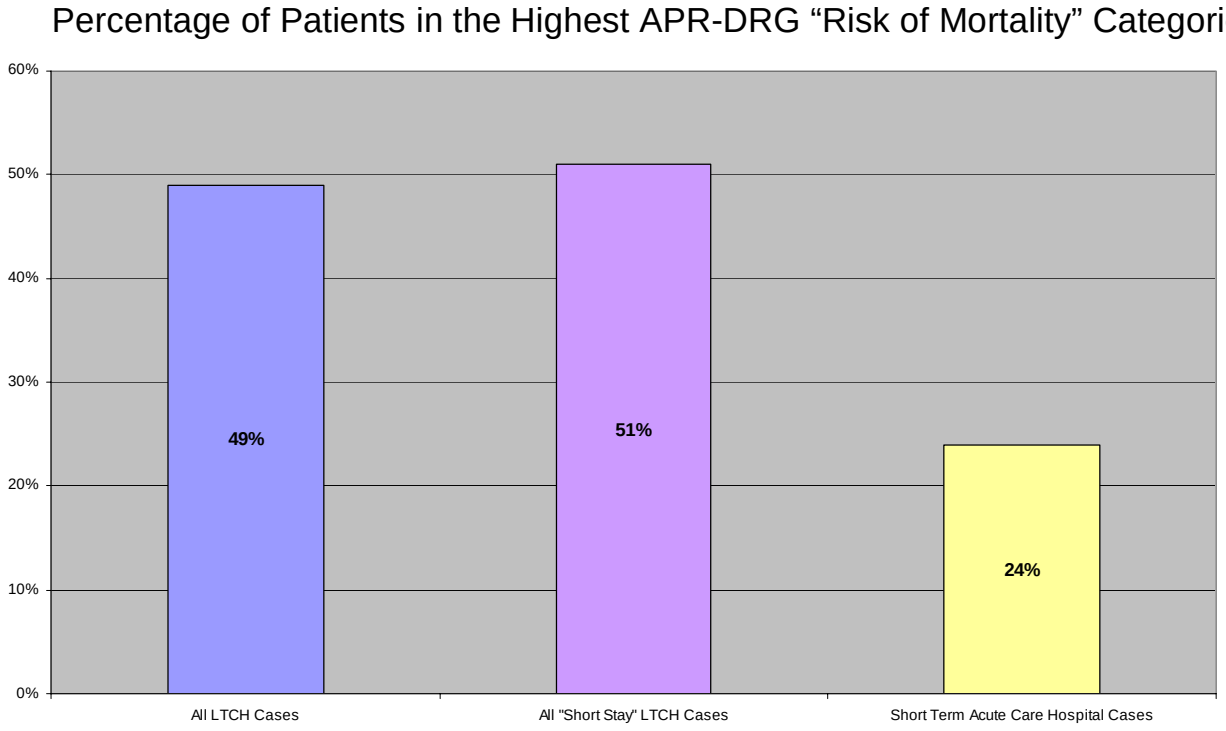
***Source: MedPAR 2004**

***Severity of Illness from APR-DRG Methodology**

8 APR-DRG scores are expressed as categories 1 to 4 and are organized to capture the risk of mortality for each patient using age, primary diagnosis, co-morbidities, and certain medical procedures. The SOI categories are rated from 1 to 4 as minor, moderate, major, and extreme, respectively. Both the acute care hospital MedPAR data and LTCH data were run through the APR-DRG GROUPER to determine SOI scores associated with each case.

The next Figure compares patients in LTCHs and short term care hospitals using the APR-DRG "risk of mortality" categories (see Figure 4). It shows that approximately half of all LTCH cases and half of all "short stay" LTCH cases are classified in the highest APR-DRG "risk of mortality" categories, yet only about a quarter of all short term care hospital cases are classified in this manner. Therefore, LTCH patients are much more likely to expire during their hospital stay than short term care hospital patients.

Figure 4: LTCH Patients Have a Higher "Risk of Mortality" than Average Short Term Hospital Patients



***Source: MedPAR 2004**

***Risk of Mortality from APR-DRG Methodology**

Additionally, the acute care hospital MedPAR file shows that cases discharged to LTCHs frequently have a higher SOI than other acute patients discharged to SNFs or IRFs. Sixty-nine percent of patients discharged to LTCHs have a major or extreme risk of mortality during their acute hospital stay compared to less than half of SNF patients and only 36 percent of IRF patients. Table 5 shows the percent SOI distribution for LTCH, SNF, and IRF cases.[9]

TABLE 5

Severity of Illness for Short Term Acute Care Discharges to LTCH, SNF, and IRF

Discharge Destination	Cases	Proportion	Cases: % in SOI 1,2	Cases: % in SOI 3,4
LTCHs	98,267	0.9%	31%	69%
IRFs	429,799	3.7%	64%	36%
SNFs	1,932,481	16.8%	52%	48%
All Discharges	11,518,734	100%	67%	33%

Finally, according to previous industry research, LTCHs see the sickest patients with many underlying co-morbidities. ALTHA anticipates that CMS will report on the RTI evaluation findings of patient outcomes in the RY 2007 LTCH PPS final rule. RTI will need to account for limitations in the MedPAR data that is available. Our preliminary review of that data revealed that the file only records up to eights secondary diagnoses for each patient. Therefore, the number of patient co-morbidities in the MedPAR file does not accurately reflect the true number of co-morbidities for acute care patients discharged to different post-acute care settings.

C. Recommendations

ALTHA supports the stated goals of the RTI study: analysis of patient demand for LTCH services, analysis of patient outcomes in LTCHs as compared to other post-acute settings, and research to assess the feasibility of developing certification criteria. ALTHA has performed numerous data analyses using publicly available Medicare data and has developed its own proposal for LTCH certification criteria. We support the work that MedPAC and RTI have conducted in the development of certification criteria and look forward to a continued dialogue with these research organizations. ALTHA recommends that, rather than slowing LTCH spending through payment policy, which is broad and imprecise, CMS consider implementing certification criteria to achieve its goals.

IV. Discussion of Freestanding LTCHs and the 25 Percent Patient Referral Criterion for Hospitals Within Hospitals (HIHs)

A. General Description

In the proposed rule, CMS states a continued concern over "inappropriate patient shifting" between acute care hospitals and LTCHs, even following implementation of the hospital within hospital ("HIH") 25% rule at 42 C.F.R. § 412.534. Based on the agency's continued monitoring efforts, CMS believes that LTCH co-location with a short-term acute care hospital in not a prerequisite for a short-term acute care hospital to discharge a patient to an LTCH prematurely. CMS states that many freestanding LTCHs accept the majority of their patients from one acute care hospital independent of co-location. Additionally, CMS believes the HIH 25% rule is intentionally being circumvented by

[9] Data taken from MedPAR 2004, December and March updates.

"creative patient shifting" in communities where there are multiple HIH and freestanding LTCHs. CMS states that it has been brought to their attention that some acute care host hospitals have arranged to cross-refer patients to HIH or satellite LTCHs of other acute care host hospitals within the same community. Another situation CMS discussed is when a patient is admitted to an LTCH HIH from the host hospital where the patient was provided initial treatment and then transferred to a freestanding location of that same LTCH. CMS states that the growth in the LTCH industry is now occurring through the development of freestanding LTCHs, and that even those hospitals may be in danger of functioning as units of a primary referral source. CMS believes that the intent of the HIH 25% rule "to hinder the *de facto* establishment of an LTCH unit of a host hospital, which is precluded by law," is being circumvented by these activities. 71 Fed. Reg. at 4,697. CMS says that it is considering appropriate adjustments to address this issue.

B. Assessment

ALTHA agrees that every effort should be made to ensure that patients are not inappropriately transferred to any LTCH (HIH or freestanding) to maximize Medicare payments. However, for several reasons, we do not believe that CMS expand or otherwise apply the HIH 25% rule to freestanding LTCHs.

The HIH 25% rule requires that, at most, 25 percent of LTCH HIH's admissions from a co-located hospital will be paid at the full LTCH PPS rate (stated another way, at least 75 percent of admissions to an HIH must be referred from a source other than the host hospital to avoid this payment adjustment). CMS believes this will reduce incentives for host hospitals to maximize Medicare payments and, consequently, the likelihood that host hospitals will transfer beneficiaries to LTCH HIHs before they reach the geometric mean LOS for their DRG. We have not found that short-term acute care hospitals are discharging patients to HIHs prior to the mean DRG length of stay. Further, CMS has presented only limited evidence of such activity.

In this proposed rule, CMS cites three data sources for its statements about alleged improper patient shifting involving freestanding LTCHs. The first is a Lewin Group study that CMS states was commissioned by an LTCH trade association. CMS does not state that it reviewed the study or the underlying data – only that CMS was informed by the association of certain findings from the study. The second source of data CMS refers to is anecdotal information about "frequent 'arrangements' in many communities between Medicare acute and post-acute hospital level providers" that do not have common ownership or governance, but are allegedly engaged in patient shifting due to "mutual financial advantage." 71 Fed. Reg. at 4,697. This information is vague, at best. CMS provides no other information about this anecdotal information, and no way for interested parties to confirm the validity of this data. The third source of data here is a data analysis that CMS states it conducted of sole-source relationships between acute care hospitals and non-co-located LTCHs. CMS presents certain data points from the FY 2004 and FY 2005 MedPAR files: 63.7 percent of 201 freestanding LTCHs have at least 25 percent of their Medicare discharges admitted from a sole acute care hospital; for 23.9 percent of freestanding LTCHs, CMS says the number of referrals is 50 percent or more; and 6.5 percent of freestanding LTCHs obtain 75 percent or more of their referrals from a single hospital source. CMS, however, fails to present any data whatsoever concerning other types of acute or post-acute care hospitals and the proportion of patients which they admit from a single referral source. Without this data as a basis of comparison, it is impossible to know whether the percentages CMS cites from its analysis are unusual in the hospital sector.

Thus, it is clear that CMS is not in a position to make further policy changes pertaining to freestanding LTCHs without a more thorough and meaningful analysis of available data. In this regard, we continue to believe that the HIH 25% rule is an ineffective method of addressing this policy issue. We believe this rule does nothing to distinguish LTCH HIHs who are following the letter and spirit of the separateness and control regulations from those who are not. CMS should focus its resources on enforcing its existing requirements for HIHs at 42 C.F.R. § 412.22(e), rather than take the premature

step of expanding this payment penalty to freestanding hospitals. Until the transition period for the HIH 25% rule is completed for all LTCH HIHs (between October 1, 2007 and September 30, 2008), CMS cannot know whether this payment adjustment is achieving the stated policy goal without having undesirable effects on patient care.

Moreover, we believe that expanding the HIH 25% rule to freestanding LTCHs is not supported by the policy reasons discussed in the proposed rule. By definition, freestanding LTCHs are not co-located with another hospital. Therefore, they could never be confused with a hospital unit. CMS is inappropriately trying to address an issue of concern to the agency – the level of LTCH discharges that were admitted from a single hospital referral source – by citing the absence of statutory authority for LTCH units. We believe that this theory exceeds any reasonable interpretation of the statute.

Finally, we are concerned about any policy that establishes a criterion that is not clinically based and is instead based on an arbitrary percentage of admissions. To the extent CMS is motivated to curb growth in the number of LTCHs, particularly HIHs, we believe certification criteria is a more rational and clinically-based approach. In its June 2004 report, MedPAC recommends that the certification criteria for the Medicare LTCH provider category be strengthened to reduce unnecessary growth in the number of LTCHs who are not treating medically complex patients with multiple co-morbidities. These strengthened criteria would apply not only to HIHs, but freestanding LTCHs. ALTHA agrees with this approach and has advocated using the following categories of criteria to effectively improve the certification criteria:

- ***Patient Characteristics.*** The revised LTCH criteria should encourage LTCHs to serve a medically complex patient population. Two relevant proxies for measuring and monitoring this medical complexity should be used: (1) the current requirement for a 25 day average length of stay for Medicare beneficiaries, and (2) a new severity of illness threshold. A significant portion (*e.g.*, 50 percent) of every hospital's Medicare discharges during its cost report year would be classified into either APR-DRG severity of illness level (SOI) three or four.

- ***Structure.*** The second LTCH certification criterion should be aimed at ensuring that the LTCH is organized and operated to support the complex care required for its patients. Long-term acute care hospitals should have criteria that require LTCHs to have structural elements in place to deliver care (e.g. daily physician contacts, availability of respiratory therapy, and interdisciplinary team assessments).

- ***Admissions and Continued Stay.*** The third criterion for LTCH certification should ensure that admissions and continued stay standards are in place so that LTCHS serve the most medically complex patients. The certification criteria should specify that QIO review be based on a nationally uniform set of admissions and continuing stay screening tools; each LTCH could use these to screen patients for medical necessity throughout their stay.

C. Recommendations

Due to the data defects we have identified, the lack of sufficient data to analyze the effectiveness of the current payment adjustment, and weak authority, we oppose the expansion of the HIH 25% rule to freestanding LTCHs and any similar payment changes.

ALTHA recommends that CMS focus on enforcing its existing regulations at 42 C.F.R. § 412.22(e)(5)(i-iii) for maintaining HIH separateness from other hospitals. We also recommend that CMS work with the LTCH industry to develop new certification criteria that more directly targets the entire LTCH provider category and permit certification for only those LTCHs that provide care to medically complex cases with multiple co-morbidities. These criteria should reflect MedPAC's recommendations and focus on patient characteristics, the structure and operation of LTCHs, and

ensuring medical necessity. Input from the provider community should be used in developing any such criteria. In addition, such new criteria should be subject to notice and comment through rule-making procedures because MedPAC's recommendations are general and the provider community must weigh any specific CMS proposals.

V. Postponement of One-Time Budget Neutrality Adjustment

A. General Description

CMS proposes to extend its option to exercise a one-time budget neutrality adjustment to the LTCH PPS rates as set forth in 42 C.F.R. § 412.523(d)(3) for two additional years. Pursuant to the regulation, CMS may implement a one-time adjustment no later than October 1, 2006 so that "any significant difference" between actual payments and estimated payments for the first year of the LTCH PPS would not be perpetuated in the LTCH PPS rates for future years. However, CMS is now proposing to extend the window for the potential one-time adjustment until July 1, 2008 – nearly two years beyond the deadline originally established in the final LTCH PPS rule and nearly one year after the industry's 5-year transition to LTCH PPS is complete.

B. Assessment

ALTHA contends that CMS's postponement of the deadline for its potential one-time prospective adjustment would constitute an abuse of its statutory authority and therefore CMS should withdraw its proposal in the final LTCH PPS rule for RY 2007.

Pursuant to section 123(a)(1) of Public Law 106-113 (BBRA of 1999), as amended by section 307(b) of Public Law 106-554 (BIPA of 1999), the Secretary "may provide for appropriate adjustments to LTCH PPS" in order to maintain the budget neutrality of the program. Consequently, CMS established by regulation the option of making a one-time prospective adjustment to the LTCH PPS rates to ensure that any errors in the original budget neutrality calculations for the first year (FY 2003) of the LTCH PPS would not be carried through in subsequent rate years. CMS established an October 1, 2006 deadline for this option, ostensibly because it believed that sufficient data regarding FY 2003 would be available by that date to determine if an adjustment was necessary (CMS did not discuss its reasoning for setting the specific deadline date of October 1, 2006 in the proposed or final LTCH PPS rules).

CMS asserts in the proposed LTCH PPS rule for RY 2007 that it presently lacks sufficient data with respect to FY 2003 such that it can reasonably decide whether to impose the one-time rate adjustment. Nonetheless, CMS also states that its "most complete full year of LTCH cost report data are from FY 2003" – the very year in which the original budget neutrality calculations were made and the same year the LTCH PPS was implemented. 71 Fed. Reg. at 4683. By its own admission, CMS already possesses the data it needs to correct for any potential errors in the original budget neutrality calculations. However, CMS then goes on to state that it believes "that for cost reports for providers on August 2004 fiscal year ending date, [CMS] would be in possession of the most reliable cost report data indicating the actual costs" of the LTCH PPS in its first year, FY 2003. 71 Fed. Reg. at 4684. If the most complete year of LTCH cost report data is for FY 2003, and the year for which any calculation errors should be corrected is also FY 2003, it is unclear why CMS views it necessary to obtain more "reliable" cost data for FY 2004 before deciding whether to impose the one-time adjustment.

Consequently, ALTHA submits that postponing the deadline for the one-time prospective adjustment would be arbitrary and capricious. The postponement of the deadline would allow CMS to wait until "any significant difference" arises in the aggregate to trigger the one-time adjustment, regardless of whether the cost data for FY 2003 actually justifies such an adjustment or not. However, the regulation clearly expresses that the one-time adjustment option is designed to correct "any

significant difference" between actual payments and estimated payments for the first year of the LTCH PPS, not for an ongoing and indeterminate number of years.

Given that CMS already employs a reasonable means to ensure budget neutrality – the reduction factor applied each year to account for the monetary effect of the 5-year transition from cost-based reimbursement – an extension of the deadline for the one-time adjustment is also unnecessary. Because establishing a new deadline of July 1, 2008 is clearly arbitrary and is not required to carry out the Congressional mandate of budget neutrality, such action would constitute an abuse of the authority granted to CMS under the BBRA and BIPA of 1999.

C. Recommendations

CMS should withdraw its proposal to extend the deadline for exercising a one-time prospective adjustment. In doing so, CMS would still have until October 1, 2006 to exercise the one-time adjustment, as originally contemplated.

VI. Statewide Average Cost-to-Charge Ratio ("CCR")

A. General Description

CMS proposes to make changes to its current policy on calculating high-cost outlier payments to LTCHs, beginning at 71 Fed. Reg. 4,674. Principally, CMS is considering a revision to § 412.525(a)(4) to specify that, for discharges on or after October 1, 2006, the fiscal intermediary may use a Statewide average CCR (established annually by CMS) if, among other things, a LTCH's CCR is in excess of the LTCH CCR ceiling. The LTCH CCR ceiling would be calculated as 3 standard deviations above the corresponding national geometric mean CCR. CMS says that it is making this proposal because LTCHs have a single "total" CCR, rather than separate operating and capital CCRs. In conjunction with this change, CMS would change its methodology for calculating the applicable Statewide average CCRs under the LTCH PPS to be based on hospital-specific "total" CCRs. CMS would codify the remaining LTCH PPS high cost outlier policy changes that were established in the June 9, 2003 IPPS high cost outlier final rule (68 Fed. Reg. 34,506), including the proposed modifications and editorial clarifications to those existing policies established in that final rule.

B. Assessment

The proposed changes for the LTCH CCR relate to the way that the CCR ceilings are calculated. CMS uses the Statewide CCR ceiling when a LTCH (1) is a new LTCH, (2) has faulty or missing data, or (3) when the LTCH's CCR is above the "combined" IPPS CCR ceiling (which is defined as the amount 3 standard deviations from the geometric mean CCR). The "combined" IPPS CCR is calculated by adding the average IPPS operating CCR with the average IPPS capital CCR. The proposed "total" CCR would be calculated by first combining each IPPS hospital's operating and capital CCRs and then averaging across all IPPS hospitals to get an average "total" CCR. The reasoning that CMS uses for making this change is that, since LTCHs get a single payment that includes operating and capital expenses (unlike IPPS hospitals), the LTCH CCR ceiling should be calculated using this "total" methodology.

In other words, the current methodology separately calculates two separate CCRs (an operating CCR and a capital CCR) by taking the average of all IPPS operating CCRs and the average of all IPPS capital CCRs, and then adding them to get a "combined" ceiling. The proposed methodology would add each hospital's operating CCR and its capital CCR together, then take the average of all the IPPS hospitals to calculate a "total" ceiling. The underlying data, the IPPS CCRs, remain the same. In the proposed rule, CMS does not provide an analysis of the effect of this proposed change, nor does the agency provide an example of the new CCR values under this proposed methodology.

In addition, CMS makes a number of statements that CMS is essentially mirroring the IPPS outlier policy. CMS states in the proposed rule that "[o]utlier payments under the LTCH PPS are determined consistent with the IPPS outlier policy." 71 Fed. Reg. at 4,674. CMS later states that "[t]hese revisions to our policy for determining a LTCH's CCR for discharges occurring on or after October 1, 2006 under proposed revised §412.525(a)(4)(iv)(A) and (B) are similar to our existing policy established in the June 9, 2003 IPPS high cost outlier final rule (68 FR 34506 through 34513)." 71 Fed. Reg. at 4,676.

C. Recommendations

We assume there will be some effect on LTCHs in making the change to a "total" CCR. CMS should present the data from its analysis of this change so that LTCH providers understand how they will be impacted by this proposal. It is not possible for ALTHA to provide meaningful comments to this proposed change unless CMS presents a detailed example of the new methodology and provides data on the impact to LTCHs. In addition, CMS should confirm that the implementation and enforcement of all high cost outlier policies for LTCHs will not be any different than for short-term acute care hospitals. We suggest that CMS implement these changes using identical language as in Transmittal A-03-058 (Change Request 2785; July 3, 2003), which contained instructions regarding the changes established in the June 9, 2003 IPPS high cost outlier final rule for both LTCHs and short-term acute care hospitals.

VII. High-Cost Outlier Regression Analysis

A. General Description

CMS is soliciting comments in the proposed rule as to whether the agency should revisit the regression analysis that it used to establish the 80 percent marginal cost factor and the 8 percent outlier pool as a means of controlling (or lowering) the fixed loss threshold. See 71 Fed. Reg. at 4,678.

B. Assessment

We oppose action by CMS at this time to revisit the regression analysis for the 80 percent marginal cost factor for at least two reasons. First, the LTCH PPS is still immature. Continued premature adjustments such as this only contribute to the instability of the system. The real reason for the dramatic change in the fixed loss threshold for RY 2007 is the extremely large 11 percent cut in LTCH reimbursement that CMS is proposing. Second, we agree with CMS's comments that keeping the marginal cost factor at 80 percent and the outlier pool at 8 percent "better identifies LTCH patients that are truly unusually costly cases" and that such policy "appropriately addresses outlier cases that are significantly more expensive than nonoutlier cases, while simultaneously maintaining the integrity of the LTCH PPS." 71 Fed. Reg. at 4,678.

Many LTCH hospitals treat a significant number of high-cost outlier cases. Lowering the marginal cost factor to 65 percent or some other number will be a strong *disincentive* to treat such complex cases, which often times are not identifiable upon admission.

C. Recommendations

We need stability in the LTCH PPS payment system, particularly with regard to the most costly LTCH patients. These are the high-cost outliers. CMS should be extremely careful when making changes to the factors that affect high-cost outlier payments to LTCHs – particularly the marginal cost factor and outlier pool percentages established by regulation. We believe it is premature for CMS to make any changes to these percentages at this time.

VIII. SSO Fixed Loss Threshold

A. General Description

CMS is soliciting comments in the proposed rule as to whether the agency should use a fixed loss amount derived from the IPPS high cost outlier policy at 42 C.F.R. § 412.80(a), where the least of the four options in the rate is comparable to the IPPS rate in the event that a SSO case also qualifies for a high cost outlier payment under the LTCH PPS. *See* 71 Fed. Reg. at 4,689.

B. Assessment

We oppose action by CMS at this time to utilize a fixed loss threshold for SSO cases that is tied into the IPPS. The fixed loss threshold used under the IPPS was developed utilizing analyses that are unrelated to LTCH PPS. To predicate future payments to LTCHs using IPPS reimbursement variables is improper and inappropriate. The IPPS fixed loss threshold was not developed while evaluating the resources consumed in the care of an LTCH high cost outlier patient. In addition, CMS has not provided the data necessary to substantiate the use of IPPS fixed loss thresholds as a means of reimbursing LTCH high cost patients.

C. Recommendations

All aspects of the LTCH PPS should be driven by factors directly related to LTCHs and the cost of caring for patients in these facilities, including the most costly LTCH patients, high-cost outliers. This is true even of patients that are classified as SSOs. As previously suggested regarding potential adjustments to the marginal cost factor and outlier pool percentages, CMS should be extremely careful when making changes to the factors that affect high-cost outlier payments to LTCHs. We recommend that CMS abide by the existing regulation governing payments related to high cost outliers at 42 C.F.R. § 412.525(a).

IX. Description of a Preliminary Model of an Update Framework under the LTCH PPS (Appendix A)

A. General Description

In this proposed rule, CMS describes an alternative market basket update methodology for LTCHs, which would incorporate concepts such as productivity, intensity, real case mix change, and an adjustment for forecast errors. CMS describes this new methodology in Appendix A to the proposed rule (71 Fed. Reg. at 4,742) and requests comments.

B. Assessment

CMS describes how this conceptual market basket update would be calculated through a series of equations which begin with a basic assessment of costs per discharge, payments per discharge, and profits. The equations eventually incorporate real case-mix, productivity, intensity, and input and output prices.

Despite the fact that CMS lays out, through conceptual equations and an illustrative example, how the agency might calculate a market basket update, CMS's description of the new methodology remains fairly general. For example, CMS does not define terms such as "real costs" and "real payments" (Equation 7, pg. 4,744) or describe how "real costs" are different from the "costs" concept used in other equations. Further, CMS does not state how it would calculate these concepts. For example, CMS only roughly defines how the agency would calculate "intensity" and introduces new concepts such as cost-effectiveness when it describes "intensity". ALTHA would like to work with

CMS as the agency refines the data sources it proposes for each market basket concept, and would like to reserve comment on these concepts until CMS provides additional information.

ALTHA is concerned that some inputs into this new methodology appear to be subjective and at the discretion of CMS. For example, CMS suggests using "soft" data in constructing this new market basket update methodology:

> Table 27 shows an illustrative update framework for the LTCH PPS for RY 2007. *Some of the factors in the LTCH framework are computed using Medicare cost report data, while others are determined based on policy considerations.*

71 Fed. Reg. at 4,746 (emphasis added).

Finally, CMS proposes to include in this new market basket methodology a case-mix creep adjustment (the sum of apparent and real case mix changes, or the negative 4% change CMS is proposing elsewhere in this proposed rule as a basis for not providing a market basket update for RY 2007), while acknowledging that such an adjustment may not be necessary due to the LTC-DRG reweighting that CMS performs annually in the IPPS rule. CMS states that "[w]hether a LTC–DRG reclassification adjustment would be necessary in the update framework would depend on the data availability and the likelihood of revisions to LTC–DRG classifications on a periodic basis." 71 Fed. Reg. at 4,746.

Thus, in this section, CMS acknowledges that the case-mix adjustment it is proposing this year and would propose under this new methodology is redundant to the LTC-DRG reclassifications (reweighting) it does each year on a non-budget neutral basis in the IPPS rule (which resulted in a decrease in payments of 4.2% in FY 2006), and a proposed zero market basket update worth 3.6% for RY 2007 for LTCHs.

C. Recommendation

ALTHA recommends that CMS further refine its proposed new market basket methodology with input from the industry. We strongly disagrees with the CMS proposal to make case-mix adjustments using the same data that were used to reweight the LTC-DRGs in a non-budget neutral manner. ALTHA firmly believes that the market basket update be calculated using objective, reliable and verifiable mathematical concepts and publicly available data, rather than using "policy considerations" and other subjective variables.

X. CMS Failed to Accurately Complete the Regulatory Impact Statement

A. General Description

CMS's Regulatory Impact Analysis (the "RIA") of the proposed rule is also problematic, in part because it necessarily relies on data that ALTHA asserts is incapable of justifying the proposed rule. Pursuant to a number of executive orders and acts of Congress, CMS is obligated to perform a RIA in order to examine the impact of the proposed rule on small businesses, rural hospitals, and state and local governments. Furthermore, the RIA must provide the public with the proposed rule's anticipated monetary effect on the Medicare program and, more importantly, estimate the impact on access and the quality of care provided to Medicare beneficiaries.

B. Assessment

As a preliminary matter, ALTHA contends that the RIA is inherently faulty because it analyzes the impact of the RY 2007 rule's proposed changes – which in turn are based upon insufficient data and flawed analyses. As discussed above, CMS's proposed 11.1 percent decrease in LTCH PPS payments

for RY 2007 was determined in part by comparing LTCH admission patterns for SSO patients in FY 2004 to those in FY 2003. Although CMS asserts that it looked at changes in SSO percentages over a three-year period, a comparison between FY 2003 and FY 2004 is clearly a one-year analysis. Moreover, FY 2004 is only the second year of the transition period to full prospective payment and is not representative of general LTCHs trends, particularly because many LTCHs continued to be paid 60 percent of their reimbursement based on costs in FY 2004. As such, the data used by CMS is not only insufficient, but the analysis of SSO admission trends is premature. Accordingly, the proposed 11.1 percent decrease in LTCH PPS payments is based upon unreliable data and analyses by CMS and, as a result, the projections set forth in the RIA are conjecture at best. Further, the significant problems regarding the underlying data undercut the industry's ability to evaluate, meaningfully comment, and rely upon CMS's findings as set forth in the RIA.

More significant, however, is CMS's assertion that it does not "expect any changes in the quality of care or access to services for Medicare beneficiaries under the LTCH PPS." 71 Fed. Reg. at 4,738. Given that CMS is proposing a 11.1 percent overall decrease in LTCH PPS payments – which does not take into account the zero percent increase to the LTCH PPS federal rate and other proposed payment changes – it is disingenuous to state that patient quality of care will be unaffected. First, CMS's belief that the 11.1 percent decrease "would only occur if LTCHs continue to admit the same number of SSO patients" is predicated on an assumption that LTCHs can accurately predict an individual patient's length of stay. 71 Fed. Reg. at 4727. However, CMS's assumption is clearly not supported by the data and current good LTCH practices. From a clinical perspective, there are no discernable differences between "short-stay" LTCH patients and longer-stay LTCH patients and physicians who make admission decisions cannot and should not predict in advance the length of stay for this small subset of medically complex, severely ill patients. In addition, many patients admitted to LTCHs already have undergone extended stays at acute care hospitals, making it even more difficult to predict how long they will stay. While the 11.1 percent decrease in LTCH payments alone would very likely affect patient care, CMS's implied recommendation that LTCHs predict in advance each patient's length of stay, if actually followed by LTCHs, would undoubtedly result in an adverse impact on quality of care and access to services for this fragile population of Medicare beneficiaries.

Moreover, CMS's conclusion that it does not anticipate changes in patient quality of care or access to services ignores other recent changes to LTCH coding that would be exacerbated by the proposed 11.1 percent decrease. In the IPPS Final Rule for FY 2006, published August 1, 2005, CMS reduced the LTC-DRG weights in a manner that will result in an agency-estimated 4.2 percent reduction in payments to LTCHs. It is difficult to understand how an 11.1 percent decrease due to changes in SSO payments – when coupled with the already-implemented 4.2 percent decrease from the reweighting of the LTC DRGs and a proposed zero market basket update – will <u>not</u> produce a noticeable effect with respect to patient quality of care and access to services. CMS also makes no effort to explain how these payment reductions impact the statutorily-mandated budget neutrality of the LTCH PPS, which should be part of the RIA.

In addition to CMS's latest reductions in the LTC-DRG weights, recent revisions to the guidelines for utilizing DRG 475 ("Respiratory System Diagnosis with Ventilator Support") have resulted in reduced payments to LTCHs. In particular, the AHA Coding Clinic revisions to DRG 475 now require that LTCHs use lower-weighted DRGs for principal diagnoses that previously fell within the parameters of DRG 475. As a result of these changes, LTCHs are now receiving reduced payment for treating patients with certain types of respiratory distress, despite that the same resources are being expended on such patients. Nonetheless, CMS failed to consider this change in the applicability of DRG 475, which many LTCH patients are classified for payment, in concluding that the currently proposed payment reductions for RY 2007 would have no net effect on patient care.

C. Recommendations

Without a doubt, the aggregate effect of the currently proposed LTCH PPS payment reduction, the recent reweighting of the LTC-DRGs, and the amended guidelines regarding DRG 475 would be significant. Consequently, ALTHA submits that CMS's conclusion that it does not "expect any changes in the quality of care or access to services for Medicare beneficiaries under the LTCH PPS" is unsubstantiated. CMS should reevaluate the regulatory impact of the proposed rule in light of the relevant factors discussed above and issue a revised RIA in a new proposed rule for comment.

XI. The Information Fails to Comply with the Data Quality Act, OMB Guidelines, HHS Guidelines, and CMS Guidelines

On January 27, 2006, CMS released the proposed rule to make certain payment changes to the LTCH PPS for RY 2007. When finalized in the spring, these payment changes will be effective for LTCH discharges on or after July 1, 2006 through June 30, 2007. CMS makes a number of changes to LTCH payments in the proposed rule, based upon certain identified and unidentified data sources. These data do not support the payment changes discussed below for the reasons stated herein.

ALTHA seeks the correction of erroneous information disseminated by CMS concerning the costs and patient characteristics of LTCHs. The erroneous information violates the Federal Data Quality Act (the "DQA"),[10] the implementing guidelines issued by the Office of Management and Budget ("OMB Guidelines"),[11] HHS ("HHS Guidelines"),[12] and CMS ("CMS Guidelines").[13] Per Section 515 of the DQA, ALTHA seeks the revision of erroneous data relied upon and disseminated by the Secretary (the "Secretary") of HHS and the Administrator (the "Administrator") of CMS in the formulation and publication of the Long-Term Care Hospital Prospective Payment System ("LTCH PPS") payment rates and policies for RY 2007 (July 1, 2006 through June 30, 2007).

Section 515 of Public Law 106-554 directs the Office of Management and Budget ("OMB") to "issue guidelines that provide policy and procedural guidance to Federal agencies for ensuring and maximizing the quality, objectivity, utility, and integrity of information (including statistical information) disseminated by Federal agencies in fulfillment of . . . the Paperwork Reduction Act." The DQA requires the OMB to issue guidelines that comply with the certain specifications.

Pursuant to the DQA, the OMB published the OMB Guidelines in the Federal Register on February 22, 2002. See supra, fn 2. In the Final Guidelines, the OMB called on agencies to issue their own implementing guidelines by October 1, 2002. The OMB Guidelines state that agencies must "adopt a basic standard of quality (including objectivity, utility, and integrity) as a performance goal and should take appropriate steps to incorporate information quality criteria into agency information dissemination practices." 67 Fed. Reg. at 8,458.

On September 30, 2002, HHS announced that its guidelines implementing the OMB Guidelines would be available on the Internet at www.hhs.gov/infoquality. See supra, fn 3. As directed by the

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[10] Public Law 106-554, amending Paperwork Reduction Act, 44 U.S.C. §§ 3501 et seq.

[11] Guidelines for Ensuring and Maximizing the Quality, Objectivity, Utility, and Integrity of Information Disseminated by Federal Agencies; Notice; Republication, 67 Fed. Reg. 8,452 (Feb. 22, 2002), *available at* www.whitehouse.gov/omb/fedreg/reproducible2.pdf.

[12] HHS Guidelines for Ensuring and Maximizing the Quality, Objectivity, Utility, and Integrity of Information Disseminated to the Public, *available at* www.hhs.gov/infoquality.

[13] Guidelines for Ensuring the Quality of Information Disseminated to the Public, *available at* www.hhs.gov/infoquality.

HHS Guidelines, CMS issued agency-specific guidelines. See supra, fn 4. Information subject to the CMS Guidelines includes the following:

(1) Statistics and information designed for public dissemination to help CMS program beneficiaries make informed choices;

(2) Statistical or actuarial information;

(3) Studies and summaries prepared for public dissemination to inform the public about the impact of CMS programs; and

(4) Studies and summaries prepared for use in formulating broad program policy.

More specifically, the program information subject to the CMS Guidelines includes program information, statistical data sets, research and evaluation reports, technical reports, and payment updates. A number of these types of program information were used by CMS in developing the proposed rule.

The CMS Guidelines require that any information released by CMS is to have been "developed from reliable data sources using accepted methods for data collection and analysis" and "based on thoroughly reviewed analyses and models." CMS Guidelines § V. The CMS Guidelines also state that "CMS reviews the quality (including the objectivity, utility, and integrity) of information before it is disseminated and treats information quality as integral to every step of the development of information, including the creation, collection, maintenance and dissemination." Id.

CMS has not thoroughly reviewed the data it cites as support for the changes to LTCH payments in the proposed rule, nor has CMS ensured the quality of that data, for the reasons discussed above. Before CMS can issue a proposed rule that can be a basis for meaningful comment, it needs to utilize more complete data sets (to include the data presented herein), conduct a proper and thorough analysis of that data, and reach supportable conclusions for its proposed changes to LTCH payments that are not the product of erroneous assumptions. Only then will CMS's proposals on LTCH payments be based upon quality information. Currently, CMS has failed to show that its data meets the standards established by the CMS Guidelines of utility, objectivity, integrity, transparency, and reproducibility. Each of these standards are discussed below.

A. Utility Standard

CMS states that "[u]tility involves the usefulness of the information to its intended users" and that [u]tility is achieved by staying informed of information needs and developing new data, models, and information products where appropriate." CMS Guidelines § V(A). The utility of the data CMS used in developing the proposed payment changes for LTCHs in the proposed rule fails to meet the utility standard. For example, as discussed above, CMS failed to look at the correct year for LTCH cost report data because a number of LTCHs did not begin the transition to LTCH PPS until almost FY 2004 – the second year of the LTCH PPS transition period. Significantly, all of Kindred Healthcare's 44 LTCH hospitals (out of a total 280 LTCHs operating in FY 2003) did not receive *any* portion of the LTCH PPS federal rate until September 1, 2003 – one month shy of the FY 2004 rate year. There were probably other LTCHs that went onto LTCH PPS late in the FY 2003 rate year as well. So CMS's assumptions that 4.0 percent of the 6.75 rise in CMI between FY 2003 and FY 2004 can be attributed to better LTCH coding and documentation is simply false – at least with respect to Kindred Healthcare's LTCHs. Therefore, the proposed elimination of the update to the federal rate for RY 2007 is based on at least two false assumptions and a failure to use the proper data (in this case, the case-mix data from FY 2004, when all LTCHs in operation at the time LTCH PPS went into effect had begun the transition to LTCH PPS). This example supports the conclusion that CMS did not use data that satisfies the utility standard in the CMS Guidelines when it developed its proposal not to update the LTCH PPS federal rate for RY 2007.

B. Objectivity Standard

In defining "objectivity," the CMS Guidelines specify that "[o]bjectivity involves a focus on ensuring that information products are presented in an accurate, clear, complete, and unbiased manner." Id. § V(B). "Objectivity is achieved by using reliable data sources and sound analytical techniques, and carefully reviewing information products prepared by qualified people using proven methods." Id. Each of the data issues and erroneous assumptions discussed above show that CMS has failed to maintain objectivity in developing the proposed rule. CMS has repeatedly performed cursory analyses of limited data sets to reach biased assumptions. CMS has failed to consider key data that is readily available to the agency. CMS also cites a single review by a Medicare program safeguard contractor and other anecdotal information about LTCH reviews. These are not reliable data sources, as the CMS Guidelines require. In sum, CMS has not met the objectivity standard in the CMS Guidelines. CMS needs to satisfy this objectivity standard before finalizing its LTCH payment proposals.

C. Integrity Standard

The data that CMS uses must satisfy the integrity standard in the CMS Guidelines as well. Data integrity refers to the purity of the data (i.e., that the data is secure, uncorrupted, maintained as confidential (as appropriate), and otherwise uncompromised). See id. § V(C). CMS offers no assurance that the data sources it used for the proposed rule meet this standard and the agency's analysis of the data that is used puts this in doubt.

D. Transparency and Reproducibility Standard

According to the CMS Guidelines, if an agency disseminates "influential" scientific, financial, or statistical information, "guidelines for dissemination should include a high degree of transparency about the data and methods to facilitate its reproducibility by qualified third parties." Id. § V(D). CMS states that "[i]nformation is considered influential if it will have a substantial impact on important public policies or important private sector decisions." Id. That is the case here because the data and other information CMS relies upon will have a substantial financial impact on all LTCHs, and ultimately, the patients that are cared for in LTCHs. In all respects, CMS has failed to discuss the data it used to develop the proposed rule in a manner that satisfies this standard. Although some data sources are identified in a general way (some are not, e.g., the review by a Medicare program safeguard contractor and other anecdotal information about LTCH reviews), the data and CMS's analyses of that data are not presented in any fashion. Accordingly, the data and other supporting information is not transparent. This is significant because it does not allow interested and affected parties to test the agency's data and analyses in order to verify the conclusions (or assumptions) CMS reaches that result in the proposed changes to LTCH payments. Therefore, the steps in CMS's data analyses are not reproducible based upon the limited information provided in the proposed rule. CMS must provide sufficient information about its data sources to allow ALTHA to test its conclusions.

XII. The Defects In Data Require CMS to Withdraw the Proposed Rule Under the APA

A. The APA Requires Rulemaking With Meaningful Comments

The data and analyses that CMS relies upon in establishing the proposed changes to LTCH PPS payments are so deficient that interested parties cannot offer meaningful comments to the proposed rule. Accordingly, the defective data results in a fatal defect in the notice-and-comment rulemaking process that requires CMS to withdraw its proposed rule until more comprehensive and statistically-sound data is evaluated by the agency and shared with the public. Should CMS choose not withdraw the proposed rule, grounds exist for a court to invalidate the final regulation due to the agency's failure to provide the public with a viable opportunity to offer meaningful comments.

Pursuant to the Administrative Procedures Act (the "APA"), federal agencies must "give interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments." 5 U.S.C. 553(c). Courts have consistently held that the public's right to participate in the rulemaking process requires an agency to "provide sufficient factual detail and rationale for the rule to permit interested parties to comment meaningfully." Florida Power & Light Co. v. United States, 846 F.2d 765, 771 (D.C. Cir. 1988). See also Home Box Office, Inc. v. FCC, 567 F.2d 9, 35 (D.C. Cir. 1977); United States v. Nova Scotia Food Products Corp., 568 F.2d 240, 251-52 (2d Cir. 1977).

The controlling law in the D.C. Circuit is well established and clear. In order for parties to offer meaningful support or criticism under the APA's notice-and-comment rulemaking process, "it is especially important for the agency to identify and make available technical studies and data that it has employed in reaching the decisions to propose particular rules." Connecticut Light & Power Co. v. Nuclear Regulatory Com., 673 F.2d 525, 530-31 (D.C. Cir. 1982). See also Sierra Club v. Costle, 657 F.2d 298 (D.C. Cir. 1981). If the federal agency relies on an outside study in promulgating a rule, the agency itself must first examine the methodology used to conduct the study. City of New Orleans v. SEC, 969 F.2d 1163, 1167 (D.C. Cir. 1992). Furthermore, the technical complexity of the analysis does not relieve the agency of the burden to consider all relevant factors and there "must be a rational connection between the factual inputs, modeling assumptions, modeling results and conclusions drawn from these results." Sierra Club, 657 F.2d at 333.

In Portland Cement Ass'n v. Ruckelshaus, 486 F.2d 375 (D.C. Cir. 1973), the D.C. Circuit invalidated a final EPA regulation because the agency's failure to utilize sufficient research data in the proposed rule hindered the opportunity for meaningful public comment. The court held that it "is not consonant with the purpose of a rule-making proceeding to promulgate rules on the basis of inadequate data." Instead, the issuing agency "must disclose in detail the thinking that has animated the form of a proposed rule" and provide a reasoned analysis of the data. Id.

Like Portland Cement, CMS's reliance on inadequate data and the resulting absence of reasoned scrutiny provides no opportunity for the public to offer meaningful support or criticism of the proposed LTCH rule. It is also questionable whether CMS adequately reviewed the methodology employed by 3M and MedPAC before adopting their research in the proposed rule. See City of New Orleans, 969 F.2d at 1167. Consequently, CMS should withdraw the proposed rule until such time that the agency can obtain more inclusive LTCH data and provide a reasonable analysis thereof.[14]

By letter dated February 1, 2006, the law firm Reed Smith LLP filed a request under the Freedom of Information Act, 5 U.S.C. § 552 ("FOIA") with the CMS Freedom of Information Group for the data cited in the proposed rule. Reed Smith filed a follow-up letter with the CMS FOI Group dated March 3, 2006, in which they restate that the request qualifies for expedited processing and that the information is needed before the close of the comment period on March 20, 2006 so that meaningful comments can be prepared. To date, Reed Smith has received no written response to its FOIA request, in violation of the agency's own regulations. The request has been assigned a case number

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[14] Federal agencies have recognized the obligation to withdraw proposed rules because the underlying data or analyses are insufficient to provide an opportunity for meaningful public input. See e.g., 70 Fed. Reg. 70,166 (CMS withdrawing entire practice expense methodology proposed in its Physician Fee Schedule for CY2006 due to incorrect and insufficient data); 69 Fed. Reg. 64,266 (FDA withdrawing proposed physical medicine devices rule due to incorrect and conflicting data); 69 Fed. Reg. 39,874 (Small Business Administration withdrawing proposed small business size rule because of public concerns over the agency's methodology in analyzing data); 67 Fed. Reg. 16,668 (Department of Labor withdrawing proposed rule due to failure to adequately consider underlying economic data); 63 Fed. Reg. 54,972 (Fish & Wildlife Service withdrawing proposed rule because of failure to incorporate the best scientific and commercial endangered species data in its analysis).

(C06FOI0920), but the case officer has made no effort to provide the request or a list of the requested records to anyone outside of the CMS FOI Group. These failings have thwarted our efforts to test the limited data and other information that CMS believes support its proposals.

B. Correction of Erroneous Information

ALTHA requests that CMS withdraw the proposed rule and revise the data it is using to develop final payment changes for LTCHs in RY 2007 to correct the flawed and incomplete data discussed above. In doing so, CMS should consider the data submitted herein, revise its assumptions and conclusions accordingly, and publish a new proposed rule.

As a more general matter, CMS needs to publish more information about the data it is using and both the design and results of its analyses so that the public has an opportunity to verify the agency's findings.

C. Public Notice of Correction

Due to the numerous data errors discussed above, the proposed rule is fatally flawed. CMS must formally withdraw the proposed rule as soon as possible. CMS has asked for comments to the proposed rule by March 20, 2006 and has stated that it will issue a final rule on LTCH PPS for RY 2007 in the Spring of this year. Therefore, there is considerable urgency for CMS to evaluate the data issues and additional data and other information provided in these comments before a final rule is published. ALTHA fully expects that CMS may need more time to fully evaluate this data. Moreover, interested parties should not be submitting comments to a proposed rule that is based on erroneous data. CMS should correct the erroneous information in the proposed rule by making the changes discussed above and publishing those changes in the Federal Register in a new proposed rule, only after the agency has fully evaluated all available data and is in a position to present that data to the public in a manner that interested parties can verify.

XIII. Conclusion

ALTHA is convinced that CMS needs to take a different approach to the LTCH PPS than using arbitrary and unsupported payment cuts to effectuate its stated policy goals. CMS should revisit the implementation of a very short-stay discharge policy similar to that proposed in March 2002, which was a more targeted and thoughtful effort to address the very same concern that CMS now proposes to address in such a draconian manner. CMS also should consider the alternatives that we have proposed in these comments, which are a more targeted approach to the agency's concerns about inappropriate admissions and potential "gaming" than the imprecise and unsupported payment changes discussed in this proposed rule. To the extent that CMS is concerned about "inappropriate" admissions to LTCHs, it should implement non-payment approaches such as pre-admission physician certifications, uniform admission screening criteria, and more extensive QIO reviews. At the very least, CMS needs to review the analyses it has already performed with respect to short-stay LTCH patients and explain how any proposal to change SSO payments is consistent with those analyses. In addition, we believe that CMS failed to satisfy its obligations under federal law to use sufficient data in its analyses and to share that data with the public. As a result, CMS has deprived interested parties of the opportunity to provide meaningful comments to the proposed rule. Based upon our analyses of the limited information that has been provided, we believe CMS has no choice but to withdraw the proposed rule so that a new proposed rule can be drafted that meets the rulemaking requirements.

We strongly suggest that CMS consider the data and analyses that we have provided in these comments, and we look forward to working with CMS on a more effective set of proposals to better define the patients and setting for long-term acute hospital care.

Sincerely,

William Walters
Chief Executive Officer

William Altman
Chair, ALTHA Public Policy Committee
Senior Vice President, Kindred Healthcare

Submitter : Dr. Jeffrey Niezgoda **Date:** 03/14/2006

Organization : Hyperbaric & Wound Care Associates

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1485-P-4-Attach-1.PDF

#4

Hyperbaric & Wound Care Associates
Exceptional Results

2901 W. KK River Pkwy Suite 311
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Jeffrey A. Niezgoda, MD, FACEP, FACHM
John D. Simanonok, MD, FACHM

Mark B. McClellan, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
P.O. Box 8012
7500 Security Boulevard
Baltimore, MD 21244-8012

Re: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007

Dear Dr. McClellan,

I am writing this letter to express my concern about the proposed rule to reduce Medicare reimbursement to Long Term Acute Care Hospitals. I am opposed to this proposal and request that this matter be reevaluated.

As a specialist in wound care and hyperbaric oxygen therapy, many of my patients receive these services as part of their overall management plan while they are inpatients at long term care hospitals in South Eastern Wisconsin, including LifeCare, Kindred and Select Specialty. This decision will significantly and negatively impact on my ability to provide care for these patients. In addition, the proposed rule will have a devastating impact on patient access to critical care, and could force many long term acute care hospitals to close their doors due to the significant payment reductions.

As you know, long term care hospitals provide acute care services to patients who are demonstrably sicker, have higher acuities, and have more comorbidities than typical patients in short-term acute care hospitals. Grouping long term care hospitals with general hospitals for payment purposes is inappropriate. Long term care hospital patients are exceedingly different than those in general hospitals, and the payment methodology to these hospitals should reflect those differences. In addition, the proposed rule goes against fundamental principles of a prospective payment system. By eliminating the opportunity for long term care hospitals to care for patients whose costs of treatment are less than Medicare reimbursement levels, CMS is eliminating any chance for these hospitals to overcome the losses of caring for patients whose costs of treatment exceed reimbursement levels. In essence, CMS is punishing long term care hospitals for providing Medicare patients with efficient care. It is also inaccurate to suggest that long term care hospitals are seeking out more profitable patients when it is impossible to definitively determine which patients are likely to have stays longer or shorter than the average length.

I am further disturbed that this action is not supported by objective, clinical data and is being contemplated before the CMS-contracted study, based on MedPAC's considered recommendations, is completed. The agency's actions are premature and unwarranted. Consequently, I strongly urge you not to implement this rule until this study is complete. These findings could then serve as the basis for a thoughtful, in-depth

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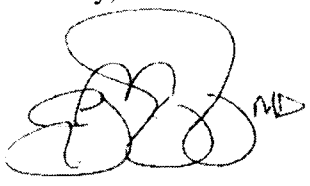
Jeffrey A. Niezgoda, MD, FACEP, FACHM
John D. Simanonok, MD, FACHM

discussion between CMS, physicians, patients, and the hospitals themselves regarding how to address the agency's concerns in a fair, fiscally sound manner.

I recognize that your work on this issue is vital to the care we provide Medicare beneficiaries and I thank you for your attention to this important matter. I again request that you reconsider this proposed rule change. If you have any additional questions or if I can be of other assistance, please do not hesitate to contact me.

Sincerely,



Jeffrey A. Niezgoda, MD, FACEP, FACHM
Medical Director
The Center for Comprehensive Wound Care
& Hyperbaric Oxygen Therapy

Form Letter
5-13

Submitter : Dr. Cynthia Ayers **Date:** 03/14/2006

Organization : Dr. Cynthia Ayers

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

see attached

CMS-1485-P-5-Attach-1.PDF

#5

Honorable Mark B. McClellan
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
P.O. Box 8012
7500 Security Boulevard
Baltimore, MD 21244-8012

Re: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule,

Dear Administrator McClellan:

I am gravely concerned about and oppose your proposed rule to reduce Medicare reimbursement to long term acute care hospitals.

I am a board certified physician in internal medicine and have been in practice for 24 years. Since LifeCare came to the community in 1999, I have been intimately involved with the concept of Long-term Acute Care. This concept has been a godsend to many of my patients as well as to my colleagues. It has been a place where patients can receive acute care and get back on their feet. As a result, many of them have a much better quality of life.

The proposed rule will have a devastating impact on patient access to critical care, and will likely force many long term acute care hospitals to close their doors due to the significant payment reductions.

As you know, long term care hospitals provide acute care services to patients who are demonstrably sicker, have higher acuities, and have more comorbidities than typical patients in short-term acute care hospitals. Grouping long term care hospitals with general hospitals for payment purposes is inappropriate. Long term care hospital patients are exceedingly different than those in general hospitals, and the payment methodology to these hospitals should reflect those differences.

When CMS begins to decide the appropriate site of care for patients, I become concerned that the agency is substituting its judgment for the medical judgment of physicians [like myself], who are the individuals that should be solely responsible for determining the best care for their patients.

In addition, the proposed rule goes against fundamental principles of a prospective payment system. By eliminating the opportunity for long term care hospitals to care for patients whose costs of treatment are less than Medicare reimbursement levels, CMS is eliminating any chance for these hospitals to overcome the losses of caring for patients whose costs of treatment exceed reimbursement levels. In essence, CMS is punishing long term care hospitals for providing Medicare patients with efficient care. It is also inaccurate to suggest that long term care

hospitals are seeking out more profitable patients when it is impossible to definitively determine which patients are likely to have stays longer or shorter than the average length.

I am further disturbed that this action is not supported by objective, clinical data and is being contemplated before the CMS-contracted study, based on MedPAC's considered recommendations, is completed. The agency's actions are premature and unwarranted. Consequently, I strongly urge you not to implement this rule until this study is complete. These findings could then serve as the basis for a thoughtful, in-depth discussion between CMS, physicians, patients, and the hospitals themselves regarding how to address the agency's concerns in a fair, fiscally sound manner.

I recognize that your work on this issue is vital to the care we provide Medicare beneficiaries and I thank you for your attention to this important matter.

Sincerely,

/s/

Cynthia Ayers, M.D.
7000 Thomas Blvd.
Pittsburgh, PA 15208

Submitter : Mr. John George **Date:** 03/14/2006

Organization : InterGroup Services Corporation

Category : Health Plan or Association

Issue Areas/Comments

GENERAL

GENERAL

see attached

CMS-1485-P-6-Attach-1.PDF

Honorable Mark B. McClellan
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
P.O. Box 8012
7500 Security Boulevard
Baltimore, MD 21244-8012

Re: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule,

Dear Administrator McClellan:

I am gravely concerned about and oppose your proposed rule to reduce Medicare reimbursement to long term acute care hospitals.

InterGroup Services Corporation is the largest PPO in Pennsylvania, New Jersey and West Virginia. We have been doing business with LifeCare Hospitals of Pittsburgh for several years and believe they serve an important role in the critical care arena.

The proposed rule will have a devastating impact on patient access to critical care, and will likely force many long term acute care hospitals to close their doors due to the significant payment reductions.

As you know, long term care hospitals provide acute care services to patients who are demonstrably sicker, have higher acuities, and have more comorbidities than typical patients in short-term acute care hospitals. Grouping long term care hospitals with general hospitals for payment purposes is inappropriate. Long term care hospital patients are exceedingly different than those in general hospitals, and the payment methodology to these hospitals should reflect those differences.

When CMS begins to decide the appropriate site of care for patients, I become concerned that the agency is substituting its judgment for the medical judgment of physicians who are the individuals that should be solely responsible for determining the best care for their patients.

In addition, the proposed rule goes against fundamental principles of a prospective payment system. By eliminating the opportunity for long term care hospitals to care for patients whose costs of treatment are less than Medicare reimbursement levels, CMS is eliminating any chance for these hospitals to overcome the losses of caring for patients whose costs of treatment exceed reimbursement levels. In essence, CMS is punishing long term care hospitals for providing Medicare patients with efficient care. It is also inaccurate to suggest that long term care hospitals are seeking out more profitable patients when it is impossible to definitively determine which patients are likely to have stays longer or shorter than the average length.

I am further disturbed that this action is not supported by objective, clinical data and is being contemplated before the CMS-contracted study, based on MedPAC's considered recommendations, is completed. The agency's actions are premature and unwarranted. Consequently, I strongly urge you not to implement this rule until this study is complete. These findings could then serve as the basis for a thoughtful, in-depth discussion between CMS, physicians, patients, and the hospitals themselves regarding how to address the agency's concerns in a fair, fiscally sound manner.

I recognize that your work on this issue is vital to the care we provide Medicare beneficiaries and I thank you for your attention to this important matter.

Sincerely,

/s/

John A. George, President
InterGroup Services Corporation
401 Shady Ave., Suite B-108
Pittsburgh, Pa. 15206

Submitter : **Ms. Rebecca Stephens** **Date: 03/14/2006**

Organization : **Ms. Rebecca Stephens**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1485-P-7-Attach-1.PDF

#7

March 14, 2006

Honorable Mark B. McClellan
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
P.O. Box 8012
7500 Security Boulevard
Baltimore, MD 21244-8012

Re: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule

Dear Administrator McClellan:

It has come to my attention that CMS is considering a reduction in the reimbursement to long term acute care hospitals. I am greatly concerned about and oppose your proposed rule.

My mother was treated at LifeCare Hospitals of San Antonio in November 2004. While there she received care that she was not getting at the other hospital.

The effect of this proposed rule, as I understand it, would reduce payments to these important long term acute care hospitals by as much as 15%. This drastic action could jeopardize patient access to critical and necessary care, and may even force these hospitals to close their doors.

I am further disturbed that this action is being proposed before the CMS-commissioned study on the proper classification of both patients and hospitals is completed.

The proposed rule should not be implemented, and any regulation that would affect these hospitals should be postponed until the aforementioned study is completed, and then based on clinical data.

Services provided in a long term acute care hospital were essential to the treatment of my mother. The important care that long term care hospitals provide must remain available for other families in need.

Please do not jeopardize the future of these critical hospitals.

Sincerely,

/s/

Rebecca Stephens
11330 Enclave Run
San Antonio TX 78213

Submitter : Ms. Bonnie Gawron **Date:** 03/14/2006

Organization : LifeCare Hospitals of Western Michigan

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1485-P-8-Attach-1.PDF

Honorable Mark B. McClellan, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
P.O. Box 8012
7500 Security Boulevard
Baltimore, MD 21244-8012

Re: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule,

Dear Administrator McClellan:

I am gravely concerned about and oppose your proposed rule to reduce Medicare reimbursement to long term acute care hospitals.

As Director of Quality Management at LifeCare Hospitals of Western Michigan, I am seeing many patients gain hope, support, strength, and healing at our long term acute care hospital. The acutely ill patients, with multiple comorbidities, are given multi-disciplinary care, treating the body as a whole which greatly improves the health outcomes. Because of the complexity of these patients, most would be a burden on short term acute hospital's DRG reimbursement and/or be lost in the system with no hope of improving the health status.

The proposed rule will have a devastating impact on patient access to critical care, and will likely force many long term acute care hospitals to close their doors due to the significant payment reductions.

As you know, long term care hospitals provide acute care services to patients who are demonstrably sicker, have higher acuities, and have more comorbidities than typical patients in short-term acute care hospitals. Grouping long term care hospitals with general hospitals for payment purposes is inappropriate. Long term care hospital patients are exceedingly different than those in general hospitals, and the payment methodology to these hospitals should reflect those differences.

When CMS begins to decide the appropriate site of care for patients, I become concerned that the agency is substituting its judgment for the medical judgment of physicians, who are the individuals that should be solely responsible for determining the best care for their patients.

In addition, the proposed rule goes against fundamental principles of a prospective payment system. By eliminating the opportunity for long term care hospitals to care for patients whose costs of treatment are less than Medicare reimbursement levels, CMS is eliminating any chance for these hospitals to overcome the losses of caring for patients whose costs of treatment exceed reimbursement levels. In essence, CMS is punishing long term care hospitals for providing Medicare patients with efficient care. It is also inaccurate to suggest that long term care

hospitals are seeking out more profitable patients when it is impossible to definitively determine which patients are likely to have stays longer or shorter than the average length.

I am further disturbed that this action is not supported by objective, clinical data and is being contemplated before the CMS-contracted study, based on MedPAC's considered recommendations, is completed. The agency's actions are premature and unwarranted. Consequently, I strongly urge you not to implement this rule until this study is complete. These findings could then serve as the basis for a thoughtful, in-depth discussion between CMS, physicians, patients, and the hospitals themselves regarding how to address the agency's concerns in a fair, fiscally sound manner.

I recognize that your work on this issue is vital to the care we provide Medicare beneficiaries and I thank you for your attention to this important matter.

Sincerely,

/s/

Bonnie Gawron, RN, BS, CPHQ
Director of Quality/Risk Management
LifeCare Hospitals of Western Michigan

Form Letter
9-14

Submitter : Mr. Tim Cranford **Date:** 03/14/2006

Organization : HealthTrust Purchasing Group

Category : Health Care Industry

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1485-P-9-Attach-1.PDF

#9

Honorable Mark B. McClellan
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
P.O. Box 8012
7500 Security Boulevard
Baltimore, MD 21244-8012

Re: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule

Dear Administrator McClellan:

It has come to my attention that CMS is considering a reduction in the reimbursement to long term acute care hospitals. I am greatly concerned about and oppose your proposed rule.

As a business partner to healthcare providers, I have had the opportunity to view first hand the quality of care delivered by long term acute care hospitals to the most seriously ill patients. They are a vital link in the health care continuum.

The effect of this proposed rule, as I understand it, would reduce payments to these important long term acute care hospitals by as much as 15%. This drastic action could jeopardize patient access to critical and necessary care, and may even force these hospitals to close their doors.

I am further disturbed that this action is being proposed before the CMS-commissioned study on the proper classification of both patients and hospitals is completed.

The proposed rule should not be implemented, and any regulation that would affect these hospitals should be postponed until the aforementioned study is completed, and then based on clinical data.

The important care that long term care hospitals provide must remain available for other families in need.

Please do not jeopardize the future of these critical hospitals.

Sincerely,

/s/

Tim Cranford
VP Sales & Marketing
HealthTrust Purchasing Group
615-344-3063

Submitter : Dr. F. Remington Sprague **Date:** 03/14/2006

Organization : Mercy General Health Partners

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1485-P-10-Attach-1.PDF

#10

March 14, 2006

Honorable Mark B. McClellan
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
P.O. Box 8012
7500 Security Boulevard
Baltimore, MD 21244-8012

Re: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule,

Dear Administrator McClellan:

I have serious reservations about your proposed rule to reduce Medicare reimbursement to long term acute care hospitals for their "short stay" patients.

As a general internist who provides care in LifeCare Hospital here in Muskegon, I have seen the complexity of the patients and the long lengths of stay their serious illnesses require. I have been impressed with the level of care provided and the remarkable results obtained for patients on long term ventilator support, patients requiring extensive wound care and patients with severe debility after prolonged life-threatening illnesses.

These patients, some of whom are classified as "short stay" under the proposed regulations, are as complex for a longer time and require far more resources than patients in the acute hospital setting with the same DRG classification. Rather than applying an arbitrary reduction in reimbursement based on pay for the same DRG in an acute care hospital, I recommend CMS undertake a thorough review of actual costs required to care for these populations, similar to the work done in preparation for instituting the DRG payment system in the 1980s. Such a study is already underway as a result of recommendations by MedPAC. The agency's actions are premature and unwarranted.

I strongly urge you not to implement this rule until this study is complete. These findings could then serve as the basis for a thoughtful, in-depth discussion between CMS, physicians, patients, and the hospitals themselves regarding how to address the agency's concerns in a fair, fiscally sound manner.

Sincerely,

/s/

F. Remington Sprague, M.D.
Mercy General Health Partners
Phone: 231.672.6470
Fax: 231.672.6235

Submitter : Mr. Rob Burkart **Date:** 03/14/2006

Organization : McKesson Health Systems

Category : Health Care Industry

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1485-P-11-Attach-1.PDF

#11

March 14, 2006

Honorable Mark B. McClellan
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
P.O. Box 8012
7500 Security Boulevard
Baltimore, MD 21244-8012

Re: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule

Dear Administrator McClellan:

It has come to my attention that CMS is considering a reduction in the reimbursement to long term acute care hospitals. I am greatly concerned about and oppose your proposed rule.

As a business partner to healthcare providers, I have had the opportunity to view first hand the quality of care delivered by long term acute care hospitals to the most seriously ill patients. They are a vital link in the health care continuum.

The effect of this proposed rule, as I understand it, would reduce payments to these important long term acute care hospitals by as much as 15%. This drastic action could jeopardize patient access to critical and necessary care, and may even force these hospitals to close their doors.
I am further concerned that this action is being proposed before the CMS-commissioned study on the proper classification of both patients and hospitals is completed.

The proposed rule should not be implemented, and any regulation that would affect these hospitals should be postponed until the aforementioned study is completed, and then based on clinical data.

The important care that long term care hospitals provide must remain available for other families in need.

Please do not jeopardize the future of these critical hospitals.

Sincerely,

/s/

Rob Burkart
Vice President National Accounts
McKesson Health Systems
Robert.Burkart@McKesson.com

Submitter : **Mr. Ken Noteboom** **Date: 03/14/2006**

Organization : **Norman Specialty Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1485-P-12-Attach-1.DOC

March 13, 2006

Hon. Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicare Program: Prospective Payment System for Long-Term Care Hospitals RY2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification: Proposed Rule, 71 Fed. Reg. 4648 (January 27, 2006)

Dear Dr. McClellan:

I'm administrator of Norman Specialty Hospital in Norman, Oklahoma; we are scheduled to become a long term acute care hospital (LTACH) in June of this year. We are owned by HCR-Manorcare and managed by a HCR subsidiary, Milestone Healthcare of Dallas. Before this position, I started and was CEO of Hillcrest Specialty Hospital in Tulsa, Oklahoma (13Years). I am also a member of the Acute Long Term Hospital Association (ALTHA) Board of Directors.

I support the comments and recommendations you received from ALTHA on March 10th of this year. These comments were in response to the Centers for Medicare & Medicaid Services' (CMS) proposed annual payment rate updates, policy changes, rate year 2007, which were proposed on January 27, 2006.

There is much concern over the drastic cuts in LTACH reimbursement and the basis from which CMS has derived the recommendations. It is believed that the data provided you was flawed and there is substantial interest from the industry to work with you, have input and assist in developing a new proposed rule. Since the nation's LTACH's are so adversely affected, we would like to be part of the solution to resolve your concerns.

I support the concept as reported to you by the Medicare Payment Advisory Commission (MedPAC) that the issue at hand should be to assure that the LTACH's are receiving payment for only the medically complex patients with severe illnesses. These are the patients most facilities are servicing and want to continue serving with the support of CMS. We too, are most concerned that our patients receive the quality of care for which we are designed and reimbursed. In the state of Oklahoma, both the QIO and the LTACHs use InterQual Long-Term Acute Care Criteria to assure the proper admissions and continued care of our Medicare patients.

From information received as to CMS's short stay outlier concerns, the actual issues can be addressed by concentrating on the "very short stay" LTACH patients (e.g., patients with lengths of stay of less than 5-7 days). ALTHA has some proposed solutions that I believe you should consider for a new set of proposed rules. Please give them the serious consideration of which they are warranted.

In my opinion, the proposed policy changes for reimbursement to LTACH's aren't fair nor are they based on actual data. Care for our patients is just 1.4% of all Medicare spending and we are asked to accept 11% of all the proposed Medicare program cuts in 2007 and 7.8% of all cuts over the next 5 years.

ALTHA's comments also address and provide justification for allowing a full update to the LTACH PPS federal rate for RY 2007. Adjustments to overpayments are addressed annually when CMS recalibrates the LTC-DRG weights.

Much future discussion is needed regarding including the freestanding LTACHs under the 25% patient referral criterion now in effect for hospitals in hospitals; this action needs to be evaluated based on the acuity, accessibility and availability of services. As you know, there is a lack of sufficient data to analyze the current hospital in hospital rules and if they have actually done anything to serve Medicare patients, except make it more difficult for legitimate referral and placement of patients needing acute long term care.

ALTHA's comments point out many other issues and concerns connected to the CMS proposals, all of which bear merit and should be considered fairly and openly. We are an industry that provides much needed care to the elderly frail and have many success stories of patients who have gained quality to their lives because of our level of care. We are an industry that would like to work with CMS and MedPAC to address concerns and possible solutions to continue caring for our patients, providing a high quality of care and at a reasonable reimbursement so as to grow with the needs of an aging population. Let us be partners with you in finding the proper solutions to your concerns—always keeping quality patient care as our goal.

Sincerely,

Ken Noteboom, Administrator
Norman Specialty Hospital

Submitter : Jevner Conover **Date:** 03/15/2006

Organization : LifeCare Hospitals of Western Michigan

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1485-P-13-Attach-1.PDF

#13

March 15, 2006

Honorable Mark B. McClellan
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
P.O. Box 8012
7500 Security Boulevard
Baltimore, MD 21244-8012

Re: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule,

Dear Administrator McClellan:

I am gravely concerned about your proposed rule to reduce Medicare reimbursement to long term acute care hospitals. I am writing to voice my strong opposition to the proposed rule changes.

As you know, long term care hospitals provide acute care services to patients who are demonstrably sicker, have higher acuities, and have more comorbidities than typical patients in short-term acute care hospitals. Grouping long term care hospitals with general hospitals for payment purposes is inappropriate. Long term care hospital patients are medically complex and quite different than those in general hospitals. The payment methodology to long term acute care hospitals should reflect these differences.

Moreover, I believe the logic of the proposed rule change which would apply short term hospital rates to patients whose stay is less than the projected average length of stay is patently flawed. Under these regulations a long term acute care hospital (LTACH) faces the prospect of receiving short term acute care rates for care rendered to a medically complex patient whose LOS is shorter than the projected length of stay for their particular illness/DRG. This payment methodology, if implemented, will in many instances severely penalize hospitals that do a good job in helping patients get well and go home as soon as they are capable.

To illustrate, consider an LTACH admission of an extremely complex patient requiring mechanical ventilation, renal dialysis, expensive medications, wound care and therapy. Care for this patient would be very demanding, very expensive and require extensive resources. If the hospital team did a great job and helped this patient progress to the point he could go home on the 26th day rather than the 28th day as projected for the DRG, the hospital, under the proposed regulations, would be reimbursed at a much lower level than provided for under the current payment methodologies. This lower payment would be less than the hospital's cost of caring for this medically complex patient and the hospital would therefore loose money for doing a great job for the patient. I cannot believe that CMS would desire to establish a rule that would actually penalize hospitals for doing good work.

I am disturbed that this action is not supported by objective, clinical data and is being contemplated before the CMS-contracted study, based on MedPAC's considered recommendations, is completed. The agency's actions are premature and unwarranted. Consequently, I strongly urge you not to implement this rule until this study is complete. These findings could then serve as the basis for a thoughtful, in-depth discussion between CMS, physicians, patients, and the hospitals themselves regarding how to address the agency's concerns in a fair, fiscally sound manner.

In addition, the proposed rule goes against fundamental principles of a prospective payment system. By eliminating the opportunity for long term care hospitals to care for patients whose costs of treatment are less than Medicare reimbursement levels, CMS is eliminating any chance for these hospitals to overcome the losses of caring for patients whose costs of treatment exceed reimbursement levels. In essence, CMS is punishing long term care hospitals for providing Medicare patients with efficient care. It is also inaccurate to suggest that long term care hospitals are seeking out more profitable patients when it is impossible to definitively determine which patients are likely to have stays longer or shorter than the average length.

I have been blessed to work in a number of excellent health care organizations over the course of my 25+ year career. These organizations have spanned the gamut from large tertiary medical centers to community hospitals. I have seen a many patients receive life changing care from the physicians, nurses and other care givers at these hospitals. All that said, I have never seen any health care organization as uniquely qualified to take care of medically complex patients as the long term acute care hospital in which I currently work.

The proposed rule will have a devastating impact on patient access to critical care, and will likely force many long term acute care hospitals to close their

doors due to the significant payment reductions. This will be a grave disservice to the American public. STOP!

I thank you for your attention to this important matter.

Sincerely,

/s/

Jevne R. Conover
Administrator and CEO
LifeCare Hospitals of Western Michigan
Jev.Conover@lifecare-hospitals.com

Submitter : **Dr. Hikmat Halasa** **Date: 03/15/2006**

Organization : **Dr. Hikmat Halasa**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1485-P-14-Attach-1.PDF

Hikmat Halasa, MD, MPH
Board Certified in Internal Medicine

1560 E. Sherman Blvd., • Suite 215 • Muskegon, MI • 49444
Phone (231) 830-8600 • Fax (231) 737-3145

Attch #14

Honorable Mark B. McClellan
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
P.O. Box 8012
7500 Security Boulevard
Baltimore, MD 21244-8012

Re: ***Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule,***

Dear Administrator McClellan:

I have serious reservations about your proposed rule to reduce Medicare reimbursement to long term acute care hospitals for their "short stay" patients.

As a general internist who provides care in LifeCare Hospital here in Muskegon, I have seen the complexity of the patients and the long lengths of stay their serious illnesses require. I have been impressed with the level of care provided and the remarkable results obtained for patients on long term ventilator support, patients requiring extensive wound care and patients with severe debility after prolonged life-threatening illnesses.

These patients, some of whom are classified as "short stay" under the proposed regulations, are as complex for a longer time and require far more resources than patients in the acute hospital setting with the same DRG classification. Rather than applying an arbitrary reduction in reimbursement based on pay for the same DRG in an acute care hospital, I recommend CMS undertake a thorough review of actual costs required to care for these populations, similar to the work done in preparation for instituting the DRG payment system in the 1980s. Such a study is already underway as a result of recommendations by MedPAC. The agency's actions are premature and unwarranted.

I strongly urge you not to implement this rule until this study is complete. These findings could then serve as the basis for a thoughtful, in-depth discussion between CMS, physicians, patients, and the hospitals themselves regarding how to address the agency's concerns in a fair, fiscally sound manner.

Sincerely,

Hikmat Halasa, MD, MPH

Submitter : Dr. Steven Sotos **Date:** 03/15/2006

Organization : LifeCare Hospitals of Pittsburgh

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1485-P-15-Attach-1.PDF

Attach #15

March 15, 20006

Honorable Mark B. McClellan
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
P.O. Box 8012
7500 Security Boulevard
Baltimore, MD 21244-8012

Re: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule,

Dear Administrator McClellan:

I am gravely concerned about and oppose your proposed rule to reduce Medicare reimbursement to long term acute care hospitals.

I am a board certified pulmonary physician who has participated in the care of critically ill patients at LifeCare Hospitals of Pittsburgh for many years. I also serve as chief of staff. I know the care here is excellent because we wean patients off the ventilator. We depend on this facility to move patients from general acute care facilities because here they receive aggressive weaning. The results have been fantastic. The care is at LifeCare is utmost and is reflected in our statistics in freeing patients from the vent. This facility is definitely needed in the community.

The proposed rule will have a devastating impact on patient access to critical care, and will likely force many long term acute care hospitals to close their doors due to the significant payment reductions.

As you know, long term care hospitals provide acute care services to patients who are demonstrably sicker, have higher acuities, and have more comorbidities than typical patients in short-term acute care hospitals. Grouping long term care hospitals with general hospitals for payment purposes is inappropriate. Long term care hospital patients are exceedingly different than those in general hospitals, and the payment methodology to these hospitals should reflect those differences.

When CMS begins to decide the appropriate site of care for patients, I become concerned that the agency is substituting its judgment for the medical judgment of physicians [like myself], who are the individuals that should be solely responsible for determining the best care for their patients.

In addition, the proposed rule goes against fundamental principles of a prospective payment system. By eliminating the opportunity for long term care hospitals to care for patients whose

costs of treatment are less than Medicare reimbursement levels, CMS is eliminating any chance for these hospitals to overcome the losses of caring for patients whose costs of treatment exceed reimbursement levels. In essence, CMS is punishing long term care hospitals for providing Medicare patients with efficient care. It is also inaccurate to suggest that long term care hospitals are seeking out more profitable patients when it is impossible to definitively determine which patients are likely to have stays longer or shorter than the average length.

I am further disturbed that this action is not supported by objective, clinical data and is being contemplated before the CMS-contracted study, based on MedPAC's considered recommendations, is completed. The agency's actions are premature and unwarranted. Consequently, I strongly urge you not to implement this rule until this study is complete. These findings could then serve as the basis for a thoughtful, in-depth discussion between CMS, physicians, patients, and the hospitals themselves regarding how to address the agency's concerns in a fair, fiscally sound manner.

I recognize that your work on this issue is vital to the care we provide Medicare beneficiaries and I thank you for your attention to this important matter.

Sincerely,

/s/

Steven Sotos, M.D.
Chief of Staff
LifeCare Hospitals of Pittsburgh

Submitter : Mr. Anthony Benevento **Date:** 03/15/2006

Organization : UPMC Health Plan

Category : Health Plan or Association

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1485-P-16-Attach-1.PDF

Attch #16

March 15, 2006

Honorable Mark B. McClellan
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
P.O. Box 8012
7500 Security Boulevard
Baltimore, MD 21244-8012

Re: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule

Dear Administrator McClellan:

My name is Anthony Benevento, VP Finance at UPMC Health Plan. I have been involved with LifeCare Hospitals of Pittsburgh for about the last 3 years. Our patients who leave from our short term hospitals to LifeCare receive quality care and great clinical outcomes.

It has come to my attention that CMS is considering a reduction in the reimbursement to long term acute care hospitals. I greatly object to and oppose your proposed rule.

The effect of this proposed rule, as I understand it, would reduce payments to these important long term acute care hospitals by as much as 15%. This drastic action could jeopardize patient access to critical and necessary care, and may even force these hospitals to close their doors.

I am further disturbed that this action is being proposed before the CMS-commissioned study on the proper classification of both patients and hospitals is completed.

The proposed rule should not be implemented, and any regulation that would affect these hospitals should be postponed until the aforementioned study is completed, and then based on clinical data.

The important care that long term care hospitals provide must remain available for families in need.

Please do not jeopardize the future of these critical hospitals.

Sincerely,

/s/

Anthony Benevento
Vice President, Finance
UPMC Health Plan

Submitter : Mr. Donald Mosites **Date:** 03/15/2006

Organization : Mr. Donald Mosites

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1485-P-17-Attach-1.PDF

Attch # 17

March 15, 2006

Honorable Mark B. McClellan
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
P.O. Box 8012
7500 Security Boulevard
Baltimore, MD 21244-8012

Re: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule

Dear Administrator McClellan:

My name is Donald Mosites and my wife, Mary, was a patient at LifeCare Hospitals of Pittsburgh. We were very pleased with the quality of care she received. We have the nursing staff as well as the entire hospital to thank for making my family feel welcome at their facility. We will always recommend LifeCare to anyone who wants quality care and quality outcomes.

It has come to my attention that CMS is considering a reduction in the reimbursement to long term acute care hospitals. I am greatly concerned about and oppose your proposed rule.

The effect of this proposed rule, as I understand it, would reduce payments to these important long term acute care hospitals by as much as 15%. This drastic action could jeopardize patient access to critical and necessary care, and may even force these hospitals to close their doors.

I am further disturbed that this action is being proposed before the CMS-commissioned study on the proper classification of both patients and hospitals is completed.

The proposed rule should not be implemented, and any regulation that would affect these hospitals should be postponed until the aforementioned study is completed, and then based on clinical data.

Services provided in a long term acute care hospital were essential to the treatment of my wife. The important care that long term care hospitals provide must remain available for other families in need.

Please do not jeopardize the future of these critical hospitals.

Sincerely,

/s/

Donald Mosites

Submitter : Dr. Vish Iyer **Date:** 03/15/2006

Organization : Dr. Vish Iyer

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1485-P-18-Attach-1.PDF

Attch #18

March 15, 20006

Honorable Mark B. McClellan
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
P.O. Box 8012
7500 Security Boulevard
Baltimore, MD 21244-8012

Re: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule,

Dear Administrator McClellan:

I am gravely concerned about and oppose your proposed rule to reduce Medicare reimbursement to long term acute care hospitals.

I am a board certified physician in family practice and have been in practice for over 20 years. Since LifeCare came to the community in 1999, I have been intimately involved with the concept of Long-term Acute Care. This concept has been a godsend to many of my patients as well as to my colleagues. It has been a place where patients can receive acute care and get back on their feet. As a result, many of them have a much better quality of life.

The proposed rule will have a devastating impact on patient access to critical care, and will likely force many long term acute care hospitals to close their doors due to the significant payment reductions.

As you know, long term care hospitals provide acute care services to patients who are demonstrably sicker, have higher acuities, and have more comorbidities than typical patients in short-term acute care hospitals. Grouping long term care hospitals with general hospitals for payment purposes is inappropriate. Long term care hospital patients are exceedingly different than those in general hospitals, and the payment methodology to these hospitals should reflect those differences.

When CMS begins to decide the appropriate site of care for patients, I become concerned that the agency is substituting its judgment for the medical judgment of physicians [like myself], who are the individuals that should be solely responsible for determining the best care for their patients.

In addition, the proposed rule goes against fundamental principles of a prospective payment system. By eliminating the opportunity for long term care hospitals to care for patients whose costs of treatment are less than Medicare reimbursement levels, CMS is eliminating any chance

for these hospitals to overcome the losses of caring for patients whose costs of treatment exceed reimbursement levels. In essence, CMS is punishing long term care hospitals for providing Medicare patients with efficient care. It is also inaccurate to suggest that long term care hospitals are seeking out more profitable patients when it is impossible to definitively determine which patients are likely to have stays longer or shorter than the average length.

I am further disturbed that this action is not supported by objective, clinical data and is being contemplated before the CMS-contracted study, based on MedPAC's considered recommendations, is completed. The agency's actions are premature and unwarranted. Consequently, I strongly urge you not to implement this rule until this study is complete. These findings could then serve as the basis for a thoughtful, in-depth discussion between CMS, physicians, patients, and the hospitals themselves regarding how to address the agency's concerns in a fair, fiscally sound manner.

I recognize that your work on this issue is vital to the care we provide Medicare beneficiaries and I thank you for your attention to this important matter.

Sincerely,

/s/

Vish Iyer, MD
Pittsburgh, PA 15223

Submitter : Dr. Patricia Canfield **Date:** 03/15/2006

Organization : LifeCare Hospitals of Pittsburgh

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1485-P-19-Attach-1.PDF

HHC #19

March 15, 20006

Honorable Mark B. McClellan
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
P.O. Box 8012
7500 Security Boulevard
Baltimore, MD 21244-8012

Re: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule,

Dear Administrator McClellan:

I am gravely concerned about and oppose your proposed rule to reduce Medicare reimbursement to long term acute care hospitals.

I'm a physiatrist and I have worked at LifeCare Hospitals of Pittsburgh since its inception. As a consultant to the hospital, I see patients who are acutely ill. LifeCare Hospitals of Pittsburgh is an appropriate facility for the types of patients they serve. I believe any changes to Medicare funding to this hospital will severely curtail their ability to provide care to our community.

Since LifeCare came to the community in 1999, I have been intimately involved with the concept of Long-term Acute Care. This concept has been a godsend to many of my patients as well as to my colleagues. It has been a place where patients can receive acute care and get back on their feet. As a result, many of them have a much better quality of life.

The proposed rule will have a devastating impact on patient access to critical care, and will likely force many long term acute care hospitals to close their doors due to the significant payment reductions.

As you know, long term care hospitals provide acute care services to patients who are demonstrably sicker, have higher acuities, and have more comorbidities than typical patients in short-term acute care hospitals. Grouping long term care hospitals with general hospitals for payment purposes is inappropriate. Long term care hospital patients are exceedingly different than those in general hospitals, and the payment methodology to these hospitals should reflect those differences.

When CMS begins to decide the appropriate site of care for patients, I become concerned that the agency is substituting its judgment for the medical judgment of physicians [like myself], who are the individuals that should be solely responsible for determining the best care for their patients.

In addition, the proposed rule goes against fundamental principles of a prospective payment system. By eliminating the opportunity for long term care hospitals to care for patients whose costs of treatment are less than Medicare reimbursement levels, CMS is eliminating any chance for these hospitals to overcome the losses of caring for patients whose costs of treatment exceed reimbursement levels. In essence, CMS is punishing long term care hospitals for providing Medicare patients with efficient care. It is also inaccurate to suggest that long term care hospitals are seeking out more profitable patients when it is impossible to definitively determine which patients are likely to have stays longer or shorter than the average length.

I am further disturbed that this action is not supported by objective, clinical data and is being contemplated before the CMS-contracted study, based on MedPAC's considered recommendations, is completed. The agency's actions are premature and unwarranted. Consequently, I strongly urge you not to implement this rule until this study is complete. These findings could then serve as the basis for a thoughtful, in-depth discussion between CMS, physicians, patients, and the hospitals themselves regarding how to address the agency's concerns in a fair, fiscally sound manner.

I recognize that your work on this issue is vital to the care we provide Medicare beneficiaries and I thank you for your attention to this important matter.

Sincerely,

/s/

Patricia H. Canfield, M.D.

Submitter : Mr. Robert Justine **Date:** 03/15/2006

Organization : Mr. Robert Justine

Category : Attorney/Law Firm

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1485-P-20-Attach-1.PDF

AH-#20

March 16, 2006

Honorable Mark B. McClellan
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
P.O. Box 8012
7500 Security Boulevard
Baltimore, MD 21244-8012

Re: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule

Dear Administrator McClellan:

My name is Robert H. Justine, Esquire, and I work in an area involving elder care. I have been involved with LifeCare Hospitals of Pittsburgh for almost four years, and I have seen plenty of great clinical outcomes.

It has come to my attention that CMS is considering a reduction in the reimbursement to long term acute care hospitals. I am greatly concerned about and oppose your proposed rule.

The effect of this proposed rule, as I understand it, would reduce payments to these important long term acute care hospitals by as much as 15%. This drastic action could jeopardize patient access to critical and necessary care, and may even force these hospitals to close their doors.

I am further disturbed that this action is being proposed before the CMS-commissioned study on the proper classification of both patients and hospitals is completed.

The proposed rule should not be implemented, and any regulation that would affect these hospitals should be postponed until the aforementioned study is completed, and then based on clinical data.

The important care that long term care hospitals provide must remain available for families in need.

Please do not jeopardize the future of these critical hospitals.

Sincerely

Robert H. Justine, Esquire

Submitter : Dr. Theodore Molnar **Date:** 03/15/2006

Organization : Almar Radiological Group

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1485-P-21-Attach-1.PDF

Attch # 21

March 15, 2006

Honorable Mark B. McClellan
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
P.O. Box 8012
7500 Security Boulevard
Baltimore, MD 21244-8012

Re: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule,

Dear Administrator McClellan:

I am gravely concerned about and oppose your proposed rule to reduce Medicare reimbursement to long term acute care hospitals.

My name is Dr. Theodore Molnar, Radiologist and President of Almar Radiological Group. My company has been doing business with LifeCare Hospitals of Pittsburgh since it came to Pittsburgh. My staff is pleased with the quality of care our patients receive at LifeCare. By lowering your payment, you might see some providers that will have to close their doors or limit their admissions. This will not be good for anybody.

Since LifeCare came to the community in 1999, I have been intimately involved with the concept of Long-term Acute Care. This concept has been a godsend to many of our patients as well as to my colleagues. It has been a place where patients can receive acute care and get back on their feet. As a result, many of them have a much better quality of life.

The proposed rule will have a devastating impact on patient access to critical care, and will likely force many long term acute care hospitals to close their doors due to the significant payment reductions.

As you know, long term care hospitals provide acute care services to patients who are demonstrably sicker, have higher acuities, and have more comorbidities than typical patients in short-term acute care hospitals. Grouping long term care hospitals with general hospitals for payment purposes is inappropriate. Long term care hospital patients are exceedingly different than those in general hospitals, and the payment methodology to these hospitals should reflect those differences.

When CMS begins to decide the appropriate site of care for patients, I become concerned that the agency is substituting its judgment for the medical judgment of physicians [like myself], who are the individuals that should be solely responsible for determining the best care for their patients.

In addition, the proposed rule goes against fundamental principles of a prospective payment system. By eliminating the opportunity for long term care hospitals to care for patients whose costs of treatment are less than Medicare reimbursement levels, CMS is eliminating any chance for these hospitals to overcome the losses of caring for patients whose costs of treatment exceed reimbursement levels. In essence, CMS is punishing long term care hospitals for providing Medicare patients with efficient care. It is also inaccurate to suggest that long term care hospitals are seeking out more profitable patients when it is impossible to definitively determine which patients are likely to have stays longer or shorter than the average length.

I am further disturbed that this action is not supported by objective, clinical data and is being contemplated before the CMS-contracted study, based on MedPAC's considered recommendations, is completed. The agency's actions are premature and unwarranted. Consequently, I strongly urge you not to implement this rule until this study is complete. These findings could then serve as the basis for a thoughtful, in-depth discussion between CMS, physicians, patients, and the hospitals themselves regarding how to address the agency's concerns in a fair, fiscally sound manner.

I recognize that your work on this issue is vital to the care we provide Medicare beneficiaries and I thank you for your attention to this important matter.

Sincerely,

/s/

Dr. Theodore Molnar, President
Almar Radiological Group
Pittsburgh, PA 15221

Submitter : **Dr. Herbert Bazron** **Date:** **03/15/2006**

Organization : **Dr. Herbert Bazron**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1485-P-22-Attach-1.PDF

Attch #22

March 15, 20006

Honorable Mark B. McClellan
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
P.O. Box 8012
7500 Security Boulevard
Baltimore, MD 21244-8012

Re: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule,

Dear Administrator McClellan:

I am gravely concerned about and oppose your proposed rule to reduce Medicare reimbursement to long term acute care hospitals.

I am a board certified physician in internal medicine and have been in practice for 18 years. Since LifeCare came to the community in 1999, I have been intimately involved with the concept of Long-term Acute Care. This concept has been a godsend to many of my patients as well as to my colleagues. It has been a place where patients can receive acute care and get back on their feet. As a result, many of them have a much better quality of life.

The proposed rule will have a devastating impact on patient access to critical care, and will likely force many long term acute care hospitals to close their doors due to the significant payment reductions.

As you know, long term care hospitals provide acute care services to patients who are demonstrably sicker, have higher acuities, and have more comorbidities than typical patients in short-term acute care hospitals. Grouping long term care hospitals with general hospitals for payment purposes is inappropriate. Long term care hospital patients are exceedingly different than those in general hospitals, and the payment methodology to these hospitals should reflect those differences.

When CMS begins to decide the appropriate site of care for patients, I become concerned that the agency is substituting its judgment for the medical judgment of physicians [like myself], who are the individuals that should be solely responsible for determining the best care for their patients.

In addition, the proposed rule goes against fundamental principles of a prospective payment system. By eliminating the opportunity for long term care hospitals to care for patients whose costs of treatment are less than Medicare reimbursement levels, CMS is eliminating any chance

for these hospitals to overcome the losses of caring for patients whose costs of treatment exceed reimbursement levels. In essence, CMS is punishing long term care hospitals for providing Medicare patients with efficient care. It is also inaccurate to suggest that long term care hospitals are seeking out more profitable patients when it is impossible to definitively determine which patients are likely to have stays longer or shorter than the average length.

I am further disturbed that this action is not supported by objective, clinical data and is being contemplated before the CMS-contracted study, based on MedPAC's considered recommendations, is completed. The agency's actions are premature and unwarranted. Consequently, I strongly urge you not to implement this rule until this study is complete. These findings could then serve as the basis for a thoughtful, in-depth discussion between CMS, physicians, patients, and the hospitals themselves regarding how to address the agency's concerns in a fair, fiscally sound manner.

I recognize that your work on this issue is vital to the care we provide Medicare beneficiaries and I thank you for your attention to this important matter.

Sincerely,

/s/

Herbert Bazron, M.D.

Submitter : Mr. Jay Wilkinson **Date:** 03/15/2006

Organization : Mr. Jay Wilkinson

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1485-P-23-Attach-1.PDF

Attach #23

March 15, 2006

Honorable Mark B. McClellan
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
P.O. Box 8012
7500 Security Boulevard
Baltimore, MD 21244-8012

Re: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule

Dear Administrator McClellan:

It has come to my attention that CMS is considering a reduction in the reimbursement to long- term acute care hospitals. I am greatly concerned about and oppose your proposed rule.

As a business partner to healthcare providers, I have had the opportunity to view first hand the quality of care delivered by long-term acute care hospitals to the most seriously ill patients. They are a vital link in the health care continuum.

The effect of this proposed rule, as I understand it, would reduce payments to these important long term acute care hospitals by as much as 15%. This drastic action could jeopardize patient access to critical and necessary care, and may even force these hospitals to close their doors.

I am further disturbed that this action is being proposed before the CMS-commissioned study on the proper classification of both patients and hospitals is completed.

The proposed rule should not be implemented, and any regulation that would affect these hospitals should be postponed until the aforementioned study is completed, and then based on clinical data.

The important care that long-term care hospitals provide must remain available for other families in need.

Please do not jeopardize the future of these critical hospitals.

Sincerely,

/s/

Jay Wilkinson
4306 Gatwick Place
Dallas, TX 75234

Submitter : Dr. Arcangela Lattari Balest **Date:** 03/15/2006

Organization : Dr. Arcangela Lattari Balest

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1485-P-24-Attach-1.PDF

Attachment #24

March 15, 2006

Honorable Mark B. McClellan
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
P.O. Box 8012
7500 Security Boulevard
Baltimore, MD 21244-8012

Re: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule

Dear Administrator McClellan:

It has come to my attention that CMS is considering a reduction in the reimbursement to long term acute care hospitals. I am greatly concerned about and oppose your proposed rule.

My mother-in-law is currently a patient at LifeCare, a long term acute care hospital in Wilkinsburg Pennsylvania. She is receiving there the kind of care that she can only receive at such a facility – close monitoring and compassionate care.

The effect of this proposed rule, as I understand it, would reduce payments to these important long term acute care hospitals by as much as 15%. This drastic action could jeopardize patient access to critical and necessary care, and may even force these hospitals to close their doors.
The mission of these facilities is quite different from acute care hospitals and there is a great need in the community for long term acute care hospitals. As a practicing physician I understand the difficulties in caring for patients like my mother-in-law who are not truly Intensive Care patients requiring hour to hour management of care but nonetheless require the kind of care that cannot be delivered on a hospital floor (ventilator management, frequent assessments, etc.).

I am further disturbed that this action is being proposed before the CMS-commissioned study on the proper classification of both patients and hospitals is completed.

The proposed rule should not be implemented, and any regulation that would affect these hospitals should be postponed until the aforementioned study is completed, and then based on clinical data.

Services provided in a long term acute care hospital were essential to the treatment of my mother-in-law. The important care that long term care hospitals provide must remain available for other families in need.

Please do not jeopardize the future of these critical hospitals.

Sincerely,

/s/

Arcangela Lattari Balest, M.D.

Submitter : **Ms. Rhonda Simpson** **Date: 03/15/2006**

Organization : **LifeCare Hospital of San Antonio**

Category : **Nurse**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1485-P-25-Attach-1.PDF

Attachment 2

March 15, 2006

Honorable Mark B. McClellan
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
P.O. Box 8012
7500 Security Boulevard
Baltimore, MD 21244-8012

Re: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule

Dear Administrator McClellan:

It has come to my attention that CMS is considering a reduction in the reimbursement to long term acute care hospitals. I am greatly concerned about and oppose your proposed rule.

This service is frequently the last chance families and clients have for recovery. LTACs' serve a specialized purpose in the healthcare continuum, not satisfied by acute or the skilled nursing level of care.

The effect of this proposed rule, as I understand it, would reduce payments to these important long term acute care hospitals by as much as 15%. This drastic action could jeopardize patient access to critical and necessary care, and may even force these hospitals to close their doors.

I am further disturbed that this action is being proposed before the CMS-commissioned study on the proper classification of both patients and hospitals is completed.

The proposed rule should not be implemented, and any regulation that would affect these hospitals should be postponed until the aforementioned study is completed, and then based on clinical data.

Services provided in a long term acute care hospitals are essential to the treatment of these acutely ill patients.

Please do not jeopardize the future of these critical hospitals.

Sincerely,

/s/

Rhonda Simpson, RN
LifeCare Hospital of San Antonio
San Antonio, TX 78229

Submitter : Ms. Carol Johnson **Date:** 03/15/2006

Organization : LifeCare Hospitals of Western Michigan

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1485-P-26-Attach-1.PDF

Attachment #26

March 15, 2006

Honorable Mark B. McClellan
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
P.O. Box 8012
7500 Security Boulevard
Baltimore, MD 21244-8012

Re: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule

Dear Administrator McClellan:

I am aware that CMS is considering a reduction in the reimbursement to long term acute care hospitals. These proposed regulations are very concerning.

As a registered nurse with LifeCare Hospitals of Western MI, I assess critical patients from referring hospitals for admission to LHWM. Most of these patients are on ventilator support, dialysis, have significant wounds and or post operative complications and require intensive level care and management. These patients are demonstrably sicker, with higher acuity upon transfer to LifeCare Hospital of Western MI. The patient outcomes and results from the complex medical and nursing care provided by LHWM are amazing.

The effect of this proposed rule, as I understand it, would reduce payments to long term acute care hospitals by as much as 15%. This drastic action could jeopardize patient access to critical and necessary care and services.

Some of our patients are fortunate to recover faster than anticipated and others, once they medically stabilized are moved to the next level of care. These patients of who are classified as "short stay" under the proposed regulations , are as or more complex for a longer time and require far more resources than patients in the acute short stay hospital with the same DRG classification. I am hopeful CMS will undertake a through review of actual costs required to care for these patients, as I understand is in process as a result of recommendations by Med PAC.

The proposed rule should not be implemented, and any regulation that would affect these hospitals should be postponed until the aforementioned study is completed.

Services provided in a long term acute care hospital are essential to the treatment of the medically complex patient.

Please do not jeopardize the future of our hospitals and the patients we serve.

Sincerely,

/s/

Carol Johnson RN.
Director of Community Education and Development
LifeCare Hospitals of Western MI
1700 Oak Ave .Muskegon, Mi. 49442
231-777-6479 fax 231-777-6350
carol.johnson@lifecare-hospitals.com

Submitter : **Ms. Kimberly Nitsche** **Date: 03/15/2006**

Organization : **Ricoh Business Systems**

Category : **Private Industry**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1485-P-27-Attach-1.PDF

Attachment
#27

Honorable Mark B. McClellan
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
P.O. Box 8012
7500 Security Boulevard
Baltimore, MD 21244-8012

Re: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule

Dear Administrator McClellan:

It has come to my attention that CMS is considering a reduction in the reimbursement to long term acute care hospitals. I am greatly concerned about and oppose your proposed rule.

As a business partner to healthcare providers, I have had the opportunity to view first hand the quality of care delivered by long term acute care hospitals to the most seriously ill patients. They are a vital link in the health care continuum.

The effect of this proposed rule, as I understand it, would reduce payments to these important long term acute care hospitals by as much as 15%. This drastic action could jeopardize patient access to critical and necessary care, and may even force these hospitals to close their doors. [*short elaboration if appropriate*]

I am further disturbed that this action is being proposed before the CMS-commissioned study on the proper classification of both patients and hospitals is completed.

The proposed rule should not be implemented, and any regulation that would affect these hospitals should be postponed until the aforementioned study is completed, and then based on clinical data.

The important care that long term care hospitals provide must remain available for other families in need.

Please do not jeopardize the future of these critical hospitals.

Sincerely

Kimber Nitsche

Kimber Nitsche
Account Representative
Ricoh Corporation

Submitter : Dr. John Hinderer **Date:** 03/15/2006

Organization : West Michigan Internal Medicine

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1485-P-28-Attach-1.PDF

Attachment
28

March 15, 20006

Honorable Mark B. McClellan
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
P.O. Box 8012
7500 Security Boulevard
Baltimore, MD 21244-8012

Re: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule,

Dear Mr. McClellan:

Allow me to express my concerns regarding the proposed rule changes reducing Medicare reimbursement for short stay patients at long term acute care hospitals.

Our Internal Medicine practice frequently utilizes LifeCare Hospital of Muskegon to care for seriously ill patients. Over the past several years, we have been impressed both by the severity and complexity of illness with which this patient population presents, and by the quality care and impressive outcomes delivered by this facility.

It is unreasonable to compare short stay patients in this setting to a similar, in name only, category of patients in acute care hospitals. The patients at LifeCare are, for the most part, a selected population of individuals with a burden of illness not appropriate for "short term" treatment in an acute care facility. This patient group frequently requires mechanical ventilation, intense wound care, specialized nutritional support, physical and occupational therapy, and similar modalities that clearly differentiate them from the short stay patient population of the acute care facility.

I feel strongly that this rule change should not be implemented without detailed study and serious conversation with all parties involved.

Thank you for your attention to this matter.

Sincerely,

/s/

Jon B. Hinderer, D.O.
West Michigan Internal Medicine
Muskegon MI

Submitter : Mr. Kenneth Simpson **Date:** 03/16/2006

Organization : Tyler ContinueCARE Hospital at Mother Frances Hosp

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1485-P-29-Attach-1.DOC

Attachment #29

TYLER

ContinueCARE Hospital

at Mother Frances Hospital

March 16, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1485-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: Comments on Medicare Program; Proposed Annual Payment Rate Updates, Policy Changes for Long-Term Acute Care Hospitals, Published at 71 Federal Register 4648 (January 27, 2006) CMS-1485-P.

Dear Dr. McClellan:

I would like to comment on the aforementioned Proposed Annual Payment Rate Updates for LTACH's.

First, I am in receipt of and have reviewed the 30 pages of comments by the National Association of Long Term Hospitals dated March 13, 2006 and concur 100% with their comments and findings.

Second, I will comment as to how the proposed rules would impact our facility, the planning for LTACH care for this community and the access to appropriate hospital care for the Medicare beneficiaries of Smith County, Texas and the surrounding counties served by the medical facilities in Tyler, Texas.

I have been a hospital executive for 32 years, with most of that experience in chief financial officer roles in short term acute care hospitals. I was a hospital CFO when IPPS was adopted in 1983. I have since watched as IPPS has been tweaked and how the GMLOS and case weights have been annually adjusted due to the changing patterns of practice identified in the data submitted by hospitals and captured by CMS in the MedPar data each year. This same annual adjustment process has already started in the LTACH PPS system with October 1, 2005 changes to the LTACH DRG case weights being decreased by an approximate 6% overall, impacting our net revenue by an approximate

$1.2M and our overall operating margin by a negative 6%.

Recommendation/Findings – The current process already includes for annual adjustments to case weights and GMLOS as a component of the LTACH PPS system. No further adjustments for coding practices or changes should be necessary, since the PPS system already makes annual adjustments to the system as evidenced by the 6% reduction in case weights effective October 1, 2005.

About 4 years ago, I had my first professional involvement with a Long Term Acute Care hospital and 2 years ago, I opened a new "hospital w/in a hospital" in Tyler, Texas for the purpose of addressing the need here in North east Texas of the Medicare beneficiaries.

Tyler Texas is a small urban community 100 miles from Dallas and 100 miles from Shreveport. Given that distance to a major metropolitan area, Tyler (Smith County) has developed into a major medical center for the region. There are two major tertiary hospitals with approximately 750 licensed short term acute care beds, two rehab hospitals (one free standing and one within East Texas Medical Center) and two Long Term Acute Care Hospitals (one within ETMC and ours within Trinity Mother Frances Hospital). The Specialty Hospital at ETMC opened prior to October 1, 1995 and as such is "grandfathered" from many of the post 1995 regulations related to LTACH's. With that grandfathering though comes a stipulation/regulation, that they can not increase their square footage nor bed capacity without giving up their grandfather status. The implications and realities of this situation are probably not unique, but they are real for the Medicare beneficiaries of Smith County and the surrounding counties. The reality is that for many years, Specialty Hospital has operated at its maximum capacity and many residents of Tyler, Smith County and the surrounding counties did not have access to LTACH hospital services without being sent to Dallas or Shreveport. The Specialty Hospital first accepts patients from their own "host hospital" and seldom was or is able to accept patients from outside of their "host hospital". We built Tyler ContinueCARE Hospital at Mother Frances Hospital by renovating hospital space, spending $3.3M on renovations and another $1.0M for equipment. We have a fine medical facility accepting approximately 550 patients per year. To put that into perspective, Trinity Mother Frances will admit/treat 20,000 inpatients per year. Last year 83% of our patients came from Mother Frances.

LTACH's do serve a critically ill medically unstable patient population who are not progressing or have failed, for example to be weaned from a ventilator and require the multidisciplinary program of long term acute care provided in a LTACH. The Medicare beneficiaries that chose Trinity Mother Frances Health System did not have access to this level and type of focused acute care until we opened in June of 2004. Soon after

receiving our LTACH certification (January 2005), CMS proposed limits on how many patients we can take from our host hospital facility. These rules were finalized mid 2005.

The summer 2005 final rules for FY 2006 sets forth arbitrary standards as to how many patients we can accept from our host hospital into the future, discriminating against and disallowing access to LTACH level/type of care for Medicare beneficiaries of our area. The other "grandfathered" LTACH in Tyler now accepts almost 100% of their patients from their host hospital and fills all of their beds with patients needing LTACH care from their host hospital. We on the other hand, have to turn away Mother Frances patients and accept patients from outside of Mother Frances if we are to meet the arbitrary 75/25% rule of this year and the arbitrary 50/50% rule of next year. In 2008, we will only be able to accept 40% (market dominant percentage) of our patients from our host hospital, denying access to LTACH care for many Mother Frances patients and Medicare beneficiaries of Smith County. Further, Mother Frances serving as a regional tertiary care hospital receives in excess of 40% of their patients from outside of Smith County. Many of those Medicare beneficiaries needing LTACH services will also be denied access to LTACH services, unless they are sent to Dallas or Shreveport for LTACH care, since we are limited to accepting 40% of our patients from Mother Frances in 2008 and into the future.

The final comment relative to this inequity in the system established by the FY 2006 rules is that CMS is creating a very uneven field of access by continuing a pre-1995 "grandfather" which limits availability of service to a growing population of residents/beneficiaries and then sets forth new proposed regulations that suggests that the physician should just keep certain patients in a short term acute care hospital even when in their medical judgment, the appropriate venue of care is a long term acute care hospital.

Recommendations/Suggestions: All LTACH's should have to play by the same rules for referrals and freedom of choice access to Medicare recipients. The fact that one of two LTACH's in Tyler has no referral cap from their Host hospital and the other LTACH is has a referral cap limitation from the 2005/2006 LTACH final rules sets barriers to freedom of choice and patient access. Further, if both LTACH's in Tyler had the referral cap, patients from Mother Frances tertiary facility would be sent across town to Specialty Hospital at ETMC and patients from ETMC would be sent across town to our LTACH. Attending physician changes would take place and duplication of diagnostic testing would occur, increasing the cost and compromising quality care to the patient. Please consider putting all LTACH's operating under the same set of guidelines and rules and removing the

**host hospital referral caps. Many "hospital w/in hospitals" are probably breaking ground now
on multi-million dollar facilities, because of the restrictions placed in the 2005 referral rules. You will not slow the growth of a needed service, but instead increase the cost of the infrastructure to provide it. Let the QIO's mandated by law do their jobs and review for appropriateness of care and medical necessity.**

Third, I would like to comment on the proposed rule relative to short stay outlier payments. The IPPS and LTACH PPS systems are both very complicated reimbursement systems to say the least. The proposed rule takes the complexity to a new high and new unmanageable level. The proposed rule says that if a patient doesn't stay 5/6's of the GMLOS most recently set by CMS, that we'll now use IPPS case weights, IPPS base rates (that do not exist for the current LTACH's) and pay LTACH's a payment designed for reimbursing short term acute care hospitals that have an average length of stay of 5.0 to 5.5 days. Our LTACH short stay cases stayed an average of 10 days last year, almost twice the ALOS of short term acute care hospital cases. Slightly more than 25% of our short stay cases were patients that were admitted and expired during their stay. We have had many patients admitted that had pretty low odds of doing well, that have discharged home or to lower levels of care with improved quality of life. If patients are more "Hospice" appropriate at the time of our assessment, we will not admit them, unless the attending physician has active treatment plans in place. We have no way of assessing and admitting only those patients that are going to survive; critical, unstable patients do sometimes die! We should not have a payment policy that takes the decision process out of the hands of the attending physician and/or that penalizes the hospital if the patient expires prior to some arbitrary length of stay.

The premise of IPPS and LTACH PPS is that some cases will be paid at a loss and some at a gain, so that the health providers can balance the gains and losses to a small margin for future healthcare improvements. The fact that the LTACH PPS system was designed with a payment mechanism for short stays and high cost stays, validated a process to recognize that of the 550 patients that we will admit per year, some 25% or so will stay less than 20 days and some 25% or so will stay 30-35 days or more, but at the end of the year, we will have accepted patients that needed long term acute care, measured against required standard/rule of a >25 day ALOS. We believe it is inappropriate to now significantly change the payment mechanism for the short stay side of that "balanced PPS" system, significantly lower payments for that sector of our patients. Ironically, that proposed payment cut causes a shift upward of the high cost outlier threshold by an approximate $8,000, further reducing payments for high cost patients and further invalidating the basic principles of the LTACH PPS system.

Recommendation/Suggestions: The proposed adjustment to the short stay outlier payment component of LTACH PPS invalidates the "averaging" process designed into the PPS system. A reduction to short term acute care rates when our average "short stay" is 90% longer than the ALOS of a short term acute care hospital is inappropriate and inequitable. Further, if you are going to cut our short stay payments, then a 80% of cost factor for high cost outliers is not appropriate. How do we balance out the cost of care, when we are paid less than our cost for short stay cases and less than our cost for high cost/long stay cases. The two "outlier" areas of LTACH PPS account for over 55% of our total cases. Again, your proposed short stay policies totally invalidates the principles embedded in a PPS payment system.

I cannot reiterate the position that NALTH has taken any clearer or more succinct. Each and every position taken in their March 13, 2006 comments is on target and very clear.

Further, the MedPac recommendation of March 2006 only recommends one change and that is to give no market basket increase in our 2007 PPS rates. The MedPac analysis also shows a 9.0% margin for LTACH's in 2004 and a projected 7.8% margin for 2006. Our facility has analyzed the case weight changes made effective October 1, 2005 and those changes have decreased our average case weight by 6%, effectively decreasing our average margin by 6%. Hence, the average margin of LTACH's is likely to drop into the lower single digits with the reduced case weights made effective October 1, 2005 and no market basket increase for FY 2007.

MedPac (March 2006 report) and CMS in their proposed rules (January 2006) comment about the large growth of LTACH's, including "hospitals w/in hospitals". That should be no surprise since there are still very large areas of our country that do not have access to this level/type of care for many millions of beneficiaries across this country. The influence of paying short term acute care hospitals under a DRG/PPS system, has caused each of them to require a relief valve for those patients that are long term acute care cases. It is not unusual for us to get referrals from Houston and Dallas, particularly when the family/Medicare beneficiary lives closer to Tyler/Smith County Texas. If we again put into perspective, our hospital admits 550 patients per year, or less than 3% the volume of patients admitted to Mother Frances Hospital. We do not have the capacity nor desire to accept every patient that Mother Frances has that exceeds the short term acute care DRG GMLOS. We focus on niche services of pulmonary vent weaning, wound care, infectious disease and medically complex cases, where patients typically require long lengths of stay to recover and we serve as a relief valve to the short term acute care facilities of the area. Further, we specialize in focusing on long stay patients (28.0 ALOS now) that will have the potential of a quality of life if given the proper care in a long term acute facility.

I can tell you though as an aging American citizen and taxpayer, I am concerned that our healthcare delivery system is being forever twisted into fragmented pieces by dramatic changes made through Medicare reimbursement policy and regulation. Congress mandates freedom of choice for Medicare beneficiaries and the 2005 final LTACH rules limiting the number of patients our LTACH can accept from one of the two major tertiary hospitals in Tyler (our host hospital) fragments and restricts access to beneficiaries, in effect discriminating against those Medicare beneficiaries that are cared for by our Host Hospital. After the 2005 final rules became effective, we somewhat accepted that CMS was out to eliminate "hospital w/in hospitals" and started planning a free standing LTACH hospital for Tyler and the Medicare beneficiaries that need that level of service in Smith County. The comments in the 2007 proposed rule imply that now you are concerned that free standing LTACH's are growing too fast and that has stalled any planning for our free standing hospital and also makes the financing of same, including the cost of capital to all LTACH's significantly higher. Our industry and the cost of healthcare is impacted each and every time a significant departure is made via policy proposals or mandates by CMS. This higher cost gets passed to me as a consumer and a taxpayer, one way or another. So, even though you may feel you have a need to oversee the Medicare trust fund, I believe you have an obligation to the healthcare delivery system of our country to do so in an educated and balanced approach to what your actions do to the healthcare delivery infrastructure of our nation.

Dr. McClellan, we have done some truly wonderful things for a select and small group of Medicare beneficiaries that we have had the good fortune to care for since opening in June 2004. I hope that CMS can get past the "budget line item" concern of LTACH's and get to a medically focused/medical necessity goal of providing access to Medicare beneficiaries that need LTACH care. I would hope that you would limit any change in reimbursement policy to limiting our market basket increase this year, allowing any policy shaping for our industry to be medically driven, not budget driven. Thank you for the opportunity to comment on the proposed LTACH rules.

Sincerely,

Kenneth L. Simpson
Administrator

Submitter : **Mr. Phillip Prosser** **Date: 03/16/2006**

Organization : **LifeCare Hospitals**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1485-P-30-Attach-1.PDF

Attachment 420

March 16, 2006

Honorable Mark B. McClellan
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
P.O. Box 8012
7500 Security Boulevard
Baltimore, MD 21244-8012

Re: Medicare Program; Prospective Payment System for Long-Term Acute Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule,

Dear Administrator McClellan:

I am concerned over your proposed rule to reduce Medicare reimbursement to long term acute care hospitals. As the corporate vise president of managed care for LifeCare Hospitals, a network of specialty care hospitals participating under the LTACH certification provisions of the Medicare program, I have witnessed first-hand the ability of our hospitals to admit the de-conditioned protocol-resistant patient directly from the community/tertiary c ommunity ho spital a nd r estore him or he r s uch that t hey c an be discharged to their homes.

Our specialty care hospitals provide acute care services to patients who are demonstrably sicker, have higher acuities, and have more comorbidities than those patients in the typical community/tertiary care hospital. **From a case rate reimbursement perspective, it is as wholly inappropriate to group the treatment-resistant population with general acute care population as it is for a health plan to commingle and singularly rate health plan utilization its under-65 commercial book of business with the over-65 cohort. Patients treated by providers such as LifeCare hospitals are exceedingly different than those in general hospitals, and the payment methodology to these hospitals should reflect those differences.**

LifeCare's experience and research has demonstrated that patients with persistent multiple system failures respond impressively to the aggressive blending of therapeutic interventions and the more typical medical interventions otherwise available in the community/tertiary hospital setting. Actuarial data would suggest that the biopsychosocial dynamics of the elderly population are very unique with utilization rates as much as seven-fold that of the under-65 population in service categories such as bed-days and office visits per thousand lives per year.

The typical community/tertiary hospital is going to be adept at the typical medical interventions given the overall efficiencies and effectiveness at resolving the vast

majority of medical maladies. Therefore, and intuitively it seems inefficient if not expensive for this sector to provide the degree of interdisciplinary team-driven clinico-therapeutic interventions to this treatment-resistant Medicare population.

CMS should consider the value LifeCare brings to the commercial Medicare Advantage sector. The Medicare Advantage plans readily intervene the moment it is determined that a Medicare Advantage member is at risk for or is de-conditioning in a community/tertiary hospital ICU bed. They will affect an immediate transfer to LifeCare knowing that the prospects for restoration are not only significantly increased, but in such a way as to positively impact the plan's ICU and over-all bed-day utilization rates.

With this context, we believe the proposed rule will have a significant impact on patient access to critical care – causing, among other things:

- Patient de-conditioning and elongated community/tertiary hospital ICU stays;
- Increased morbidity and mortality rates in the multiple system failure patient populations; and,
- A real risk for significant increases in AAPCC rates due to the associated costs for community/tertiary hospital ICU stays.

We are concerned that the proposed rule is not supported by objective, clinical data and is being contemplated before the CMS-contracted study, based on MedPAC's considered recommendations, is completed. The agency's actions are premature and unwarranted. Consequently, we strongly urge you not to implement this rule until this study is complete. These findings could then serve as the basis for a thoughtful, in-depth discussion between CMS, physicians, patients, and the hospitals themselves regarding how to address the agency's concerns in a fair, fiscally sound manner.

I recognize that your work on this issue is vital to the care we provide Medicare beneficiaries and I thank you for your attention to this important matter.

Sincerely,

Phil Prosser

Phillip E. Prosser
Vice President – Managed Care
LifeCare Hospitals
469-241-2119

Submitter : Mrs. Kathryn Madsen **Date:** 03/16/2006

Organization : Mrs. Kathryn Madsen

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1485-P-31-Attach-1.PDF

Attachment #31

March 15, 2006

Honorable Mark B. McClellan, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
P.O. Box 8012
7500 Security Boulevard
Baltimore, MD 21244-8012

Re: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule

Dear Administrator McClellan:

It has come to my attention that CMS is considering a reduction in the reimbursement to long term acute care hospitals. I am greatly concerned about and oppose your proposed rule.

My name is Kathryn Madsen and my husband Joseph is currently a patient at LifeCare Hospital of Western Michigan. He had multiple complex medical conditions like kidney failure, infection and wounds on admission that are being carefully medically managed by the LifeCare medical team. We are hopeful to be going home after almost 3 weeks of hospitalization because Joe has recovered faster than anticipated. I am convinced it is because of the wonderful care and complex medical management my husband received. He no longer needs dialysis and his infection and wounds are resolving.

The effect of this proposed rule, as I understand it, would reduce payments to these important long term acute care hospitals by as much as 15%. This drastic action could jeopardize patient access to critical and necessary care, and may even force these hospitals to close their doors. If funds had not been available to Life Care, my mother would not be near to us today and again, placed in a home, out of state due to her special needs.

I am further disturbed that this action is being proposed before the CMS-commissioned study on the proper classification of both patients and hospitals is completed.

The proposed rule should not be implemented, and any regulation that would affect these hospitals should be postponed until the aforementioned study is completed, and then based on clinical data.

Services provided in a long term acute care hospital were essential to the treatment of my husband. The important care that long term care hospitals provide must remain available for other families in need.

Please do not jeopardize the future of these critical hospitals.

Sincerely

/s/

Mr and Mrs. Madsen
18628 180th Ave.
Spring Lake, MI 49456
cc: Life Care Hospital, Western Michigan
cc: Jill Force

Submitter : **Ms. Peggy Brown** **Date: 03/16/2006**

Organization : **Ricoh Corp.**

Category : **Private Industry**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1485-P-32-Attach-1.PDF

Attachment #32

March 16, 2006

Honorable Mark B. McClellan
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
P.O. Box 8012
7500 Security Boulevard
Baltimore, MD 21244-8012

Re: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule

Dear Administrator McClellan:

It has come to my attention that CMS is considering a reduction in the reimbursement to long term acute care hospitals. I am greatly concerned about and oppose your proposed rule.

As a business partner to healthcare providers, I have had the opportunity to view first hand the quality of care delivered by long term acute care hospitals to the most seriously ill patients. They are a vital link in the health care continuum.

The effect of this proposed rule, as I understand it, would reduce payments to these important long term acute care hospitals by as much as 15%. This drastic action could jeopardize patient access to critical and necessary care, and may even force these hospitals to close their doors. [*short elaboration if appropriate*]

I am further disturbed that this action is being proposed before the CMS-commissioned study on the proper classification of both patients and hospitals is completed.

The proposed rule should not be implemented, and any regulation that would affect these hospitals should be postponed until the aforementioned study is completed, and then based on clinical data.

The important care that long term care hospitals provide must remain available for other families in need.

Please do not jeopardize the future of these critical hospitals.

Sincerely
/s/
Peggy Brown

National Account Manager
Ricoh Corporation
955 Freeport Parkway, Suite 100
Coppell, Texas 75019

Submitter : Dr. Anthony Wilson **Date:** 03/16/2006

Organization : Orthopaedic Associates of Muskegon

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1485-P-33-Attach-1.PDF

March 16, 2006

Honorable Mark B. McClellan
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
P.O. Box 8012
7500 Security Boulevard
Baltimore, MD 21244-8012

Re: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule,

Dear Administrator McClellan:

Please consider my expressed concerns about your proposed rule to reduce Medicare reimbursement to long term acute care hospitals for their "short stay" patients.

As the Medical Director of Physiatry services for LifeCare Hospital of Western Michigan, I have seen the complexity of the patients and the long lengths of stay their serious illnesses require. I have been impressed with the level of care provided and the remarkable results obtained for patients on long term ventilator support, patients requiring extensive wound care and patients with severe debility after prolonged life-threatening illnesses.

These patients, some of whom are classified as "short stay" under the proposed regulations, are as complex for a longer time and require far more resources than patients in the acute hospital setting with the same DRG classification. Rather than applying an arbitrary reduction in reimbursement based on pay for the same DRG in an acute care hospital, I recommend CMS undertake a thorough review of actual costs required to care for these populations, similar to the work done in preparation for instituting the DRG payment system in the 1980s. Such a study is already underway as a result of recommendations by MedPAC.

I strongly urge you not to implement this rule until this study is complete and serious conversation with all parties involved.

Sincerely,

/s/

Dr. Wilson

Anthony Wilson, M.D.
Orthopaedic Associates of Muskegon
1440 E. Sherman Blvd.
Muskegon, MI. 49444

Submitter : Dr. James Grace **Date:** 03/16/2006

Organization : Westshore Internal Medicine

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1485-P-34-Attach-1.PDF

Attachment 434

Honorable Mark B. McClellan
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
P.O. Box 8012
7500 Security Boulevard
Baltimore, MD 21244-8012

3/15/06

Re: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule,

Dear Administrator McClellan:

Allow me to express my concerns about and oppose your proposed rule to reduce Medicare reimbursement to long term acute care hospitals.

The patients at LifeCare Hospitals of Western Michigan (LifeCare) have been a part of my practice for the last five years. They present unique challenges because their cases often are not handled well in the acute care setting. We have several examples of patients (i.e. patients who need to be weaned from a ventilator) who simply could not progress in an acute care setting, but were able to improve with the different emphasis offered in this long term acute care setting. Not only would these patients suffer by not having this alternative focus, but the general hospitals and their patients would have to share more of the precious resources of these short stay hospitals.

The differences presented by these patients such as end stage renal disease, lung disease, and mental illness as well are often not taken into account as they should be. LifeCare is sought out by the general hospital physicians to care for their sickest patients.

There is considerable risk in assuming the care of these patients and the staff is constantly aware of the time and money constraints. Facilities that focus strictly on physical rehabilitation have long been recognized as beneficial and efficient and likewise for these medically complicated patients where a different setting is clearly justified.

The proposed rule will have a devastating impact on patient access to critical care, and will likely force many long term acute care hospitals to close their doors due to the significant payment reductions.

As you know, long term care hospitals provide acute care services to patients who are demonstrably sicker, have higher acuities, and have more comorbidities than typical patients in short-term acute care hospitals. Grouping long term care hospitals with general hospitals for payment purposes is inappropriate. Long term care hospital patients are exceedingly different than those in general hospitals, and the payment methodology to these hospitals should reflect those differences.

When CMS begins to decide the appropriate site of care for patients, I become concerned that the agency is substituting its judgment for the medical judgment of physicians like me, who are the individuals that should be solely responsible for determining the best care for their patients.

In addition, the proposed rule goes against fundamental principles of a prospective payment system. By eliminating the opportunity for long term care hospitals to care for patients whose costs of treatment are less than Medicare reimbursement levels, CMS is eliminating any chance for these hospitals to overcome the losses of caring for patients whose costs of treatment exceed reimbursement levels. In essence, CMS is punishing long term care hospitals for providing Medicare patients with efficient care. It is also inaccurate to suggest that long term care hospitals are seeking out more profitable patients when it is impossible to definitively determine which patients are likely to have stays longer or shorter than the average length.

I am further disturbed that this action is not supported by objective, clinical data and is being contemplated before the CMS-contracted study, based on MedPAC's considered recommendations, is completed. The agency's actions are premature and unwarranted. Consequently, I strongly urge you not to implement this rule until this study is complete. These findings could then serve as the basis for a thoughtful, in-depth discussion between CMS, physicians, patients, and the hospitals themselves regarding how to address the agency's concerns in a fair, fiscally sound manner.

I recognize that your work on this issue is vital to the care we provide Medicare beneficiaries and I thank you for your attention to this important matter.

Sincerely,

/s/

James Grace, M.D.
Westshore Internal Medicine
1150 Sherman Blvd.
Muskegon, MI 49442

Submitter : Mr. Randall Stokes **Date:** 03/16/2006

Organization : LifeCare Hospitals of San Antonio

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1485-P-35-Attach-1.PDF

Attachment # 35

LIFECARE
HOSPITALS
of SAN ANTONIO

March 14, 2006

Honorable Mark B. McClellan
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
P.O. Box 8012
7500 Security Boulevard
Baltimore, MD 21244-8012

Re: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification

Dear Administrator McClellan:

I am gravely concerned about and oppose your proposed rule to reduce Medicare reimbursement to long term acute care hospitals.

I am the CEO of LifeCare Hospitals of San Antonio, Texas, a long term acute care hospital (LTACH). I have been in health care for over thirty years, both as a caregiver and as a CEO. I was involved in the STACH (short term acute care hospital) DRG conversion in 1983, and our company's switch to LTACH DRG's two years ago. I find that the current proposed changes will adversely affect the ability of my hospital to admit the right patients at the right time and to continue to provide the outstanding patient care outcomes that our hospital is able to achieve.

I strongly feel the proposed rule will have a devastating impact on patient access to critical care, and will likely force many long term acute care hospitals to close their doors due to the significant payment reductions.

As you know, long term care hospitals provide acute care services to patients who are demonstrably sicker, have higher acuities, and have more comorbidities than typical patients in short-term acute care hospitals. Grouping long term care hospitals with general hospitals for payment purposes is inappropriate. Long term care hospital patients are exceedingly different than those in general hospitals, and the payment methodology to these hospitals should reflect those differences.

8038 Wurzbach · Suite 600 · San Antonio, Texas 78229 · (210) 575-8005 · (210) 575-8041 Fax · www.lifecare-hospitals.com

The proposed rule goes against fundamental principles of a prospective payment system. By eliminating the opportunity for long term care hospitals to care for patients whose costs of treatment are less than Medicare reimbursement levels, CMS is eliminating any chance for these hospitals to overcome the losses of caring for patients whose costs of treatment exceed reimbursement levels. In essence, CMS is punishing long term care hospitals for providing Medicare patients with efficient care. It is also inaccurate to suggest that long term care hospitals are seeking out more profitable patients when it is impossible to definitively determine which patients are likely to have stays longer or shorter than the average length.

I am further disturbed that this action is not supported by objective, clinical data and is being contemplated before the CMS-contracted study, based on MedPAC's considered recommendations, is completed. The agency's actions are premature and unwarranted. Consequently, I strongly urge you not to implement this rule until this study is complete. These findings could then serve as the basis for a thoughtful, in-depth discussion between CMS, physicians, patients, and the hospitals themselves regarding how to address the agency's concerns in a fair, fiscally sound manner.

I recognize that your work on this issue is vital to the care we provide Medicare beneficiaries and I thank you for your attention to this important matter.

Sincerely,

Randell Stokes, CEO
LifeCare Hospitals of San Antonio

cc: Dr. Randall Bell
Chief of Staff
LifeCare Hospitals of San Antonio

John Cornyn
Senator, State of Texas

Kay Bailey Hutchison
Senator, State of Texas

Submitter : Ms. Cindi Wegner **Date:** 03/16/2006

Organization : LifeCare Hospitals of San Antonio

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1485-P-36-Attach-1.PDF

Attachment #5

March 15, 2006

Honorable Mark B. McClellan
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
P.O. Box 8012
7500 Security Boulevard
Baltimore, MD 21244-8012

Re: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification

Dear Administrator McClellan:

I am gravely concerned about and oppose your proposed rule to reduce Medicare reimbursement to long term acute care hospitals.

I am the Director of Respiratory Therapy for LifeCare Hospitals of San Antonio, Texas, a long term acute care hospital (LTACH). I have been in health care for over twenty-three years, both as a caregiver and as a member of management. I find that the current proposed changes will adversely affect the ability of our hospital to admit the right patients at the right time and to continue to provide the outstanding patient care outcomes that our hospital is able to achieve.

I strongly feel the proposed rule will have a devastating impact on patient access to critical care, and will likely force many long term acute care hospitals to close their doors due to the significant payment reductions.

As you know, long term care hospitals provide acute care services to patients who are demonstrably sicker, have higher acuities, and have more comorbidities than typical patients in short-term acute care hospitals. Grouping long term care hospitals with general hospitals for payment purposes is inappropriate. Long term care hospital patients are exceedingly different than those in general hospitals, and the payment methodology to these hospitals should reflect those differences.

The proposed rule goes against fundamental principles of a prospective payment system. By eliminating the opportunity for long term care hospitals to care for patients whose costs of treatment are less than Medicare reimbursement levels, CMS is eliminating any chance for these hospitals to overcome the losses of caring for patients whose costs of treatment exceed reimbursement levels. In essence, CMS is punishing long term care hospitals for providing Medicare patients with efficient care. It is also inaccurate to suggest that long term care hospitals are seeking out more profitable patients when it is impossible to definitively determine which patients are likely to have stays longer or shorter than the average length.

I am further disturbed that this action is not supported by objective, clinical data and is being contemplated before the CMS-contracted study, based on MedPAC's considered recommendations, is completed. The agency's actions are premature and unwarranted. Consequently, I strongly urge you not to implement this rule until this study is complete. These findings could then serve as the basis for a thoughtful, in-depth discussion between CMS, physicians, patients, and the hospitals themselves regarding how to address the agency's concerns in a fair, fiscally sound manner.

I recognize that your work on this issue is vital to the care we provide Medicare beneficiaries and I thank you for your attention to this important matter.

Sincerely,

/s/

Cindi Wegner
Director of Respiratory Therapy
LifeCare Hospitals of San Antonio

Submitter : Ms. Martha Logan **Date:** 03/16/2006

Organization : LifeCare Hospitals of San Antonio

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1485-P-37-Attach-1.PDF

Attachment #31

March 15, 2006

Honorable Mark B. McClellan
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
P.O. Box 8012
7500 Security Boulevard
Baltimore, MD 21244-8012

Re: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification

Dear Administrator McClellan:

I am gravely concerned about and oppose your proposed rule to reduce Medicare reimbursement to long term acute care hospitals.

I am the Director of Therapy Services for LifeCare Hospitals of San Antonio, Texas, a long term acute care hospital (LTACH). I have been in health care for over fifteen years, both as a caregiver and as a member of management. I find that the current proposed changes will adversely affect the ability of our hospital to admit the right patients at the right time and to continue to provide the outstanding patient care outcomes that our hospital is able to achieve.

I strongly feel the proposed rule will have a devastating impact on patient access to critical care, and will likely force many long term acute care hospitals to close their doors due to the significant payment reductions.

As you know, long term care hospitals provide acute care services to patients who are demonstrably sicker, have higher acuities, and have more comorbidities than typical patients in short-term acute care hospitals. Grouping long term care hospitals with general hospitals for payment purposes is inappropriate. Long term care hospital patients are exceedingly different than those in general hospitals, and the payment methodology to these hospitals should reflect those differences.

The proposed rule goes against fundamental principles of a prospective payment system. By eliminating the opportunity for long term care hospitals to care for patients whose costs of treatment are less than Medicare reimbursement levels, CMS is eliminating any chance for these hospitals to overcome the losses of caring for patients whose costs of treatment exceed reimbursement levels. In essence, CMS is punishing long term care hospitals for providing Medicare patients with efficient care. It is also inaccurate to suggest that long term care hospitals are seeking out more profitable patients when it is impossible to definitively determine which patients are likely to have stays longer or shorter than the average length.

I am further disturbed that this action is not supported by objective, clinical data and is being contemplated before the CMS-contracted study, based on MedPAC's considered recommendations, is completed. The agency's actions are premature and unwarranted. Consequently, I strongly urge you not to implement this rule until this study is complete. These findings could then serve as the basis for a thoughtful, in-depth discussion between CMS, physicians, patients, and the hospitals themselves regarding how to address the agency's concerns in a fair, fiscally sound manner.

I recognize that your work on this issue is vital to the care we provide Medicare beneficiaries and I thank you for your attention to this important matter.

Sincerely,

/s/

Martha Logan
Director of Therapy Services
LifeCare Hospitals of San Antonio

Submitter : Ms. Cathy White **Date:** 03/16/2006

Organization : LifeCare Hospitals of San Antonio

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1485-P-38-Attach-1.PDF

Attachment #38

March 15, 2006

Honorable Mark B. McClellan
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
P.O. Box 8012
7500 Security Boulevard
Baltimore, MD 21244-8012

Re: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification

Dear Administrator McClellan:

I am gravely concerned about and oppose your proposed rule to reduce Medicare reimbursement to long term acute care hospitals.

I am the Director of Nursing for LifeCare Hospitals of San Antonio, Texas, a long term acute care hospital (LTACH). I have been in health care for over thirteen years, both as a caregiver and as a member of management. I find that the current proposed changes will adversely affect the ability of our hospital to admit the right patients at the right time and to continue to provide the outstanding patient care outcomes that our hospital is able to achieve.

I strongly feel the proposed rule will have a devastating impact on patient access to critical care, and will likely force many long term acute care hospitals to close their doors due to the significant payment reductions.

As you know, long term care hospitals provide acute care services to patients who are demonstrably sicker, have higher acuities, and have more comorbidities than typical patients in short-term acute care hospitals. Grouping long term care hospitals with general hospitals for payment purposes is inappropriate. Long term care hospital patients are exceedingly different than those in general hospitals, and the payment methodology to these hospitals should reflect those differences.

The proposed rule goes against fundamental principles of a prospective payment system. By eliminating the opportunity for long term care hospitals to care for patients whose costs of treatment are less than Medicare reimbursement levels, CMS is eliminating any chance for these hospitals to overcome the losses of caring for patients whose costs of treatment exceed reimbursement levels. In essence, CMS is punishing long term care hospitals for providing Medicare patients with efficient care. It is also inaccurate to suggest that long term care hospitals are seeking out more profitable patients when it is impossible to definitively determine which patients are likely to have stays longer or shorter than the average length.

I am further disturbed that this action is not supported by objective, clinical data and is being contemplated before the CMS-contracted study, based on MedPAC's considered recommendations, is completed. The agency's actions are premature and unwarranted. Consequently, I strongly urge you not to implement this rule until this study is complete. These findings could then serve as the basis for a thoughtful, in-depth discussion between CMS, physicians, patients, and the hospitals themselves regarding how to address the agency's concerns in a fair, fiscally sound manner.

I recognize that your work on this issue is vital to the care we provide Medicare beneficiaries and I thank you for your attention to this important matter.

Sincerely,

/s/

Cathy White
Director of Nursing
LifeCare Hospitals of San Antonio

Submitter : Ms. Marie Gould **Date:** 03/16/2006

Organization : LifeCare Hospitals of Western Michigan

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1485-P-39-Attach-1.PDF

Attachment #37

March 16, 2006

Honorable Mark B. McClellan
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
P.O. Box 8012
7500 Security Boulevard
Baltimore, MD 21244-8012

Re: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule

Dear Administrator McClellan:

It has come to my attention that CMS is considering a reduction in the reimbursement to long term acute care hospitals. I am greatly concerned about and oppose your proposed rule.

I am the Business Office Manager at LifeCare Hospitals of Western Michigan. A part of my function is obtaining the completed Admitting forms upon arrival. I physically observe how critically ill these patients are. Their illnesses range from vent dependence to severe wound infections, as well as to being immobile due to the fact that they have been bedridden sometimes for weeks prior to their arrival here. After weeks of care at our facility, I have the privilege of witnessing amazing improvement in these patients, not only physically but also emotionally. The patients are now off the vents, their wounds are healing or they are perhaps now strong enough to walk in the halls

The effect of this proposed rule, as I understand it, would reduce payments to these important long term acute care hospitals by as much as 15%. This drastic action could jeopardize patient access to critical and necessary care, and may even force these hospitals to close their doors.

I am further disturbed that this action is being proposed before the CMS-commissioned study on the proper classification of both patients and hospitals is completed.

The proposed rule should not be implemented, and any regulation that would affect these hospitals should be postponed until the aforementioned study is completed, and then based on clinical data.

Services provided in a long term acute care hospital were essential to the treatment of [insert relation, e.g. my father]. The important care that long term care hospitals provide must remain available for other families in need.

Please do not jeopardize the future of these critical hospitals.

Sincerely,

/s/

Marie Gould
Business Office Manager
1700 Oak Ave
Muskegon, MI 49442

Submitter : Mr. Douglas Wynne **Date:** 03/16/2006

Organization : Neponset Valley Chamber of Commerce

Category : Other Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1485-P-40-Attach-1.DOC

Attachment #40

190 Vanderbilt Avenue
Norwood, Massachusetts 02062-5047
(781) 769-1126 • Fax (781) 769-0808
www.nvcc.com

Serving the Businesses of the Neponset Valley Region

March 16, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1485-P
P.O. Box 8012
Baltimore, Maryland 21244-8012

Dear Dr. McClellan:

On behalf of the Neponset Valley Chamber of Commerce, I am submitting these comments on proposed rules published on January 27, 2006 at 71 Fed. Reg. 4648 et seq. This rulemaking seeks to make significant changes to the admission practices of long term care hospitals (LTCHs), as well as payment policies. New England Sinai Hospital, a long term acute care hospital in Stoughton, Massachusetts, serves a significant percentage of Medicare patients residing in the communities served by this Chamber: Canton, Dedham, Foxborough, Medfield, Milton, Norfolk, Norwood, Randolph, Sharon, Stoughton, Walpole, Westwood, and the Neponset River neighborhoods of the City of Boston (Dorchester, Hyde Park/Readville, and Mattapan).

New England Sinai is a 212-bed hospital providing care to severely ill patients in need of complex medical, pulmonary, ventilator care and physical rehabilitation. It offers specialized services and programs of care that are not otherwise available. New England Sinai has a rich history of caring for long term acute care patients, and, since its founding in 1927 as the Jewish Tuberculosis Sanitorium, has carried forth a tradition in service to the poor of Boston and southeastern Massachusetts. It has served the men and women in the Chamber's service area since opening in 1976 in Stoughton, Massachusetts. Many of these people are able to function independently today and have a good quality of life because of the care they received at New England Sinai Hospital.

New England Sinai Hospital, and other hospitals like Sinai, serve as vital components of the Massachusetts health care system. CMS' proposed Short Stay Outlier rule and Zero Update proposal would drastically reduce payments to New England Sinai Hospital in fiscal year 2007 by approximately 17 percent, forcing Sinai to operate at a loss when treating Medicare patients. A large percentage of Sinai's patients are dependent on Medicare (70%) or Medicaid (15%). CMS' proposed rule would result in a $5.4Million operating loss from Medicare, placing Sinai and the patients it serves in jeopardy. This would make access to long-term acute care extremely difficult for the families of Chamber members and all residents of this area. I strongly urge CMS to not adopt this proposed Short-Stay Outlier rule and Zero Update proposal. At the very least Sinai, and other older hospitals like Sinai, should be grandfathered from implementation of this rule.

Respectfully Submitted,

(Signed) ***Douglas R. Wynne***

Attachment #40

Douglas R. Wynne, CAE
President & CEO