Submitter : Dr. Paul Dongilli **Date:** 03/17/2006

Organization : Madonna Rehabilitation Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1485-P-41-Attach-1.DOC

March 17, 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

Re: Comments on Medicare Program; 2007 Proposed Update Rule
Published at 71 Federal Register 4648 *et seq.*

Dear Dr. McClellan:

Madonna Rehabilitation Hospital (Madonna) submits 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. Madonna is a 303 bed Catholic, free-standing, not-for-profit rehabilitation hospital sponsored by Diocesan Health Ministries and located in Lincoln, Nebraska. Madonna has been in existence since 1959. It serves a significant percentage of Medicare patients residing in not only Lincoln, but the entire state of Nebraska. CMS' proposed short-stay outlier rule and zero update proposal would drastically reduce payments to Madonna in fiscal year 2007 by approximately 15 percent, forcing Madonna to operate at a loss when treating Medicare patients. Madonna urges CMS to not adopt the proposed short-stay outlier rule and zero update proposal. If adopted, the continued operation of Madonna and the patients it serves will be placed in jeopardy. We believe that the reasons for this proposed change in Medicare payment policy are incorrect. We would like to address these reasons, state our concerns, and offer alternate recommendations.

I. A short-stay outlier case is an inappropriate LTCH admission.

The proposed SSO policy falsely equates a short-stay outlier case as an inappropriate LTCH admission. The rule overlooks the fact that by its very design, the LTCH PPS presumes a range of lengths of stay including cases above and below the ALOS. CMS states its concern that SSO cases represent 37 percent of all LTCH cases and that SSO cases "may indicate a premature discharge from the acute-care hospital and an unnecessary admission to the LTCH." However, length of stay on its own is neither an effective nor insightful indicator of medical necessity.

Given that the definition for SSO cases includes 5/6, or 83 percent, of the cases with a LOS below the mean, CMS should presume that a significant proportion of all LTCH cases would fall within the SSO range. The agency should not expect that the 37 percent rate of SSO cases would continue to drop indefinitely, given the current SSO definition. When the LTCH SSO definition is applied to the inpatient PPS, approximately 40 percent of inpatient PPS cases satisfy the LTCH SSO definition - a rate similar to the LTCH SSO rate. Therefore, a SSO level in the current range should be expected and not

viewed as an indication of misconduct. If CMS wants to see the percentage of SSO cases decline further, then the definition for SSO cases needs to be changed.

II. A short-stay outlier case is clinically the same as an acute hospital patient.

LTCHs care for a clinically distinct population requiring more intense medical resources. Through the SSO policy, CMS has assumed that SSO patients in LTCHs are similar to short-term acute hospital patients assigned to the same DRGs. Data obtained from a March 3, 2006 report by the Lewin Group prepared for the National Association for Long Term Hospitals in addition to averaged data from Madonna's SSO population illustrate this distinction between these two groups.

	Madonna	Lewin Group Study	Acute Hospital
CMI		2.059	0.987
ALOS	12.1 days	12.7 days	7.4 days
Mortality Rate	8%	19.61%	4.81%

The average length of stay of SSO cases in LTCHs is 72% greater (12.7 days vs. 7.4 days) than the average stay in short-term acute care hospitals. As you can see, Madonna's ALOS for this group is consistent with the figure at 12.1 days. To the contrary SSO patients have a relative case-mix index of 2.0592 which is 110% greater than the relative case-mix index of 0.98734 assigned to patients with the same DRGs in short-term acute hospitals. These SSO patients therefore have a higher medical acuity and use more medical resources than are reflected in short-term hospital payments. The higher acuity of LTCH SSO cases is further demonstrated by a higher death rate of 19.61% for SSO cases in LTCHs vs. 4.81%. Although Madonna's death rate of 8% is less than 19% reported by Lewin group, it is 76% greater than the rate noted for the acute hospital. As a specialty hospital designed to serve critically ill patients we believe that we will have a disproportionate rate of patients who will expire due to the complexity of their illness.

III. A short-stay outlier patient can be predicted.

CMS also assumes that Madonna is able to predict, prior to admission, which patients will become SSOs. There is no way for us to make such a prediction. Long-term care hospital patients suffer from multi-system body failures with peaks and valleys in their medical conditions. Their conditions may unpredictability improve or deteriorate at any time. SSO cases are admitted to LTCHs at the appropriate level of care based on the medical judgment of their treating physicians. Although our Nurse Liaisons pre-screen patients it is difficult to identify all patients that will become SSOs. There are a myriad of reasons why a patient admitted to an LTCH may become a SSO. Some SSO cases may achieve medical stability sooner than originally expected. Other cases may become SSOs because they require discharge to an acute hospital due to a deteriorating condition or a new condition which develops subsequent to their admission to an LTCH. Other patients admitted to LTCHs from acute care hospitals may become SSO cases due to their unexpected death. Some patients and their families, after realizing the gravity of their condition, may simply give up and request that aggressive treatment be stopped after admission. As you can see, a patient may become a SSO for a variety of reasons including the number of comorbidities and complexity of illness. SSO status does not, in and of itself, indicate an inappropriate admission.

The proposed SSO rule is an unprecedented intrusion on physician decision making and contrary to long standing Medicare principles that govern medical necessity determinations. It would impose a payment adjustment as a mechanism to disqualify a patient for hospital services and intrude upon a physician's ability to admit patients to LTCHs based on medical necessity, i.e., the need for specific programs of care and services provided in the LTCH.

No Fiscal Year 2007 Update

CMS' proposal to provide a zero fiscal year 2007 update, combined with the proposed SSO proposal will force Madonna to operate at a loss. It is unfair and unreasonable to deny LTCHs any inflation allowance particularly since the applicable fiscal year 2007 market basket increase is 3.6%. CMS' proposal places the ongoing operation of Madonna in jeopardy. At a minimum, it will reduce our ability to finance medical care and services provided to indigent populations and defray the cost of bad debts. Ultimately, it will threaten Madonna's very existence.

Summary and Recommendation

In view of the foregoing, Madonna respectfully requests CMS to not adopt the proposed SSO policy and to grant LTCHs a reasonable inflation update for fiscal year 2007. Madonna recognizes that the recent LTCH growth is concerning to CMS and that close oversight is needed. Madonna also believes that current post-acute care payment and regulatory systems are flawed and inadequate and that improved coordination and integration are needed. Madonna supports CMS' goal to overhaul the present system and create comprehensive post-acute care policies which would include a common patient assessment tool and payment structure for all levels of post-acute inpatient care. At this time, such an instrument does not exist; therefore, we ask that CMS consider balanced and thoughtful policymaking that ensures access for patients who are medically appropriate for LTCH care. In order to move the CMS agenda forward, we recommend that the preliminary work commissioned by CMS and completed by the Research Triangle Institute (RTI) be used as the foundation for the creation of specific admission criteria that would identify the most appropriate post-acute site of care. During this development time, to help assure CMS that LTCHs are admitting appropriate patients, Quality Improvement Organizations (QIO) review could be expanded. This would also allow access to LTCH care by Medicare beneficiaries.

Madonna appreciates the opportunity to comment on this proposed rule.

Sincerely,
Paul A Dongilli, Jr., Ph.D., CHE
Vice President Rehabilitation

Submitter : **Mr. Gary Carter** **Date: 03/17/2006**

Organization : **New Jersey Hospital Association**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

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

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

see attachment

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

see attachment

CMS-1485-P-42-Attach-1.PDF

Attachment A 42

NJHA
NEW JERSEY HOSPITAL ASSOCIATION

March 17, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Attn: CMS-1485-P
P.O. Box 8011
Baltimore, MD 20244-8011

RE: Medicare Program; Prospective Payment System for Long-Term Care Hospitals: Proposed Annual Payment Rate Updates, Policy Changes and Clarifications; Proposed Rule

Dear Dr. McClellan:

The New Jersey Hospital Association appreciates the opportunity to provide comments on the notice of proposed rulemaking published on Jan. 27 at 71 *Fed. Reg. 4727 et seq.* and referenced above.

NJHA's 115 acute care, inpatient rehabilitation, inpatient psychiatric and long term care hospitals have grave concerns specifically about the short-stay outlier proposal set forth by CMS for the LTCH PPS 2007 rate year, and about the lack of a market basket update. The overall impact of almost a 15 percent reduction in Medicare payments to LTCH providers is severe and could threaten access to necessary care.

Acute care hospitals in New Jersey have a Medicare length of stay that is still almost a full day longer than the national average. The post-acute care network of services in New Jersey is not as fully developed and accessible as in other regions of the country partly because New Jersey is still a certificate of need state.

Because of our acute care hospitals' struggle to reduce Medicare length of stay, NJHA worked closely with the New Jersey Department of Health and Senior Services from 2000 until 2003 to develop both certificate of need and licensing standards so that long-term care hospitals could be established here. Consistently, hospital discharge planners indicate that this level of care is needed by their patients, and there is no suitable alternative in New Jersey without LTCHs. Many patients and their families were discharged to LTCHs in Pennsylvania to receive this care at great hardship.

Since 2003, nine hospital-in-hospital LTCHs have opened in New Jersey, with some of these being satellites of existing hospital-in-hospital LTCHs, in accordance with our certificate of need methodology. The growth in this level of care was controlled and

based on a need methodology driven by patient volume in DRGs representative of the LTCH population nationally. Physicians in New Jersey are beginning to see how this level of care significantly benefits patients and their families, and they are working closely with LTCH providers to ensure appropriate referrals are being made. In fact, patients and families are highly satisfied with the care they receive in the LTCH setting.

Of specific concern to NJHA members is the proposed change to the LTCH short-stay outlier policy. According to CMS, the data show that 37 percent of LTCH patients are short-stay cases. However, given that the definition of SSO cases includes 5/6 of the GMLOS, it is to be expected that a significant portion of LTCH cases would fall in this range. In addition, patients who expired were not excluded from CMS' analysis. Therefore, CMS' presumption that all SSO cases are inappropriate admissions to LTCH is unfounded.

The proposed fourth payment option for SSO cases, which would *de facto* be the lowest payment in most instances, would significantly increase patients' length of stay in acute care hospitals. Acute care hospitals are not oriented toward or specialized enough to address the needs of very long-stay patients. This is a result of today's healthcare environment, which has been fostered by government payment policy. Through the proposed SSO payment change, CMS would be intruding on physician decision making on the basis of medical necessity.

In addition, we believe CMS has assumed incorrectly that short-stay outlier patients in LTCHs are similar to acute care patients classified to the same DRG. However, our experience shows that SSO LTCH patients have a much higher case-mix index because of their acuity and stay much longer than acute care patients in the same DRG. If, through the implementation of this drastic policy change, physicians are forced to keep their patients in general acute care hospitals longer, there will be a domino effect in terms of cost and utilization.

In New Jersey, as in other states, our emergency departments are frequently on divert status. Often, this is because of limited bed availability for admitting patients from the ED. If patients who would have otherwise been discharged to an LTCH are now remaining in the acute care hospital – often in an ICU bed - EDs will be even more overcrowded and spend more days on divert status. There is a cost to this in terms of quality and access, not to mention the cost to the Medicare program in dollars for patients who could move to a more suitable level of care. Patients who spend an inordinate amount of time waiting in the ED for an inpatient bed can experience skin breakdown, agitation and have a lack of privacy that impacts their sense of dignity.

Rather than pursue this drastic SSO policy, NJHA recommends that CMS focus its approach on slowing LTCH growth and on developing a balanced policy that ensures access and quality of care. At the facility level, adding criteria to the current 25-day ALOS requirement would provide needed direction. At the patient level, expanding medical necessity review by the QIOs would both ensure prudent use of Medicare dollars and preserve beneficiary rights to access needed care. In addition, using the Research

Triangle Institute's findings as a starting point and conducting a more thorough clinical analysis should be a priority so that appropriate targeting of patient populations who can benefit from LTCH services can be achieved. Artificial caps and thresholds do not achieve this and only serve to negatively impact quality and access to those who are denied care as a result of their application.

New Jersey providers are working together daily to ensure that patients receive the level of care they need in the appropriate setting. Given the aging and diversity of our Medicare population, post-acute resources of different types are needed so that this can occur. Such a drastic change in Medicare payment policy for LTCHs would lead to diminished access to appropriate levels of care at a time when our demographics demand just the opposite.

Thank you for your consideration.

Sincerely,

Gary S. Carter
President & CEO

Submitter : **Miss. Alexis Ahlstrom** **Date: 03/17/2006**

Organization : **Avalere Health LLC**

Category : **Other**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1485-P-43-Attach-1.DOC

Avalere

March 17, 2006

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

SUBMITTED ELECTRONICALLY

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

Dear Dr. McClellan:

Avalere Health LLC (Avalere) respectfully submits these comments concerning CMS's proposed payment policy for short-stay outlier (SSO) patients treated by long-term acute care hospitals. The proposed policy was published on January 27, 2006 as part of CMS's annual payment rate updates, policy changes, and clarifications under the prospective payment system for long-term care hospitals (LTCHs).

Avalere is a leading strategic advisory firm in the health care field. We provide strategic, research and analytical services to our customers, with a particular focus on research and analyses of the implications of public policy on health care entities. We have been assisting several leading operators of LTCHs in analyzing the impact of, and alternatives to, the proposed SSO payment policy.

CMS's proposed SSO payment policy represents a major departure from the current payment methodology for these patients. Patients fall within this category if their length of stay in an LTCH does not exceed 5/6th of the geometric average length of stay for the LTC-DRG to which they are assigned. The CMS proposal reduces one payment option from 120% of cost to 100% of cost and adds a fourth option to pay at rates comparable to inpatient prospective payment system (IPPS) rates. CMS estimates that approximately 96% of LTCH SSO cases would be paid using these proposed rates.

CMS offers this proposal due to concerns about the number of LTCH patients that are SSO cases (approximately 37% of patients according to the agency), and suggests that the current SSO payment policies may provide financial incentives for short-stay hospitals to discharge prematurely, and LTCHs to admit inappropriately, patients who are ultimately categorized as SSO patients. CMS states that the agency has modeled the effect of implementing this new payment policy; in the regulatory impact statement the agency estimates that the policy would reduce spending by 11% in RY2007. CMS also states that it believes it will achieve its policy goal of reducing the number of SSOs through these revised payment policies; the agency

1350 Connecticut Avenue, NW | Suite 900 | Washington, DC 20036 | Tel 202.207.1300 | Fax 202.467.4455

therefore predicts that payments will be cut by less than 11% because LTCHs will reduce the number of SSO cases they admit.

There are two aspects of the CMS SSO proposal on which we wish to comment. First, the SSO policy as described in the rule, in particular the new fourth option to pay for SSO cases at an IPPS comparable rate, would create a payment cliff between SSO cases and full-stay cases and may produce unintended behavior changes if implemented. Of particular note, the CMS policy would create a substantial payment cliff for an SSO case paid at the IPPS rate that had almost reached the 5/6th geometric mean threshold versus a case with a stay one day longer which would be paid at the full LTCH PPS amount; the magnitude of this payment cliff could be reduced through alternative SSO options which would not provide incentives for discharging patients on one day versus another. CMS has in the past rejected payment cliffs for SSO cases and we suggest CMS review its past reasoning on this issue.[1]

Second, an outcome of the implementation of the CMS proposed SSO payment policy is that as a result the agency would pay for almost all SSO cases at or below cost, producing overall payments to LTCHs at less than cost, even given current LTCH industry margins. In other words, the proposed SSO policy, when combined with a PPS that is designed to pay for inliers on average at cost and for high-cost outliers at below cost, would likely produce a system where CMS pays LTCH providers on average below cost. As CMS contemplates implementing its SSO policy in final regulation, the agency may find it useful to model the effect of SSO policies that would, on average, pay LTCHs at or slightly above cost. Therefore, we present two SSO policy alternatives below that smooth (but not completely eliminate) payment cliffs while respecting the principle that total LTCH program payments cover costs.

We present our alternative SSO policy options in payment ranges; these ranges represent a balance of payment adequacy and payment cliff smoothing that we believe will ensure LTCH providers have the proper incentives for admitting patients. However, we suggest that CMS incorporate these options into its own models to arrive at what the agency believes the proper balance between payment adequacy and financial incentives.

SSO Option A

Description. Under SSO Option A, a very short-stay discharge would be defined as a patient who has a length of stay (LOS) of 7 days or fewer, all other cases with stays less than 5/6th of the geometric mean would be treated separately. Under SSO Option A, payments to LTCHs for SSO patients would depend on whether or not the patient is a very short-stay discharge, as follows:

Very Short-Stay Discharges (LOS of 7 days or fewer) – LTCH payment would be the least of:

100% of the cost of the case;

120% of the LTC-DRG specific per diem amount multiplied by the LOS of the discharge; or

The full LTC-DRG payment.

[1] See discussion on page three on CMS statements on payment cliffs for SSO cases.

All Other SSO Cases (LOS less than or equal to 5/6 of the geometric average LOS and more than 7 days) – LTCH payment would be the least of:

110-115% of the cost of the case;

120% of the LTC-DRG specific per diem amount multiplied by the LOS of the discharge; or

The full LTC-DRG payment.

Rationale. The 7-day threshold for defining very short-stay discharges is derived from the "Very Short-Stay Discharge Policy" that CMS included in its March 22, 2002 LTCH PPS proposal, but did not adopt in the LTCH PPS final rule published on August 30, 2002. In the March 2002 proposal, CMS based the 7-day threshold on its findings that, from a clinical perspective, it takes about 3 days to evaluate the appropriateness of an LTCH admission and typically an additional 3 to 4 days for any treatment to begin to have any impact on the patient's health status. CMS had proposed to establish two LTC-DRGs specific to very short-stay cases, and to pay for such cases at a per diem rate, which would have been determined by dividing the Federal payment rate of the applicable LTC-DRG category (that is, Federal payment rate X the LTC-DRG weight) by seven.

In determining not to adopt the Very Short-Stay Discharge Policy proposed in March 2002, CMS was particularly concerned about the existence of a payment cliff that could create an incentive for LTCHs to keep, rather than discharge, patients who would otherwise have been paid for as very short-stay discharges. As compared with the March 2002 proposal, the SSO Option A moderates the payment cliff between very short-stay discharges and other SSO cases by (1) utilizing per diem rates derived from the LTC-DRG to which the patient would otherwise be assigned, rather than LTC-DRGs specific to very short-stay discharges, and (2) limiting payment for non-very short-stay discharge cases based on the cost of care. SSO Option A also moderates the potential payment cliff between SSO cases and inlier cases by increasing the payment amount of the "lesser of" options for SSO cases that are not very short-stay discharges.

Statistical Data. Table 1 below presents 2004 data showing for ten LTC-DRGs the number of LTCH SSO cases that would fall into each of the SSO payment categories under Option A.[2]

Table 1: SSO Option A – Number of SSO cases for most common LTC-DRGs falling into recommended option categories

	Very Short-Stay SSO Cases (LOS 7 days or less)	All Other SSO Cases (LOS greater than 7 days)	TOTAL SSO cases[3]
LTC-DRG	CASES	CASES	CASES
475	1,296	3,765	5,061
87	638	1,555	2,193
271	471	1,527	1,998
88	588	1,408	1,996

[2] Data for Tables 1, 2, and 3 come from the CMS MedPAR 2004 data file.
[3] "Total SSO cases" column is total cases for these 10 LTC-DRGs. We estimate that there were approximately 45,000 SSO cases in 2004.

Table 1: SSO Option A – Number of SSO cases for most common LTC-DRGs falling into recommended option categories			
	Very Short-Stay SSO Cases (LOS 7 days or less)	All Other SSO Cases (LOS greater than 7 days)	TOTAL SSO cases[3]
LTC-DRG	CASES	CASES	CASES
249	339	1,595	1,934
89	567	1,317	1,884
12	360	1,405	1,765
462	430	1,289	1,719
79	416	1,289	1,705
466	440	1,190	1,630
TOTAL	5,545	16,340	21,885
% of TOTAL	25%	75%	100%

SSO Option B

Description. SSO Option B would create three categories of SSO cases: very short-stay discharges, intermediate short-stays, and all other SSO cases. A very short-stay discharge would be defined as a discharge that has a length of stay of equal to or less than 2/6 of the geometric average length of stay for the assigned LTC-DRG. Intermediate short-stays would encompass patients whose lengths of stay are more than 2/6 of the geometric average lengths of stay for their LTC-DRGs, but equal to or less than 4/6 of such geometric average lengths of stay. All other SSO cases would be those where the lengths of stay exceed 4/6 of geometric average lengths of stay for their LTC-DRGs, but are equal to or less than 5/6 of such geometric average lengths of stay. Payments to LTCHs for SSO patients would depend on which of the three categories they fall into, as follows:

Very Short-Stay Discharges (LOS less than or equal to 2/6 of the geometric average LOS) – LTCH payment would be the least of:

100% of the cost of the case;

120% of the LTC-DRG specific per diem amount multiplied by the LOS of the discharge; or

The full LTC-DRG payment.

Intermediate Short-Stays (LOS less than or equal to 4/6 of the geometric average LOS and more than 2/6 of the geometric average LOS) – LTCH payment would be the least of:

110 to 115% of the cost of the case;

120% of the LTC-DRG specific per diem amount multiplied by the LOS of the discharge; or

The full LTC-DRG payment.

All Other SSO Cases (LOS less than or equal to 5/6 of the geometric average LOS and more than 4/6 of the geometric average LOS) – LTCH payment would be the least of:

115 to 120% of the cost of the case;

120% of the LTC-DRG specific per diem amount multiplied by the LOS of the discharge; or

The full LTC-DRG payment.

Rationale. SSO Option B similarly provides lower rates of reimbursement for SSO cases with shorter lengths of stay. By creating three categories of SSO cases, rather than the two categories contemplated by SSO Option A, the magnitude of the payment cliffs that result from a patient staying in an LTCH for an additional day is decreased. In particular, as a patient's stay continues in an LTCH and the patient moves through each of the recommended SSO categories, the marginal increase in payment relative to the LTCH's costs will be modest. Also, the magnitude of additional payments that an LTCH will receive for a patient that moves from the SSO category to an inlier patient will be moderated by the fact that the LTCH's payment relative to its costs will increase prior to the point at which the patient becomes an inlier patient.

Statistical Data.

Table 2 below shows, for each of the most common SSO LTC-DRGs, the length of stay thresholds for each of the three SSO categories for Option B.

Table 2: SSO Option B – length of stay thresholds (in days) for each of the three recommended SSO categories

LTC-DRG	Geometric average LOS	Very Short-stay Discharges (up to 2/6 of geometric average LOS)	Intermediate Short-stays (up to 4/6 of geometric average LOS)	All Other SSO Cases (up to 5/6 of geometric average LOS)
475	34.6	11.5	23.1	28.8
87	25.4	8.5	16.9	21.2
271	27.7	9.2	18.5	23.1
88	19.6	6.5	13.1	16.3
249	24.7	8.2	16.5	20.6
89	20.8	6.9	13.9	17.3
12	25.5	8.5	17.0	21.3
462	22.4	7.5	14.9	18.7
79	22.9	7.6	15.3	19.1
466	21.9	7.3	14.6	18.3

Table 3 below presents 2004 statistical information showing, by LTC-DRG, the number of SSO cases in LTCHs that would fall into each of the three SSO categories under Option B.

Table 3: SSO Option B – Number of SSO cases for most common LTC-DRGs falling into recommended options categories							
LTC-DRG	Very Short-Stay Discharges (up to 2/6 of geometric average LOS)		Intermediate Short-Stays (up to 4/6 of geometric average LOS)		All Other SSO Cases (up to 5/6 of geometric average LOS)		TOTAL SSO cases
	CASES	LOS <	CASES	LOS <	CASES	LOS <	TOTAL CASES
475	1,988	12	2,170	24	903	29	5,061
87	740	9	858	17	595	22	2,193
271	631	10	859	19	508	24	1,998
88	454	7	1,036	14	506	17	1,996
249	412	9	992	17	530	21	1,934
89	439	7	904	14	541	18	1,884
12	4469	9	883	17	436	22	1,765
462	430	8	771	15	518	19	1,719
79	416	8	848	16	441	20	1,705
466	440	8	736	15	454	19	1,630
Total	6,396		10,057		5,432		21,885
% of Total	29%		46%		25%		100%

As indicated, we believe that either of these two alternatives would directly address CMS's stated concerns about possible incentives to treat those patients who may be more appropriately cared for in a short-stay general hospital. It would also moderate the payment cliffs in CMS's proposal. Finally, adopting either of these alternatives would reduce the estimated payment impact on LTCHs. Whichever SSO payment policy CMS adopts, we expect that it in conjunction with payment for other LTCH cases will provide for overall payment adequacy in the LTCH PPS.

Thank you for your careful consideration of these SSO payment policy alternatives.

Respectfully,

AVALERE HEALTH LLC

By: _____
Alexis Ahlstrom
Senior Manager

Submitter : **Ms. Ellen Smith** **Date: 03/17/2006**

Organization : **Dubuis Health System, Inc.**

Category : **Long-term Care**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1485-P-44-Attach-1.PDF

Dubuis
Health System

System Office
10333 Richmond Ave
Suite 300
Houston, Texas 77042

March 16, 2006

Mark McClellan, M.D., Ph.D.
Administrator, Centers for Medicare & Medicaid Services
Attn: CMS–1485–P
P.O. Box 8011
Baltimore, MD 20244-8011

Comments of Dubuis Health System, Inc.
Docket: CMS-1485-P

Dear Dr. McClellan:

Dubuis Health System, Inc. appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed changes to the regulations governing long-term care hospitals. Dubuis is the largest not-for-profit, faith-based, long-term acute care hospital system in the U.S. Dubuis owns or manages LTCHs at fourteen locations in Louisiana, Texas, Georgia, Arkansas, Missouri, and Oklahoma.

We are concerned that the proposed [CMS-1485-P] rule continues the agency's pattern of enacting arbitrary payment provisions that will have devastating effects on the LTCH industry and completely disregards the medical needs of our patients. We are particularly concerned with the ill-advised changes to the short-stay outlier (SSO). Rather than assuming that the growth of LTCHs in recent years indicates abuse of the system, CMS should consider whether the growth is in response to a legitimate need as the value of LTCHs has become more apparent. It seems logical that the demand for LTCH services should continue to grow due to technology improvements and the aging population.

First of all, allow me to assure you that Dubuis fully understands the concerns CMS has expressed regarding inappropriate admissions of some LTCH patients. Dubuis Health System hospitals only accept patients who are pre-screened by an interdisciplinary team to determine that admission criteria are met. We worked hard for several years to develop criteria that would ensure that our hospitals make appropriate admissions decisions. Our criteria served as the template for those later refined and adopted by the National Association of Long Term Hospitals (NALTH). However, not all LTCHs use the same criteria. We frequently deny admission to patients who do not require a hospital level of care; these referrals come from our host hospitals as well as other acute providers. We often document in our denial note a recommendation to refer the patient to SNF or even home with home health. We will later be informed that the patient was admitted to a competitor LTCH. Simply put, it is in Dubuis' best interest to see

Dubuis
Health System

inappropriate LTCH admissions stopped. However, in our experience neither length of stay nor admission source is an indicator of inappropriate admissions. Therefore, neither the short stay outlier provision nor the 25 percent patient cap on hospital-within-hospital LTCHs will do anything to address inappropriate admissions practices. They will, however, irreparably harm those attempting to play by the rules and will needlessly place access to LTCH care in jeopardy. Only standardized industry-wide admission criteria, along with rigorous QIO review, can ensure that LTCH care is limited to those patients truly in need of intensive interdisciplinary services.

CMS seems to be under the impression that LTCH patients are no different than patients being treated as outliers in acute care hospitals. This assumption is simply false. It is true that in many parts of the country where there are no LTCHs, patients are being treated in acute care hospitals. However, one cannot assume these patients are receiving the same quality of care as would be provided in an LTCH, nor can it be assumed they have the same outcomes. LTCHs offer cost-effective clinical benefit to patients suffering from severe and complex illnesses and provide specialized services that are not always available in acute care hospitals. Studies have shown that, compared to acute care outliers, appropriately admitted LTCH patients have a lower mortality rate, a lower readmission rate, a lower utilization of other post acute services, lower overall costs, and better ventilator weaning outcomes. Clearly, CMS is failing to recognize the high level of care patients receive in LTCHs. To provide a parallel example, we note that the vast majority of the country is not served by a children's hospital. In these areas, children are often treated in the pediatric units of acute care hospitals. Does CMS believe that severely ill children are no better off in a children's hospital than in an acute care pediatric unit or in a general hospital?

The fundamental principle behind any prospective payment system is the law of averages. By definition, in any system 50% of all cases will have length of stay above the median and 50% will fall below it. Likewise, because the 5/6th threshold is a function of the distribution, one should expect to see 40 percent of cases below it. The short stay outlier provision is just not logical. Additionally, what the rule does not recognize is that LTCH patients are significantly more medically complex than acute care hospital patients. CMS has not demonstrated that there is any relationship between a SSO patient's LTCH LOS and the patient's level of medical complexity. Yet the agency is using one (LOS) as a proxy to represent the other (medical complexity), thereby making the false assumption that all short stay outliers represent inappropriate LTCH admissions. To drastically cut payments for the short stay outliers based on this flawed assumption will undermine the very law of averages on which prospective payment systems are based.

Dubuis
Health System

In an effort to more fully understand our short stay outliers, I recently asked several of our physicians to explain the reason for short stays. Nearly all of our physicians have privileges at both an acute care hospital and our LTCH – they discharge patients from acute care, then admit and continue to treat them in the LTCH – so they truly understand the difference in care attributable to each hospital setting. One pulmonologist described a patient that he treated in the acute care hospital with pneumonia, respiratory failure, and sepsis. She had a history of leukemia and a prior bone marrow transplant. When the same physician admitted her to Dubuis Hospital, he had already unsuccessfully tried twice to wean her from the ventilator. She was in a great deal of pain, had a tracheotomy, and was malnourished, anemic, and extremely weak. The median LOS for that DRG was 34 days, and the interdisciplinary team expected it to take at least that long for recovery; many similar patients require much longer. Within 11 days, she was weaned from the ventilator and was breathing independently. She received specialized tube feeding to resolve her malnutrition, blood transfusions, antibiotic therapy, and physical and occupational therapy for strengthening. By the 18th day she was eating on her own and able to walk independently; she was deemed ready for discharge. She returned to her independent life at home and has subsequently returned to work and continues to do well. Basically, all of the physicians I talked to repeated the same theme: You just cannot predict length of stay based on clinical status at the time of admission. Because of Dubuis' expertise in ventilator weaning, it is not uncommon to wean some patients from a ventilator within 1 or 2 weeks. With this faster than anticipated progress, these patients sometimes become short-stay outliers. If these same patients had stayed at the acute care facility, they very likely would have taken significantly longer to wean from the ventilator, if at all. We often successfully wean patients from the ventilator that were felt to be "unweanable" by the acute care hospital. Clearly, the ability to get patients home sooner will result in overall lower health care costs.

CMS will undoubtedly question why this can't happen in an acute care hospital. The physician I previously mentioned further explained to me that his patient's recovery in the LTCH required daily coordination among all disciplines of the care team (including physician, nursing, respiratory therapy, physical therapy, occupational therapy, speech therapy, nutritional therapy, pharmacy and case management). Although acute care hospitals strive to provide such coordinated dedication to an individual patient's long term recovery, the reality is that it is interrupted by more urgent, though not necessarily more important priorities. It is the volume, turnover, and urgency of new, unstable patients throughout the day which greatly limits the acute care provider's ability to focus attention on the chronic critically-ill patient.

Dubuis
Health System

In a study commissioned by NALTH, the Lewin Group compared the resource use of IPPS cases to LTCH SSO cases for all common DRGs. They used average standardized charge data for LTCH and acute care hospital cases combined and used CMS' methodology for computing relative weights for each LTCH DRG and Acute Care DRG using a common national average charge denominator. The Lewin Group study found that LTCH SSO cases have mean DRG weights that are 76 percent higher than comparable DRG weights for IPPS cases. As a result, they concluded the IPPS payment system is not appropriate for the payment of LTCH SSO cases. This data negates the agency's assumption that SSO is a proxy for inappropriate LTCH admission. Should CMS finalize this policy the result will simply be an arbitrary 11% reduction in payments to LTCHs.

Make no mistake, the financial impact of the proposed short stay outlier changes is severe – our system has forecast that reimbursement will decrease 17%. This is well into the negative range for us. Because of our commitment to charity care and the acuity of patients we serve, we do not have the large profit margins that have been cited.

Properly admitted LTCH patients are by definition the most severe and medically-complicated cases. As such, the expected length of stay will be much longer than that of an acute care hospital, even for common DRGs. Take for example DRG 12 (degenerative nervous system disorder). Under the proposed SSO policy, there is no distinction made for severity of the condition, i.e., a minor stroke that might be treated in an acute care hospital versus a major stroke with complications and residual effects that might be better treated in a LTCH. The LTCH mean length of stay for this DRG is 25.5 days. Therefore, the 5/6th threshold is 21.25 days. The IPPS length of stay is only 4.3 days. A patient with LTCH DRG 12 may stay at a LTCH for 20 days and thus be a short-stay outlier, but that stay is still five times the IPPS length of stay. Is a stay that is 83 percent of the average LOS really an abuse of the short stay outlier? It is simply wrong to reimburse a 20 day LTCH stay at a 4 day acute care level. In addition to forcing closure of LTCHs, this policy will severely harm patient care and have no effect on the issues CMS is attempting to address. In fact, some LTCHs may be inclined to delay discharge of patients until they reach the 5/6th threshold regardless of their medical situation. The proposed rule will be an incentive for "gaming" the system for financial benefit. However, let me assure you, Dubuis' decisions will continue to be guided first and foremost by medical professionals and the best interests of our patients.

The more appropriate approach to ensuring that medical necessity is the sole driving force behind clinical care decisions would be to tie reimbursement under the LTCH PPS system to clinical quality measures and facility criteria such as those suggested by MedPAC,

Dubuis
Health System

and admissions criteria such as NALTH's. Dubuis is impressed with the diligent efforts that MedPAC has undertaken and is fully supportive of MedPAC's recommendations to define LTCHs by facility and patient criteria that ensure that patients admitted to these facilities are medically complex and have a good chance of improvement.

The agency's concerns about the potential for inappropriate admissions could easily and appropriately be addressed by adopting a set of criteria with QIO monitoring that would directly address the issue of appropriate care being delivered in appropriate settings throughout the entire provider group. Not only would this result in better care for Medicare beneficiaries, but also it should address all concerns about the relationships between acute care hospitals and LTCHs in general. I understand that in the past CMS has expressed a concern over the lack of available funding for additional QIO reviews. I also understand that in response to this concern, NALTH suggested that LTCHs forgo half of their expected market basket increase with the other half being used to fund QIO reviews. Since CMS has proposed no market basket increase for LTCHs in this rule, I can only assume there are now funds available to help defray the cost of QIO reviews if CMS chooses to do so.

In conclusion, I strongly urge CMS to reconsider the misguided changes to the short stay outlier policy and to make a meaningful commitment to the development of facility and patient-centered admissions criteria. As mentioned previously, both the short stay outlier policy and the 25 percent patient cap for hospital-within-hospital LTCHs are arbitrary policies that will put patient care in severe jeopardy, while making no progress toward MedPAC's goal of ensuring that patients are treated in the most appropriate settings. Utilizing QIO reviews to enforce facility and patient centered admissions criteria, consistent with MedPAC's recommendations, is a viable patient-centered solution that will address CMS' concerns, promote free and fair competition throughout the LTCH industry, and not harm those providers who are admitting patients appropriately.

As always, Dubuis stands ready to work with CMS in properly addressing any issue related to the LTCH industry. Please do not hesitate to call on us if we may be of assistance.

Sincerely,

Ellen Smith

Ellen Smith, CHE
President / CEO
Dubuis Health System, Inc.

Submitter : Mr. David Parmer **Date:** 03/17/2006

Organization : Roosevelt Warm Springs Institute for Rehabilitatio

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

see attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : Mr. Edward Coyle **Date:** 03/17/2006

Organization : Mercy Health System

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1485-P-46-Attach-1.DOC

Mercy
Health System

One West Elm Street,
Conshohocken, PA 19428

March 17, 2006

Administrator
Center for Medicare & Medicaid Services
Department of Health and Human Services
CMS-1485-P
P.O. Box 8012
Baltimore, MD 21244-8012

RE: CMS-1485-P, Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007, 71 Federal Register 4648

Dear Administrator:

Thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule on prospective payment system for long-term care hospitals rate year 2007, published January 27, 2006 in the Federal Register. I am the Director of Revenue and Reimbursement for Mercy Health System of Southeastern Pennsylvania.

PROPOSED CHANGES TO LTCH PPS PAYMENT RATES FOR THE 2007 LTCH PPS RATE YEAR – OTHER PROPOSED POLICY CHANGES FOR THE 2007 LTCH PPS RATE YEAR:

Section V.A.1.a. Adjustment for SSO Cases (page 4685): CMS should not be so concerned that 1/3 of the LTCH cases fall below $5/6^{th}$ of the geometric mean length of stay (GMLOS) resulting in a short stay outlier (SSO), when the GMLOS represents an average. One would expect a substantial number of cases to have lengths of stay both above and below the GMLOS. The GMLOS is not always the midpoint, as with the arithmetic mean, but does represent an average that should always have a substantial portion of the population with values below that GMLOS. Perhaps CMS should reevaluate whether or not $5/6^{th}$ of the GMLOS is the proper length of stay differential to identify a case as a short stay outlier. The whole premise of prospective payment and DRGs is that some cases will be longer and some will be shorter. For the majority of LTCH DRGs the $1/6^{th}$ differential is only 3 to 5 days of a 25 to 35 day GMLOS. That does not seem a material enough drop in length of stay to necessitate using the new "lower of" option of IPPS payment base in place of the LTCH PPS payment. I would propose that CMS change their criteria for identifying a short stay outlier from $5/6^{th}$ of the GMLOS to $3/4^{th}$ or $4/5^{th}$ of the GMLOS to allow for more representative lengths of stay as were used to calculate the GMLOS in the first place. CMS mentions, "LTCHs may be admitting patients that should otherwise be

treated in acute care hospitals, as evidenced by length of stays more in keeping with an acute care hospital." How can this statement be reconciled with the SSO beginning at 5/6th of the GMLOS when the LTCH-DRG 475 5/6th GMLOS is 28.8 days and the IPPS DRG GMLOS for DRG 475 is 8.1 days?

Should CMS continue to feel that the fourth option (IPPS payment) should be added to the SSO "lesser of" options, I would like to propose the following two alternative payment methods based on existing CMS payment methodologies. Should the IPPS payment model continue to be favored by CMS, instead of calculating as if it were an IPPS case, complete with outlier, CMS should consider converting the IPPS payment into a per diem (similar to the Transfer DRG methodology) and pay based on the actual number of days the patient was in the LTCH without capping the payment at the full IPPS DRG amount, in order to recognize the amount of resources and effort expended by the LTCH. The other option I would like to propose would have to be the only SSO payment option, and would entail adding an additional LTCH-DRG to the table, similar to CMG 5000 under IRF-PPS, if the length of stay is below a certain number of days, the case would be coded to that LTCH-DRG and receive a low fixed payment amount.

Another issue related to the short stay outlier is that the 5/6th criteria is applied regardless of discharge disposition. CMS is concerned that the LTCH is not the proper level of care or treatment setting. However, I believe that when a patient expires prior to 5/6th of the GMLOS, the LTCH should not be judged to be an inappropriate level of care and penalized with a lower payment. Patients expire in all levels of care; it is an unavoidable fact of life. The SSO should not be applied when the discharge disposition is the patient expired.

PROPOSED CHANGES TO LTCH PPS PAYMENT RATES FOR THE 2007 LTCH PPS RATE YEAR – REGULATORY IMPACT ANALYSIS:

Section XIII.B.5. (page 4738) Effect on the Medicare Program: CMS is proposing a postponement of the requirement established in §412.523(d)(3) from the existing October 1, 2006 deadline to July 1, 2008 for a one-time prospective adjustment to the LTCH PPS rates. I believe that CMS has made that one-time prospective adjustment to LTCH PPS rates in proposing the zero percent update to the Federal Rate rather than basing the update solely on the RPL Market Basket amount. This zero percent update will be perpetuated through all future years, as the RY 2008 update percentage will be based on the RPL Market Basket for 2007 to 2008, not 2006 to 2008, so the LTCH facilities will effectively lose one year of inflation adjustments going forward. CMS should either give an update based on the RPL Market Basket in RY 2007 or admit that this zero percent update is their one-time prospective adjustment to the LTCH PPS rates and not extend their deadline.

PROPOSED CHANGES TO LTCH PPS PAYMENT RATES FOR THE 2007 LTCH PPS RATE YEAR:

Section IV.D.3.c. (page 4676) Establishment of Proposed Fixed-Loss Amount: The outlier fixed-loss amount is proposed to increase by over 75%. The primary reason given for the large increase is the proposed change in the SSO policy. This large increase will adversely impact those LTCHs that do not have a material short stay outlier issue, in that they will not be

adequately reimbursed for their high cost cases. This increase in the fixed-loss amount coupled with no increase in the Federal rate will serve as a disincentive for LTCH facilities to accept patients who have the potential for high costs and lengths of stay in excess of the GMLOS, thereby effecting patient access to this level of care.

Thank you for the opportunity to comment on this proposed rule. If you have any questions, please call me at 610-567-5563.

Very Truly Yours,

Edward J. Coyle
Director, Revenue & Reimbursement

Submitter : **Mrs. Michelle Hamilton** **Date: 03/17/2006**

Organization : **Dubuis Hospital of Lake Charles**

Category : **Long-term Care**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1485-P-47-Attach-1.DOC

CMS-1485-P-47-Attach-2.WPD

March 16, 2006

Mark McClellan, M.D., Ph.D.

Administrator, Centers for Medicare & Medicaid Services

Attn: CMS–1485–P

P.O. Box 8011

Baltimore, MD 20244-8011

RE: Comments of Dubuis Health System, Inc.

Docket: CMS-1485-P

Dear Dr. McClellan:

I am the CEO of Dubuis Hospital of Lake Charles, located in Lake Charles, Louisiana. I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed changes to the regulations governing long-term care hospitals. Dubuis Hospital of Lake Charles is a member of Dubuis Health System. Dubuis is the largest not-for-profit, faith-based, long-term acute care hospital system in the U.S.

I am concerned that the proposed [CMS-1485-P] rule continues CMS' pattern of enacting arbitrary payment provisions that will have devastating effects on my hospital and the entire LTCH industry and completely disregards the medical needs of our patients. I am particularly concerned with the ill-advised changes to the short-stay outlier. Rather than assuming that the growth of LTCHs in recent years indicates abuse of the system, CMS should consider whether the growth is in response to a legitimate need as the value of LTCHs has become more apparent.

Allow me to assure you that I fully understand the concerns CMS has expressed that there may be inappropriate admissions of some LTCH patients. Like all hospitals in the Dubuis system, my hospital only accepts patients who are pre-screened by an interdisciplinary team to determine that admission criteria are met. Dubuis worked hard for several years to develop criteria that would ensure that its hospitals make appropriate admissions decisions. The criteria served as the template for those later refined and adopted by the National Association of Long Term Hospitals (NALTH). However, not all LTCHs use the same criteria. Neither the short stay outlier provision nor the 25 percent patient cap on hospital-within-hospital LTCHs will do anything to address inappropriate admissions practices. They will, however, irreparably harm hospitals like mine who are attempting to play by the rules and will needlessly place access to LTCH care in jeopardy. Only admission criteria that are standardized industry-wide, along with intensive QIO review, will effectively address the problem.

CMS seems to be under the impression that LTCH patients are no different than patients being treated as outliers in acute care hospitals. This assumption is simply false. It is true that in many parts of the country where there are no LTCHs, patients are being treated in acute care hospitals. However, one cannot assume these patients are receiving the same quality of care as would be provided in an LTCH, nor can CMS assume they have the same outcomes. LTCHs offer cost-effective clinical benefit to patients suffering from severe and complex illnesses and provide specialized services that are not always available in acute care hospitals. Let me share just one patient story with you showing the benefit of our LTCH service. Mr. P was admitted to the acute hospital for an emergency aortic valve replacement for endocarditis. He was admitted to Dubuis Hospital for Ventilator weaning with an expected Length of stay of 29-34 days. Mr. P progressed

with ventilator weaning very well and was successfully taken off the ventilator sooner than expected. He was discharged a week earlier with a total length of stay of 24 days.

Studies have shown that compared to acute care outliers, appropriately admitted LTCH patients have a lower mortality rate, a lower readmission rate, a lower utilization of other post acute services, lower overall costs, and are often discharged with a higher level of functionality. Clearly, CMS is failing to recognize the high level of care patients receive in LTCHs. To provide a parallel example, we note that the vast majority of the country is not served by a children's hospital. In these areas, children are often treated in the pediatric units of acute care hospitals. Does CMS believe that severely ill children are no better off in a children's hospital than an acute care pediatric unit or in a general hospital?

The fundamental principle behind any prospective payment system is the law of averages. By definition, the mean length of stay in any system will see 50 percent of the cases above it and 50 percent of the cases below it. Likewise, $5/6^{th}$ of the mean length of stay will always see approximately 40 percent of cases below it. Because the $5/6^{th}$ threshold is a function of the distribution you should expect to see 40 percent of cases below it. What the rule does not recognize is that LTCH patients are significantly more medically complex than ACH patients. You have not demonstrated that there is any relationship between a SSO patient's LTCH LOS and the patient's level of medical complexity. Yet, you are using one (LOS) as a proxy to represent the other (medical complexity), thereby making the false assumption that all short stay outliers represent inappropriate LTCH admissions. To drastically cut payments for the short stay outliers based on this flawed assumption will undermine the very law of averages on which prospective payment systems are based.

Many times a patient's recovery in the LTAC requires daily coordination among all disciplines of their care team (including physician, nursing, respiratory therapy, physical therapy, occupational therapy, speech therapy, nutritional therapy, and case management). Although acute care hospitals try to provide such coordinated dedication to an individual patient's long term recovery, the reality is that it is interrupted by more urgent, though not necessarily more important priorities. It is the volume and urgency of new, unstable patients throughout the day which greatly limits the acute care provider's attention to the chronic critically-ill patient.

Contrary to CMS' assumptions, the Lewin Group compared the resource use of IPPS cases to LTCH SSO cases for all common DRGs. They used average standardized charge data for LTCH and acute care hospital cases combined and used CMS' methodology for computing relative weights for each LTCH DRG and Acute Care DRG using a common national average charge denominator. The Lewin Group study found that LTCH SSO cases have mean DRG weights that are 76 percent higher than comparable DRG weights for IPPS cases. As a result, they concluded the IPPS payment system is not appropriate for the payment of LTCH SSO cases. This data flies in the face of your assumption that SSO is a proxy for inappropriate LTCH admission. As a result, should you finalize this policy, you are simply making an arbitrary 11% reduction in payments to LTCHs.

Make no mistake, the financial impact of the proposed short stay outlier changes are severe. For Dubuis Hospital of Lake Charles there would be a total negative financial impact - $221,000/year. The Dubuis system as a whole has forecasted that if we continued to do business exactly the way we do now, our reimbursement would decrease 17%. This is well into the negative range for us. Because of our commitment to charity care and the acuity of patients we serve, we do not have the large profit margins that have been cited.

Properly admitted LTCH patients are by definition the most severe and medically-complicated cases. As such, the expected length of stay will be much longer than that of an acute care hospital, even for common DRG's. Take for example DRG 12 (degenerative nervous system disorder). Under the proposed SSO policy, there is no distinction made for severity of the condition, i.e. a minor stroke that might be treated in an acute care hospital versus a major stroke with complications and residual effects that might be better treated in a LTCH. The LTCH mean length of stay for this DRG is 25.5 days. Therefore, the $5/6^{th}$ threshold is 21.25 days. The IPPS length of stay is only 4.3 days. A patient with LTCH DRG 12 may stay at a LTCH for 20 days and thus be a short-stay outlier, but that stay is still five times the IPPS length of stay. Is a stay that is 83 percent of the average LOS really an abuse of the short stay outlier? It is simply wrong to reimburse a 20 day LTCH stay at a 4 day acute care level. This policy will severely harm patient care and have no effect on the issues CMS is attempting to address. In fact, some LTCHs may be inclined to keep anyone passing the acute mean LOS up to the LTCH mean regardless of their medical situation, thus ensuring "gaming" of the system for financial benefit. However, let me assure you, our decisions will continue to be guided first and foremost by medical professionals and the best interests of our patients.

The more appropriate approach to ensuring that medical necessity is the sole driving force behind clinical care decisions would be to tie reimbursement under the LTCH PPS system to clinical quality measures, such as those proposed by MedPAC, and admissions criteria such as NALTH's. Dubuis is impressed with the diligent efforts that MedPAC has undertaken and is fully supportive of MedPAC's recommendations to define LTCHs by facility and patient criteria that ensure that patients admitted to these facilities are medically complex and have a good chance of improvement.

CMS' concerns about the potential for inappropriate admissions could easily and appropriately be addressed by adopting a set of criteria with QIO monitoring that would directly address the issue of appropriate care being delivered in appropriate settings throughout the entire provider group. Not only would this result in better care for Medicare beneficiaries, but also it should address all of CMS' concerns about the relationships between acute care hospitals and LTCHs in general. I understand that in the past CMS has expressed a concern over the lack of available funding for additional QIO reviews. I also understand that in response to this concern, NALTH suggested that LTCHs forgo half of their expected market basket increase with the other half being used to fund QIO reviews. Since CMS has proposed no market basket increase for LTCHs in this rule, I can only assume there are now funds available to help defray the cost of QIO reviews if CMS chooses to do so.

In addition, CMS' proposal to provide a zero fiscal year 2007 update, combined with the proposed SSO proposal will amount to an 11 percent payment cut for LTCHs and will force many LTCHs to operate at a loss. It is unfair and unreasonable to deny LTCHs any inflation allowance. At a minimum, it will reduce our ability to finance medical care and services provided to indigent populations and defray the cost of bad debts.

In conclusion, I strongly urge CMS to reconsider the misguided changes to the short stay outlier policy and to make a meaningful commitment to the development of facility and patient centered admissions criteria. As mentioned previously, both the short stay outlier policy, and the 25 percent patient cap for hospital-within-hospital LTCHs, are arbitrary policies that will put patient care in severe jeopardy, while making no progress toward MedPAC's goal of ensuring that patients are treated in the most appropriate settings. Utilizing QIO reviews to enforce facility and

patient centered admissions criteria, consistent with MedPAC's recommendations, is a viable patient-centered solution that will address CMS' concerns, promote free and fair competition throughout the LTCH industry, and not harm those providers who are admitting patients appropriately.

Thank you for your consideration. Please do not hesitate to call on us if we may be of assistance.

Sincerely,

Michelle Hamilton

Administrator

Dubuis Hospital of Lake Charles

Submitter : **Ms. Marilyn Litka-Klein** **Date: 03/17/2006**

Organization : **Michigan Health & Hospital Association**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Please see the attached letter.
Thanks!

CMS-1485-P-48-Attach-1.DOC

MICHIGAN HEALTH & HOSPITAL ASSOCIATION

Advocating for hospitals and the patients they serve.

March 17, 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

Re: Comments on Medicare Program; 2007 Proposed Update Rule Published at 71 Federal Register 4648 *et seq.*

Dear Dr. McClellan:

On behalf of its 145 acute care hospital members and approximately 20 long term acute care hospital members, the Michigan Health & Hospital Association (MHA) welcomes this opportunity to submit comments to the Centers for Medicare & Medicaid Services regarding the Medicare proposed rule published on January 27, 2006. This rule proposes significant changes to the admission practices of long-term care hospitals (LTCHs) as well as payment policies that would be financially devastating to many facilities.

LTCHs treat severely ill and medically complex patients, offering specialized services and programs of care which are not otherwise available, and serve a significant percentage of Medicare patients residing in Michigan. As such, LTCHs play an integral role in the continuum of care and in ensuring that beneficiaries receive the most beneficial care and are able to return to a high quality of life in the shortest timeframe. The CMS' FY 2007 proposed short-stay outlier rule, zero market basket update and a significant increase to the outlier threshold would drastically reduce payments to LTCHs by approximately 15 percent, forcing LTCHs to operate at a loss when treating Medicare patients.

Short-Stay Outlier Proposal

The CMS states the objective of the Short-Stay Outlier (SSO) rule is to preclude admission of SSO patients to long-term care hospitals (LTCHs). The CMS' presumption is that SSO cases should have remained in acute hospitals. As indicated in our comments below, we do not agree with this presumption.

Through the SSO policy CMS has assumed that SSO patients in LTCHs are similar to short-term acute hospital patients assigned to the same DRGs. To the contrary, SSO patients have a relative case-mix index (CMI) of 2.0592 which is 110 percent higher than the relative CMI of 0.98734 assigned to patients with the same DRGs in short-term acute hospitals. These SSO patients have a higher medical acuity and use more medical resources than are reflected in short-term hospital payments. The higher acuity of LTCH SSO cases is further demonstrated by a higher death rate of 19.61 percent for SSO cases in LTCHs vs. 4.81 percent. The average length of stay for SSO cases in LTCHs is 72 percent greater (12.7 days vs. 7.4 days) than the average LOS in short-term acute care hospitals.[1]

The CMS also assumes that, prior to admission, LTCHs are able to predict which patients will become SSOs. LTCH patients offer suffer from multi-system body failures experiencing many peaks and valleys in their medical conditions, making it impossible for LTCHs to accurately determine which patients will become SSOs. Due to their fragile medical state, the overall medical condition of an LTCH patient may unpredictability improve or deteriorate at any time. **SSO cases are admitted to LTCHs at the appropriate level of care based on the medical judgment of the treating physician.** It is impossible to pre-screen patients and effectively identify which patients may become SSOs. There are a myriad of reasons why a patient admitted to an LTCH may become a SSO such as:

- Patient may achieve medical stability sooner than initially anticipated;
- Patient may require discharge to an acute hospital due to a deteriorating condition or a new condition which develops subsequent to their admission to an LTCH.
- Patient admitted to LTCHs from acute care hospitals may become SSO cases due to their unexpected death;
- Some patients and their families, after realizing the grave nature of their condition, may request that aggressive treatment be stopped after admission;
- Other patients may sign themselves out against medical advice.

The CMS lacks evidence to support a solid basis for this proposed change which assumes that SSO cases should have remained in acute hospitals. The proposed rule

[1] This data is obtained from a March 3, 2006 report by The Lewin Group prepared for the National Association of Long Term Hospitals.

ignores the fact that a significant number of SSO cases are not admitted from acute hospitals but rather, at the direction of a patient's attending physician, are admitted from home or a nursing facility. **It is inappropriate for the CMS to presume that a patient admitted to an LTCH from a non-acute hospital setting, at the direction of the patient's attending physician, who subsequently becomes a SSO should not have been admitted to the LTCH in the first place.**

The CMS also disregards the fact that a percentage of SSO cases are crossover cases that exhaust Medicare Part A benefits during their LTCH stay. It would be unfair to preclude these Medicare recipients from admission to an LTCH simply based on the number of their remaining Medicare days.

The proposed SSO rule is an unprecented intrusion on physician decision making and contrary to long standing Medicare principles that govern medical necessity determinations. The proposal would impose a payment adjustment as a mechanism to disqualify a patient for hospital services and intrude upon a physician's ability to admit patients to LTCHs based on medical necessity, i.e., the need for specific programs of care and services provided in the LTCH.

The adoption of the SSO rule would soon negatively acute care hospitals if the LTCH refuse to accept these patients as admissions. The acute hospitals will incur significant cost increases to provide the additional care. In addition, many of these patients are ventilator-dependent, and will remain in ICU or other designated special care units, limiting future admissions to the acute care hospital. Potential future admissions to the acute hospital requiring these services may be forced to seek care outside their community, if the specialty beds are full, without the attendant care from their primary care physician. Also, maintaining the patient at the acute hospital may result in the patient not receiving the specialized care available at the LTCH. If the acute hospital could wean a patient off a ventilator, they would. Many LTCH have considerable success with this aspect of care, resulting in the patient returned to their primary residence.

Finally, a LTCH that routinely admits short stay patients would risk losing their LTCH certification status because they will no longer be able to meet the 25-day length of stay threshold for qualifying as an LTCH. Most LTCH desire to remain in operation and would not intentionally select patients that would jeopardize their future viability.

The MHA recommends the expansion of the SSO provision be eliminated as it would improperly pay LTCHs at the lower rate of the IPPS hospital. If the CMS believes LTCH payment is too high for very short length of stay, 7 days, the CMS could develop a lower payment for these patients utilizing LTCH patient cost to determine the revised payment level, rather than basing the payment on IPPS which has a totally different patient base.

HIH or satellite LTCHs in Michigan are
ospitals. These LTCHs will be financially
om their community. Analysis of the
HIH or satellite LTCHs, the greater the
n becomes to import patients from outside
compliant, or suffer extreme financial
e sent to a LTCH in another community,
bers, the CMS would pay the full LTCH

n of this Rule and further reduction to
ls referring patients out of the
is financial disincentive.

No Fiscal Year 2007 Marketbasket Upd

The CMS' proposal to provide a zero
with the proposed SSO proposal will force
unreasonable to deny LTCHs an inflation
fiscal year 2007 market basket increase is
fundamental principle that Medicare shoul
with caring for patients, which in this case
patients. The CMS' proposal places the or
jeopardy, reducing access to LTCH servic

The MHA recommends that the CMS in
adjustment in the FY 2007 proposed rul
LTCHs in the past year.

Impact of October 1, 2005 DRG Reweig

Most LTCHs experienced a significan
DRG weights that became effective Oct. 1,
represented a payment reduction of five pe
proposed rule. LTCHs have already been
this reduction while at the same time conti
patients.

The MHA recommends that the CMS in
(8.6% vs. 3.6%) to remedy the payment
DRG reweighting.

Increase in Outlier Threshold

The CMS is proposing a seventy-eight perc
the current $10,501 to $18,489. The ration
are exceeding the outlier payment pool of 8
recommended based on mathematics witho
their acuity. **LTCHs would only receive t**
outlier threshold, at significant cost to th
threshold will increase the LTCH loss on ea
as a high-cost outlier.

If the CMS deems an increase in the outl
recommends the CMS raise the outlier th
update factor.

Host Hospital 25 Percent Rule

Effective October 1, 2006 current CMS poli
patients referred to a hospital within a hospi
hospital if referrals in total from host exceed

Submitter : **Ms. Jill Force** **Date: 03/17/2006**

Organization : **LifeCare Holdings, Inc.**

Category : **Long-term Care**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

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

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

See Attachment

CMS-1485-P-49-Attach-1.PDF

LIFECARE
HOSPITALS

March 17, 2006

By Electronic Mail

Honorable Mark B. McClellan
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1485-P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: CMS-1485-P; 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:

On behalf of LifeCare Holdings, Inc. (LifeCare), which owns and operates long-term acute care hospitals, I am writing to comment on the Centers for Medicare & Medicaid Services' proposed rule entitled "Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification" (the "Proposed Rule").[1] We appreciate this opportunity to comment on this important Proposed Rule, and look forward to working with CMS to ensure that these provisions are implemented in a manner that reflects our concerns.

I. EXECUTIVE SUMMARY

The Proposed Rule represents flawed Medicare payment policy that is predicated on a number of fundamental misconceptions about the long-term care (LTC) hospital industry. If finalized, the Proposed Rule would implement devastating Medicare payment reductions for LTC hospitals in Rate Year 2007. Specifically, the Proposed Rule would:

- Reduce payments by approximately 11.5 percent as a result of changes to the short stay outlier (SSO) methodology; and
- Deny LTC hospitals a market basket update, despite an estimated 3.6 percent cost increase.

[1] See 71 Fed. Reg. 4,648 (Jan. 27, 2006)

These changes are in addition to the approximate five percent reduction in LTC hospital payments that were implemented in last year's payment adjustments. Thus, these adjustments would have the combined effect of reducing Medicare payments to LTC hospitals by approximately 20 percent over the past two years. We have a number of concerns about the Proposed Rule, which are summarized below:

A. The Proposed Adjustments to the Short Stay Outlier Payment Methodology Would Jeopardize Patient Access to Necessary Services

1. The Proposed Adjustments Would Sharply Curtail LTC Hospital Services to Patients

If implemented, the Proposed Rule would threaten the ability of highly vulnerable patients to obtain high levels of care in the most appropriate setting. Despite the fact that LTC hospitals account for only about one percent of total Medicare spending, the proposed cuts represent more than 10 percent of the Administration's proposed Medicare savings for FY 2007. Specifically, the Proposed Rule would result in Medicare payment reductions to LTC hospitals of $362 million, resulting in payments industry-wide that are estimated to be approximately eight percent less than the cost of providing care. Faced with such crippling losses, some facilities may have to curtail their operations, while others may be forced into bankruptcy. As a result, many patients may have to remain in short-term acute care hospitals that are simply not designed to provide extended acute care services.

2. The Proposed Adjustment Incorrectly Assumes that SSO Patients Do Not Need LTC Hospital-level Care

Medicare data show that LTC hospitals specialize in treating medically complex patients and that LTC hospitals, more than any other provider type, admit and treat the sickest patients. More than twice as many LTC hospital patients are classified as high-acuity patients compared to patients in short-term acute care hospitals. Significantly, even SSO LTC hospital patients are sicker and present with more comorbidities than comparable patients in short-term acute care hospitals. These patients require the acute hospital-level care for extended periods of time that LTC hospitals provide. Further, reviews by Medicare's quality improvement organizations (QIOs) demonstrate that very few short stay LTC hospital admissions have been denied for lack of medical necessity.

3. The Proposed Adjustment Penalizes LTC Hospitals for Providing Efficient Care

LTC hospital clinicians and staff possess significant expertise in treating medically complex patients. As a result of this expertise, LTC hospitals are able to achieve favorable outcomes for patients more effectively and efficiently, often resulting in earlier discharges than would occur in short-term acute care hospitals. Rather than rewarding LifeCare and other LTC hospitals for achieving these efficiencies, the Proposed Rule would penalize them by providing payment comparable to what would be paid to a general acute care hospital, often resulting in significant losses for the LTC hospital.

4. The Proposed Adjustment Ignores Fundamental Principles of PPS

CMS's proposed SSO policy change contravenes the basic principles of a prospective payment system (PPS), which is premised on the law of averages – overpaying for some cases and underpaying for others, but, on average, reimbursing the provider for its costs. The proposed SSO change means that LTC hospitals will be paid below cost on many more cases than under the current system.

5. The Data Underlying CMS's Proposal Are Incomplete and Flawed

In support of the Proposed Rule, CMS relies on several data sources that are limited and potentially misleading. Specifically, CMS cites to FY 2004 MedPAR data that may not fully reflect the impact of the LTC hospital PPS and to limited QIO data that examine claim denials from only one LTC hospital.

6. The Proposed Adjustment Violates Congressional Intent

The Social Security Act defines an LTC hospital as a facility having an average length of stay exceeding 25 days. If finalized, the Proposed Rule would pay LTC hospitals at a rate comparable to that of general acute care hospitals, even if a patient's stay exceeds the 25-day threshold. For example, the average length of stay for DRG 475 is 34 days. The SSO threshold, 5/6 of the average LOS, is 28 days. Under the Proposed Rule, an LTC hospital that treats and discharges a medically complex, ventilator-dependent patient in 26, 27, or 28 days would be reimbursed on the basis of the general inpatient PPS rate, rather than the LTC hospital rate. Such a result is clearly inconsistent with the statutory threshold established by Congress.

7. The Proposed Adjustment Is Premature

With regard to the proposed change to the SSO payment methodology, CMS has not allowed sufficient time to study and collect data on the impact of other recent payment adjustments to the LTC hospital PPS, including the 25 percent rule for LTC hospitals-within-hospitals (HwHs) and the reweighting of LTC-DRG weights. In particular, the 25 percent rule, which limits LTC HwHs to the inpatient PPS payment rate if more than 75 percent of admissions are referred from the host hospital, is designed to address many of the concerns regarding inappropriate LTC hospital admissions in the specific setting where the agency believes they are most likely to be generated. This change, initiated in FY 2005, is being phased in over three years, and CMS cites only anecdotal evidence of its impact in the Proposed Rule. The agency should delay implementing the severe cuts it has proposed until credible, statistically valid data is available to evaluate the effectiveness of the 25 percent rule in reducing SSOs.

8. CMS Should Reassess Its Efforts to Slow Industry Growth

To the extent the proposed SSO payment policy is an effort by CMS to rein in rapid growth in the LTC hospital industry, the agency should delay further action until it has sufficient data to determine whether recent regulatory changes have slowed industry expansion. We understand, for example, that the 25 percent rule has already sharply slowed the growth in the number of LTC hospital beds and facilities. In addition, if further measures are needed to curb

growth, we urge CMS to consider action that is targeted at those segments of the industry about which it has the greatest concern – e.g., HwHs.

B. The Federal Payment Rate Should Be Updated to Reflect Increases in LTC Hospital Costs

The Proposed Rule would freeze the LTC hospital federal payment rate at $38,086.04 for Rate Year 2007. This proposal is based, in part, on an analysis of Medicare margins which indicates that LTC hospital margins were 8.8 percent for FY 2003 and 11.7 percent for FY 2004. However, these data are outdated and fail to reflect other payment changes implemented for FY 2006 that will result in significant reductions in LTC hospital margins. Specifically, the margin analysis conducted by MedPAC and cited by CMS fails to consider the impact of the reweighting of LTC-DRG weights in the FY 2006 inpatient PPS rule. This recent change could potentially reduce LTC hospital margins to a level that CMS believes is appropriate. CMS should evaluate the impact of this reduction and adjust the federal payment rate appropriately to recognize the projected cost increases for LTC hospitals in Rate Year 2007.

C. The 25 Percent Hospitals within Hospitals Payment Provision Should Not Be Extended to Freestanding Facilities

After just over one year of implementation of the 25 percent HwH provision, CMS is proposing to expand it to freestanding LTC hospitals on the basis that it is becoming "increasingly aware that the intent of our existing policy is being thwarted." However, the agency does not provide any support for this assertion. Absent definitive support for its findings, CMS should not implement a proposal that could significantly impede patient access to care.

D. The High-cost Outlier Threshold Should Be Adjusted to Reflect Any Changes in the SSO Payment Proposal

As a result of the proposed changes to the SSO payment, CMS also proposes to make significant changes to high-cost outlier payments to maintain estimated outlier payments at a projected 8 percent of the total estimated payments under the LTC hospital PPS. We request that CMS review this provision to reflect any changes in the SSO proposal so that high-cost outliers also receive appropriate payment.

II. OVERVIEW/INTRODUCTION

A. Company and Industry Background

LifeCare was founded in 1993. We currently operate 18 LTC hospitals, with 893 licensed beds in nine states. Our facilities employ approximately 2,800 people in various clinical and support capacities.

LTC hospitals are just that – hospitals. They provide services that are similar to that provided in short-term acute care hospitals, but must sustain these high levels of care for far longer periods. Because of their high acuity patients, LTC hospitals often require more resources to provide patient care than do general acute care hospitals. As the Medicare Payment Advisory Commission (MedPAC) stated in its March 2006 report, "LTCHs provide care to patients with

clinically complex problems, such as multiple acute or chronic conditions, who need hospital-level care for relatively extended periods of time."[2] Therefore, in developing or modifying payment rates for LTC hospitals, it is important to distinguish them from rehabilitation facilities, psychiatric facilities, and skilled nursing facilities. These other alternatives to short-term acute care hospitals treat patients with conditions that are less likely to be associated with the higher acuities experienced by LTC hospitals.

Significantly, CMS data demonstrate that 52 percent of all patients admitted to LTC hospitals are in the highest APR-DRG "Risk of Mortality" categories, whereas only 24 percent of patients in general acute care hospitals are in these highest categories.[3] Similarly, 69 percent of all LTC hospital patients are in the highest "Severity of Illness" APR-DRG categories, compared to only 33 percent of patients in general acute care hospitals.[4] Additionally, the typical LTC hospital patient has more than one comorbidity. In fact, most patients have more conditions, as represented by ICD-9 codes, than can be reported on the typical UB-92. As a result, LTC hospital patients require treatment by experts from many different clinical areas, including nursing, physical therapy, and nutrition.

LTC hospitals are able to provide these high levels of care because of their experience and expertise in treating these more complex patients for extended periods of time. We provide patients with a multidisciplinary approach that blends therapeutic and traditional interventions. This multidisciplinary team has a specialized skill set and competencies that focus on the problems of very ill patients who do not respond to typical short-term hospital interventions. For example, LTC hospital pulmonary physicians and respiratory staff are experts at weaning patients from ventilators. Each member of the team has a significant role in enhancing the patient's condition during the weaning process. The patient requires stronger muscles to breathe independently from the ventilator, which necessitates assistance from a variety of therapists. Dieticians assist in ensuring the patient receives adequate nutrition. Respiratory specialists are required to monitor the status of and to administer and manage the multiplicity of medications prescribed to these patients. Additionally, psychological support is required and provided by all staff members.

Finally, LTC hospitals provide an important discharge option for short-term acute care hospitals. Post-acute care providers, such as rehabilitation facilities and skilled nursing facilities, do not have the resources and expertise necessary to care for patients who are as medically complex as LTC hospital patients. If LTC hospitals are not available to provide this level of care, these patients will be required to remain in short-term acute care hospitals, which are simply not equipped to provide high-level extended care on a consistent basis.

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[2] Report to Congress, Medicare Payment Advisory Commission (Mar. 2006) at 207.

[3] See Ex. A.

[4] See Ex. B.

B. Provisions of the Proposed Rule

In the Proposed Rule, CMS proposes a number of Medicare payment changes that, if finalized, could have a devastating impact on the LTC hospital industry and the patients it serves. Most significantly, CMS is proposing to revise the payment methodology for SSOs to reduce reimbursement to a level comparable to that paid to general acute care hospitals. Specifically, CMS proposes to modify the existing payment calculation so that an LTC hospital is reimbursed for a short-stay patient at the lesser of: (1) 120 percent of the per diem amount for the specific LTC-DRG multiplied by the length of stay (LOS); (2) 100 percent (reduced from 120 percent) of the estimated costs of the case; (3) the full LTC hospital prospective payment system (PPS) payment; or (4) an amount "comparable to the payment that would otherwise be paid under the [general inpatient PPS]."[5] The Rule also proposes to freeze the federal payment rate for LTC hospitals at Rate Year 2006 levels and to extend the current 25 percent admission threshold applicable to LTC HwHs to freestanding LTC hospitals. As described below, these proposed changes would impede the ability of LTC hospitals to provide high-quality care to a particularly vulnerable class of Medicare beneficiaries.

III. THE HISTORY OF LTC HOSPITALS' SPECIAL PAYMENT STATUS

Congress and CMS have long recognized that LTC hospitals have unique characteristics that require special payment status under the Medicare Program.[6] LTC hospitals, like many providers, were formerly reimbursed on the basis of their reasonable costs, subject to the cost limits established under Section 223 of the Social Security Act Amendments of 1972 (the "Section 223 limits").[7] In 1982, Congress passed the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA),[8] which granted the Secretary authority to exempt hospitals "as he deems appropriate" from the Section 223 limits.[9] TEFRA also required the Secretary "to develop, in consultation with the Senate Finance Committee and House Ways and Committee, [M]edicare prospective reimbursement proposals for hospitals, skilled nursing facilities and to the extent feasible other providers."[10]

Significantly, prior to the enactment of TEFRA, the House of Representatives initially approved legislation that instructed the Secretary to develop a prospective payment system for both short-stay and long-stay hospitals, stating that "the Secretary [is] to develop and to submit to Congress by December 31, 1982, a Medicare prospective payment plan for hospital inpatient services and extended care services designed to take effect October 1, 1983."[11] However, the House-Senate Conference rejected this language, thus clearly indicating that Congress

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[5] 71 Fed. Reg. at 4,687.

[6] Prior to 2001, CMS was known as the Health Care Financing Administration.

[7] Pub. L. No. 92-603, § 223; 86 Stat. 1329 (1972).

[8] Pub. L. No. 97-248.

[9] Id. § 101(a)(1).

[10] Id.

[11] H.R. Rep. No. 97-760, at 421 (1982) (Conf. Rep.).

recognized the special problems a prospective payment system presents for extended care hospital services. Subsequently, the Secretary's response to the TEFRA congressional directive to develop prospective reimbursement proposals stated that "the 467 DRGs were not designed to account for these types of [extended care] treatment" and that applying them to LTC hospitals "would be inaccurate and unfair."[12] Based on these findings and pursuant to its statutory discretion, CMS exempted LTC hospitals from the Section 223 limits on reasonable costs, noting that "[d]ata from long-term care hospitals are not adequate to include them in a system of case-mix adjusted limits based primarily on records from general short-term acute care hospitals."[13]

This recognition of the unique nature of LTC hospitals was reinforced in 1983 when Congress mandated implementation of a PPS for most hospitals, but specifically exempted LTC hospitals.[14] In enacting this provision, Congress expressly noted that "[t]he 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."[15] Thus, it is clear that, for almost 25 years, Congress and CMS have recognized that the standard inpatient PPS is an inadequate payment methodology for LTC hospitals.

Subsequently, in response to the overall growth in the number of hospitals excluded from PPS (which also included inpatient rehabilitation facilities, inpatient psychiatric facilities, skilled nursing facilities, cancer hospitals, and children's hospitals), Congress revisited the concept of creating a PPS for LTC hospitals and other exempt facilities. In the Balanced Budget Act (BBA) of 1997,[16] Congress required the Secretary to develop a legislative proposal to establish a case-mix adjusted PPS for LTC hospitals.[17] Significantly, such a system was to include an "adequate patient classification system that reflects the differences in patient resource use and costs among such hospitals."[18] The BBA also gave the Secretary authority to collect relevant data from LTC hospitals, and required the Secretary to consider several payment methodologies, including the feasibility of expanding the DRG-based acute care PPS to cover LTC hospitals.[19]

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[12] 67 Fed. Reg. 55,954, 55,957 (Aug. 30, 2002) (quoting HHS Report: "Hospital Prospective Payment for Medicare" (1982)).

[13] 47 Fed. Reg. 43,296, 43,299 (Sept. 30, 1982) This exclusion was subsequently codified at 42 C.F.R. 405.460(b)(4).

[14] Pub.L. No. 98-21, § 601(a)(1) (excluding from PPS "a hospital which has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days").

[15] H.R. Rep. No. 98-25. See also S. Rep. No. 98-23, at 54. ("The DRG classification 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 and as used in the medicare program is inappropriate for certain classes of patients").

[16] Pub. L. No. 105-33.

[17] Id. § 4422.

[18] Id.

[19] Id.

Still later, in the Balanced Budget Refinement Act of 1999,[20] Congress directed the Secretary to develop and implement a DRG-based PPS for LTC hospitals.[21] This mandate was revised by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA),[22] which required the Secretary to "examine the feasibility and the impact of basing payment under such a system on the use of existing (or refined) hospital diagnostic related groups (DRGs) that have been modified to account for different resource use of long-term care hospital patients as well as the use of the most recently available hospital discharge data."[23] In addition, BIPA noted that, if the Secretary were unable to implement a PPS for such hospitals by October 1, 2002, she was to implement a PPS using the existing acute care hospital DRGs, as modified where feasible.[24] Thus, in directing the Secretary to modify the DRGs to reflect different resource usage levels among various provider types, Congress reiterated its historic finding that general acute care hospitals and LTC hospitals provide different levels of care, and that the payment methodologies for these facilities should reflect this reality.

The Final Rule implementing the LTC hospital PPS was promulgated on August 30, 2002.[25] In that Rule, CMS noted the policy underlying any PPS – that hospitals will incur costs in excess of payments for some patients and costs below payments for others, and that an efficiently operated facility should be able to deliver care at an overall cost that is at or below the reimbursement rate.[26] CMS also recognized the inappropriateness of directly applying an acute care PPS to LTC hospitals, noting that "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 . . . [T]hese hospitals could be systemically underpaid if the same DRG system were applied to them."[27]

IV. THE PROPOSED RULE

A. The Proposed Adjustments to the Short Stay Outlier Payment Methodology Would Jeopardize Patient Access to Necessary Services

1. The Proposed Adjustments Would Sharply Curtail LTC Hospital Services to Patients

As described above, LTC hospitals provide services to patients who are demonstrably sicker, have higher acuities, and have more comorbidities than patients in the typical short-term

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[20] Pub. L. No. 106-113.

[21] Id. § 123.

[22] Pub. L. No. 106-554.

[23] Id. § 307(b)(1).

[24] Id. § 307(b)(2).

[25] 67 Fed. Reg. 55,954.

[26] Id. at 55,957.

[27] Id.

acute care hospital. If implemented in its current form, the Proposed Rule would threaten the ability of these highly vulnerable patients to obtain high levels of care in the most appropriate setting.

The Proposed Rule would result in Medicare payment reductions to LTC hospitals of $362 million,[28] resulting in payments industry-wide that are expected to be approximately eight percent less than the cost of providing care. LifeCare's facilities in particular would experience a decrease in their Medicare margins from approximately +7 percent to approximately –10 percent. Faced with such crippling losses, some facilities may have to curtail their operations, while others may simply close. Because Medicare patients comprise more than 80 percent of its census, the magnitude of such cuts would be enterprise-threatening for LifeCare, and presumably for other LTC hospital providers of comparable size. The Proposed Rule thus threatens to create havoc among LTC hospitals and their patients comparable to that caused on a larger scale by the BBA of 1997.

Significantly, even taking into consideration recent growth in the industry, LTC hospitals represent only about one percent of total Medicare spending. However, in the President's FY 2007 budget proposal, which seeks to save $36 billion from Medicare over the next five years, cuts to LTC hospitals represent seven percent of the proposed savings, including more than 10 percent of the projected savings in FY 2007. Thus, the level of proposed cuts is clearly disproportionate to the LTC hospital industry's share of Medicare spending.

LTC hospitals also have significant ventilator capacity, comprising approximately 25-30 percent of the ventilators used by acute care hospitals in the treatment of Medicare patients. As has been widely reported, the U.S. currently has a shortage of ventilators.[29] Thus, LTC facilities would constitute a critical component of our public health infrastructure in the event of a bird flu pandemic. If implemented in its current form, the Proposed Rule would severely compromise the ability of LTC hospitals to serve this vital public health function.

2. The Proposed Adjustment Incorrectly Assumes that SSO Patients Do Not Need LTC Hospital-level Care

a. SSO Patients Are Medically Complex

In the Proposed Rule, CMS expresses its concern that "an inappropriate number of patients [are] 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."[30] The agency reaches this conclusion based on a review of the FY 2004 MedPAR data, which indicates that 37 percent of LTC hospital patients qualify as SSO patients. CMS apparently believes that many of these patients are being transferred from general acute

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[28] See 71 Fed. Reg. 4,727.

[29] See, e.g., Donald G. McNeil, Jr., "Experts Say Medical Ventilators Are in Short Supply in Event of Bird Flu Pandemic," NY Times at 19 (Mar. 12, 2006).

[30] 71 Fed. Reg. at 4,686.

care hospitals for the sole purpose of achieving higher reimbursement under the LTC hospital PPS.

This conclusion is simply at odds with the facts. As noted above, LTC hospital patients are medically more complex than patients in general acute care hospitals. Significantly, even short stay LTC hospital patients are sicker and present with more comorbidities than comparable patients in short-term acute care hospitals. As illustrated below in Table 1, Medicare data show that short stay LTC hospital patients have stays that are much longer than the average general acute care hospital patient with the same diagnosis:

TABLE 1

LTC Hospital DRG	Description	LTC Hospital SSO ALOS	Non-LTC Hospital Geometric Mean LOS for all Patient Types
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

Source: 2004 MedPAR data

These differences in lengths of stay reflect the complexities associated with treating LTC hospital patients, complexities that are present even if the stay is shorter than the average LOS for a particular DRG.

This difference in complexity is further demonstrated by examining the lengths of stay of patients in general acute care hospitals that are transferred to an LTC hospital. As shown in Table 2, these LOS data reveal that, in general, transfer patients have a LOS in general acute care hospitals that exceeds the geometric mean LOS for their DRGs:

TABLE 2

LTC Hospital DRG	Description	Short-Term Hospital GMLOS	LTC Hospital Patients: Prior Short-Term Hospital LOS	LTC Hospital Patients: GMLOS for All LTC Hospital 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

Source: 2004 MedPAR data and 71 Fed. Reg. 4,684

These are not patients that are being prematurely discharged from the short-term acute care setting, as CMS alleges, but in fact are staying longer than the average patient because of medical complexities, and being transferred to an LTC hospital only after an extended general acute care stay. Thus, these are patients that clearly need hospital-level care for extended periods of time, as MedPAC observed in its recent report, and are not being admitted to the LTC hospital to "game" the payment system.

b. LTC Hospitals Cannot Predict a Patient's Length of Stay

In the Proposed Rule, CMS hypothesizes that the number of SSOs is high because LTC hospitals are admitting patients who are likely to be short stay patients. The agency fails to recognize the clinical reality that, when a patient is admitted to a LTC hospital, the patient does not present with discernable characteristics indicating whether she will be a short stay patient or have a "normal" length of stay. LTC hospitals must make their admissions decisions on the basis of the patient's medical condition at the time she presents for admission, not on some "Magic 8-ball" prognostication that the patient will be an SSO. Moreover, many LTC hospital admissions are referred from other providers based on the medical judgment of the referring physician.

Further, based on a review of 2004 MedPAR data, the proportion of SSO patients who present with diagnoses with the highest severity of illness and risk of mortality scores is consistent with that presented by longer stay patients within the same DRGs. In DRG 475, for example, approximately 93 percent of SSOs present an APR-DRG severity score of three or four. The severity scores for non-SSO patients within this DRG are virtually the same, with 94 percent presenting with severity scores of three or four. As shown in Table 3, the severity scores associated with other DRGs lead to the same conclusion – that, at the time of admission, the likelihood that a particular patient will be an SSO patient cannot be predicted based on severity of illness scores:

TABLE 3

LTC Hospital DRG	Description	LTC Hospital Geo LOS for All Patient Types	LTC Hospital 5/6 Geo Mean for all Patient Types	Non-SSO 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 LTC hospital DRGs (weighted by case frequency)	26.6	NA	68%	64%

Source: 2004 MedPAR data

Thus, it is clear that LTC hospitals cannot predict the expected length of stay in an LTC hospital based on the information available at admission. Instead, LTC hospitals make these decisions based on a clinical evaluation of medical need. Currently, most LTC hospitals use tools such as the InterQual® Long-Term Acute Care Criteria to assess the appropriateness of a patient's admission, continued stay, and ultimate discharge. These are among the criteria that MedPAC has recommended using to define more precisely the level of care provided by LTC hospitals.[31] Many of Medicare's QIOs use similar criteria to evaluate LTC hospital admissions.

LifeCare also uses the InterQual® Long-Term Acute Care Criteria to guide its admissions decisions. A recent review of the QIO activity in seven of our hospitals revealed a statistically insignificant number of denials. We understand that other LTC hospitals have also experienced very low denial rates. Thus, there is a clear record that virtually all LTC hospital short stay patients have been appropriately admitted and require the specialized services our facilities provide.

Nonetheless, CMS proposes to reduce payments for treating all short stay patients to a level that is comparable to what would be paid under the general inpatient PPS. We recognize CMS's concern that some short stay patients may not have been appropriately admitted to LTC facilities and therefore should not receive full LTC-DRG payments. However, there is simply no support for the proposition that short stay patients at LTC hospitals generally do not require the same level of service as longer stay patients. Rather than arbitrarily cutting payments and placing patients at risk, if CMS's goal is to ensure that patients are properly admitted to LTC hospitals, it should adopt a criteria-based system that would only admit patients who are medically complex and in need of the services provided by these facilities. In particular, LifeCare urges the development of criteria that: (1) measure patient characteristics to ensure that only medically complex patients are admitted to LTC hospitals; (2) ensure that LTC hospitals are capable of supporting the care of these medically complex patients; and (3) condition continued LTC hospital stays on appropriate patient medical complexity. Establishing such patient severity

[31] See "Report to Congress," Medicare Payment Advisory Commission (June 2004) at 121-34.

criteria would help reduce the number of admissions CMS perceives to be "inappropriate," but without jeopardizing patient access to the appropriate level of care provided by LTC hospitals.

3. The Proposed Adjustment Penalizes LTC Hospitals for Providing Efficient Care

As noted above, LTC hospital clinicians and staff possess significant expertise in treating medically complex patients. As a result of this expertise, LifeCare's facilities and other LTC hospitals are able to achieve favorable outcomes for patients more effectively and efficiently than general acute care hospitals, often resulting in earlier discharges than comparable patients would experience in short-term acute care providers. For example, as described above, we provide a multi-disciplinary team approach to caring for our patients that allows us to customize care for patients who do not "fit" within the typical, standardized care pathways provided by short-term acute care hospitals. We possess expertise in weaning patients from ventilators and treating wound patients whose conditions are too complex to be cared for in other settings. Our staff are also trained to provide support to the patient and family in the various complicating aspects of slow recovery, including the depression which frequently accompanies chronically ill patients.

Rather than rewarding LifeCare and other LTC hospitals for developing this expertise and achieving these efficiencies, the Proposed Rule would penalize them. This punitive outcome can be demonstrated by examining the case of a ventilator-dependent patient (DRG 475). The payment rate for such a patient is based on an average length of stay of 34 days. If, as a result of the excellent care provided in the LTC hospital, the patient is discharged after 26 days, the facility's reimbursement under the Proposed Rule would be reduced to an amount comparable to what would be paid to a general acute care hospital, which payment assumes an eight-day hospitalization. Thus, this payment would clearly not reflect the quality and efficiency of the care provided. These draconian payment cuts would create a perverse incentive of discouraging efficiency, thereby undermining one of the primary goals of a prospective payment system.

4. The Proposed Adjustment Ignores Fundamental Principles of PPS

"The basic premise of a PPS recognizes that Medicare pays hospitals in an amount per discharge based on the average costs of delivering care for that diagnosis."[32] The Proposed Rule would violate this premise by removing from the equation a significant number of cases for which payments will exceed LTC hospital costs without also removing cases for which reimbursement rates are lower than costs. In so doing, CMS's proposal would also contravene its historical pronouncements regarding LTC hospital PPS payments, as well as Congress's premise for first excluding LTC hospitals from PPS and then establishing a separate PPS – that the general inpatient PPS rates are inadequate to reimburse LTC hospitals for the care they provide.

As discussed above, in 1982, the Department of Health and Human Services reported to Congress that the inpatient DRGs were not designed to account for the type of treatment provided by excluded hospitals (LTC hospitals, children's hospitals, psychiatric hospitals, and

[32] 71 Fed. Reg. at 4,693 (emphasis added).

rehabilitation units)[33] and stated that including these hospitals in the inpatient PPS "would be inaccurate and unfair."[34] Congress in 1983 acknowledged this reality, stating 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."[35] Yet, CMS is proposing a policy change that clearly violates this historical precedent by effectively treating SSOs as if they were in short-term acute care hospitals, based solely on its observation that slightly more than one-third of LTC hospital admissions fall below the geometric average length of stay for the DRGs in question. Because the PPS rates are based on average costs, it is completely predictable that a significant number of cases would fall below the average. Thus, it is CMS's proposal to reduce reimbursement to the levels described in the Proposed Rule, not the number of SSOs treated by LTC hospitals, that is flatly inconsistent with the fundamental precepts of PPS.

Moreover, notwithstanding CMS's historical concern about payment cliffs in the SSO methodology,[36] the Proposed Rule would introduce such a cliff by incenting LTC hospitals to keep patients one day beyond the 5/6 geometric LOS threshold so as to obtain the full LTC-DRG payment. This new cliff is demonstrated in Table 4 for the most common LTC hospital DRGs:

TABLE 4

DRG	Base LTC hospital payment	SSO payment under IPPS DRG Option	Difference
475	$ 79,333	$ 18,597	$ (60,736)
249	$ 25,048	$ 3,655	$ (21,392)
12	$ 26,091	$ 4,636	$ (21,455)
271	$ 33,209	$ 5,253	$ (27,957)
462	$ 22,039	$ 4,482	$ (17,557)
88	$ 25,078	$ 4,523	$ (20,556)
87	$ 41,192	$ 7,035	$ (34,157)
89	$ 26,609	$ 5,317	$ (21,292)
466	$ 25,391	$ 4,022	$ (21,369)
79	$ 31,534	$ 8,366	$ (23,168)

Consequently, the Proposed Rule would undermine another central purpose of PPS – encouraging efficiency in the provision of care. Instead, the payment cliff could incent facilities to focus more on covering their costs by keeping patients in the hospital longer than the SSO threshold.

5. The Data Underlying CMS's Proposal Are Incomplete and Flawed

In announcing its proposals to reduce SSO payments, CMS cites several sources of data to justify its actions – LTC hospital claims data from the FY 2004 MedPAR files and pre-PPS

[33] 67 Fed Reg. at 55,597 (citing the report).

[34] Id.

[35] Id.

[36] 71 Fed Reg. at 4,686-87.

data derived from a regression analysis and simulations based on reasonable cost claims data. The agency states that the MedPAR data show that 37 percent of LTC hospital discharges are SSO patients, which compares unfavorably, in CMS's view, to the 48 percent of LTC hospital patients that would have been SSO patients under the pre-PPS reasonable cost-based payment system. According to the agency, this 11 percent drop does not reflect a sufficient decrease in SSO patients, and thus warrants the proposed changes in the payment methodology.

It is clearly premature to base such significant payment changes on these data, even assuming arguendo that a clear relationship exists between the decline in SSOs and the integrity of the LTC hospital PPS. FY 2004 represented only the second year of PPS data. Further, because the PPS was implemented at the beginning of each affected hospital's cost reporting period beginning on or after October 1, 2002, for many LTC hospitals, the data cited by CMS would only reflect one year of PPS experience.

Using the FY 2004 data is also problematic and potentially misleading because CMS used a blended rate to transition to PPS. For cost reports beginning in FY 2004, payments were based on a 60/40 blend, with 60 percent of the payment still based on individual hospital costs and not on prospective payment rates. Consequently, the inherent incentives of a PPS were not fully in place at the time these data were generated. However, despite the limitations of the available data, CMS still reported an 11 percent drop in SSOs within the first two years of the PPS. As the PPS becomes more fully implemented, more current data may reveal additional reductions in subsequent years. For example, based on internal analysis, LifeCare's SSO patient population has declined steadily since the implementation of PPS. In 2005, less than 33 percent of our patients were SSOs. For these reasons, CMS should refrain from making the proposed SSO payment cuts until it can evaluate more accurate and credible data that will become available later this year reflecting FY 2005 discharges. Such data will better enable CMS to determine whether the SSO population represents an inappropriately high proportion of LTC hospital patients.

However, even if more appropriate data leads CMS to determine that a significant number of SSO patients remain in the system, the agency should not rely solely on the raw number of SSOs in evaluating the appropriateness of admission to LTC hospitals. As described above, even for patients who require LTC hospital-level care, the expertise and efficiency of the care they receive in the LTC hospital setting may result in discharges to alternate care settings in shorter times than the average length of stay for the applicable DRGs. To accurately assess whether such admissions were appropriate, CMS would need to obtain and analyze patients' clinical data, including any medical necessity review conducted by a QIO, rather than drawing clinical conclusions based only on length of stay.

However, as the previously discussed QIO data indicate, neither LifeCare nor the industry as a whole has been shown to admit significant numbers of patients for whom LTC hospital-level care is inappropriate. CMS appears to have ignored such data in its analysis, citing to only one QIO's review of a sample of denied claims from one LTC hospital to support its proposed reduction in the SSO payment.[37] This review seemingly was a self-selected study of

[37] Id. at 4,668-69.

previously denied claims to support the preconceived hypothesis that LTC hospitals frequently make inappropriate admissions decisions. The discussion in the Proposed Rule does not indicate that the reviewer compared the percentage of LTC hospital admissions denied for lack of medical necessity to the universe of LTC hospital patients admitted for whom hospital-level services were clinically appropriate, clearly the most important element of any such analysis. The simple fact that some admissions are inappropriate does not prove anything unless the inappropriate admissions are statistically compared to the appropriate admissions. Therefore, we urge CMS to conduct a more extensive study of all available data on the admission decisions of LTC hospitals, and to re-evaluate its proposals in light of what will undoubtedly be significantly different facts from the conclusory findings it made in the Proposed Rule.

6. The Proposed Adjustment Violates Congressional Intent

As CMS is aware, the Social Security Act defines an LTC hospital as a facility having an average length of stay exceeding 25 days. If finalized, the Proposed Rule would pay LTC hospitals at a rate comparable to that of general acute care hospitals, even if a patient's stay exceeds the 25-day threshold. For example, the average length of stay for DRG 475 is 34 days. The SSO threshold, 5/6 of the average LOS, is 28 days. Under the Proposed Rule, an LTC hospital that treats and discharges a medically complex, ventilator-dependent patient in 26, 27, or 28 days would be reimbursed on the basis of the general inpatient PPS rate, rather than the LTC hospital PPS rate, despite the significant clinical differences described above between LTC hospital patients and typical short-term acute care hospital patients. The average LOS for a general acute care hospital patient in DRG 475 is 8 days. Such a result would be inconsistent with the statutory threshold established by Congress and would plainly controvert Congressional intent to provide separate payment to LTC hospitals in recognition of their treatment of sicker, more medically complex patients.

7. The Proposed Adjustment Is Premature

Finally, with regard to the proposed change to the SSO payment methodology, CMS is acting without allowing sufficient time to study and collect data on the impact of other recent payment adjustments to the LTC hospital PPS, including the 25 percent rule for LTC hospitals-within-hospitals and the reweighting of LTC-DRG weights.[38] In particular, the 25 percent rule, which limits LTC hospital HwHs to the inpatient PPS payment rate if more than 75 percent of admissions are referred from the host hospital, is designed to address many of the concerns regarding inappropriate LTC hospital admissions in the specific setting where the agency believes they are prone to be generated. This change, initiated in FY 2005, is being phased in over three years, and CMS cites only anecdotal evidence of its impact in the Proposed Rule.[39] The agency should delay implementing the severe cuts that it has proposed until credible, statistically valid data is available to evaluate the effectiveness of the 25 percent rule in reducing SSOs.

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[38] 69 Fed Reg. 48,916, 49,213 (Aug. 11, 2004); 70 Fed. Reg. 47,278, 47,324 (Aug. 12, 2005).

[39] 71 Fed Reg. at 4,697.

Further, the Research Triangle Institute (RTI) study cited by CMS in the Proposed Rule is still in the draft stage. As you are aware, in 2004, MedPAC recommended that Congress and CMS address LTC hospital payment issues by developing criteria that would assess not only whether the facility qualifies as an LTC hospital, but also whether LTC hospital patients are appropriate for admission.[40] Among MedPAC's recommendations, which are the subject of the RTI study, was the use of staffing and patient mix to assess LTC hospital qualifications and the use of clinical characteristics and treatment modalities to evaluate admissions criteria.[41] The final RTI report, expected later this year, may provide more specific recommendations that are better targeted to achieve the agency's goals with regard to inappropriate admissions, without also placing patient access to medically necessary treatments at risk. LifeCare, and indeed the entire LTC hospital industry, certainly welcome the prospect that this study may provide suggestions for a criteria-based LTC hospital classification system that would likely address most, if not all, of CMS's concerns in this area. In the interim, the LTC hospital industry, including LifeCare, is currently developing its own facility classification and patient admissions criteria, with MedPAC noting in its most recent report that it was "encouraged that the industry is starting to develop new quality indicators" that could be used in a criteria-based classification system.[42] We anticipate presenting this classification system to CMS in the near future. This will enable the agency to implement more appropriate facility certification and patient admission criteria until CMS completes its review of the RTI study. We look forward to working with CMS to achieve this objective.

8. CMS Should Reassess Its Efforts to Slow Industry Growth

In the Proposed Rule and in public statements, CMS has expressed concern about rapid growth in the LTC hospital industry.[43] In making these statements, the agency fails to consider that LTC hospitals are a young industry and, as such, rapid expansion should be expected until equilibrium is achieved that satisfies market demand. Nonetheless, to the extent CMS perceives this growth as inappropriate and is attempting to curtail it through the SSO payment provision in the Proposed Rule, we urge the agency to delay this action until it has sufficient data to determine whether recent regulatory changes have slowed industry expansion. For example, we understand that the 25 percent rule has sharply slowed the growth of LTC hospital beds and facilities. Specifically, CMS's public use files indicate that the number of new LTC hospital certifications declined by 36 percent from CY 2004 to CY 2005.[44] Before implementing industry-wide payment cuts, CMS should evaluate the impact of the 25 percent rule. Further, both the agency and MedPAC have cited HwHs as a significant source of LTC industry growth.[45] Therefore, if further measures are needed to curb growth, we urge CMS to consider action that is

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[40] "Report to Congress," Medicare Payment Advisory Commission (June 2004) at 128-30.

[41] Id. at 130.

[42] "Report to Congress," Medicare Payment Advisory Commission (Mar 2006) at 215.

[43] 71 Fed. Reg. at 4,697.

[44] "Provider of Services," Extracted from the Online Survey and Certification Reporting System (Fourth Quarter 2005); available from CMS Public Use Files, Accounting Division.

[45] Id.; "Report to Congress," Medicare Payment Advisory Commission (Mar. 2006) at 213.

targeted at those segments of the industry about which it has the greatest concern – e.g., HwHs – and not enact payment changes that negatively impact all LTC hospitals.

B. The Federal Payment Rate Should Be Updated to Reflect Increases in LTC Hospital Costs

CMS is proposing to freeze the LTC hospital federal payment rate at $38,086.04 for Rate Year 2007. This proposal is based, in part, on an analysis of hospital margins which indicates that LTC hospital Medicare margins were 8.8 percent for FY 2003 and 11.7 percent for FY 2004. However, these data are outdated and fail to reflect other payment changes implemented for FY 2006 that will produce significant reductions in LTC hospital margins. CMS should reconsider its proposal to freeze the federal payment rate and instead should make an appropriate adjustment to reflect increases in the costs of providing LTC hospital services.

Specifically, the margin analysis conducted by MedPAC and cited by CMS fails to consider the impact of the reweighting of LTC-DRG weights in the FY 2006 inpatient PPS rule. In that Final Rule, the agency estimated that the reweighting would result in a 4.2 percent reduction in LTC hospital payments, and in fact implemented the reweighting to achieve this effect and more closely align LTC hospital payments with costs. In the current Proposed Rule, CMS is proposing to freeze rates because it believes that payments still exceed costs. In making this proposal, however, CMS is not taking into account the reductions implemented in the FY 2006 inpatient PPS rule because its impact is unknown at this point. What is known is that LTC hospitals' costs will be increasing in Rate Year 2007 and, in the absence of data demonstrating that current payment rates are excessive, the federal payment rate should be increased by an appropriate amount to recognize these higher costs.

C. The 25 Percent Hospitals within Hospitals Payment Provision Should Not Be Extended to Freestanding Facilities

In the FY 2005 inpatient PPS Final Rule, CMS implemented a policy that required all LTC HwHs to comply with the requirement that 75 percent of admissions be referred from a source other than the host hospital to receive full payment under the LTC hospital PPS.[46] This provision was enacted to reduce the number of inappropriate admissions to co-located LTC hospitals (i.e., medically unnecessary referrals from a host hospital to an LTC HwH to maximize Medicare reimbursement). After just over one year of implementation, CMS states that it is becoming "increasingly aware that the intent of our existing policy is being thwarted,"[47] but does not provide any support for its assertion. Such an anecdotal and amorphous statement does not provide a meaningful opportunity for independent verification and comment by interested stakeholders. CMS also cites MedPAR data that describe the percentage of freestanding LTC hospitals with admissions of 25 percent or more from a single acute care hospital (63.7 percent).[48] However, the agency does not cite data reflecting referral patterns for other provider

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[46] 69 Fed. Reg. at 49,213. The requirement is being phased in over a three-year period.

[47] 71 Fed. Reg. at 4,697.

[48] See id. at 4,698

types, whether acute care or post-acute care, to provide context as to whether this ratio is at, above, or below the average within the hospital industry. In the absence of more definitive support for its findings, CMS should not implement drastic payment reductions that could have significant patient access implications.

As CMS is aware, LTC hospitals are slowly spreading to areas that previously did not offer LTC hospital-level care. As this expansion continues, LTC hospitals may wish to enter areas that are served primarily by a single general acute care hospital. However, if an LTC hospital is limited in the number of referrals it receives from a single institution, it may be difficult, if not impossible, to operate in areas dominated by one short-term acute care hospital, which in turn will result in reduced patient access to necessary long-term acute care services.

LifeCare recognizes CMS's concern regarding the potential for inappropriate LTC hospital admissions in certain business relationships between short-term acute care and LTC hospitals. As described above, we believe that adopting admissions criteria that are clinically based and do not rely solely on arbitrary admissions percentages would be a more effective method to curtail such practices.

D. The High-cost Outlier Threshold Should Be Adjusted to Reflect Any Changes in the SSO Payment Proposal

As a result of the proposed changes to the SSO payment, CMS also proposes to make significant changes to high-cost outlier payments to maintain estimated outlier payments at a projected 8 percent of the total estimated payments under the LTC hospital PPS. Specifically, CMS proposes to increase the high-cost outlier threshold from $10,501 to $18,489, reflecting the anticipated reductions in LTC hospital payments that will occur if the Proposed Rule is finalized. We request that CMS reconsider this provision if it revises its SSO proposal so that high-cost outliers also receive appropriate payment.

V. CONCLUSION

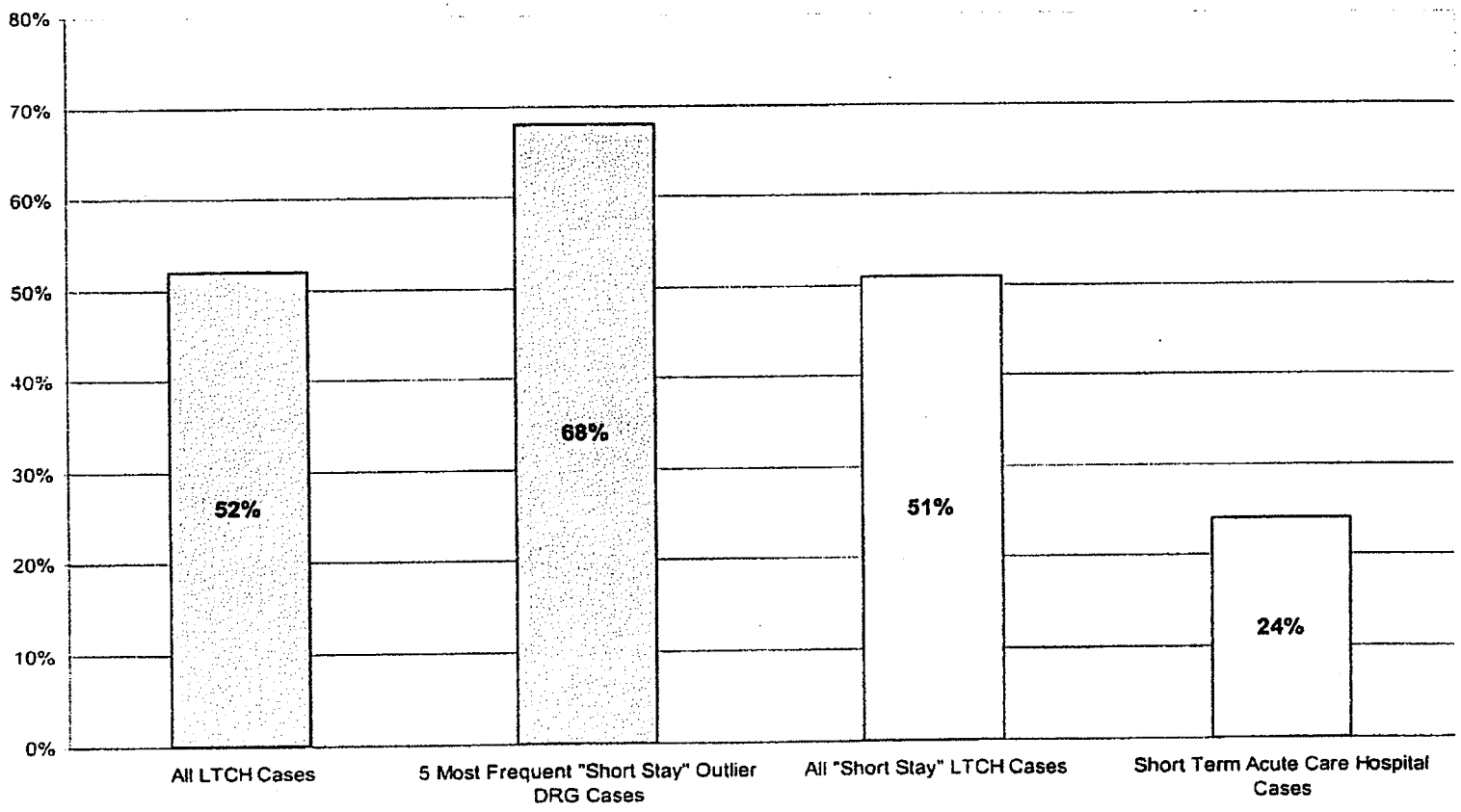
We appreciate the opportunity to comment on the important issues raised by the Proposed Rule, and urge you to address these concerns in a manner that fully protects patient access to medically necessary treatments for complex conditions. We request that CMS carefully consider the recommendations offered above in developing a more targeted approach to reforming the LTC hospital payment methodology. Please let us know if we can provide you with any additional information or other assistance.

Sincerely,

Jill C Force
EVP
LifeCare Holdings, Inc.

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

Percentage of Patients in the highest APR-DRG "Risk of Mortality" Categories

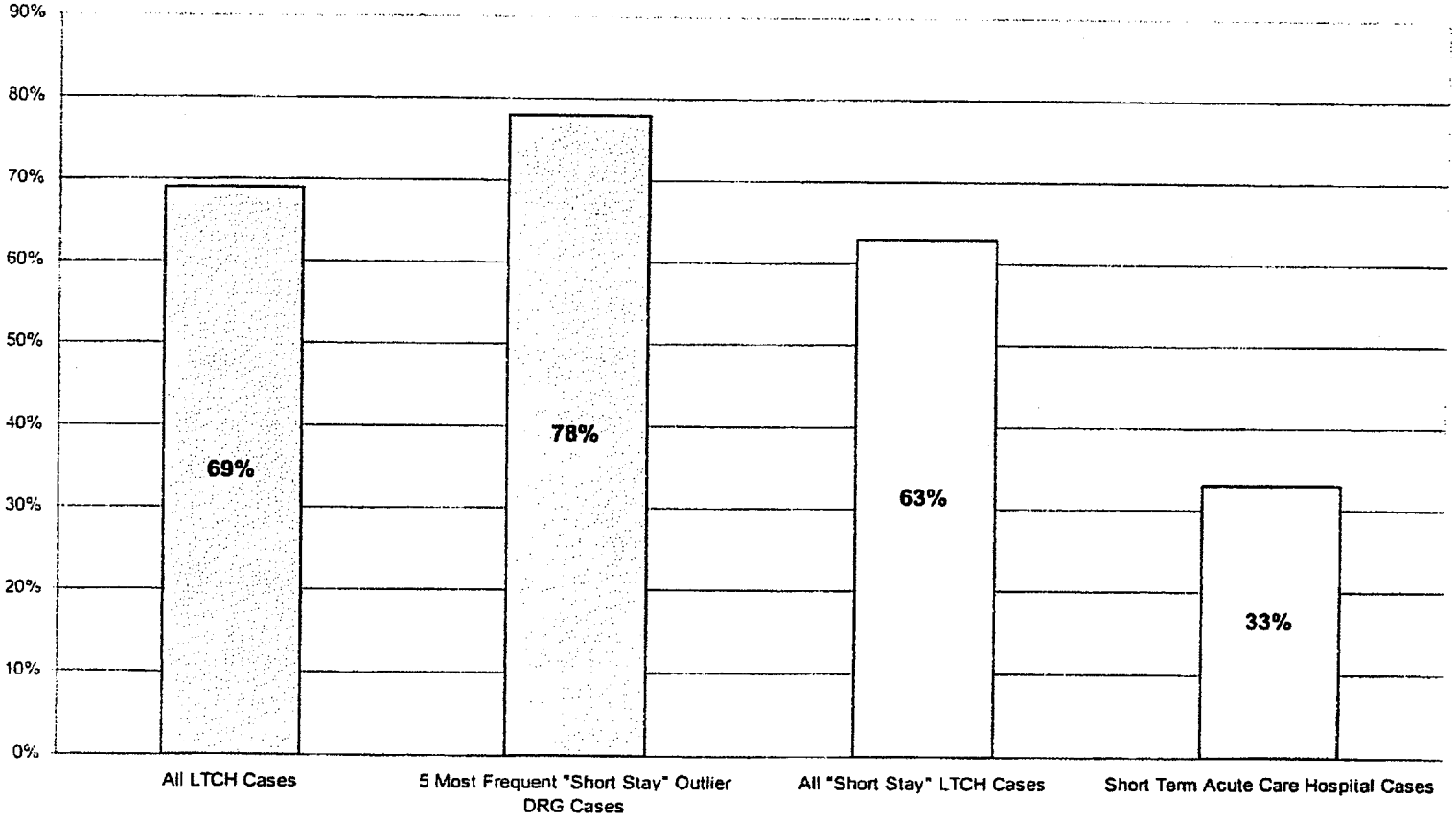


*Source: MedPAR 2004

*Risk of Mortality from APR-DRG Methodology

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

Submitter : Mr. Ray Owens **Date:** 03/17/2006

Organization : Dubuis Hospital of Alexandria

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1485-P-50-Attach-1.DOC

March 17, 2006

Mark McClellan, M.D., Ph.D.
Administrator, Centers for Medicare & Medicaid Services
Attn: CMS–1485–P
P.O. Box 8011
Baltimore, MD 20244-8011

RE: Comments of Dubuis Health System, Inc.
Docket: CMS-1485-P

Dear Dr. McClellan:

I am the CEO of Dubuis Hospital of Alexandria, located in Alexandria, Louisiana. I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed changes to the regulations governing long-term care hospitals. Dubuis Hospital of Alexandria is a member of Dubuis Health System. Dubuis is the largest not-for-profit, faith-based, long-term acute care hospital system in the U.S.

I am concerned that the proposed [CMS-1485-P] rule continues CMS' pattern of enacting arbitrary payment provisions that will have devastating effects on my hospital and the entire LTCH industry and completely disregards the medical needs of our patients. I am particularly concerned with the ill-advised changes to the short-stay outlier. Rather than assuming that the growth of LTCHs in recent years indicates abuse of the system, CMS should consider whether the growth is in response to a legitimate need as the value of LTCHs has become more apparent.

Allow me to assure you that I fully understand the concerns CMS has expressed that there may be inappropriate admissions of some LTCH patients. Like all hospitals in the Dubuis system, my hospital only accepts patients who are pre-screened by an interdisciplinary team to determine that admission criteria are met. Dubuis worked hard for several years to develop criteria that would ensure that its hospitals make appropriate admissions decisions. The criteria served as the template for those later refined and adopted by the National Association of Long Term Hospitals (NALTH). However, not all LTCHs use the same criteria. Neither the short stay outlier provision nor the 25 percent patient cap on hospital-within-hospital LTCHs will do anything to address inappropriate admissions practices. They will, however, irreparably harm hospitals like mine who are attempting to play by the rules and will needlessly place access to LTCH care in jeopardy. Only admission criteria that are standardized industry-wide, along with intensive QIO review, will effectively address the problem.

CMS seems to be under the impression that LTCH patients are no different than patients being treated as outliers in acute care hospitals. This assumption is simply false. It is true that in many parts of the country where there are no LTCHs, patients are being treated in acute care hospitals. However, one cannot assume these patients are receiving the same quality of care as would be provided in an LTCH, nor can CMS assume they have the

same outcomes. LTCHs offer cost-effective clinical benefit to patients suffering from severe and complex illnesses and provide specialized services that are not always available in acute care hospitals. An example is a patient whom we cared for earlier this year. This patient was a seventy-three year old man who was employed as a minister for a local Baptist Church. He had gone to the Texas Medical Center in Houston for a double heart valve replacement, where he developed numerous complications following surgery and became ventilator dependent and was placed on tube feeding. Although he was later weaned from the ventilator, both his respiratory status and his nutritional status were seriously compromised. After approximately two weeks, he returned to Alexandria and was admitted to our LTCH hospital under the care of a Cardiologist. Upon admission to our hospital, he was still recovering from the cardiac surgery, had several cardiac problems and required close monitoring by Cardiology; he had a severe pressure wound, and his functional abilities in mobility, ambulation and activities of daily living had decreased to the point that he required total assistance in all functions. Although this man was very ill, he was very much alert and was absolutely intent upon regaining his health and returning to his life's calling as a preacher. Our LTCH hospital was the appropriate place for him to receive care, because his complex medical condition, with its components of cardiac complications, compromised respiratory status, compromised nutritional status, functional impairments and skin wounds, required an intense and long term treatment program provided by an interdisciplinary team of specialized physicians, nurses and therapists. His medical needs were far more intense than what any sub-acute care facility could provide, and he was unable to participate in an intensive rehabilitation program due to his very low level of strength, endurance and respiratory functioning. Our team worked together as a single unit to plan and provide medical care, nursing care, wound care, respiratory care, rehabilitation therapy and nutritional therapy in the most efficient and effective way possible. As for all of our patients, this patient's care team, including the physicians, communicated daily and formally met weekly to ensure the appropriateness of his care, to ensure that progress toward goals was occurring efficiently and to validate the continuing medical necessity of his hospitalization. After seventeen days in our hospital, the patient was discharged home and began preaching again for his Church. He achieved independence in all areas of functional ability; his severe skin wound healed, he maintained independent and sufficient respiratory status; and his post-surgical complications were resolved. While the clinical services that we provided are available individually in a short-term acute hospital, they are not available in the way that we provided them. The combination of the truly interdisciplinary nature of the full care team, the specialization in wound care, the intensity of respiratory care, the individualized level of rehabilitation, the integration of the family into the care team and the understanding of the special needs of long term patients are unique to LTCH hospitals. Without the care that we provided, this patient would not have reached his goal of returning to his home and family as their father and returning to his church and congregation as their pastor. His stay in the short-term acute hospital would have eventually become medically unnecessary, and he almost certainly would have required nursing home placement at that point. Because we were able to provide care to this man, he returned to our community as a church leader, a productive employee and a provider for his family.

This patient was a short stay outlier in our hospital. The short stay outlier threshold for his DRG was eighteen days, which was five-sixths of the average length of stay for his DRG. At seventeen days, his stay fell one day short of the minimum stay required for us to receive the full DRG payment as reimbursement for his care. This patient was medically ready for discharge at day seventeen; he had met his goals and we had completed all necessary patient/family education. We discharged the patient on that day, because hospitalization was no longer medically necessary for him, and his discharge setting was ready. Had this patient remained hospitalized for only one more day, our Medicare reimbursement for his care would have increased by more than twice; our reimbursement was $10,688, and the full DRG payment would have been $23,362. However, we made no attempt whatsoever to extend his stay, by even one day, beyond what was clinically appropriate. We did suffer a payment penalty because his stay was a short stay outlier. Under the current short stay rule, this payment, although reduced, was almost sufficient to cover the costs of this patient's care, which were $12,409. Under the proposed rule, however, our costs of his care would have been more than three times our reimbursement of $3,600. I understand that there have to be payment penalties for short stay outliers, and I accept the penalties as they now exist under the current rules. But, the payment penalties included in the proposed rules are so extreme that they would have prevented us from providing care to this man and many others like him.

This patient's case tells only one story, but on a much larger scale, studies have shown that compared to acute care outliers, appropriately admitted LTCH patients have a lower mortality rate, a lower readmission rate, a lower utilization of other post acute services, lower overall costs, and are often discharged with a higher level of functionality. Clearly, CMS is failing to recognize the high level of care patients receive in LTCHs. To provide a parallel example, we note that the vast majority of the country is not served by a children's hospital. In these areas, children are often treated in the pediatric units of acute care hospitals. Does CMS believe that severely ill children are no better off in a children's hospital than an acute care pediatric unit or in a general hospital?

The fundamental principle behind any prospective payment system is the law of averages. By definition, the mean length of stay in any system will see 50 percent of the cases above it and 50 percent of the cases below it. Likewise, $5/6^{th}$ of the mean length of stay will always see approximately 40 percent of cases below it. Because the $5/6^{th}$ threshold is a function of the distribution you should expect to see 40 percent of cases below it. What the rule does not recognize is that LTCH patients are significantly more medically complex than short-term acute hospital patients. You have not demonstrated that there is any relationship between a short-stay outlier patient's LTCH LOS and the patient's level of medical complexity. Yet, you are using one (LOS) as a proxy to represent the other (medical complexity), thereby making the false assumption that all short stay outliers represent inappropriate LTCH admissions. To drastically cut payments for the short stay outliers based on this flawed assumption will undermine the very law of averages on which prospective payment systems are based.

Many times a patient's recovery in the LTCH requires daily coordination among all disciplines of their care team (including physician, nursing, respiratory therapy, physical

therapy, occupational therapy, speech therapy, nutritional therapy, and case management). Although acute care hospitals try to provide such coordinated dedication to an individual patient's long term recovery, the reality is that it is interrupted by more urgent, though not necessarily more important priorities. It is the volume and urgency of new, unstable patients throughout the day which greatly limits the acute care provider's attention to the chronic critically-ill patient.

Contrary to CMS' assumptions, the Lewin Group compared the resource use of IPPS cases to LTCH SSO (short stay outlier) cases for all common DRGs. They used average standardized charge data for LTCH and acute care hospital cases combined and used CMS' methodology for computing relative weights for each LTCH DRG and Acute Care DRG using a common national average charge denominator. The Lewin Group study found that LTCH SSO cases have mean DRG weights that are 76 percent higher than comparable DRG weights for IPPS cases. As a result, they concluded the IPPS payment system is not appropriate for the payment of LTCH SSO cases. This data flies in the face of your assumption that SSO is a proxy for inappropriate LTCH admission. As a result, should you finalize this policy, you are simply making an arbitrary 11% reduction in payments to LTCHs.

Make no mistake, the financial impact of the proposed short stay outlier changes are severe. For my hospital, annual reimbursement would decrease by $1.9 million in the first year under the proposed rules in their entirety, with $1.6 million of this decrease attributable to the short stay outlier changes. The Dubuis system as a whole has forecasted that if we continued to do business exactly the way we do now, our reimbursement would decrease 17%. This is well into the negative range for us. Because of our commitment to charity care and the acuity of patients we serve, our system does not have the large profit margins that have been cited.

Properly admitted LTCH patients are by definition the most severe and medically-complicated cases. As such, the expected length of stay will be much longer than that of an acute care hospital, even for common DRG's. Take for example DRG 12 (degenerative nervous system disorder). Under the proposed SSO policy, there is no distinction made for severity of the condition, i.e. a minor stroke that might be treated in an acute care hospital versus a major stroke with complications and residual effects that might be better treated in a LTCH. The LTCH mean length of stay for this DRG is 25.5 days. Therefore, the $5/6^{th}$ threshold is 21.25 days. The IPPS length of stay is only 4.3 days. A patient with LTCH DRG 12 may stay at a LTCH for 20 days and thus be a short-stay outlier, but that stay is still five times the IPPS length of stay. Is a stay that is 83 percent of the average LOS really an abuse of the short stay outlier? It is simply wrong to reimburse a 20 day LTCH stay at a 4 day acute care level. This policy will severely harm patient care and have no effect on the issues CMS is attempting to address. In fact, some LTCHs may be inclined to keep anyone passing the acute mean LOS up to the LTCH mean regardless of their medical situation, thus ensuring "gaming" of the system for financial benefit. However, let me assure you, our decisions will continue to be guided first and foremost by medical professionals and the best interests of our patients.

The more appropriate approach to ensuring that medical necessity is the sole driving force behind clinical care decisions would be to tie reimbursement under the LTCH PPS system to clinical quality measures, such as those proposed by MedPAC, and admissions criteria such as NALTH's. Dubuis is impressed with the diligent efforts that MedPAC has undertaken and is fully supportive of MedPAC's recommendations to define LTCHs by facility and patient criteria that ensure that patients admitted to these facilities are medically complex and have a good chance of improvement.

CMS' concerns about the potential for inappropriate admissions could easily and appropriately be addressed by adopting a set of criteria with QIO monitoring that would directly address the issue of appropriate care being delivered in appropriate settings throughout the entire provider group. Not only would this result in better care for Medicare beneficiaries, but also it should address all of CMS' concerns about the relationships between acute care hospitals and LTCHs in general. I understand that in the past CMS has expressed a concern over the lack of available funding for additional QIO reviews. I also understand that in response to this concern, NALTH suggested that LTCHs forgo half of their expected market basket increase with the other half being used to fund QIO reviews. Since CMS has proposed no market basket increase for LTCHs in this rule, I can only assume there are now funds available to help defray the cost of QIO reviews if CMS chooses to do so.

In addition, CMS' proposal to provide a zero fiscal year 2007 update, combined with the proposed SSO proposal will amount to an 11 percent payment cut for LTCHs and will force many LTCHs to operate at a loss. It is unfair and unreasonable to deny LTCHs any inflation allowance. At a minimum, it will reduce our ability to finance medical care and services provided to indigent populations and defray the cost of bad debts.

In conclusion, I strongly urge CMS to reconsider the misguided changes to the short stay outlier policy and to make a meaningful commitment to the development of facility and patient centered admissions criteria. As mentioned previously, both the short stay outlier policy, and the 25 percent patient cap for hospital-within-hospital LTCHs, are arbitrary policies that will put patient care in severe jeopardy, while making no progress toward MedPAC's goal of ensuring that patients are treated in the most appropriate settings. Utilizing QIO reviews to enforce facility and patient centered admissions criteria, consistent with MedPAC's recommendations, is a viable patient-centered solution that will address CMS' concerns, promote free and fair competition throughout the LTCH industry, and not harm those providers who are admitting patients appropriately.

Thank you for your consideration. Please do not hesitate to call on us if we may be of assistance.

Sincerely,

Ray Owens
Administrator
Dubuis Hospital of Alexandria

Submitter : **Mr. Peter Miller** **Date: 03/20/2006**

Organization : **Noland Health Services**

Category : **Hospital**

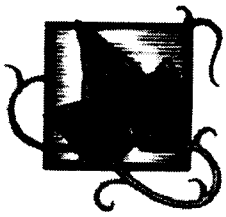
Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1485-P-51-Attach-1.PDF



NOLAND HEALTH SERVICES

March 17, 2006

Hon. Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & 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 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 the comments and recommendations of Noland Health Services, Inc to the proposed annual payment rate updates, policy changes, and clarifications under the prospective payment system for long-term care hospitals ("LTCH PPS") for fiscal year ("FY") 2007, which were published by the Centers for Medicare & Medicaid Services ("CMS") on January 27, 2006.

Noland Health Services (NHS) is a not-for-profit healthcare organization headquartered in Birmingham, Alabama that operates five Long Term Acute Care Hospitals in Anniston, Birmingham, Dothan, Montgomery and Tuscaloosa, AL. Noland Health Services is a member of the Acute Long Term Hospital Association (ALTHA) and fully supports the comment letter and proposals from ALTHA dated March 11, 2006.

NHS 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. NHS has analyzed the financial impact of the proposed rule on its operations and has determined that the impact on NHS reimbursement will be a significant reduction in Medicare revenue and operating margin. At least one of our hospitals (Long Term Hospital of Tuscaloosa, the only LTCH in a six county region of West Alabama), would not have been financially viable, i.e. would have experienced negative Medicare margins, if this rule had been in effect this year. Its closure would remove Long Term Acute Care Services from a six county, largely rural region in West Central Alabama.

Like ALTHA, we believe that CMS used materially flawed and incomplete data in developing the proposed changes to LTCH payments for FY 2007.

NHS 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. NHS 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 uses 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 five of Noland Health Service's 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 to address the concern 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).

CMS's proposal to limit the payment for SSO cases at the IPPS payment rate would cause Noland's LTCHs to be significantly underpaid In order to quantify the impact; Noland reviewed all Medicare discharges at all five hospitals for a one year period. For SSO cases, which represent a significant percent of the Medicare patients served by Noland's LTCHs, the proposal would cause payment amounts to fall materially below the actual costs of providing care.

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 Noland *significantly* less than it costs us 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.

CMS assumes that we can change our 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, Noland's LTCHs and physicians are not able to predict a patient's length of stay at the time of admission. Therefore, Noland cannot change their behavior to accommodate these payment cuts. Instead, Noland's 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.

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 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.

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.

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. Noland LTCHs admit patients only after applying an objective and rigorous set of admissions screening criteria, known as the "InterQual Criteria for Long Term Acute Care" 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.

Over the past three years, Noland Health Services has had a number of reviews performed by the Alabama QIO (Alabama Quality Assurance Foundation). All of the QIO reviews have determined that Noland's LTHC admissions were appropriate and medically necessary. Our experience reinforces the experience of Kindred and Select cited in the ALTHA letter. Noland believes that 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.

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 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 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. 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.

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. 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 those 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 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.) DRG classification does not occur until after discharge, when the GROUPER software identifies the proper LTC-DRG for payment. Because the $5/6^{th}$ geometric stay thresholds are different for each LTC-DRG, it is impossible to predict whether a patient will be a SSO upon admission.

The SSO policy would penalize LTCHs for admitting LTCH-appropriate patients by paying providers below cost most of the time. Currently, Noland's LTCHs uses a patient assessment tools, 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 Alabama's QIO 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.

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.

NHS 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. NHS 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:

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 (*e.g.*, hospice and home health) 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.

CMS should allow a full update to the LTCH PPS federal rate for FY 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.

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. NHS 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.

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.

Conclusion

NHS 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. 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 review of ALTHA's analysis 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 ALTHA provided in their comment letter and we anticipate reviewing a more effective set of proposals to better define the patients and setting for long-term acute hospital care.

Sincerely,

Peter J. Miller, FACHE

Vice President, Hospital Division
Noland Health Services
PO Box 925
Fairfield, AL 35064
205.783.8581

Submitter : **Mr. mike vicario** **Date: 03/20/2006**

Organization : **ncha**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

Dear Dr. McClellan:

NCHA represents 135 hospitals in North Carolina, and thanks you for the opportunity to comment on the Long Term Care Hospital Prospective Payment System.

North Carolina has a wide network of acute care hospitals, supplemented by a smaller group of Long Term Acute Care Hospitals. These (LTCH) facilities work closely with our general acute hospitals to serve patients in need of extended hospitalization, mainly medically complex patients with needs such as ventilator care. And as more of our residents live longer, chronic illnesses and multiple co-morbidities suggest the need for LTCH care will be more pronounced. We are therefore concerned about proposed regulations in the January 27, 2006 Federal Register that would limit payments to these hospitals.

CMS has proposed to implement a new (RPL) market basket methodology to LTCHs, yet does not recommend applying it in 2007. The rationale is partly based on a Fiscal Intermediary and QIO s findings as well as anecdotal reports that patients were not receiving hospital-level care. We believe CMS should undertake a more comprehensive review of national LTCH patient records before applying such a conclusion to justify withholding the market basket based update from hospitals.

CMS also proposes to make changes to increase the outlier threshold, effectively reducing LTCH eligibility for outlier payments, and to lower the per diem rates now paid for short stay outlier (SSO) cases through modifications to the payment formula. We are concerned that this reduction in SSO payments will result in more patients remaining in short term hospital beds for extended stays when they could have benefited from LTCH services, and that a Lewin Group study found that these combined proposals would lower Medicare payments to LTCHs to 5% below the cost of providing care. The impact on LTCH hospitals, with SSOs being an estimated 40% of admissions, could result in hospital closures and thereby remove an important care option for Medicare beneficiaries.

In 2004 CMS commissioned a report from Research Triangle Institute International to assist in the development of criteria for assuring appropriate and cost-effective use of LTCHs in the Medicare Program. The report is expected in the Spring of 2006, and we believe that CMS should wait until this report is issued before promulgating new payment rules on LTCH services. This is particularly critical when such significant payment cuts to providers are being proposed.

Thank you for the opportunity to comment on these proposed rules, and please feel free to contact me if I can provide further information.

Sincerely,

Mike Vicario
Vice-President of Regulatory Affairs

CMS-1485-P-52-Attach-1.DOC

NCHA
PO Box 4449
Cary, NC 27519 - 4449

919 / 677-2400
919 / 677-4200 fax
www.ncha.org

North Carolina Hospital Association

March 16, 2006

Mark B. McClellan, M.D., Ph.D.
Administrator, Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
PO Box 8012
Baltimore, MD 21244-8012

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Thank you for the opportunity to comment on these proposed rules, and please feel free to contact me if I can provide further information.

Sincerely,

Mike Vicario
Vice-President of Regulatory Affairs

Submitter : **Mr. Robert Notarianni** **Date: 03/20/2006**

Organization : **Long Term Hospital of Anniston**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1485-P-53-Attach-1.PDF

Long Term Hospital of Anniston

March 17, 2006

Hon. Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & 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 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 the comments and recommendations of Long Term Hospital of Anniston to the proposed annual payment rate updates, policy changes, and clarifications under the prospective payment system for long-term care hospitals ("LTCH PPS") for fiscal year ("FY") 2007, which were published by the Centers for Medicare & Medicaid Services ("CMS") on January 27, 2006.

Long Term Hospital of Anniston is one of Noland Health Services hospitals. NHS is a not-for-profit healthcare organization headquartered in Birmingham, Alabama that operates five Long Term Acute Care Hospitals in Anniston, Birmingham, Dothan, Montgomery and Tuscaloosa, AL. Noland Health Services is a member of the Acute Long Term Hospital Association (ALTHA) and fully supports the comment letter and proposals from ALTHA dated March 11, 2006.

Long Term Hospital of Anniston 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. NHS has analyzed the financial impact of the proposed rule on its operations and has determined that the impact on LTHA's reimbursement will be a significant reduction in both Medicare revenue and operating margin if the rules had been in place this year.

Like ALTHA, we believe that CMS used materially flawed and incomplete data in developing the proposed changes to LTCH payments for FY 2007.

NHS 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. NHS 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 uses incomplete data and analyses to reach false assumptions about LTCHs and the patients these hospitals care for. The proposed payment changes will

400 East 10th Street - 4th Floor, Anniston, Alabama 36207
(256) 741-6141 Fax (256) 741-6158

Noland Health Services
www.nolandhealth.com

have a severe impact on Long Term Hospital of Anniston 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 to address the concern 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).

CMS's proposal to limit the payment for SSO cases at the IPPS payment rate would cause Noland's LTCHs to be significantly underpaid. In order to quantify the impact, Noland reviewed all Medicare discharges at all five hospitals for a one year period. For SSO cases, which represent a significant percent of the Medicare patients served by Noland's LTCHs, the proposal would cause payment amounts to fall materially below the actual costs of providing care.

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 Noland *significantly* less than it costs us 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.

CMS assumes that we can change our 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, Noland's LTCHs and physicians are not able to predict a patient's length of stay at the time of admission. Therefore, Noland cannot change their behavior to accommodate these payment cuts. Instead, Noland's 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.

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 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.

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.

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. Noland LTCHs admit patients only after applying an objective and rigorous set of admissions screening criteria, known as the "InterQual Criteria for Long Term Acute Care" 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.

Over the past three years, Long Term Hospital of Anniston has had a number of reviews performed by the Alabama QIO (Alabama Quality Assurance Foundation). All of the QIO reviews have determined that our admissions were appropriate and medically necessary. Our experience reinforces the experience of Kindred and Select cited in the ALTHA letter. Noland believes that 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.

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 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 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. 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.

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. 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 those 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 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.) 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.

The SSO policy would penalize LTCHs for admitting LTCH-appropriate patients by paying providers below cost most of the time. Currently, Noland's LTCHs uses a patient assessment tools, 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 Alabama's QIO 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.

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.

NHS 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. NHS 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:

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 (*e.g.*, hospice and home health) 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

NHS 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.

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 not 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.

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, NHS 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.

Conclusion

NHS 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. 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 review of ALTHA's analysis 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 ALTHA provided in their comment letter, and we anticipate reviewing a more effective set of proposals to better define the patients and setting for long-term acute hospital care.

Sincerely,

Robert G. Notarianni, CHE
Administrator
Long Term Hospital of Anniston

Submitter : Mr. Xavier Ritchie **Date:** 03/20/2006

Organization : Long Term Hospital of Birmingham

Category : Hospital

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

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

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50 Medical Park East Drive
8th Floor
Birmingham, AL 35235
(205) 838-5100
Fax: (205) 838-5101

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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 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 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. 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.

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. 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 those 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 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.) DRG classification does not occur until after discharge, when the GROUPER software identifies the proper LTC-DRG for payment. Because the $5/6^{th}$ geometric stay thresholds are different for each LTC-DRG, it is impossible to predict whether a patient will be a SSO upon admission.

The SSO policy would penalize LTCHs for admitting LTCH-appropriate patients by paying providers below cost most of the time. Currently, Noland's LTCHs uses a patient assessment tools, 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 Alabama's QIO 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.

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.

NHS 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. LONG TERM HOSPITAL OF BIRMINGHAM 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:

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 (*e.g.*, hospice and home health) 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.

CMS should allow a full update to the LTCH PPS federal rate for FY 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.

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. LONG TERM HOSPITAL OF BIRMINGHAM 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.

NHS 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.

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.

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, LONG TERM HOSPITAL OF BIRMINGHAM 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.

Conclusion

NHS 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. 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 review of ALTHA's analysis 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 ALTHA provided in their comment letter, and we anticipate reviewing a more effective set of proposals to better define the patients and setting for long-term acute hospital care.

Sincerely,

Xavier Ritchie

Xavier Ritchie, Administrator
Long Term Hospital of Birmingham

Submitter : **Mr. Adam Wright** **Date: 03/20/2006**

Organization : **Long Term Hospital of Tuscaloosa**

Category : **Long-term Care**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1485-P-55-Attach-1.PDF

Long Term Hospital of Tuscaloosa

March 17, 2006

Hon. Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & 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 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 the comments and recommendations of Long Term Hospital of Tuscaloosa, LLC to the proposed annual payment rate updates, policy changes, and clarifications under the prospective payment system for long-term care hospitals ("LTCH PPS") for fiscal year ("FY") 2007, which were published by the Centers for Medicare & Medicaid Services ("CMS") on January 27, 2006.

Long Term Hospital of Tuscaloosa is one of Noland Health Services' (NHS) Hospitals. NHS is a not-for-profit healthcare organization headquartered in Fairfield, Alabama that operates five Long Term Acute Care Hospitals in Anniston, Birmingham, Dothan, Montgomery and Tuscaloosa, AL. Noland Health Services is a member of the Acute Long Term Hospital Association (ALTHA) and fully supports the comment letter and proposals from ALTHA dated March 11, 2006.

NHS 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. NHS has analyzed the financial impact of the proposed rule on its operations and has determined that the impact on Medicare reimbursement and operating margin will be significant. My hospital, the only LTCH in a seven county region of West Alabama), would not have been financially viable, i.e. would have experienced a negative operating margin, if this rule had been in effect this year. Our closure would remove Long Term Acute Care Services from these Medicare beneficiaries in Lamar, Fayette, Tuscaloosa, Hale, Greene, Sumter and Pickens county.

Like ALTHA, we believe that CMS used materially flawed and incomplete data in developing the proposed changes to LTCH payments for FY 2007.

NHS 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. NHS 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 uses 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 five of Noland Health Service's 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 to address the concern 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).

CMS's proposal to limit the payment for SSO cases at the IPPS payment rate would cause Noland's LTCHs to be significantly underpaid. In order to quantify the impact, Noland reviewed all Medicare discharges at all five hospitals for a one year period. For SSO cases, which represent a significant percent of the Medicare patients served by Noland's LTCHs, the proposal would cause payment amounts to fall materially below the actual costs of providing care.

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 Noland ***significantly*** less than it costs us 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.

CMS assumes that we can change our 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, Noland's LTCHs and physicians are not able to predict a patient's length of stay at the time of admission. Therefore, Noland cannot change their behavior to accommodate these payment cuts. Instead, Noland's 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.

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 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.

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.

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. Noland LTCHs admit patients only after applying an objective and rigorous set of admissions screening criteria, known as the "InterQual Criteria for Long Term Acute Care" 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.

Over the past three years, Noland Health Services has had a number of reviews performed by the Alabama QIO (Alabama Quality Assurance Foundation). All of the QIO reviews have determined that Noland's LTHC admissions were appropriate and medically necessary. Our experience reinforces the experience of Kindred and Select cited in the ALTHA letter. Noland believes that 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.

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 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 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. 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.

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 does not support this assumption. 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.

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The SSO policy would penalize LTCHs for admitting LTCH-appropriate patients by paying providers below cost most of the time. Currently, Noland's LTCHs uses a patient assessment tools, 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 Alabama's QIO 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.

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.

NHS 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. NHS 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:

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 (*e.g.*, hospice and home health) 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.

CMS should allow a full update to the LTCH PPS federal rate for FY 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.

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. NHS 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.

NHS 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.

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.

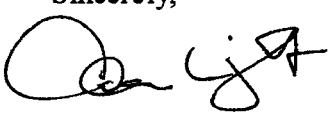
Without a doubt, the aggregate effect of the currently proposed LTCH PPS payment reduction, the recent reweighting of the LTC-DRGs, and the amended guidelines regarding DRG 475 would be significant. Consequently, NHS submits that CMS's conclusion that it does not "expect any changes in the quality of 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.

Conclusion

NHS 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. 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 review of ALTHA's analysis 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 ALTHA provided in their comment letter, and we anticipate reviewing a more effective set of proposals to better define the patients and setting for long-term acute hospital care.

Sincerely,



Adam Wright,
Administrator
Long Term Hospital of Tuscaloosa

Submitter : Mr. David Adcock

Date: 03/20/2006

Organization : Dubuis Hospital of Texarkana

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attachment

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

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

Please see attachment

CMS-1485-P-56-Attach-1.DOC

CMS-1485-P-56-Attach-2.DOC

March 20, 2006

Mark McClellan, M.D., Ph.D.
Administrator, Centers for Medicare & Medicaid Services
Attn: CMS–1485–P
P.O. Box 8011
Baltimore, MD 20244-8011

RE: Comments of Dubuis Health System, Inc.
Docket: CMS-1485-P

Dear Dr. McClellan:

I am the CEO of Dubuis Hospital, located in Texarkana, Texas. I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed changes to the regulations governing long-term care hospitals. Dubuis Hospital is a member of Dubuis Health System. Dubuis is the largest not-for-profit, faith-based, long-term acute care hospital system in the U.S.

I am concerned that the proposed [CMS-1485-P] rule continues CMS' pattern of enacting arbitrary payment provisions that will have devastating effects on my hospital and the entire LTCH industry and completely disregards the medical needs of our patients. I am particularly concerned with the ill-advised changes to the short-stay outlier. Rather than assuming that the growth of LTCHs in recent years indicates abuse of the system, CMS should consider whether the growth is in response to a legitimate need as the value of LTCHs has become more apparent.

Allow me to assure you that I fully understand the concerns CMS has expressed that there may be inappropriate admissions of some LTCH patients. Like all hospitals in the Dubuis system, my hospital only accepts patients who are pre-screened by an interdisciplinary team to determine that admission criteria are met. Dubuis worked hard for several years to develop criteria that would ensure that its hospitals make appropriate admissions decisions. The criteria served as the template for those later refined and adopted by the National Association of

Long Term Hospitals (NALTH). However, not all LTCHs use the same criteria. Neither the short stay outlier provision nor the 25 percent patient cap on hospital-within-hospital LTCHs will do anything to address inappropriate admissions practices. They will, however, irreparably harm hospitals like mine who are attempting to play by the rules and will needlessly place access to LTCH care in jeopardy. Only admission criteria that are standardized industry-wide, along with intensive QIO review, will effectively address the problem.

CMS seems to be under the impression that LTCH patients are no different than patients being treated as outliers in acute care hospitals. This assumption is simply false. It is true that in many parts of the country where there are no LTCHs, patients are being treated in acute care hospitals. However, one cannot assume these patients are receiving the same quality of care as would be provided in an LTCH, nor can CMS assume they have the same outcomes. LTCHs offer cost-effective clinical benefit to patients suffering from severe and complex illnesses and provide specialized services that are not always available in acute care hospitals. One local acute care hospital operates a ventilator step down unit in their facility. Our hospital receives, on the average, two patients each month from the ventilator step down unit. These patients have at least two weeks in the step down unit without successful weaning. Upon admission to Dubuis Hospital, 60% of these patients are successfully weaned from the ventilator and subsequently discharged to a lower level of care.

Studies have shown that compared to acute care outliers, <u>appropriately</u> admitted LTCH patients have a lower mortality rate, a lower readmission rate, a lower utilization of other post acute services, lower overall costs, and are often discharged with a higher level of functionality. Clearly, CMS is failing to recognize the high level of care patients receive in LTCHs. To provide a parallel example, we note that the vast majority of the country is not served by a children's hospital. In these areas, children are often treated in the pediatric units of acute care hospitals. Does CMS believe that severely ill children are no better off in a children's hospital than an acute care pediatric unit or in a general hospital?

The fundamental principle behind any prospective payment system is the law of averages. By definition, the mean length of stay in any system will see 50 percent of the cases above it and 50 percent of the cases below it. Likewise, $5/6^{th}$ of the mean length of stay will always see approximately 40 percent of cases below it. Because the $5/6^{th}$ threshold is a function of the distribution you should expect to see 40 percent of cases below it. What the rule does not recognize is that LTCH patients are significantly more medically complex than

ACH patients. You have not demonstrated that there is any relationship between a SSO patient's LTCH LOS and the patient's level of medical complexity. Yet, you are using one (LOS) as a proxy to represent the other (medical complexity), thereby making the false assumption that all short stay outliers represent inappropriate LTCH admissions. To drastically cut payments for the short stay outliers based on this flawed assumption will undermine the very law of averages on which prospective payment systems are based.

Many times a patient's recovery in the LTAC requires daily coordination among all disciplines of their care team (including physician, nursing, respiratory therapy, physical therapy, occupational therapy, speech therapy, nutritional therapy, and case management). Although acute care hospitals try to provide such coordinated dedication to an individual patient's long term recovery, the reality is that it is interrupted by more urgent, though not necessarily more important priorities. It is the volume and urgency of new, unstable patients throughout the day which greatly limits the acute care provider's attention to the chronic critically-ill patient.

Contrary to CMS' assumptions, the Lewin Group compared the resource use of IPPS cases to LTCH SSO cases for all common DRGs. They used average standardized charge data for LTCH and acute care hospital cases combined and used CMS' methodology for computing relative weights for each LTCH DRG and Acute Care DRG using a common national average charge denominator. The Lewin Group study found that LTCH SSO cases have mean DRG weights that are 76 percent higher than comparable DRG weights for IPPS cases. As a result, they concluded the IPPS payment system is not appropriate for the payment of LTCH SSO cases. This data flies in the face of your assumption that SSO is a proxy for inappropriate LTCH admission. As a result, should you finalize this policy, you are simply making an arbitrary 11% reduction in payments to LTCHs.

Make no mistake, the financial impact of the proposed short stay outlier changes are severe. For my hospital, the revenue reduction is projected to be $1.1 million. The Dubuis system as a whole has forecasted that if we continued to do business exactly the way we do now, our reimbursement would decrease 17%. This is well into the negative range for us. Because of our commitment to charity care and the acuity of patients we serve, we do not have the large profit margins that have been cited.

Properly admitted LTCH patients are by definition the most severe and medically-complicated cases. As such, the expected length of stay will be much longer

than that of an acute care hospital, even for common DRG's. Take for example DRG 12 (degenerative nervous system disorder). Under the proposed SSO policy, there is no distinction made for severity of the condition, i.e. a minor stroke that might be treated in an acute care hospital versus a major stroke with complications and residual effects that might be better treated in a LTCH. The LTCH mean length of stay for this DRG is 25.5 days. Therefore, the 5/6th threshold is 21.25 days. The IPPS length of stay is only 4.3 days. A patient with LTCH DRG 12 may stay at a LTCH for 20 days and thus be a short-stay outlier, but that stay is still five times the IPPS length of stay. Is a stay that is 83 percent of the average LOS really an abuse of the short stay outlier? It is simply wrong to reimburse a 20 day LTCH stay at a 4 day acute care level. This policy will severely harm patient care and have no effect on the issues CMS is attempting to address. In fact, some LTCHs may be inclined to keep anyone passing the acute mean LOS up to the LTCH mean regardless of their medical situation, thus ensuring "gaming" of the system for financial benefit. However, let me assure you, our decisions will continue to be guided first and foremost by medical professionals and the best interests of our patients.

The more appropriate approach to ensuring that medical necessity is the sole driving force behind clinical care decisions would be to tie reimbursement under the LTCH PPS system to clinical quality measures, such as those proposed by MedPAC, and admissions criteria such as NALTH's. Dubuis is impressed with the diligent efforts that MedPAC has undertaken and is fully supportive of MedPAC's recommendations to define LTCHs by facility and patient criteria that ensure that patients admitted to these facilities are medically complex and have a good chance of improvement.

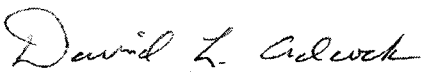
CMS' concerns about the potential for inappropriate admissions could easily and appropriately be addressed by adopting a set of criteria with QIO monitoring that would directly address the issue of appropriate care being delivered in appropriate settings throughout the entire provider group. Not only would this result in better care for Medicare beneficiaries, but also it should address all of CMS' concerns about the relationships between acute care hospitals and LTCHs in general. I understand that in the past CMS has expressed a concern over the lack of available funding for additional QIO reviews. I also understand that in response to this concern, NALTH suggested that LTCHs forgo half of their expected market basket increase with the other half being used to fund QIO reviews. Since CMS has proposed no market basket increase for LTCHs in this rule, I can only assume there are now funds available to help defray the cost of QIO reviews if CMS chooses to do so.

In addition, CMS' proposal to provide a zero fiscal year 2007 update, combined with the proposed SSO proposal will amount to an 11 percent payment cut for LTCHs and will force many LTCHs to operate at a loss. It is unfair and unreasonable to deny LTCHs any inflation allowance. At a minimum, it will reduce our ability to finance medical care and services provided to indigent populations and defray the cost of bad debts.

In conclusion, I strongly urge CMS to reconsider the misguided changes to the short stay outlier policy and to make a meaningful commitment to the development of facility and patient centered admissions criteria. As mentioned previously, both the short stay outlier policy, and the 25 percent patient cap for hospital-within-hospital LTCHs, are arbitrary policies that will put patient care in severe jeopardy, while making no progress toward MedPAC's goal of ensuring that patients are treated in the most appropriate settings. Utilizing QIO reviews to enforce facility and patient centered admissions criteria, consistent with MedPAC's recommendations, is a viable patient-centered solution that will address CMS' concerns, promote free and fair competition throughout the LTCH industry, and not harm those providers who are admitting patients appropriately.

Thank you for your consideration. Please do not hesitate to call on us if we may be of assistance.

Sincerely,



David L. Adcock, CHE

March 20, 2006

Mark McClellan, M.D., Ph.D.
Administrator, Centers for Medicare & Medicaid Services
Attn: CMS–1485–P
P.O. Box 8011
Baltimore, MD 20244-8011

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CMS' concerns about the potential for inappropriate admissions could easily and appropriately be addressed by adopting a set of criteria with QIO monitoring that would directly address the issue of appropriate care being delivered in appropriate settings throughout the entire provider group. Not only would this result in better care for Medicare beneficiaries, but also it should address all of CMS' concerns about the relationships between acute care hospitals and LTCHs in general. I understand that in the past CMS has expressed a concern over the lack of available funding for additional QIO reviews. I also understand that in response to this concern, NALTH suggested that LTCHs f orgo half of their expected market basket increase with the other half being used to fund QIO reviews. Since CMS has proposed no market basket increase for LTCHs in this rule, I can only assume there are now funds available to help defray the cost of QIO reviews if CMS chooses to do so.

In addition, CMS' proposal to provide a zero fiscal year 2007 update, combined with the proposed SSO proposal will amount to an 11 percent payment cut for LTCHs and will force many LTCHs to operate at a loss. It is unfair and unreasonable to deny LTCHs any inflation allowance. At a minimum, it will reduce our ability to finance medical care and services provided to indigent populations and defray the cost of bad debts.

In conclusion, I strongly urge CMS to reconsider the misguided changes to the short stay outlier policy and to make a meaningful commitment to the development of facility and patient centered admissions criteria. As mentioned previously, both the short stay outlier policy, and the 25 percent patient cap for hospital-within-hospital LTCHs, are arbitrary policies that will put patient care in severe jeopardy, while making no progress toward MedPAC's goal of ensuring that patients are treated in the most appropriate settings. Utilizing QIO reviews to enforce facility and patient centered admissions criteria, consistent with MedPAC's recommendations, is a viable patient-centered solution that will address CMS' concerns, promote free and fair competition throughout the LTCH industry, and not harm those providers who are admitting patients appropriately.

Thank you for your consideration. Please do not hesitate to call on us if we may be of assistance.

Sincerely,

David L. Adcock

David L. Adcock, CHE

Submitter : Ms. PATRICIA ANDERSEN **Date:** 03/20/2006

Organization : OKLAHOMA HOSPITAL ASSOCIATION

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED LETTER FROM OKLAHOMA HOSPITAL ASSOCIATION
THANK YOU.

CMS-1485-P-57-Attach-1.DOC

March 20, 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

Re: Comments on Medicare Program; 2007 Proposed Update Rule Published at 71 Federal Register 4648 *et seq*.

Dear Dr. McClellan:

The Oklahoma Hospital Association submits 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. LTCHs serve a significant percentage of Medicare patients residing in Oklahoma. They treat severely ill and medically complex patients and offer specialized services and programs of care which are not otherwise available. LTCHs serve as a vital component of the State's health care system. CMS' proposed short-stay outlier rule and zero update proposals would drastically reduce payments to LTCHs in fiscal year 2007 by approximately 15 percent forcing LTCHs to operate at a loss when treating Medicare patients. The Oklahoma Hospital Association urges CMS to not adopt the proposed short-stay outlier rule and zero update proposal because the continued operation of LTCHs in the State of Oklahoma and the patients they serve will be placed in jeopardy if they are adopted.

Short-Stay Outlier Proposal

CMS states the objective of the Short-Stay Outlier (SSO) rule is to preclude admission of SSO patients to long-term care hospitals (LTCHs). CMS' presumption is that SSO cases should have remained in acute hospitals. 71 Fed. Reg. at 4688. As discussed below this presumption is wrong.

Through the SSO policy CMS has assumed that SSO patients in LTCHs are similar to short-term acute hospital patients assigned to the same DRGs. To the contrary SSO patients have a relative case-mix index of 2.0592 which is 110% greater than the relative case-mix index of 0.98734 assigned to patients with the same DRGs in short-term

acute hospitals. These SSO patients therefore have a higher medical acuity and use more medical resources than are reflected in short-term hospital payments. The higher acuity of LTCH SSO cases is further demonstrated by a higher death rate of 19.61% for SSO cases in LTCHs vs. 4.81%. The average length of stay of SSO cases in LTCHs is 72% greater (12.7 days vs. 7.4 days) than the average stay in short-term acute care hospitals.[1]

CMS also assumes that LTCHs are able to predict, prior to admission, which patients will become SSOs. There is no way for LTCHs to make such a prediction. Long-term care hospital patients suffer from multi-system body failures with peaks and valleys in their medical conditions. Their conditions may unpredictability improve or deteriorate at any time. SSO cases are admitted to LTCHs at the appropriate level of care based on the medical judgment of their treating physicians. It is impossible to pre-screen patients and effectively identify which patients may become SSOs. There are a myriad of reasons why a patient admitted to an LTCH may become a SSO. Some SSO cases may achieve medical stability sooner than originally expected. Other cases may become SSOs because they require discharge to an acute hospital due to a deteriorating condition or a new condition which develops subsequent to their admission to an LTCH. Other patients admitted to LTCHs from acute care hospitals may become SSO cases due to their unexpected death. Some patients and their families, after realizing the gravity of their condition, may simply give up and request that aggressive treatment be stopped after admission. Other patients may sign themselves out against medical advice.

There is no basis for a proposed rule which assumes that SSO cases should have remained in acute hospitals. CMS ignores the fact that a significant number of SSO cases are not admitted from acute hospitals but rather, at the direction of a patient's attending physician, are admitted from home or a nursing facility. It is inappropriate for CMS to presume that a patient admitted to an LTCH from a non-acute hospital setting, at the direction of the patient's attending physician, who subsequently becomes a SSO should not have been admitted to the LTCH in the first place.

CMS also disregards the fact that a percentage of SSO cases are crossover cases that exhaust Medicare Part A benefits during their LTCH stay. It would be unfair to preclude these Medicare recipients from admission to an LTCH simply based on the number of their remaining Medicare days.

The proposed SSO rule is an unprecented intrusion on physician decision making and contrary to long standing Medicare principles that govern medical necessity determinations. It would impose a payment adjustment as a mechanism to disqualify a patient for hospital services and intrude upon a physician's ability to admit patients to LTCHs based on medical necessity, i.e., the need for specific programs of care and services provided in the LTCH.

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[1] This data is obtained from a March 3, 2006 report by The Lewin Group prepared for the National Association of Long Term Hospitals.

Further, CMS ignores MedPAC's recommendation contained in its June 2004 report to Congress that CMS designate Quality Improvement Organizations (QIOs) to review the medical necessity of LTCH patient admissions. There is a comprehensive statutory and regulatory scheme which vests QIOs with authority to review the medical necessity of hospital services provided to Medicare beneficiaries. QIOs, which are composed of licensed doctors of medicine, determine, among other things, whether inpatient hospital services furnished to Medicare beneficiaries are consistent with generally accepted standards of medical care, or could be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type and the medical necessity, reasonableness and appropriateness of hospital admissions and discharges. See Sections 1154(a)(1) and (3)(C) and of the Social Security Act and 42 C.F.R. §476.71(a).

The proposed SSO policy conflicts with the principles applied by QIOs to determine whether SSO cases should remain in an acute hospital. QIOs apply professionally developed criteria including screening criteria in making their determinations. See Section 1154(a)(1)(B) and 6(A) of the Act and 42 C.F.R. §476.100. They also assess the appropriate medical care available in the community. See 50 *Fed. Reg.* 15312, 15316 (April 17, 1985). QIOs are required to use national, or where appropriate, regional norms in conducting their review. See Section 1154(a)(6)(A) of the Act and 42 C.F.R. §476.100(a). QIOs also are required to establish written criteria based on typical patterns of practice in the QIO area, or to use national criteria, where appropriate. See 42 C.F.R. §476.100(c). CMS' presumption that all SSO cases should remain in acute care hospitals lacks factual support and fails to consider which type of hospital care and programs are in the best interest of Medicare beneficiaries. It irreconcilably conflicts with the statutory and regulatory scheme which delegates to QIOs' the responsibility to establish criteria which are to operate in the best interest of Medicare beneficiaries.

No Fiscal Year 2007 Update

CMS' proposal to provide a zero fiscal year 2007 update, combined with the proposed SSO proposal will force LTCHs to operate at a loss. It is unfair and unreasonable to deny LTCHs any inflation allowance particularly since the applicable fiscal year 2007 market basket increase is 3.6%. CMS' proposal places the ongoing operation of LTCHs in the State of [Name of State] in jeopardy. At a minimum, it will reduce LTCHs' ability to finance medical care and services provided to indigent populations and defray the cost of bad debts. Ultimately, it will threaten LTCHs' in the State of [Name of State] ability to survive.

In view of the foregoing the Oklahoma Hospital Association respectfully requests CMS to not adopt the proposed SSO policy and to grant LTCHs a reasonable inflation update for fiscal year 2007.

Sincerely,

OKLAHOMA HOSPITAL ASSOCIATION

Patricia Andersen

Patricia Andersen, CPA

Vice-President for Finance & Strategic Information

Submitter : Ms. Melissa Dehoff **Date: 03/20/2006**

Organization : The Hospital & HealthSystem Assoc. of PA

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1485-P-58-Attach-1.DOC

HAP

THE HOSPITAL & HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA

March 20, 2006

Mark McClellan, M.D. PhD.
Administrator
Centers for Medicare & Medicaid Services
Attn: CMS-1485-P
P.O. Box 8012
Baltimore, MD 20244-8011

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

Dear Dr. McClellan:

On behalf of The Hospital & Healthsystem Association of Pennsylvania (HAP), which represents approximately 250 member institutions, including 125 stand-alone hospitals and another 120 hospitals that comprise 32 health systems across the state, we appreciate this opportunity to comment on the proposed rule concerning the long-term care hospital prospective payment system (LTCH PPS) for rate year (RY) 2007. Our comments focus on several significant changes in this proposed rule: omission of the 3.6 percent market basket update and most importantly, the proposed changes to the short-stay outlier (SSO) policy. The net impact of this proposed rule, which lower payments by 14.7 percent, is significant and would severely harm and threaten patient access to LTCH care.

Proposed Changes to LTCH PPS Payment Rates for 2007 Rate Year

Based on CMS' introduction of a new market basket methodology (rehabilitation, psychiatric and long-term care–RPL) for LTCHs in fiscal year (FY) 2007, the rate of inflation and growth for LTCHs in 2007 was calculated by the Centers for Medicare & Medicaid Services (CMS) to be 3.6 percent. However, CMS is not recommending that this inflationary update be applied, thus proposing to maintain the LTCH standard payment rate at the current level of $38,086.04. CMS' rationale for this decision was based on the case-mix index (CMI) and their analysis that indicated that from FY 2003 to FY 2004, the LTCH CMI increased 6.75 percent. CMS estimated that 4.0 percent of this change was due to changes in coding practices and increases in patient acuity. CMS also cites concerns that case-mix index increases have led to Medicare payment increases in the cost of treating patients and alluded to LTCHs possibly treating patients that do not need hospital-level care.

4750 Lindle Road
P.O. Box 8600
Harrisburg, PA 17105-8600
717.564.9200 Phone
717.561.5334 Fax
www.haponline.org

While HAP supports the introduction of the new RPL market basket methodology for the LTCH PPS to provide a more precise measure of inflation and a more homogeneous group, we have reservations about the new methodology. For example, it appears that disparate length of stay trimming methodologies were used to develop this RPL market basket. Additionally, it appears that data gaps were filled by substituting inpatient prospective payment (IPPS) data. Because of this inconsistent approach, we urge CMS to work with the LTCH community to improve the RPL cost reports to eliminate the need to use the data from IPPS, which is not an accurate reflection of LTCHs.

We also recommend that CMS update the RPL market basket on a regular basis, especially since a large percentage of these providers only recently converted to prospective payment and their cost structures may be changing. For example, there are many LTCHs that did not begin the transition to LTCH PPS until close to the start of fiscal year 2004, which was the second year of the LTCH PPS transition period. Updating the market basket on an annual basis allows providers to compensate for year-to-year inflationary increases in the cost of delivering health care services. In particular, the increases are necessary for maintaining an accurate payment system that helps providers safely care for patients. CMS has stated that freezing the federal rate will eliminate the effect of coding or classification changes that do not reflect changes in the LTCHs' case mix. There are questionable beliefs on CMS' part regarding their interpretation of rises in case-mix index for LTCHs 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. As a result of all of these factors, the LTCH PPS federal rate for RY 2007 should be updated.

Proposed Changes to Short-Stay Outlier Payments

System Based on Averages

CMS proposes to significantly modify the LTCH Short-Stay Outlier (SSO) policy, which is intended to discourage LTCHs from admitting short-stay cases. 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 (ALOS) for each long-term care diagnosis related group (LTC-DRG). Currently, payment for SSO patients is based on the lesser of:

- the full LTCH DRG payment;
- 120 percent of the LTCH DRG per diem; or
- 120 percent of the cost of the SSO case.

CMS proposes to modify the current SSO policy in two ways:

- lower the SSO case reimbursement based on 120 percent of cost to 100 percent; and
- add a new (fourth component to the current formula), and substantially lower, payment alternative- an amount "comparable" to the DRG rate under the inpatient PPS.

Prospective payment systems by design are based on averages. Some patients have longer lengths of stay; some shorter. CMS' proposed policy looks at the SSO data out of context and therefore is inconsistent with averages that are the backbone of every prospective payment system developed by Medicare. For the system of averages to be fair and sustainable, patients with below-average costs are needed to offset those losses experienced for patients with above-average costs. CMS has validated this principle on many occasions. For example, in the August 2002 final rulemaking that established the LTCH PPS, CMS stated that paying for cases treated in excluded hospitals, such as LTCHs, under the inpatient PPS would be "inaccurate and unfair" since these cases were not included in the inpatient PPS system of averages. CMS indicated that the LTCHs would essentially be underpaid if paid under the inpatient PPS. By CMS' own admission, they cannot pay LTCHs at rates comparable to the IPPS rates for SSO patients. As a result, we feel the proposed SSO changes would violate the integrity of the LTCH PPS by applying the inpatient PPS rates to an LTCH population that is very different from the inpatient PPS population.

Additionally, it is critical that each Medicare PPS set payments at a level that covers the cost of providing care. Doing so helps ensure that providers have the resources they need to deliver appropriate care in a safe manner. The data does not support the position provided 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. Our LTCH members serve a unique population of patients—those that are too medically complex to be discharged to home, skilled nursing facility, nursing home or even acute rehabilitation settings, and yet not acute enough to warrant continued stay in the intensive care unit setting. LTCHs, therefore, provide a viable means of addressing patient flow challenges in the acute care setting, while simultaneously meeting the complex medical needs of this special group of patients. CMS' proposed rule will result in payment levels well below the LTCHs' costs of caring for these short stay patients. The bottom line is that 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. The combined effect of CMS' proposed rule is to cut rates to an unprecedented level where LTCHs would actually experience negative Medicare margins. Under this proposed rule, CMS would exclude the 3.6 percent market basket update and reduce overall LTCH payments by 11.1 percent, largely through the proposed SSO changes. According to an analysis by The Lewin Group, the combined impact of CMS' recommendations for RY 2007 would lower Medicare payments to LTCHs to 5 percent below the cost of providing care. This would greatly impact the ability of providers to provide care to their patients in a safe manner.

In the proposed rule, CMS asserts that SSO patients do not require the full measure of resources available in a hospital that has been established to treat patients requiring long-stay hospital services and basically equates a short-stay outlier case as an inappropriate LTCH admission. Based on this assertion, it is clear CMS does not have a full understanding of SSO thresholds. The SSO thresholds have nothing to do with the appropriateness of an LTCH admission. The SSO thresholds are the mathematical result of the per diem rates that CMS established for cases whose lengths of stay is less than the average for a particular LTC-DRG. Given the definition for SSO cases includes a five-sixths of the cases with a length of stay mean, CMS should presume that a large portion

of all LTCH cases would fall within the SSO range. CMS should not expect that the 37 percent rate of SSO cases would continue to drop, given the current definition of a SSO. When the LTCH SSO definition is applied to inpatient PPS, approximately 40 percent of inpatient PPS cases satisfy the LTCH SSO definition, which is a rate similar to the LTCH SSO rate. As a result, a SSO level in the current range should be expected and not viewed as inappropriate. In order for the percentage of SSO cases to decline further, CMS needs to consider changing the definition for SSO cases. The LTCH SSO policy should not be adopted as proposed. CMS' proposal would lead to a significant and unwarranted reduction in payments for patients appropriately admitted to, and receiving care in, LTCHs.

LTCHs Care For a Unique Population

CMS states that by treating SSO cases, LTCHs may be functioning like an acute care hospital. Based on this statement, CMS needs to review the essential differences between the LTCH case mix, including SSO cases, and the case mix treated by acute care hospitals under inpatient PPS. The Lewin Group compared common LTCH and inpatient PPS DRGs and found that the CMI for LTCH SSO cases is more than double the CMI for acute care hospitals. There is clinical documentation that LTCHs treat a substantially different patient population, with virtually no other treatment options than the typical short-term general hospital patient in similar diagnostic categories. These patients have a higher acuity and multiple medical complexities. This is the reason why Congress created this special class of hospitals in 1983.

There is also a major difference when comparing average length of stay (ALOS). Medicare data show that "short stay" LTCH patients actually have a much longer length of stay than the average short-term acute hospital patient with the same diagnosis. The length of stay is longer because the LTCH patient is, on average, more medically complex. Data based on the five most common SSO LTC-DRGs compared with the average length of stay for those stays with the average length of stay for the average general acute care hospital patient shows that the LTCH SSO patient lengths of stay greatly exceed that of patients treated in general short-term care hospitals. In fact the LTCH SSO cases have an ALOS that is more than twice as long as the ALOS for inpatient PPS hospitals, 12.7 days versus 5.6 days, respectively. Therefore, these patients are not clinically similar. These differences reflect the more specialized needs, and more complex 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 and are fundamentally different.

Analyses of patient severity and cost also validate the need for a separate LTCH payment system based on the distinctly unique population treated by LTCHs. The studies affirm the inappropriateness of applying an inpatient PPS payment—based on the average cost of treating an entirely different set of patients—to LTCHs. The inpatient PPS rates, even when adjusted for outliers, are not designed or intended for the high-complexity, long-stay population treated in LTCHs. As such, the agency's proposal to include inpatient PPS rates among the payment alternatives for SSO cases is unjustifiable since it is in direct contrast to the Medicare principle of establishing payments based on the average cost of treating specific types of patients. In this case, the LTCH and general acute populations are distinctly unique from one another.

Recommendations

HAP recognizes the need for appropriate oversight of LTCHs. However, the efforts used to address oversight should be based on policymaking that ensures access for patients who are medically appropriate for LTCH care. Expanding medical necessity review by clinical experts at the patient level would achieve the goals of using Medicare resources and preserving the rights of beneficiaries to access necessary care. Additionally, adding criteria to the current 25-day ALOS requirement at the facility level would produce improvement in focusing LTCH care on specific populations. These approaches should be utilized rather than the proposed SSO policy changes and the current cap on host-hospital referrals for co-located LTCHs.

The proposed rule summarizes preliminary data analyses conducted by the Research Triangle Institute International (RTI) based on research completed on analyzing the LTCH provider category and determining the feasibility of implementing MedPAC's recommendations for creating new LTCH facility and patient criteria. The research was basically completed to ensure the patients admitted to LTCHs are medically complex and have a good chance of improvement. HAP cannot provide comment to the preliminary data analyses that are presented in the proposed rule due to the insufficient description of the methodology that was used to analyze the LTCH data. The pending recommendations from RTI should be thoroughly examined by CMS and the LTCH community. HAP is open to working with CMS and the LTCH organizations to use the RTI findings as a basis for expanding the current LTCH criterion to ensure that LTCH services are targeted to patients who are clinically appropriate for the setting.

HAP strongly supports the June 2004 and March 2006 MedPAC recommendation to require CMS' Quality Improvement Organizations (QIO) to review LTCH admissions for medical necessity and monitor LTCH compliance with the expanded qualification criteria. We believe this effort demonstrates that the QIOs are equipped to perform this function in a manner that preserves access for patients who need LTCH-level care while identifying and denying payment for cases that should be treated in a different setting.

The QIO review places the decision of where a patient should be treated in the hands of licensed physicians and nurses, rather than penalizing LTCHs for treating cases simply based on the LOS or referral source. When reviewing LTCH cases for medical necessity, QIOs apply professionally developed criteria; an assessment of the appropriate medical care available in the community; and national, regional and local norms. QIO review also includes safeguards that protect the interests of Medicare beneficiaries. Under the QIO review process, beneficiaries and their physicians are eligible to discuss a particular case with the QIO reviewer prior to a determination. In addition, the QIO reviewer is required to explain "the nature of the patient's need for health care services, including all factors that preclude treatment of the patient..." QIO review also includes appeal rights for beneficiaries. This system would be clinically-focused and therefore a more effective means of ensuring appropriate patients are treated in LTCHs than the agency's SSO proposal and the current policy pertaining to host-hospital referrals to co-located LTCHs. CMS should authorize and fund an expanded QIO review. This would provide assurance to Congress and the Secretary that the Medicare funds are being utilized cautiously while still maintaining the access rights of Medicare beneficiaries. The expanded QIO review

would be an effective accompaniment to new and more specific LTCH criteria. LTCHs, in turn, would be more confident they are serving the appropriate patients. The proposed SSO policy changes incorrectly assumes that the SSO population is homogeneous, when in fact this population encompasses cases that have LOS ranges from one day to 30 days, as well as some being eligible for LTCH high-cost outlier status. Due to this large variability, these SSO cases should not be treated the same under LTCH PPS. CMS should consider the following SSO changes:

- Implement targeted payment reforms directed at very short stay cases to ensure there are no concerns with inappropriate admissions, such as transferring patients who may be near death. These cases should be paid 100 percent of costs.
- Removal of LTCH cases with a LOS greater than 20 days from the SSO definition. All cases with LOS in this category are consistent with the population intended for the LTCH setting and should be eligible for the full LTCH DRG payment.
- Remaining SSO cases should continue to be paid under the current SSO policy.

HAP appreciates the opportunity to comment on this proposed rule. We are committed to improving the LTCH PPS and look forward to working with CMS toward this goal. To discuss any questions or reactions to our comments, please contact Melissa Dehoff, HAP's director, health care continuum finance policy, at (717) 561-5318.

Sincerely,

Paula A. Bussard

PAULA A. BUSSARD
Senior Vice President, Policy & Regulatory Services

PAB/dd

Submitter :

Date: 03/20/2006

Organization : **Georgia Hospital Association**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1485-P-59-Attach-1.DOC

March 20, 2005

Mark McClellan, M.D., Ph.D.
Administrator, Centers for Medicare & Medicaid Services
Attn: CMS–1485–P
P.O. Box 8011
Baltimore, MD 20244-8011

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

Dear Dr. McClellan:

On behalf of the Georgia Hospital Association our 180 member hospitals, we appreciate the opportunity to comment on the proposed rule concerning the long-term care hospital prospective payment system (LTCH PPS) for rate year (RY) 2007. The proposed rule recommends several significant changes that are of concern to the GHA – most notably the proposal to omit the 3.6 percent market basket update and proposed changes to the short-stay outlier (SSO) policy. The alarming net impact of this proposal – negative 14.7 percent – is excessive and would severely and inappropriately threaten patient access to LTCH care.

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

The GHA supports the introduction of a new market basket methodology for the LTCH PPS – the rehabilitation, psychiatric and long-term care (RPL) market basket. While we support this more targeted and current measure of inflation for the LTCH PPS, we have some reservations about the new methodology. For instance, to develop the RPL market basket the Centers for Medicare & Medicaid Services (CMS) had to piece together sufficient data for each of the represented provider types by using disparate length of stay trimming methodologies. CMS also filled in data gaps by substituting inpatient PPS data. Thus, we encourage CMS to work with providers to improve the RPL cost reports to eliminate the need to use proxy data from the inpatient PPS. We urge CMS to update the RPL market basket on a regular basis, especially since these providers have only recently converted to prospective payment and their cost structures may be changing.

Annual market basket updates are intended to compensate for year-to-year inflationary increases in the cost of delivering health care services. An annual inflationary update to the LTCH PPS, and all prospective payment systems, is essential to maintaining an accurate payment system that helps providers safely care for patients. As such, it is

wholly inappropriate to exclude a market basket update for LTCHs in RY 2007, as recommended by the proposed rule. The RY 2007 market basket calculation of 3.6 percent under both the RPL market basket method and the current methodology validates the real inflation costs LTCHs will face next year, which must not be overlooked in the final rule. In addition, to omit the market basket update to offset coding changes is a misuse of the market basket.

Proposed Adjustment for SSO Cases

A system based on averages. An essential principle for all Medicare prospective payment systems is that payments are based on the average cost of all patients treated under that system, given the clinical characteristics and the cost of treatments associated with a particular group of patients. For the system of averages to be fair and sustainable, patients with below-average costs are needed to offset losses experienced for patients with above-average costs. The significance of upholding this principle has been validated by CMS on many occasions.

When the LTCH PPS was introduced in 2003, the agency stated in the *Federal Register* that paying for cases treated in excluded hospitals, such as LTCHs, under the inpatient PPS would be "inaccurate and unfair" since these cases were not included in the inpatient PPS system of averages. The agency also noted that paying LTCHs under the inpatient PPS could result in the systematic underpayment of LTCHs. We support CMS' views and therefore, as discussed below, feel that **the proposed SSO changes would violate the integrity of the LTCH PPS by applying inpatient PPS rates to an LTCH population that is dramatically different from the inpatient PPS population.**

In addition, it is critical that each Medicare PPS sets payments at a level that covers the cost of providing care. Doing so helps ensure that providers have the resources to deliver appropriate care in a safe manner. Under this proposed rule, CMS would exclude the 3.6 percent market basket update and reduce overall LTCH payments by 11.1 percent, largely through the proposed SSO changes. Based on analysis by The Lewin Group, **the combined impact of CMS' recommendations for RY 2007 would lower Medicare payments to LTCHs to 5 percent below the cost of providing care. This unjustifiable outcome would irresponsibly threaten the ability of providers to safely care for their patients.**

CMS proposes to significantly modify the LTCH SSO policy, which is intended by CMS to discourage LTCHs from admitting short-stay cases. SSO cases have a duration that is up to 5/6 of the geometric mean length of stay (ALOS) for a particular LTCH diagnosis-related group (DRG). Currently, SSO cases are paid the lesser of the following:

- the full LTCH DRG payment;
- 120 percent of the LTCH DRG per diem; or
- 120 percent of the cost of the SSO case.

CMS proposes to modify the current SSO policy in two ways:

- lower the SSO case reimbursement based on 120 percent of cost to 100 percent; and
- add a new, and substantially lower, payment alternative – an amount "comparable" to the DRG rate under the inpatient PPS.

The proposed SSO policy falsely equates a short-stay outlier case as an inappropriate LTCH admission. The rule overlooks the fact that by its very design, the LTCH PPS presumes a range of lengths of stay including cases above and below the ALOS. CMS states its concern that SSO cases represent 37 percent of all LTCH cases and that SSO cases "may indicate a premature discharge from the acute-care hospital and an unnecessary admission to the LTCH." However, length of stay on its own is neither an effective nor insightful indicator of medical necessity.

Given that the definition for SSO cases includes 5/6, or 83 percent, of the cases with a LOS below the mean, CMS should presume that a significant proportion of all LTCH cases would fall within the SSO range. The agency should not expect that the 37 percent rate of SSO cases would continue to drop indefinitely, given the current SSO definition. When the LTCH SSO definition is applied to the inpatient PPS, approximately 40 percent of inpatient PPS cases satisfy the LTCH SSO definition – a rate similar to the LTCH SSO rate. Therefore, a SSO level in the current range should be expected and not viewed as an indication of misconduct. If CMS wants to see the percentage of SSO cases decline further, then the definition for SSO cases needs to be changed.

The LTCH SSO policy should not be adopted as proposed. CMS' proposal is based on the unsubstantiated bias that all SSO cases are inappropriate admissions and would penalize LTCHs for treating patients who are clinically appropriate for the setting.

LTCHs care for a distinct population. CMS states that by treating SSO cases LTCHs may be "functioning like an acute care hospital." However, in taking this position CMS has overlooked essential differences between the LTCH case mix, including SSO cases, and the case mix treated by hospitals under the inpatient PPS. For instance, The Lewin Group has compared common LTCH and inpatient PPS DRGs and found that the case-mix index (CMI) for LTCH SSO cases is more than double the CMI for general acute hospitals.

A dramatic difference also is found when comparing ALOS. LTCH SSO cases have an ALOS that is more than twice as long as the ALOS for inpatient PPS hospitals, 12.7 days versus 5.6 days, respectively. Analysis by Avalere Health using All Patient Refined DRGs found that for both the total LTCH population and the LTCH SSO population, the presence of the highest levels of medically complex patients (Levels 3 and 4) is approximately double the rate found in general acute hospitals. **Similarly high severity levels for both the LTCH population and LTCH SSO cases highlight the inability of referring general acute hospitals and admitting LTCHs to identify SSO cases upon**

admission to the LTCH. This *reality* of treating severely ill patients directly challenges CMS' assertion that all SSO cases result from *intentionally* inappropriate transfers to LTCHs. In addition, these data make a clear case that the **patients treated in LTCHs, including SSO cases, are fundamentally different than the patients treated in general acute hospitals.**

These analyses of patient severity and cost also validate the need for a separate LTCH payment system with weights and rates based on the distinctly unique population treated by LTCHs. The studies affirm the inappropriateness of applying an inpatient PPS payment – based on the average cost of treating an entirely different set of patients – to LTCHs. The inpatient PPS rates, even when adjusted for outliers, are not designed or intended for the high-complexity, long-stay population treated in LTCHs. As such, **the agency's proposal to include inpatient PPS rates among the payment alternatives for SSO cases is unjustifiable since it is in direct violation of the Medicare principle of establishing payments based on the average cost of treating specific types of patients.** And in this case, the LTCH and general acute populations are distinctly unique from one another.

GHA Recommendations

The GHA recognizes that recent LTCH growth is appropriate for close oversight by Congress, CMS and others. However, **efforts to slow LTCH growth should be based on balanced and thoughtful policymaking that ensures access for patients who are medically appropriate for LTCH care.** At the facility level, adding criteria to the current 25-day ALOS requirement would produce a major improvement in focusing LTCH care on specific populations. At the patient level, expanding medical necessity review by clinical experts would achieve the goals of prudently using Medicare resources and preserving the rights of beneficiaries to access necessary care. **These balanced approaches, discussed in greater detail below, should be utilized rather than the blunt policies such as the current cap on host-hospital referrals for co-located LTCHs and the proposed SSO policy changes.** Both of these policies fail to focus on the clinical characteristics and needs of patients and instead rely on overly broad, non-clinical proxies (LOS and referral source) to determine whether an LTCH admission is appropriate.

We fully support the June 2004 and March 2006 recommendations by the Medicare Payment Advisory Committee (MedPAC) to develop more specific LTCH criteria that would expand the current facility qualification criterion to target medically-complex, long-stay patients. The pending recommendations from the Research Triangle Institute International (RTI) are highly anticipated and should be thoroughly examined by CMS and the LTCH field. **We are committed to collaborating with CMS and other LTCH organizations to use the RTI findings as a basis for expanding the current LTCH criterion to ensure that LTCH services are targeted to patients who are clinically appropriate for the setting. This endeavor should be a top priority for CMS and others concerned about rapid LTCH growth.**

We also strongly endorse the June 2004 MedPAC recommendation to require CMS' Quality Improvement Organizations (QIO) to review long-term care hospital admissions for medical necessity and monitor LTCH compliance with the expanded qualification criteria. Although CMS has declined to include the review of LTCH cases within the QIO scope of work, in 2004 the agency reinstituted QIO review of a small national sample of approximately 1,400 cases, which resulted in the denial of 29 percent of the reviewed cases. We believe this effort demonstrates that the QIOs are equipped to perform this function in a manner that preserves access for patients who need LTCH-level care while identifying and denying payment for cases that should be treated in another setting.

QIO review places the decision of where a patient should be treated in the hands of licensed physicians and nurses, rather than penalizing LTCHs for treating cases simply based on the LOS or referral source. When reviewing LTCH cases for medical necessity, QIOs apply professionally developed criteria; an assessment of the appropriate medical care available in the community; and national, regional and local norms. QIO review also includes safeguards that protect the interests of Medicare beneficiaries. Under the QIO review process, beneficiaries and their physicians are eligible to discuss a particular case with the QIO reviewer prior to a determination. In addition, the QIO reviewer is required to explain "the nature of the patient's need for health care services, including all factors that preclude treatment of the patient..." QIO review also includes appeal rights for beneficiaries. This system would be clinically-focused and therefore a more effective means of ensuring appropriate patients are treated in LTCHs than the agency's SSO proposal and the current policy pertaining to host-hospital referrals to co-located LTCHs.

CMS should authorize and fund expanded QIO review, which would provide assurance to Congress and the Secretary that Medicare funds are being utilized prudently while preserving the access rights of Medicare beneficiaries. Expanded QIO review would be an effective complement to new, more specific LTCH criteria. In tandem, these changes would help ensure that LTCHs are serving appropriate patients.

The proposed SSO changes wrongly assume that the SSO population is homogeneous. The SSO population includes cases with LOS ranging from one day to 30 days, and some even qualify for LTCH high-cost outlier status. **Given this wide variability, all SSO cases should not be treated the same under the LTCH PPS. CMS should change the way it identifies and pays for SSO cases and implement the following SSO changes:**

- Establish a method for identifying a subset of SSOs – very short-stay cases – to ensure there is no incentive to transfer patients who may be near death.
- This subset of very short-stay cases should be paid at 100 percent of costs.
- LTCH cases with a LOS greater than 20 days should be removed from the SSO definition. Any case of such a substantial duration is clearly not suitable for a downward payment adjustment. All cases with LOS in this range are obviously

consistent with the population intended for the LTCH setting and should be eligible for the full LTCH DRG payment.

- Remaining SSO cases should continue to be paid under the current SSO policy.

Outlier Payments

For many of our providers, caring for individuals who require long term care in a hospital is very expensive. In addition, as expected with the very, very acutely injured and ill patients, there is great variability of costs within this group. If the outlier threshold is increased from $10, 501 to $18,489. providers will experience a large loss increase caring for these individuals.

GHA Recommendation

We strongly support leaving the current the outlier threshold in place. This would better reflect the cost of caring for this very vulnerable population.

The GHA appreciates the opportunity to comment on this proposed rule. We are committed to improving the LTCH PPS and look forward to working with CMS toward this goal. To discuss any questions or reactions to our comments, please contact Karen Waters at 770 249-4540 or kwaters@gha.org.

Sincerely,

Joseph Parker
President

Submitter : **Mr. Glenn Hackbarth** **Date: 03/20/2006**

Organization : **Medicare Payment Advisory Commission**

Category : **Federal Government**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1485-P-60-Attach-1.DOC

MEDPAC Medicare Payment Advisory Commission

601 New Jersey Avenue, N.W. • Suite 9000
Washington, DC 20001
202-220-3700 • Fax: 202-220-3759
www.medpac.gov

Glenn M. Hackbarth, J.D., Chairman
Robert D. Reischauer, Ph.D., Vice Chairman
Mark E. Miller, Ph.D., Executive Director

March 20, 2006

Mark McClellan, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Blvd.
Baltimore, MD 21244-1850

Re: File code CMS-1485-P

Dear Dr. McClellan:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule entitled *Medicare Program; Prospective Payment System for Long-Term Care Hospitals, RY 2007*, Federal Register, Vol. 71, No. 18, p. 4648 (January 27, 2006). We appreciate your staff's work on this prospective payment system (PPS), particularly given the competing demands on the agency.

The Commission has shared CMS's concerns about long-term care hospitals (LTCHs) for a number of years. We both have observed rapid growth in the number of these facilities and in Medicare spending for them. In our own work for our March 2006 report to the Congress, we found a high degree of profitability—an estimated margin of almost 8 percent for 2006—and other indications that payments were more than adequate. Based on the evidence, Commissioners recommended a zero update for rate year 2007. Your proposal to eliminate the update to LTCH payments is consistent with our recommendation.

CMS also has proposed changes in the short stay outlier policy for the LTCH PPS. We believe short-stay outlier policies for prospective payment systems are reasonable to contemplate. Short-stay outlier policies protect the Medicare program by reducing the incentive for providers to generate excess profits by admitting short-stay patients. At the same time, however, we believe the proposed short-stay outlier policy is too severe. The proposed policy affects a substantial percentage of LTCH patients. Furthermore, over time the policy would continue to affect a large percentage of admissions regardless of the admission policies of LTCHs.

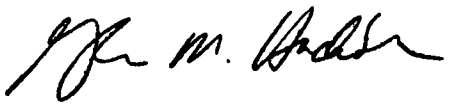
The proposed policy also does not address the underlying problem in this setting. MedPAC has recommended the development of patient and facility criteria.[1] For example, patient level criteria could include national admission standards (such as specific clinical characteristics and treatments) as well as discharge criteria. Facility characteristics could include requirements for multidisciplinary care teams and the percentage of cases meeting an established severity of illness criteria. Therefore,

[1] Medicare Payment Advisory Commission. 2004. *Report to the Congress: New approaches in Medicare.* Washington, DC: MedPAC.

we strongly urge CMS to move forward with MedPAC's recommendations to implement patient and facility criteria. Such criteria would better target LTCH care to beneficiaries who need the level of care provided by LTCHs and provide better value to the program. We believe criteria are being developed that could serve as a starting point for CMS to propose national criteria for public comment.

If you have any questions or require clarification of our comments, please feel free to contact Mark Miller, MedPAC's Executive Director.

Sincerely,



Glenn M. Hackbarth
Chairman

Submitter : Mr. Lewis Ransdell **Date:** 03/20/2006

Organization : Long Term Hospital of Montgomery, LLC

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1485-P-61-Attach-1.PDF

CMS-1485-P-61-Attach-2.PDF

March 17, 2006

Hon. Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & 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 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 the comments and recommendations of Long Term Hospital of Montgomery, LLC to the proposed annual payment rate updates, policy changes, and clarifications under the prospective payment system for long-term care hospitals ("LTCH PPS") for fiscal year ("FY") 2007, which were published by the Centers for Medicare & Medicaid Services ("CMS") on January 27, 2006.

Long Term Hospital of Montgomery is one of Noland Health Services (NHS) hospitals. NHS is a not-for-profit healthcare organization headquartered in Fairfield, Alabama that operates five Long Term Acute Care Hospitals in Anniston, Birmingham, Dothan, Montgomery and Tuscaloosa, AL. Noland Health Services is a member of the Acute Long Term Hospital Association (ALTHA) and fully supports the comment letter and proposals from ALTHA dated March 11, 2006.

NHS 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. NHS has analyzed the financial impact of the proposed rule on it's operations and has determined that the impact on NHS reimbursement will be significant.

1725 Pine Street

5th Floor, North Wing

Montgomery, AL 36106

(334) 240-0532

Fax: (334) 832-2425

Like ALTHA, we believe that CMS used materially flawed and incomplete data in developing the proposed changes to LTCH payments for FY 2007.

NHS 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. NHS 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 uses 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 five of Noland Health Services's 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 to address the concern 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).

CMS's proposal to limit the payment for SSO cases at the IPPS payment rate would cause Noland's LTCHs to be significantly underpaid In order to quantify the impact, Noland reviewed all Medicare discharges at all five hospitals for a one year period. For SSO cases, which represent a significant percent of the Medicare patients served by Noland's LTCHs, the proposal would cause payment amounts to fall materially below the actual costs of providing care.

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 Noland *significantly* less than it costs us 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.

CMS assumes that we can change our 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, Noland's LTCHs and physicians are not able to predict a patient's length of stay at the time of admission. Therefore, Noland cannot change their behavior to accommodate these payment cuts. Instead, Noland's 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.

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 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.

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.

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. Noland LTCHs admit patients only after applying an objective and rigorous set of admissions screening criteria, known as the "InterQual Criteria for Long Term Acute Care" 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.

Over the past three years, Long Term Hospital of Montgomery has had a number of reviews performed by the Alabama QIO (Alabama Quality Assurance Foundation). All of the QIO reviews have determined that Noland's LTHC admissions were appropriate and medically necessary. Our experience reinforces the experience of Kindred and Select cited in the ALTHA letter. Noland believes that 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.

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 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 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. 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.

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. 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 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.) 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.

The SSO policy would penalize LTCHs for admitting LTCH-appropriate patients by paying providers below cost most of the time. Currently, Noland's LTCHs uses a patient assessment tools, 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 Alabama's QIO 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.

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.

NHS 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. NHS 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:

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 (*e.g.*, hospice and home health) 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.

CMS should allow a full update to the LTCH PPS federal rate for FY 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.

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. NHS 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.

NHS 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.

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 not 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.

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, NHS 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.

Conclusion

NHS 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. 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 review of ALTHA's analysis 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 ALTHA provided in their comment letter, and we anticipate reviewing a more effective set of proposals to better define the patients and setting for long-term acute hospital care.

Sincerely,

Lewis Ransdell, Administrator
Long Term Hospital of Montgomery

Long Term Hospital
of Montgomery

March 17, 2006

Hon. Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & 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 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 the comments and recommendations of Long Term Hospital of Montgomery, LLC to the proposed annual payment rate updates, policy changes, and clarifications under the prospective payment system for long-term care hospitals ("LTCH PPS") for fiscal year ("FY") 2007, which were published by the Centers for Medicare & Medicaid Services ("CMS") on January 27, 2006.

Long Term Hospital of Montgomery is one of Noland Health Services (NHS) hospitals. NHS is a not-for-profit healthcare organization headquartered in Fairfield, Alabama that operates five Long Term Acute Care Hospitals in Anniston, Birmingham, Dothan, Montgomery and Tuscaloosa, AL. Noland Health Services is a member of the Acute Long Term Hospital Association (ALTHA) and fully supports the comment letter and proposals from ALTHA dated March 11, 2006.

NHS 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. NHS has analyzed the financial impact of the proposed rule on it's operations and has determined that the impact on NHS reimbursement will be significant.

1725 Pine Street

5th Floor, North Wing

Montgomery, AL 36106

(334) 240-0532

Fax: (334) 832-2425

Like ALTHA, we believe that CMS used materially flawed and incomplete data in developing the proposed changes to LTCH payments for FY 2007.

NHS 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. NHS 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 uses 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 five of Noland Health Services's 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 to address the concern 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).

CMS's proposal to limit the payment for SSO cases at the IPPS payment rate would cause Noland's LTCHs to be significantly underpaid In order to quantify the impact, Noland reviewed all Medicare discharges at all five hospitals for a one year period. For SSO cases, which represent a significant percent of the Medicare patients served by Noland's LTCHs, the proposal would cause payment amounts to fall materially below the actual costs of providing care.

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 Noland *significantly* less than it costs us 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.

CMS assumes that we can change our 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, Noland's LTCHs and physicians are not able to predict a patient's length of stay at the time of admission. Therefore, Noland cannot change their behavior to accommodate these payment cuts. Instead, Noland's 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.

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 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.

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.

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. Noland LTCHs admit patients only after applying an objective and rigorous set of admissions screening criteria, known as the "InterQual Criteria for Long Term Acute Care" 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.

Over the past three years, Long Term Hospital of Montgomery has had a number of reviews performed by the Alabama QIO (Alabama Quality Assurance Foundation). All of the QIO reviews have determined that Noland's LTHC admissions were appropriate and medically necessary. Our experience reinforces the experience of Kindred and Select cited in the ALTHA letter. Noland believes that 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.

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 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 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. 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.

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. 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 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.) 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.

The SSO policy would penalize LTCHs for admitting LTCH-appropriate patients by paying providers below cost most of the time. Currently, Noland's LTCHs uses a patient assessment tools, 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 Alabama's QIO 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.

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.

NHS 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. NHS 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:

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 (*e.g.*, hospice and home health) 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.

CMS should allow a full update to the LTCH PPS federal rate for FY 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.

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. NHS 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.

NHS 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.

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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,

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Sincerely,

Lewis Ransdell, Administrator
Long Term Hospital of Montgomery

Submitter : Albert Shay **Date: 03/20/2006**

Organization : Sonnenschein Nath & Rosenthal LLP

Category : Long-term Care

Issue Areas/Comments

GENERAL

GENERAL

We seek to comment on CMS' discussion of the 25% referral limitation currently applicable to LTCH's co-located in another hospital. We oppose any attempt by CMS to expand this referral limiation to freestanding LTCHs for the reasons set forth in our attached comments.

CMS-1485-P-62-Attach-1.DOC

Sonnenschein
SONNENSCHEIN NATH & ROSENTHAL LLP

1301 K Street N.W.
Suite 600, East Tower
Washington, D.C. 20005-3364
202.408.6400
202.408.6399 fax
www.sonnenschein.com

Chicago
Kansas City
Los Angeles
New York
San Francisco
Short Hills, N.J.
St. Louis
Washington, D.C.
West Palm Beach

Albert W. Shay
202.408.6401
ashay@sonnenschein.com

Memorandum

Via E-Mail

TO• Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services

FROM• Sonnenschein Nath & Rosenthal LLP
Albert W. Shay

DATE• March 20, 2006

RE• CMS-1485-P; Medicare Prospective Payment System for Long-Term Care Hospitals for Rate Year 2007; Proposed Annual Payment Rate Updates, Policy Changes, and Clarifications; Proposed Rule

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The purpose of this memorandum is to offer comments, observations and recommendations to certain provisions of the above-referenced proposed rule (the "Proposed Rule") published by the Centers for Medicare & Medicaid Services ("CMS") on January 27, 2006. We are submitting these comments on behalf of a client that operates several long-term care hospitals ("LTCH"), some as freestanding LTCHs and others as LTCHs co-located in another hospital. Specifically, we wish to address on behalf of our client certain suggestions made by CMS when discussing the 25 percent referral limitation applicable to LTCHs operated as hospitals within hospitals ("HwH").

Our client seeks to meet the post acute care needs of communities located in the Southwest and Mountain states. While some of these communities are considered "rural" by CMS, many others are located in smaller Metropolitan Statistical Areas ("MSAs") served by one or two primary acute care hospitals. These are not the areas where MedPAC has observed most of the growth in LTCH providers.[1] Our client believes that the post acute care needs of these communities have been neglected by other LTCH providers, perhaps because the size of these communities will not support the development of a 40 or 50 bed LTCH. Our client overcomes

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[1] MedPAC Report to Congress, June 2004, Defining Long-Term Care Hospitals, p. 124.

this limitation by developing LTCHs that are appropriately sized to meet the needs of the community, which often calls for an LTCH of between 10 and 20 beds.

1. General Description of CMS Comments

In the Proposed Rule, CMS expressed its continued concern over "inappropriate patient shifting" between acute care hospitals and LTCHs, even following its implementation of the payment limitations set forth at 42 C.F.R. § 412.534 (hereinafter, the "25% Rule"). Under that rule, when an LTCH functions as a HwH, no more that 25 percent of the LTCH's admissions from the co-located hospital will be paid at the full LTCH prospective payment rate.[2] To the extent the LTCH HwH receives more than 25 percent of its admissions from the co-located hospital, the LTCH payments for those patients exceeding the 25 percent limitation would be adjusted to the lesser of what is paid under the LTCH prospective payment system or an amount equivalent to what Medicare would pay under the inpatient prospective payment system. One of the reasons CMS adopted the 25% Rule was to address its concern that locating the LTCH within an acute care hospital might encourage the shifting of patients from the host hospital to the LTCH HwH for financial rather than medically appropriate reasons.

CMS reports observing a shift in the growth patterns of LTCHs following the implementation of the 25% Rule. The development of LTCHs operated as HwHs has slowed considerably, while the growth of freestanding LTCHs has increased substantially. CMS also reports observing that many freestanding LTCHs received at least 25 percent of their patient referrals from a sole acute care hospital, and roughly a quarter of these LTCHs receive over 50 percent of their patient referrals from a sole acute care hospital. According to CMS, these data suggest that "the danger of LTCHs functioning as 'units' appears to be occurring not only in LTCH HWHs and LTCH satellites but also with freestanding LTCHs."[3] CMS now appears concerned that the intent of the 25% Rule is being circumvented through the creation of freestanding LTCHs. To address this concern, CMS plans to continue analyzing patient claims data for acute care hospital patients who are admitted to freestanding LTCHs "to evaluate whether Medicare is paying twice for what would essentially be one episode of care" and it is "considering appropriate adjustments to address this issue."[4]

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2 For LTCH HwHs operating in rural areas, the referral limit from the host hospital is increased from 25 percent to 50 percent.

3 71 Fed. Reg. 4648, 4698 (January 27, 2006).

4 71 Fed. Reg. at 4698.

2. Response to CMS Observations

Our client does not take part in or condone the types of cross-referral arrangements described by CMS on page 4697 of the Proposed Rule. Moreover, our client shares CMS' concerns about patient transfers from acute care hospitals to LTCHs for the purpose of maximizing Medicare payments rather than treating the patient in the setting most appropriate to address the patient's clinical needs. However, our client also is concerned about the "adjustments" CMS is considering to address this issue. For the reasons discussed below, application of the 25% Rule to freestanding LTCHs would be the wrong approach to take, for it would apply unfairly to freestanding LTCHs located in communities served by one or two dominant hospitals, and it simply serves as a poor proxy for measuring the clinical appropriateness of LTCH admissions.

We appreciate CMS' view that, to the extent an LTCH receives patients from multiple sources, such referral patterns may be evidence that the LTCH is not functioning as a unit of another hospital. We also appreciate that Congress, not CMS, decided to prohibit LTCHs from operating as units of other hospitals, so it is important that co-located LTCHs maintain their separateness from their host hospitals. We disagree, however, with the suggestion that an LTCH which receives more than 25 percent of its patients from a single acute care hospital is (1) functioning as a unit of that hospital or (2) admitting patients who are not appropriate for an LTCH level of care.

This is particularly the case in those underserved markets that are the focus of our client — that is, communities served by one or two primary acute care hospitals. For example, our client operates a 15-bed LTCH in a single-county MSA located in the Southwest. There are two primary acute care hospitals in this county and, prior to opening the LTCH, severely ill medically complex patients in need of LTCH services were transported over 120 miles to another state. Alternatively, these patients were admitted to skilled nursing facilities that simply were not equipped or staffed to care for severely ill medically complex patients. As MedPAC found, treating LTCH patients in the inappropriate setting (i.e., a skilled nursing facility) often costs the Medicare program more money for patient's total episode of care, as compared to the cost of care had the patient been admitted to an LTCH.[5] In short, the development of an appropriately sized LTCH in this community filled a critical and previously unmet need for post acute care services. There are dozens of similarly situated communities across the country that lack the availability of an LTCH provider.

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[5] MedPAC Report to Congress, June 2004, Defining Long-Term Care Hospitals, pp. 126 and 127.

The LTCH operated by our client in this Southwest community necessarily receives more than 25 percent of its patient referrals from the two acute care hospitals that serve the community. By no means, however, does this suggest that the patients admitted to the LTCH were inappropriately discharged from the acute care hospitals. Nor does it suggest that the LTCH effectively operates a long-term care unit of the acute care hospitals. It is simply a function of our client filling a community need for LTCH services, a need that had long gone unmet. Indeed, application of the 25% Rule to freestanding LTCHs would be tantamount to denying the residents of this Southwest community and all similarly situated communities the benefits a local LTCH provider because under no conceivable circumstances would an LTCH be capable of complying with the 25% Rule in these communities. Application of the 25% Rule to freestanding LTCHs located in rural areas would have the same effect, since an LTCH located in a community served by one or two primary acute care hospitals will receive over a majority of its patient referrals from one of those acute care hospitals. Finally, it is unlikely that any LTCH could survive financially if it were to receive the equivalent of inpatient prospective payment rates in return for the provision of LTCH services, even to a small percentage of its patients.

In addition, the 25% Rule lacks any meaningful relationship to the clinical conditions of patients admitted to the LTCH and, for that reason, serves as a poor proxy for measuring the clinical appropriateness of LTCH admissions. Instead of making payment decisions based on an arbitrary percentage, CMS should devote its energies to implementing the recommendations of MedPAC, which, in its June 2004 Report to Congress, recommended the "adoption of criteria that would delineate the types of patients who are appropriately treated in [LTCHs] and more distinctly define these facilities."[6] Specifically, MedPAC recommended the development of facility and patient focused certification criteria in order to control any unnecessary growth of LTCHs and ensure that patients treated in LTCHs are those for whom an LTCH level of care is most appropriate.

For example, MedPAC suggested the creation of national admission criteria for each major category of patients treated by LTCHs, such as the InterQual Long-Term Acute Care Criteria developed by McKesson. The LTCH operator for whom we write these comments applies these InterQual criteria to each patient admitted to one of its LTCHs. MedPAC also recommended that CMS develop facility specific certification criteria for LTCHs, similar to what exists for other hospital providers, such as daily physician contacts, the availability of certain services (e.g., respiratory therapy), and interdisciplinary team assessments. Requiring LTCHs to provide a certain level of care can differentiate LTCHs from other health care providers that may also treat medically complex patients. Another MedPAC recommendation focused on measuring

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6 MedPAC Report to Congress, June 2004, Defining Long-Term Care Hospitals, p. 128.

patient mix and severity to ensure that patients admitted to LTCHs require the intensive level of care and resources available in an LTCH, as opposed to a skilled nursing facility.

For the same reasons MedPAC found the current LTCH 25-day length of stay criterion ineffective in preventing the inappropriate admission of patients to LTCHs, the 25% Rule is equally ineffective at predicting the appropriateness of LTCH admissions. This is especially the case for LTCHs located in communities served by one or two acute care hospitals, regardless of whether the community is considered "rural," because the LTCH will always receive over a majority of its patient referrals from one of the community's primary acute care hospitals.

Based on the foregoing, we oppose any expansion of the 25% Rule to freestanding LTCHs, as it is an ineffective and arbitrary predictor of the appropriateness of LTCH admissions. In addition, compliance with the 25% Rule would be impossible in communities served by only one or two dominant acute care hospitals. The application of the Rule to freestanding LTCHs would effectively eliminate the ability of any LTCH (freestanding or HWH) to exist in these communities, and residents in need of LTCH services would be required to travel outside the community to receive the necessary services, or receive care in a setting that is not designed or intended to treat severely ill medically complex patients. Both scenarios are unacceptable for a multitude of reasons. Instead of expanding the 25% Rule to freestanding LTCHs, CMS should work with the LTCH industry to develop the types of clinically-based certification criteria recommended by MedPAC, which focus on the patients characteristics and the level of patient care services that should be available at every LTCH.

* * * *

Thank you for the opportunity to comment on this very important aspect of the Proposed Rules. Please do not hesitate to contact me should you have any questions regarding these comments.

Submitter : Dr. Waleed Najeeb **Date:** 03/20/2006

Organization : MedPoint Family Care Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1485-P-63-Attach-1.PDF

MedPoint
Family Care Center
2501 West Silver Spring Drive
Glendale, WI 53209

Waleed S. Najeeb, M.D. Medical Director
Abbas Ali, M.D.
Ricardo Sinense, M.D..
Kamal Amin, M.D.
Primo Tamayo, M.D.
Ashutosh Sachdeva, M.D.
Vijay Anne, M.D.
Syed Gardezi, M.D
Harry Kanin, M.D
C.M.M.Sundaram,M.D
Jerome RandallJr, D.P.M
Ty Wade, D.C

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:

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

I am a pulmonologist who has a busy private practice and works as a consultant in multiple area hospitals including Life Care Hospital of Milwaukee, WI. I take care of the seriously ill patients in intensive care units at the acute care hospitals. Then follow them after their acute stage in the step down kind of facility at Life Care Hospital for long-term acute care. My experience with this kind of arrangement has been wonderful and fulfilled my patient care needs and allowing me to continue the same good care we are providing to our patients.

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.

Submitter : **Date: 03/20/2006**

Organization :

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See attachement

CMS-1485-P-64-Attach-1.PDF

CATHOLIC HEALTH EAST

Kenneth Becker
Vice President
Advocacy and Government Relations
14 Campus Boulevard, Suite 300
Newtown Square, PA 19073-3277
(610) 355-2121 (610) 355-2050 fax

March 20, 2006

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

Re: CMS-1485-P – Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification *(71 Federal Register 4648).*

Dear Dr. McClellan:

On behalf of Catholic Health East (CHE), I would like to thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule regarding the Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes and Clarification, published January 27, 2006 in the *Federal Register*. Catholic Health East (CHE) is a multi-institutional, Catholic health system located in 11 eastern states from Maine to Florida, including four long term care acute hospitals.

CHE appreciates the effort that CMS put into developing this proposed rule for the prospective payment system for long term acute care hospitals. Utilizing the public use files provided from the CMS website, CHE estimates that total PPS payments (based on DRG and high cost outlier payments only) would reduce payments between 11 percent and 15 percent from the FY 2006 final LTCH rule. When the impact of the short stay outlier policy is added into the calculation, reduction in payments could be even more substantial. Such reductions will have significant impacts on CHE's LTCHs and therefore, I would like to offer the following comments regarding the proposed rule.

PROPOSED CHANGES TO LTCH PPS PAYMENT RATES FOR THE 2007 LTCH PPS RATE YEAR

Proposed Standard Federal Rate for the 2007 LTCH PPS Rate Year

CMS is proposing a zero percent increase in the standard federal rate for the 2007 LTCH PPS Rate Year noting that on average, LTCHs experienced a 4.0 apparent CMI due to improvements in documentation and coding as well as an 8.8 percent and 11.7 percent Medicare margin in FY 2003 and FY 2004 respectively. While it may be true that some LTCHs posted significant positive margins and saw significant increases in their case mix index, not all LTCHs had that experience. In fact, one of CHE's LTCHs in FY 2005 (its first year of operation) posted a negative (17%). It is unclear how LTCHs that posted negative margins in FY 2006 will survive with a zero percent increase for FY 2007. In addition, this policy will likely reward those LTCHs that are in a position to admit those patients who fall into desirable DRGs at the expense of community hospitals who admit patients regardless of their reimbursement.

OTHER PROPOSED POLICY CHANGES FOR THE 2007 LTCH PPS RATE YEAR

Adjustment for Short Stay Outlier Cases

For short stay outlier (SSO) cases, that is those cases that have a LOS of less than or equal to five-sixths of the geometric ALOS for each LTC-DRG, CMS currently reimburses LTCHs 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;
3. the full LTC-DRG payment.

CMS is proposing to change its payment methodology by:

1. reducing one of the current adjustments that is based on 120 percent of the costs of the case to 100 percent of the costs of the cases.
2. including a fourth alternative payment method that would reimburse what Medicare would pay to an acute care hospital for the same case.

The Acute Long Term Care Association has estimated that 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.

CMS has proposed these changes to its SSO payment methodology because it is concerned 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...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.

CMS is assuming that this change in payment policy will encourage LTCHs to deny admissions for patients that will not stay for less than five-sixths of the average length of stay for the LTC-DRG. However, it is difficult to for a LTCH to predict a patient's length of stay at the time of admission. A number of scenarios could occur that would result in a patient who rightly should have been admitted to an LTCH leaving the facility prior to the length of stay for the LTC-DRG. For example,

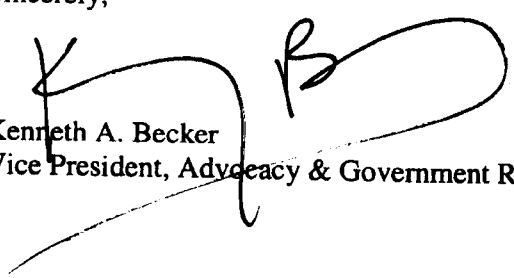
according to MedPAR data from 2004, 13.8 percent of all LTCH patients expire, one must assume that a certain number of those patients expire early on in their stay. Additionally, some patients require the resource intensive care provided by LTCHs when they are admitted, but their condition improves quicker than expected and they are then transferred to a more appropriate care facility. In addition, any concern CMS has that acute care hospitals are transferring patients inappropriately to their affiliated LTCHs should have been addressed in the "25% Rule" policy that requires a hospital within a hospital or satellite LTCH to only receive 25% of their admissions from the host hospital in order to receive Medicare reimbursement under the LTCH PPS. Any additional patients above the 25% level would be reimbursed under the Inpatient PPS rate.

The Medicare program, through the prospective payment system, is designed to provide an incentive to providers to give the appropriate level of care to patients in the most efficient way possible to improve their health. The proposed short stay outlier policy outlined by CMS for LTCHs could provide an incentive for LTCHs to refuse to admit patients who need the resource intensive care offered by LTCHs because of the possibility the patient may expire or recover early on in their stay, a decision that could be completely arbitrary given it would have to be made prior to admission. Alternatively, the proposed policy could provide an incentive for LTCHs to keep patients longer than necessary in order to get beyond the short stay outlier threshold. Yet, CMS has proposed a SSO payment policy that would make it very difficult for LTCHs to continue their current policies and still remain financially viable.

CHE hopes that CMS will take these comments into serious consideration and will include them in the final regulation in order to provide adequate reimbursement to long term acute care hospitals.

Thank you for your review and consideration of these comments. If you have any questions, please feel free to contact me at (610) 355-2121.

Sincerely,



Kenneth A. Becker
Vice President, Advocacy & Government Relations

Submitter : **Mr. William Altman** **Date: 03/20/2006**

Organization : **Kindred Healthcare**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1485-P-65-Attach-1.DOC

Kindred
Healthcare

March 20, 2006

BY HAND AND ELECTRONIC FILING

Hon. Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

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 Kindred Healthcare, Inc. ("Kindred") 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, Kindred 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. Kindred 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. Kindred'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.

Kindred 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. Kindred 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.

680 South Fourth Street Louisville, Kentucky 40202
502.596.7300 502.596.7300 Fax www.kindredhealthcare.com

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, Kindred 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.

Kindred Healthcare is one of the nation's largest LTCH providers, with 61 freestanding facilities, seventeen hospital within hospitals, and 6,278 beds. In 2005, Kindred provided care to over 27,000 Medicare beneficiaries. As a long-term acute care hospital company, Kindred provides specialized acute care for medically complex patients who are critically ill with multi-system complications and/or failures and require hospitalization averaging at least 25 days. Many of Kindred's patients—including Medicare beneficiaries—are admitted directly from short-stay hospital intensive care units with respiratory/ventilator-dependent conditions or other complex medical conditions. At Kindred's LTCHs, they receive a specialized treatment program with aggressive clinical and therapeutic intervention.

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 Kindred, as well as all LTCHs around the country. Kindred also adopts, in their entirety, the comments submitted on March 10, 2006 by the Acute Long Term Hospital Association ("ALTHA") on behalf of over 300 LTCH locations in the United States. Kindred is an ALTHA member.

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.

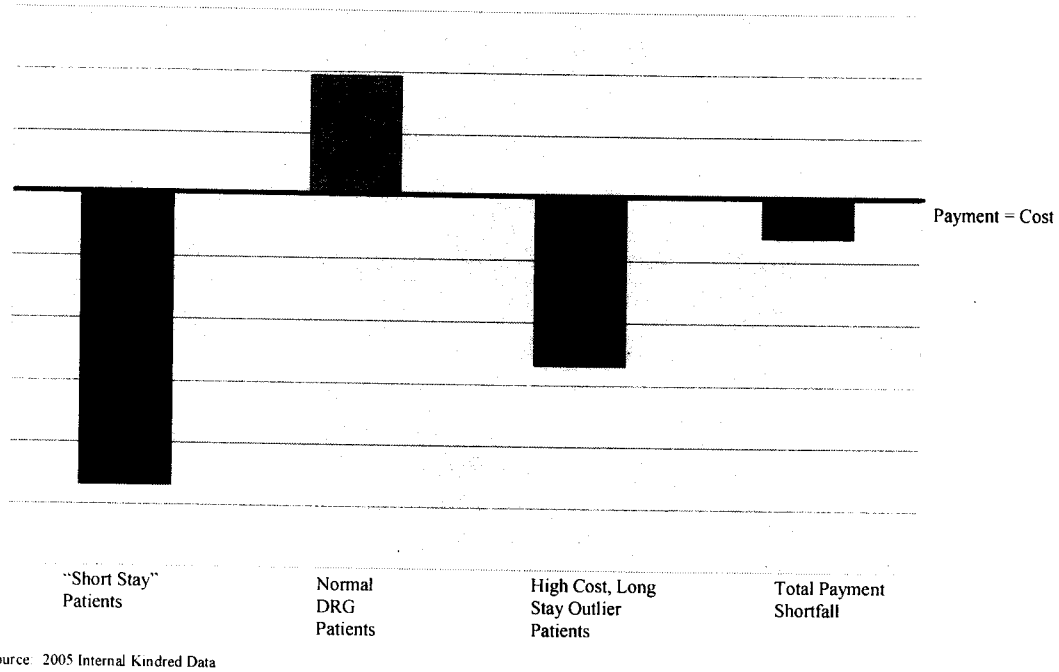
B. Assessment

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 Kindred for SSO cases under the proposed policy would represent only 53 percent of the actual costs incurred in caring for those patients.

Overall, CMS's proposal would drastically cut payments to Kindred 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 our LTCHs *significantly* less than it costs them to care for appropriately admitted patients. Kindred has calculated a payment shortfall of minus 6.2% for Kindred's LTCHs, based upon 2005 cost report data (see Figure 1).

FIGURE 1: CMS's Proposed Payment System Fails to Cover the Cost of Caring for Kindred LTCH Patients



Source: 2005 Internal Kindred Data
CMS 2006 Proposed Rule

If CMS finalizes these changes to SSO payments, 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. These proposals could impact the ability of Kindred and the entire LTCH industry to provide future ventilator services. This comes at a time when there are public concerns about the ability of hospitals in the United States to provide adequate ventilator services should a pulmonary flu epidemic occur, most notably, a bird flu pandemic. We estimate that 8 to 10 percent of all ventilators in hospitals in the United States are currently located in LTCHs.

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. Moreover, Kindred will not be able to make up these costs from other patients as the overall effect of this rule is to create total revenue that is less than total costs.

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.

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.

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.

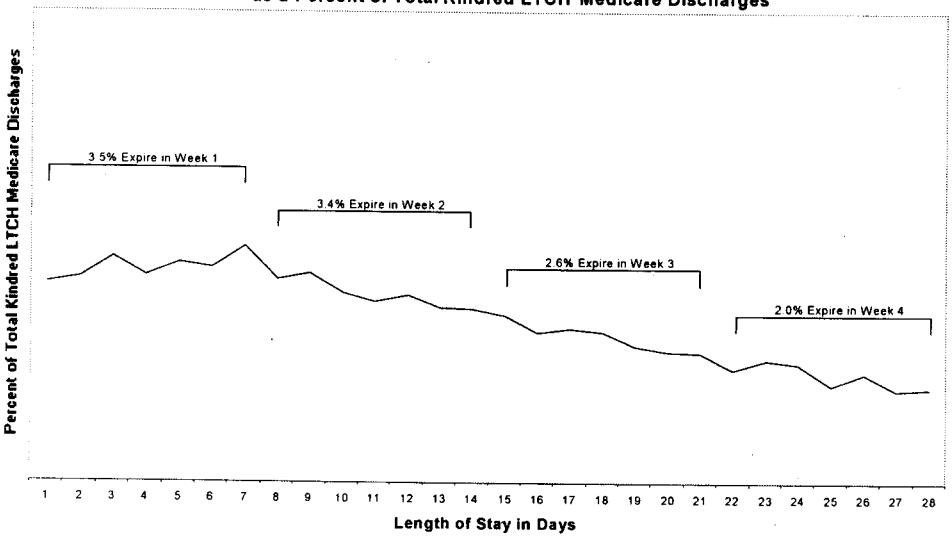
b. CMS's Analysis Is Defective For Not Examining the Types of Short-Stay Outlier Cases, Only a Portion of Which Could Bear Any Meaningful Relationship to CMS's Stated Policy Goals

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.

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 at Kindred hospitals, 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 3.5% of Kindred LTCH discharges expire within the first week of admission, another 3.4% expire during week two, 2.6% during week three, and 2.0% expire in week four. Approximately 2.4% of long stay, high cost outlier patients expire. Overall, 18.5% of Kindred 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 Kindred LTCH Medicare Discharges



Note 18 5% 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. 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.

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%. This data 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.[1] 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 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. Kindred's data for the five most common SSO LTC-DRGs are

[1] 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.

presented in Table 2.[2] 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. Kindred's 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	Kindred Cases: % in SOI 3,4	Kindred 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	95%	86%
88	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	20.1	16.8	61%	45%
271	SKIN ULCERS	28.4	23.7	75%	70%
89	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	21.2	17.7	77%	64%
	All DRG cases (weighted by Kindred case-mix)	27.7		73%	67%

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.

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[2] 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."

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.[3] 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.

Currently, most LTCHs, including Kindred's 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 LTCH 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. However, 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.

In addition, the 2004 MedPAR data shows that SSO cases are indistinguishable from full-stay cases on several important clinical measures, making it extremely difficult, if not impossible, for LTCH admitting physicians to distinguish SSO patients from full-stay patients at the time of admission. Accordingly, the disincentives built into CMS's proposed payment

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

changes for SSO cases do not have the ability to change the behavior of admitting physicians. 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 Kindred LTCH and short-term general hospital patients.[4] 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."

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	Kindred SSO ALOS	Kindred SSO Cases: % in SOI 3,4	Kindred SSO Cases: % in ROM 3,4	GMLOS for All LTCH Cases	All Kindred Cases: % in SOI 3,4	All Kindred Cases: % in ROM 3,4
475	8.0	95%	92%	13.2	94%	89%	34.2	94%	85%
87	4.9	70%	90%	13.5	86%	92%	30.4	95%	95%
88	4.1	27%	18%	9.7	45%	34%	20.1	61%	40%
271	5.5	41%	22%	13.3	70%	49%	28.4	75%	51%
89	4.8	47%	23%	10.4	64%	37%	21.2	77%	45%
All DRGs	5.6	33%	24%	12.5	67%	55%	27.7	73%	57%

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:

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

> 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.

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

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.[5] 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

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

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 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

Kindred 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. Kindred 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 also have concerns about the ability of the fiscal intermediaries to implement the necessary system edits for these SSO payment changes by the July 1, 2006 effective date. CMS needs to take this into account so that LTCHs continue to be paid in a timely manner.

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.

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

"Phase-In" of SSO Policy Proposed by CMS. Kindred generally supports the agency's use of phase-ins to ease the transition for LTCHs to new payment changes; however, Kindred 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.

Specific Payment Adjustment for Very Short Stay Deaths. Kindred 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.

Per Diem Amount for Very Short Stay Cases. 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'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 Kindred 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'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.

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. It 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.

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). Because the same alleged PPS coding transition problem was previously corrected in the 2006 IPPS rule, there is no need to eliminate the market basket update in RY 2007. Eliminating the update for RY 2007 would be nothing more than an unjustified penalty upon LTCHs.

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

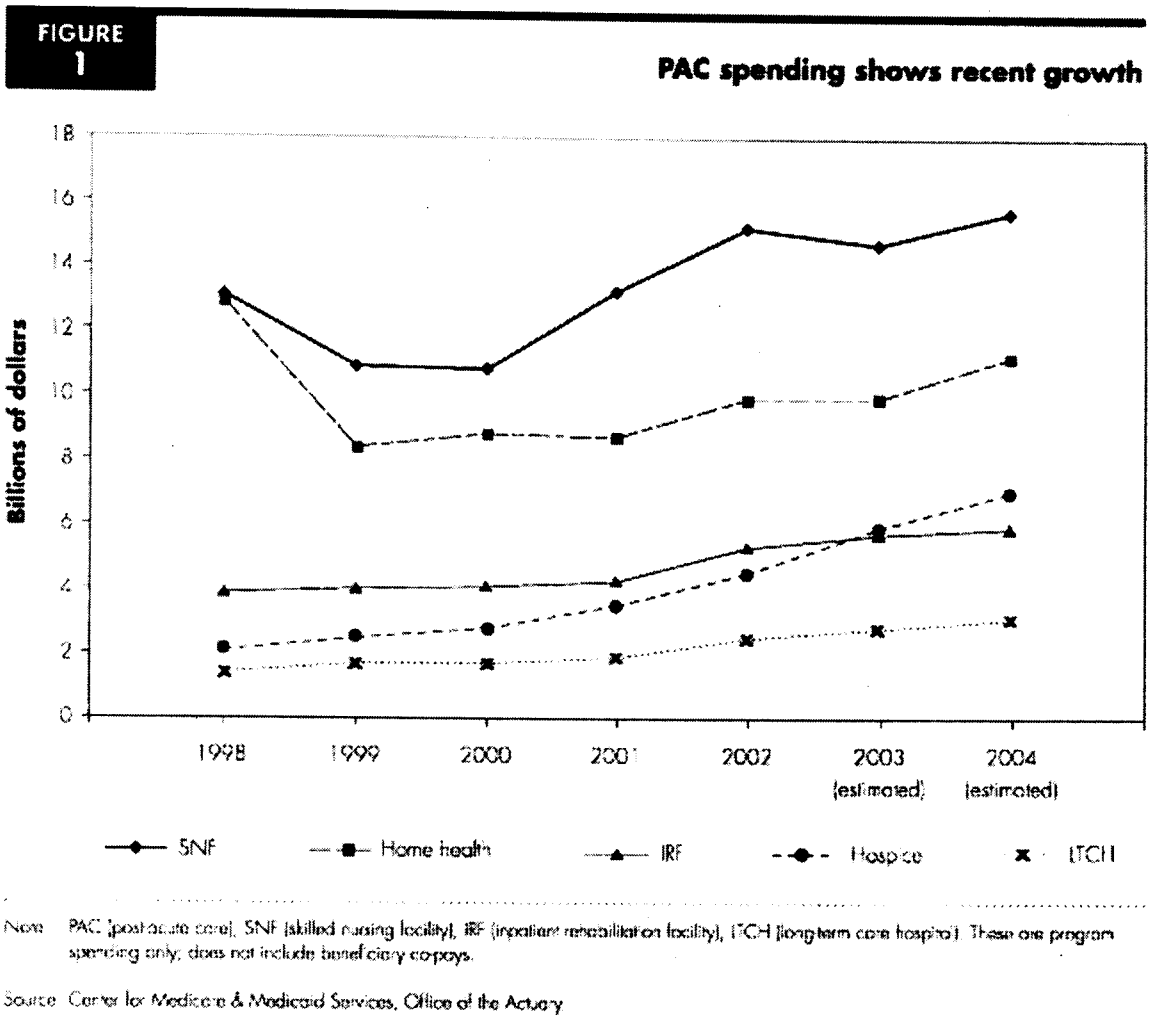
1. Insufficient Description of Methodology to Comment

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. In MedPAC's June 16, 2005 prepared testimony before Congress on Medicare post-acute care, MedPAC presented the following figure to illustrate Medicare spending growth for various post-acute care provider types between 1998 and 2004 (see Figure 3 (taken from Figure 1 at page 3 of MedPAC testimony)). The data show that overall Medicare spending on LTCHs remains far less than all other post-acute care provider types, and growth in spending on LTCHs has not outpaced other types of post-acute providers during this period.

FIGURE 3



We note that despite LTCH numbers growth, CMS Medicare spending for LTCHs is estimated to be about 1% of total Medicare spending.[6] In addition, by RTI's own findings, there are many places in the country where Medicare beneficiaries do not have access to LTCHs.

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6 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 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.

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

Kindred 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.

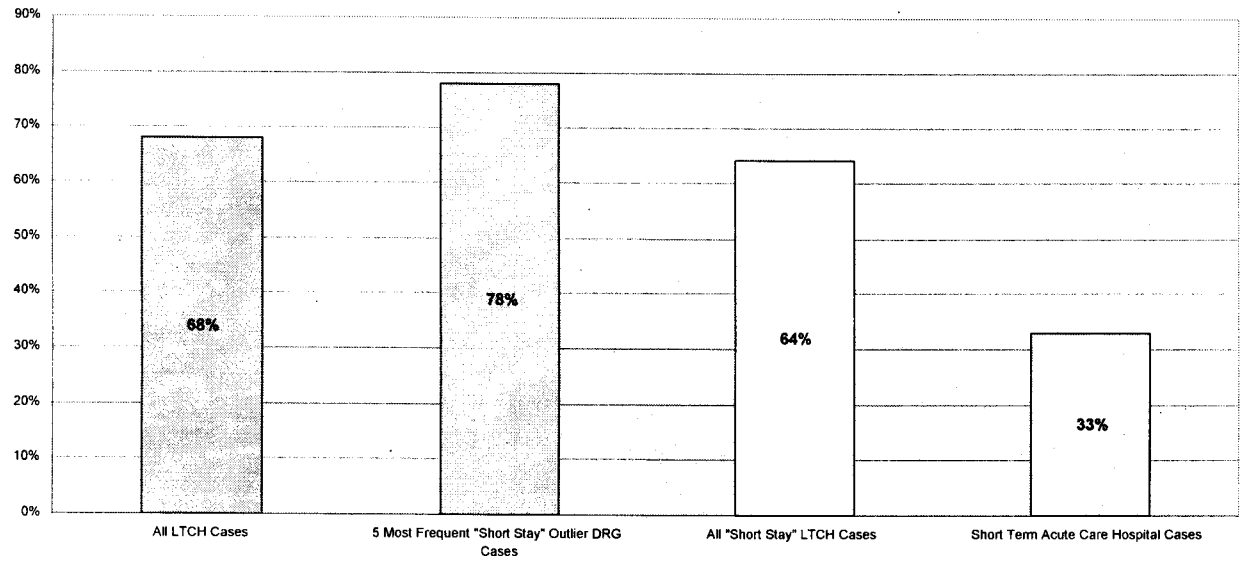
Kindred, in collaboration with ALTHA and other LTCH providers, conducted an evaluative study of the LTCH provider community with a focus on patient and facility level characteristics. This study builds on previous work we have done to identify appropriate LTCH certification criteria. The all patient refined-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.[7] The Figure below shows that the vast majority of

[7] 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

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 4). This supports the conclusion that LTCH patients are, in fact, much sicker than short term hospital patients.

FIGURE 4: 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**

The next Figure compares patients in LTCHs and short term care hospitals using the APR-DRG "risk of mortality" categories (see Figure 5). 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.

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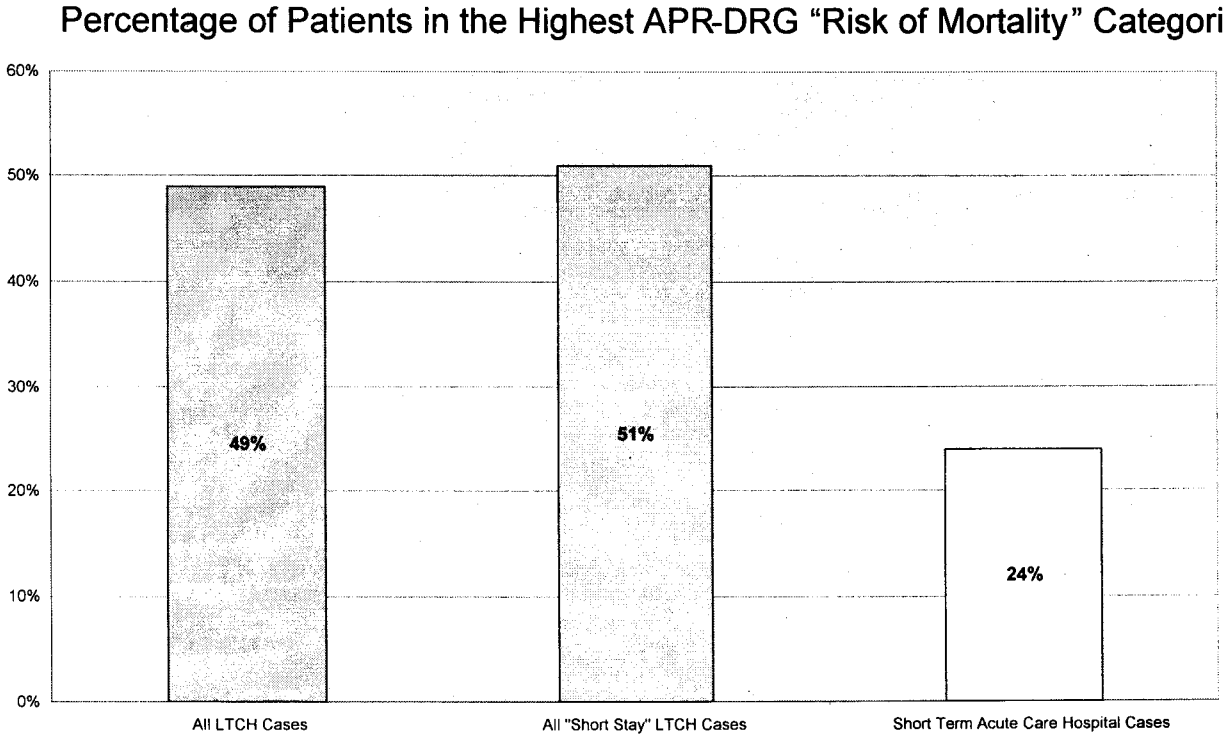
procedures. The SOI categories are rated from 1 to 4 as minor, moderate, major, and extreme, respectively. Both the acute care hospital MedPAR data and LTCH data were run through the APR-DRG GROUPER to determine SOI scores associated with ach case.

Figure 5: 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.[8]

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%

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

Finally, according to previous industry research, LTCHs see the sickest patients with many underlying co-morbidities. Kindred 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

Kindred 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. Kindred 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. Kindred recommends that, rather than slowing LTCH spending through payment policy, which is broad and imprecise, CMS consider implementing certification criteria to achieve its goals, and we look forward to working with CMS in that effort.

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 is 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 "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

Kindred 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.

In May 2004, CMS proposed new payment policies applicable to LTCH HIHs, which CMS then adopted in August 2004. Motivated by a supposed "proliferation" of LTCH HIHs, CMS asserted that the HIH separateness criteria were insufficient to address CMS's concerns. Based on "anecdotal information", CMS asserted that entities have used "complex arrangements among corporate affiliates, and obtained services from those affiliates, thereby impairing or diluting the separateness of the corporate entity" even though those arrangements "technically [remain] within the parameters" of the separateness criteria. 69 Fed. Reg. 49193. CMS asserted that these complex arrangements include the common ownership of host hospitals and LTCHs, which would enable "payments generated from care delivered at both settings [to] affect their mutual interests." 69 Fed. Reg. 49193. Going further, but citing no evidence to support the validity of CMS's concerns, CMS broadly claimed that host hospitals may be prematurely discharging patients to LTCH HIHs because they are incentivized to do so under IPPS, such that both the host and the LTCH HIH receive separate payments for what might be a single episode of care. Although citing no evidence – or even any effort to study the issue – CMS thus implied that LTCH HIHs are providing services to patients inappropriate for LTCH admission.

On July 9, 2004, MedPAC submitted comments to CMS concerning CMS's then-proposed 25% admissions threshold for HIHs. MedPAC did not endorse CMS's proposal, but rather expressed concerns about it and suggested the need for more empirical evidence and analysis prior to the development of appropriate policy. Specifically, among other things, MedPAC noted that the 25% admissions threshold would do nothing to "ensure that patients go to the most appropriate post-acute setting". MedPAC also noted that it has declined to recommend a moratorium on new LTCH HIHs in response to growth in the number of these facilities since, MedPAC believed, further analysis of the risks posed by LTCH HIHs should take place first. Similarly, MedPAC declined to endorse the 25% admissions threshold for HIHs, noting the need for more evidence of the unique risk posed by these facilities.

In finalizing the 25% admissions threshold for HIH's in August 2004, CMS off-handedly dismissed MedPAC's comment letter and ignored the suggestions contained in MedPAC's June 2004 report to Congress. Despite CMS's stated concerns about the use of complex corporate arrangements, CMS did not preclude the use of complex common ownership arrangements to circumvent the separateness criteria. Nor did CMS pause to validate its assumptions that LTCH HIH are being paid for the same course of treatment provided at a general acute care hospital. CMS did not even seek to develop principles that would adjust payments to LTCH HIHs in those cases where an LTCH patient could be shown to have been inappropriately admitted and effectively continuing to receive general acute care hospital care in an LTCH. Further, CMS did not wait for the results of the RTI study to determine whether its concerns could be addressed through facility and patient criteria to define LTCH care. Rather, in effect, CMS sweepingly assumed that a large number of patients admitted to LTCH HIHs from host hospitals are inappropriate for LTCH care, and implemented payment adjustments that significantly reduce payments to LTCH HIHs to the extent that the LTCH HIH receives more than 25% of its admissions from the host hospital.

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.

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by CMS, we found that only 95 hospitals were certified as LTCHs from 2003 thru 2005. More notably, there were only 22 new hospitals in 2005, down from the 37 new hospitals commencing participation in 2004, and 36 in 2003. We believe this reduction in new Medicare-participating LTCHs is a direct result of the HIH 25% rule which was published in August 2004. Our analysis of this data further shows that the dramatic drop in growth is predominantly occurring in the HIHs, although the freestanding hospital growth also declined by one hospital in 2005, as compared to 2004 and 2003. This data does not include the number of LTCHs that were forced to close during this time period. We believe this is evidence that the HIH 25% rule is restricting the growth of LTCH HIHs. We also believe that this rule is making LTCH services less available or unavailable in communities where short-term care hospitals and other provider types are having difficulty caring for a growing number of patients that would quality for LTCH care. The HIH 25% rule is clearly having an impact on patient access to LTCH care. CMS should wait until the HIH 25% rule fully takes effect at the conclusion of the transition period before any expansion of the HIH 25% rule is considered.

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. Kindred 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.

Kindred 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. In addition, if CMS is concerned about "patient shifting," or the conversion of HIHs to freestanding LTCHs, it is well within the agency's regulatory authority to address those issues through the provider enrollment process (*e.g.*, by refusing to permit the transfer of provider numbers to new freestanding LTCHs engaging in inappropriate activities). It is neither necessary nor appropriate to apply penalties to all freestanding LTCHs that have operated in compliance with applicable regulations. 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

Kindred 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, Kindred 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 Kindred 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". Kindred 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.

Kindred 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

Kindred 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. Kindred 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 Kindred 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, Kindred 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 not 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, Kindred 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.

Kindred 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"),[9] the implementing guidelines issued by the Office of Management and Budget ("OMB Guidelines"),[10] HHS ("HHS Guidelines"),[11] and CMS ("CMS Guidelines").[12] Per Section 515 of the DQA, Kindred 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 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

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

10 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.

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

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

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 Kindred 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 to 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.[13]

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

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[13] 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).

written response to its FOIA request, in violation of the agency's own regulations. The request has been assigned a case number (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

Kindred 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. Kindred 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

Kindred 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 Altman
Senior Vice President, Kindred Healthcare

680 South Fourth Street Louisville, Kentucky 40202
502.596.7300 502.596.7300 Fax www.kindredhealthcare.com

Submitter : Mr. Dennis Swan

Date: 03/20/2006

Organization : Sparrow Health System

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

see attachment

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

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

See attachment

CMS-1485-P-66-Attach-1.DOC

March 13, 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

Re: Comments on Medicare Program; 2007 Proposed Update Rule Published at 71 Federal Register 4648 *et seq.*

Dear Dr. McClellan:

The Sparrow Health System submits these comments on proposed rules published on January 27, 2006 at 71 *Fed. Reg.* 4648 et seq.

As a regional health system engaged in referrals to long-term acute care hospitals as an appropriate component to the continuum of care offering in the Mid-Michigan area, the Sparrow Health System is extremely concerned regarding the proposed changes to the long-term care hospital prospective payment system ("LTCH-PPS") for fiscal year 2007. The Sparrow Health System believes the proposed changes will have a devastating effect on hospitals within our system and other acute hospitals, which utilize LTCH's as appropriate referral points. More importantly, it will have a negative effect on the Medicare beneficiaries served here in the Mid-Michigan region and elsewhere by reducing access, inappropriately impairing the medical judgment of treating physicians and placing the continued availability of LTCH services at risk.

Short-Stay Outlier Proposal

CMS states the objective of the Short-Stay Outlier (SSO) rule is to preclude admission of SSO patients to LTCH's. CMS' presumption is that SSO cases should have remained in acute (referring) hospitals. 71 Fed. Reg. at 4688. As discussed below this presumption is wrong.

Through the SSO policy CMS has assumed that SSO patients in LTCH's are similar to short-term acute hospital patients assigned to the same DRG's. To the contrary SSO patients have a relative case-mix index of 2.0592, which is 110% greater than the relative case-mix index of 0.98734 assigned to patients with the same DRG's in short-term referring acute hospitals. These SSO patients therefore have a higher medical acuity and use more medical

resources than are reflected in short-term hospital payments. The higher acuity of LTCH SSO cases is further demonstrated by a higher death rate of 19.61% for SSO cases in LTCH's vs. 4.81%, and the average length of stay of SSO cases in LTCH's is 72% greater (12.7 days vs. 7.4 days) than the average stay in short-term (referring) acute care hospitals.[1]

CMS also assumes that LTCH's and the referring physicians are able to predict, prior to admission, which patients will become SSO's. There is no way for LTCH's or referring physicians to make such a prediction. The condition of LTCH patients may unpredictability improve or deteriorate at any time. SSO cases are referred to LTCH's at the appropriate level of care based on the medical judgment of their treating physicians. It is impossible to pre-screen patients and effectively identify which patients may become SSO's in the LTCH setting. There is no basis for a proposed rule, which assumes that SSO cases should have remained in acute (referring) hospitals.

The proposed SSO rule is an unprecedented intrusion on referring hospital and physician decision-making and contrary to long-standing Medicare principles that govern medical necessity determinations. It would impose a payment adjustment as a mechanism to disqualify a patient for hospital services and intrude upon a physician's ability to admit patients to LTCH's based on medical necessity, i.e., the need for specific programs of care and services provided in the LTCH.

Further, CMS ignores MedPAC's recommendation contained in its June 2004 report to Congress that CMS designate Quality Improvement Organizations (QIO's) to review the medical necessity of LTCH patient admissions. There is a comprehensive statutory and regulatory scheme which vests QIO's with authority to review the medical necessity of hospital services provided to Medicare beneficiaries. QIO's, which are composed of licensed doctors of medicine, determine, among other things, whether inpatient hospital services furnished to Medicare beneficiaries are consistent with generally accepted standards of medical care, or could be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type and the medical necessity, reasonableness and appropriateness of hospital admissions and discharges. See Sections 1154(a)(1) and (3)(C) and of the Social Security Act and 42 C.F.R. §476.71(a).

The proposed SSO policy conflicts with the principles applied by QIO's to determine whether SSO cases should remain in an acute hospital. QIO's apply professionally developed criteria including screening criteria in making their determinations. See Section 1154(a)(1)(B) and 6(A) of the Act and 42 C.F.R. §476.100. They also assess the appropriate medical care available in the community. See 50 *Fed. Reg.* 15312, 15316 (April 17, 1985). QIO's are required to use national, or where appropriate, regional norms in conducting their review. See Section 1154(a)(6)(A) of the

[1] This data is obtained from a March 3, 2006 report by The Lewin Group prepared for the National Association of Long Term Hospitals.

Act and 42 C.F.R. §476.100(a). QIO's also are required to establish written criteria based on typical patterns of practice in the QIO area, or to use national criteria, where appropriate. See 42 C.F.R. §476.100(c). CMS' presumption that all SSO cases should remain in acute care hospitals lacks factual support and fails to consider which type of hospital care and programs are in the best interest of Medicare beneficiaries. It irreconcilably conflicts with the statutory and regulatory scheme which delegates to QIO's the responsibility to establish criteria, which are to operate in the best interest of Medicare beneficiaries.

No Fiscal Year 2007 Update

CMS' proposal to provide a zero fiscal year 2007 update for LTCH's, combined with the proposed SSO proposal will force LTCH's to operate at a loss when treating a significant portion of Medicare patients. It is unfair and unreasonable to deny LTCH's any inflation allowance particularly since the applicable fiscal year 2007 market basket increase is 3.6%. CMS' proposal places the ongoing existence of LTCH's in jeopardy. At a minimum, it will reduce LTCH's ability to finance medical care and services provided to indigent populations and defray the cost of bad debts. Ultimately, it will threaten their ability to survive.

As a regional health system engaged in referrals to long-term acute care hospitals, the Sparrow Health System believes the proposed rule will place LTCH services at great jeopardy and compromise this vital component of the continuum of care. By doing so, it places undue burden on the acute (referring) hospitals, as many Medicare beneficiaries who would otherwise appropriately benefit from LTCH services may be left without this option and remain in the short-stay acute hospital.

In view of the foregoing, the Sparrow Health System respectfully requests CMS to not adopt the proposed SSO policy and to grant LTCH's a reasonable inflation update for fiscal year 2007.

Sincerely,

Dennis Swan

President & CEO

Submitter : Mrs. Lena Dobbs-Johnson

Date: 03/20/2006

Organization : Advocate Bethany Hospital

Category : Long-term Care

Issue Areas/Comments

GENERAL

GENERAL

See Attached.

CMS-1485-P-67-Attach-1.DOC

CMS-1485-P-67-Attach-2.PDF

3435 W. Van Buren Street
Chicago, Illinois 60624-3359
Telephone 773.265.7700

Advocate Bethany Hospital

March 17, 2006

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

File Code CMS-1485-P: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification

Dear Dr. McClellan:

On behalf of Advocate Health Care and Advocate Bethany Hospital, I am pleased to submit comments on the rate year ("RY") 2007 proposed rule for the Medicare inpatient prospective payment system ("PPS") for inpatient hospital services provided by long-term care hospitals ("LTCHs").

Advocate Bethany Hospital ("Bethany"), which has served Chicago's West Side for more than 85 years, is now being converted into that community's first and only LTCH. Bethany will concentrate on serving the extended care needs of patients with complex medical conditions, including heart disease, cancer, respiratory conditions, stroke, kidney disease, and severe wounds. Bethany also will continue to partner with community-based groups, congregations, and others to promote health and wellness and to address health conditions that remain prevalent in the community.

Oak Brook-based Advocate Health Care ("Advocate"), the largest health care provider in Illinois, is ranked among the nation's top health care systems. A faith-based, non-profit system, Advocate is related to both the Evangelical Lutheran Church in America and the United Church of Christ. Advocate's 200-plus sites of care in metropolitan Chicago include eight acute care hospitals and two children's hospitals, a home health care company, and four of Chicago's largest medical groups. Through its academic and teaching affiliations, Advocate trains more resident physicians than does any non-university teaching hospital in Illinois.

As a new LTCH that is filling a previously unmet need on Chicago's West Side, we are deeply concerned about the significant reductions in Medicare payments to LTCHs proposed by the Centers for Medicare and Medicaid Services ("CMS"). These cuts would have an estimated net impact of negative 11.1 percent across the LTCH system. Even before these cuts were announced, we anticipated that our hospital would incur multi-million dollar losses for the next several years. The proposed rule will further exacerbate these losses and make it even more challenging to continue providing quality care for Medicare patients.

Proposed Standard Federal Rate for the RY 2007 LTCH PPS

Although CMS calculated the rate of inflation and growth for LTCHs in 2007 to be 3.6 percent (as measured by the agency's new market basket methodology for LTCHs), the agency does not recommend applying this inflationary update. Instead, CMS proposes to hold the RY 2007 LTCH standard payment at the current level of $38,086.04.

Unfortunately, in failing to include a market basket update in the proposed rule, CMS ignores the real cost of inflation associated with providing health care services in the LTCH setting. Like most LTCHs, Bethany's medical liability insurance costs continue to rise, as do its pharmaceutical costs. Moreover, due to a shortage of qualified medical personnel, employee salaries also continue to increase.

Therefore, we strongly disagree with CMS's proposal to omit the market basket update and recommend that the agency provide LTCHs with the full update of 3.6 percent to preserve our ability to ensure Medicare patient access to the highest quality of care.

Proposed Changes to the Method for Determining the Payment Amount for Short-Stay Outlier Cases

Currently, LTCH short-stay outlier ("SSO") cases are paid the lesser of the following: the full LTCH diagnosis-related group ("DRG") payment; 120 percent of the LTCH DRG per diem multiplied by the length of stay ("LOS") of the discharge; or 120 percent of the cost of the SSO case, calculated using a LTCH's cost-to-charge ratio ("CCR"). CMS implemented this policy to discourage LTCHs from admitting short-stay cases that should have remained in the acute-care setting.

In the proposed rule, CMS expresses its ongoing concern with "premature and inappropriate" discharges from acute-care hospitals in conjunction with "inappropriate" admissions to LTCHs. The agency's proposed changes to SSO policy have the largest fiscal impact in the proposed rule – an 11.4 percent reduction in payments. CMS proposes to modify current SSO policy in two ways:

1) Lower SSO reimbursement based on cost from 120 percent to 100 percent; and
2) Add a fourth, and substantially lower, payment alternative – an amount "comparable" to the general acute care hospital rate for a given DRG.

We understand and agree with CMS's goal of preventing LTCHs from "behaving like acute care hospitals" by "removing what may be an inappropriate financial incentive for a LTCH to admit a short-stay case" to take advantage of the higher levels of reimbursement they receive. However, we are confident that the same goal can be achieved through an approach that is both more targeted and not punitive to LTCHs that could not have possibly anticipated a short stay by a particular patient.

First, we recommend that CMS maintain reimbursement based on the cost of a SSO case at 120 percent. As stated earlier, Advocate already had budgeted for Bethany to lose money this year and next year under current LTCH reimbursement rates, and Bethany continues to experience significant inflationary pressures due to medical personnel shortages and the rising costs of medical liability insurance and pharmaceuticals.

Second, instead of randomly sweeping various LTCHs into the proposed fourth, lower payment alternative – "comparable" to the general acute care hospital rate – we recommend that CMS take a more measured approach. Specifically, if a patient stay at a LTCH is less than or equal to the geometric mean of the short-term LOS for the given acute care DRG, CMS's proposed fourth payment alternative could be employed. If, however, a patient stay at a LTCH is greater than the geometric mean of the short-term LOS but less than or equal to five-sixths of the geometric mean of the average LOS for the given LTCH DRG, there would be a presumption that the LTCH placement had been appropriate; and the fourth payment alternative would not be an option. A spreadsheet with specific examples is attached to this comment letter.

Third, Bethany urges CMS to consider LTCH patients' mortality rates when judging whether or not a given LTCH attempted to improperly admit short-stay cases. LTCHs are structured to serve homogenous populations of severely ill patients. Thus, these hospitals have a disproportionate rate of patients who expire due to the nature of their illnesses. We recommend that CMS construct the SSO methodology to account for the real possibility that, although appropriate for LTCH care at the time of admissions, patients can die because of co-morbidities and complications, resulting in shorter-than-projected mean lengths of stay. Without such an allowance in the SSO methodology, many LTCHs will be unfairly penalized through a significant reduction in reimbursement.

We greatly appreciate the opportunity to provide comments on the RY 2007 LTCH PPS proposed rule. We are excited about the tremendous promise that Bethany holds for elderly and infirm individuals in Chicago's West Side community and look forward to working with CMS to ensure that our health care mission is fulfilled. Please do not hesitate to contact me if you have any questions about our comments or Advocate Bethany Hospital.

Sincerely,

Lena D Johnson

Lena Dobbs-Johnson
President

cc: Congressman Danny K. Davis

Bethany Hospital
LTCH Alternate Payment Methodologies

Scenario 1

DRG Info	DRG	WT	Geometric Mean LOS	Arithmetic Mean LOS	5/6	Name
STACH	484	5.1438	9.3	12.8		CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA
LTCH	484	0.5837	21.3	17.8	17.8	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA

Patient admitted on	03/01/2006
Patient discharged on	03/08/2006
LOS	7

All potential short stays would be coded under the short stay DRG for payment methodology.

Since the length of stay (LOS) for this patient is less than the geometric mean for the short-term acute care facility (STACH), the provider would be paid at the short-term DRG rate.

Scenario 2

Patient admitted on	03/01/2006
Patient discharged on	03/13/2006
LOS	12

All potential short stays would be coded under the short stay DRG

Since the LOS for this patient is greater than the geometric mean for the STACH but less than 5/6 of the LOS for the LTCH, the provider would be paid at the LTCH SSO rate currently in effect.

Scenario 3

Patient admitted on	03/01/2006
Patient discharged on	03/23/2006
LOS	22

All potential short stays would be coded under the short stay DRG. This patient wolud not have to be coded for STACH because of the obvious average LOS.

Since the LOS for this patient is greater than the geometric mean for the LTCH, the provider would be paid at the full LTCH currently in effect.

Exceptions to Above Payment Methodology: DRGs 541 and 542

	DRG	WT	Geometric Mean LOS	Arithmetic Mean LOS	5/6	Name
STACH	541	19.8038	38.1	45.7		ECMO OR TRACH W MV 96+HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.
LTCH	541	4.2287	65.6	54.7	54.7	ECMO OR TRACH W MECH VENT 96+ HRS OR PDX EXCEPT FACE,MOUTH & NECK DIAG WITH MAJOR OR

DRGs 541 and 542 are two specific examples of the short-stay LOS being too long to equitably pay the hospitals under Scenario 2 above. Thus, a different payment methodology for the SSO would need to be determined.

Submitter : Stephen Mills

Date: 03/20/2006

Organization : Dubuis Hospital Beaumont/Port Arthur

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-1485-P-68-Attach-1.DOC

March 20, 2006

Mark McClellan, M.D., Ph.D.
Administrator, Centers for Medicare & Medicaid Services
Attn: CMS–1485–P
P.O. Box 8011
Baltimore, MD 20244-8011

RE: Comments of Dubuis Health System, Inc.
Docket: CMS-1485-P

Dear Dr. McClellan:

I am the CEO of Dubuis hospital, located in **Beaumont/Port Arthur, Texas**. I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed changes to the regulations governing long-term care hospitals. **Dubuis hospital** is a member of Dubuis Health System. Dubuis is the largest not-for-profit, faith-based, long-term acute care hospital system in the U.S.

I am concerned that the proposed [CMS-1485-P] rule continues CMS' pattern of enacting arbitrary payment provisions that will have devastating effects on my hospital and the entire LTCH industry and completely disregards the medical needs of our patients. I am particularly concerned with the ill-advised changes to the short-stay outlier. Rather than assuming that the growth of LTCHs in recent years indicates abuse of the system, CMS should consider whether the growth is in response to a legitimate need as the value of LTCHs has become more apparent.

Allow me to assure you that I fully understand the concerns CMS has expressed that there may be inappropriate admissions of some LTCH patients. Like all hospitals in the Dubuis system, my hospital only accepts patients who are pre-screened by an interdisciplinary team to determine that admission criteria are met. Dubuis worked hard for several years to develop criteria that would ensure that its hospitals make appropriate admissions de cisions. The c riteria s erved a s t he t emplate for t hose l ater r efined and adopted by the National Association of Long Term Hospitals (NALTH). However, not all LTCHs us e t he s ame c riteria. Ne ither t he s hort s tay o utlier p rovision no r t he 25 percent patient cap on hospital-within-hospital LTCHs will do anything to address inappropriate admissions practices. They will, however, irreparably harm hospitals like mine who are attempting to play by the rules and will needlessly place access to LTCH care in jeopardy. Only admission criteria that are standardized industry-wide, along with intensive QIO review, will effectively address the problem.

CMS seems to be under the impression that LTCH patients are no different than patients being treated as outliers in acute care hospitals. This assumption is simply false. It is true that in many parts of the country where there are no LTCHs, patients are being treated in acute care hospitals. However, one cannot assume these patients are receiving the same quality of care as would be provided in an LTCH, nor can CMS assume they have the

same outcomes. LTCHs offer cost-effective clinical benefit to patients suffering from severe and complex illnesses and provide specialized services that are not always available in acute care hospitals.

Studies have shown that compared to acute care outliers, appropriately admitted LTCH patients have a lower mortality rate, a lower readmission rate, a lower utilization of other post acute services, lower overall costs, and are often discharged with a higher level of functionality. Clearly, CMS is failing to recognize the high level of care patients receive in LTCHs. To provide a parallel example, we note that the vast majority of the country is not served by a children's hospital. In these areas, children are often treated in the pediatric units of acute care hospitals. Does CMS believe that severely ill children are no better off in a children's hospital than an acute care pediatric unit or in a general hospital?

The fundamental principle behind any prospective payment system is the law of averages. By definition, the mean length of stay in any system will see 50 percent of the cases above it and 50 percent of the cases below it. Likewise, $5/6^{th}$ of the mean length of stay will always see approximately 40 percent of cases below it. Because the $5/6^{th}$ threshold is a function of the distribution you should expect to see 40 percent of cases below it. What the rule does not recognize is that LTCH patients are significantly more medically complex than ACH patients. You have not demonstrated that there is any relationship between a SSO patient's LTCH LOS and the patient's level of medical complexity. Yet, you are using one (LOS) as a proxy to represent the other (medical complexity), thereby making the false assumption that all short stay outliers represent inappropriate LTCH admissions. To drastically cut payments for the short stay outliers based on this flawed assumption will undermine the very law of averages on which prospective payment systems are based.

Many times a patient's recovery in the LTAC requires daily coordination among all disciplines of their care team (including physician, nursing, respiratory therapy, physical therapy, occupational therapy, speech therapy, nutritional therapy, and case management). Although acute care hospitals try to provide such coordinated dedication to an individual patient's long term recovery, the reality is that it is interrupted by more urgent, though not necessarily more important priorities. It is the volume and urgency of new, unstable patients throughout the day which greatly limits the acute care provider's attention to the chronic critically-ill patient.

Contrary to CMS' assumptions, the Lewin Group compared the resource use of IPPS cases to LTCH SSO cases for all common DRGs. They used average standardized charge data for LTCH and acute care hospital cases combined and used CMS' methodology for computing relative weights for each LTCH DRG and Acute Care DRG using a common national average charge denominator. The Lewin Group study found that LTCH SSO cases have mean DRG weights that are 76 percent higher than comparable DRG weights for IPPS cases. As a result, they concluded the IPPS payment system is not appropriate for the payment of LTCH SSO cases. This data flies in the face of your assumption that SSO is a proxy for inappropriate LTCH admission. As a result,

should you finalize this policy, you are simply making an arbitrary 11% reduction in payments to LTCHs.

Make no mistake, the financial impact of the proposed short stay outlier changes are severe. The Dubuis system as a whole has forecasted that if we continued to do business exactly the way we do now, our reimbursement would decrease 17%. This is well into the negative range for us. Because of our commitment to charity care and the acuity of patients we serve, we do not have the large profit margins that have been cited.
Properly admitted LTCH patients are by definition the most severe and medically-complicated cases. As such, the expected length of stay will be much longer than that of an acute care hospital, even for common DRG's. Take for example DRG 12 (degenerative nervous system disorder). Under the proposed SSO policy, there is no distinction made for severity of the condition, i.e. a minor stroke that might be treated in an acute care hospital versus a major stroke with complications and residual effects that might be better treated in a LTCH. The LTCH mean length of stay for this DRG is 25.5 days. Therefore, the 5/6th threshold is 21.25 days. The IPPS length of stay is only 4.3 days. A patient with LTCH DRG 12 may stay at a LTCH for 20 days and thus be a short-stay outlier, but that stay is still five times the IPPS length of stay. Is a stay that is 83 percent of the average LOS really an abuse of the short stay outlier? It is simply wrong to reimburse a 20 day LTCH stay at a 4 day acute care level. This policy will severely harm patient care and have no effect on the issues CMS is attempting to address. In fact, some LTCHs may be inclined to keep anyone passing the acute mean LOS up to the LTCH mean regardless of their medical situation, thus ensuring "gaming" of the system for financial benefit. However, let me assure you, our decisions will continue to be guided first and foremost by medical professionals and the best interests of our patients.

The more appropriate approach to ensuring that medical necessity is the sole driving force behind clinical care decisions would be to tie reimbursement under the LTCH PPS system to clinical quality measures, such as those proposed by MedPAC, and admissions criteria such as NALTH's. Dubuis is impressed with the diligent efforts that MedPAC has undertaken and is fully supportive of MedPAC's recommendations to define LTCHs by facility and patient criteria that ensure that patients admitted to these facilities are medically complex and have a good chance of improvement.

CMS' concerns about the potential for inappropriate admissions could easily and appropriately be addressed by adopting a set of criteria with QIO monitoring that would directly address the issue of appropriate care being delivered in appropriate settings throughout the entire provider group. Not only would this result in better care for Medicare beneficiaries, but also it should address all of CMS' concerns about the relationships between acute care hospitals and LTCHs in general. I understand that in the past CMS has expressed a concern over the lack of available funding for additional QIO reviews. I also understand that in response to this concern, NALTH suggested that LTCHs forgo half of their expected market basket increase with the other half being used to fund QIO reviews. Since CMS has proposed no market basket increase for LTCHs in this rule, I can only assume there are now funds available to help defray the cost of QIO reviews if CMS chooses to do so.

In addition, CMS' proposal to provide a zero fiscal year 2007 update, combined with the proposed SSO proposal will amount to an 11 percent payment cut for LTCHs and will force many LTCHs to operate at a loss. It is unfair and unreasonable to deny LTCHs any inflation allowance. At a minimum, it will reduce our ability to finance medical care and services provided to indigent populations and defray the cost of bad debts.

In conclusion, I strongly urge CMS to reconsider the misguided changes to the short stay outlier policy and to make a meaningful commitment to the development of facility and patient centered admissions criteria. As mentioned previously, both the short stay outlier policy, and the 25 percent patient cap for hospital-within-hospital LTCHs, are arbitrary policies that will put patient care in severe jeopardy, while making no progress toward MedPAC's goal of e nsuring that patients are treated in the most appropriate settings. Utilizing QIO reviews to enforce facility and patient centered admissions criteria, consistent with MedPAC's recommendations, is a viable patient-centered solution that will address CMS' concerns, promote free and fair competition throughout the LTCH industry, and not harm those providers who are admitting patients appropriately.

Thank you for your consideration. Please do not hesitate to call on us if we may be of assistance.

Sincerely,

Stephen Mills
Dubuis Hospital Beaumont/Port Arthur

Submitter : Mr. Robert Wright

Date: 03/20/2006

Organization : Bay Regional Medical Center

Category : Other Health Care Professional

Issue Areas/Comments

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

See attachment

CMS-1485-P-69-Attach-1.PDF

March 20, 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

Re: Comments on Medicare Program; 2007 Proposed Update Rule
Published at 71 Federal Register 4648 *et seq.*

Dear Doctor McClellan:

As Chief Executive Officer at Bay Regional Medical Center, Bay County, Michigan largest employer, I am very concerned about the financial risk that Medicare's proposed update rule published at 71 Federal Register 4648 *et seq.* will impose upon the only long-term acute care hospital, Bay Special Care Hospital (LTCHs) in our county.

The proposed changes to the admission practices and reimbursement policies of LTCHs will significantly reduce payments to Bay Special Care Hospital in fiscal year 2007. We estimate a reduction of approximately 15 percent in reimbursement during 2007 as a result of these proposed changes. These revenues are needed at Bay Special Care Hospital to support hospital modernization, to refurbish, and to keep current with emerging technologies. Bay Special Care Hospital serves a significant percentage of Medicare patients residing in Bay County, Saginaw, Midland, and surrounding counties.

Therefore, I urge you to not adopt the proposed short-stay outlier rule and zero update proposal because of the adverse impact it will have on our community and the patients we serve. CMS' proposal to provide a zero fiscal year 2007 update, combined with the proposed Short Stay penalties, will force Bay Special Care Hospital to operate at a loss.

To deny LTCHs any inflation allowance, particularly since the applicable fiscal year 2007 market basket increase is 3.6% seems without basis and places the ongoing operation of Bay Special Care Hospital in jeopardy. At a minimum, it will reduce Bay Special Care Hospital's ability to finance medical care and services provided to indigent populations and ultimately will threaten Bay Special Care Hospital's ability to survive.

In closing, I urge you to not adopt the proposed SSO policy and to grant LTCHs a reasonable inflation update for fiscal year 2007.

Sincerely,

Robert N. Wright
President & CEO

RNW/nw

Submitter : Mr. Michael Rodgers **Date: 03/20/2006**

Organization : Catholic Health Association of the United States

Category : Long-term Care

Issue Areas/Comments

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

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

See attached CHA comment letter

CMS-1485-P-70-Attach-1.PDF

March 20, 2006

THE
CATHOLIC HEALTH
ASSOCIATION
OF THE UNITED STATES

Mark McClellan, MD, Ph.D.
Administrator, Center for Medicare & Medicaid Services
Attn: CMS-1485-P
P.O. Box 8011
Baltimore, MD 20244-8011

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

Dear Dr. McClellan:

The Catholic Health Association of the United States (CHA) is pleased to provide comments on the above proposed rule published by CMS in the *Federal Register* on January 27, 2006. CHA is the national leadership organization of the Catholic health ministry, representing more than 2,000 sponsors, systems, facilities, and related organizations that form the nation's largest group of not-for-profit health care.

Our comments are based on the input from CHA members including long-term care hospital (LTCH) providers, as well as written and oral testimony provided by CMS, MedPAC, and other LTCH representatives at a hearing of the House Ways and Means Subcommittee on Health on March 15, 2006.

CHA is seriously concerned about the impacts the proposed rule will have on beneficiaries and their access to LTCH services. With the proposed rule offering no market basket update for 2007, and cutting current LTCH payments by an additional 11.1 percent, the net 14.7 percent reduction would be devastating for LTCHs, likely forcing some out of business. This would deprive the medically complex, often ventilator-dependent Medicare patients of access to those providers who know their needs best: LTCHs, which have the specialized expertise and dedicated multi-disciplinary teams to optimize patient outcomes. Without the availability of LTCHs, patients are often kept in an acute hospital's intensive care unit, which is geared more to shorter term stabilization of patients, as opposed to restoring patients to optimal health and independence.

Unfortunately, it appears CMS's proposed rule is being dictated heavily by Medicare savings targets, when patient access and well being should be the primary policy driver.
This fiscally biased approach to LTCH reimbursement policy still leaves the most important issue unaddressed: assuring placement of patients in the most appropriate care setting.

CHA is perplexed by the fact that CMS would propose such draconian cuts in LTCH reimbursement, when both CMS and LTCH providers agree that the most pressing priority is the creation and usage of a set of uniform, clinically based patient assessment and placement criteria, to assure beneficiaries are treated in the most appropriate post-acute care setting based on medical need. It is hard to conceive why CMS is proposing such dramatic payment changes now, especially regarding its short-stay outlier policy, when in just two months a CMS commissioned study on LTCH-PPS payment policies will be issued with recommendations by its contractor, Research Triangle Institute. Why not simply wait for the results of this important research before proposing such drastic cuts, especially when they could do so much harm to beneficiaries and providers alike?

WASHINGTON OFFICE
1875 Eye Street, NW
Suite 1000
Washington, DC 20006-5409
Phone 202-296-3993
Fax 202-296-3997
www.chausa.org

In addition, CHA feels CMS is undermining the basic premise of prospective payment systems, which use average patient stays and costs to set fixed DRG rates. The proposed rule departs from this approach, penalizing LTCHs for patients whose stays are 5/6 or less of the geometric mean length of stay for a given DRG. This is patently unfair to LTCH providers, which will now lose at both ends of the scale—for the vast majority of patients with short-stays, and for all those with long stays as well. By continually changing the rules of the game, and shifting away from payment based on averages, CMS has greatly undermined LTCHs' ability to conduct rational financial planning, and placed their continued existence in jeopardy.

At the March 15, 2006 LTCH-PPS hearing held by the House Ways and Means Subcommittee on Health, testimony was provided by CMS, MedPAC, and representatives of the LTCH industry. Chairperson Nancy Johnson noted that the proposed CMS rule would threaten LTCH industry viability, swinging Medicare margins from +9.17 percent to -4.90 percent, on average. However, CMS's Herb Kuhn acknowledged that only the largest LTCH providers would be able to sustain positive margins, meaning smaller facilities would experience negative Medicare margins far in excess of -4.9%. In fact, these estimates may be conservative. Two CHA members, Youville Hospital and Rehabilitation Center and Dubuis Health Systems, both classified as large LTCH providers, are projecting huge Medicare revenue losses of 16 percent and 13 percent, respectively. If the proposed CMS rule takes effect, both these providers have intimated that cessation of operations is a very real possibility, meaning thousands of medically complex Medicare beneficiaries would no longer be able to get the care they truly need.

CHA agrees strongly with Representative Johnson's statements that the entire LTCH industry may be put at risk if CMS's proposed rule is implemented, and that cuts of this magnitude are unprecedented for a specific provider type. All parties at the hearing, including CMS, agreed that the most important issue requiring immediate attention is the lack of uniform patient assessment and placement criteria to assure patients receive the right care in the most appropriate post-acute setting. Consensus already exists that such criteria are absolutely necessary, and that achieving agreement on these criteria should be a first tier program priority.

As a number of persons testified at the hearing, it is very hard to predict which patients will respond quickly to LTCH care, and which will have longer stays. In fact, according to the Lewin Group's just released analysis of CMS's RY 2007 LTCH-PPS proposed rule, under the new CMS definition of short-stay outliers, i.e., stays less than 5/6 of the geometric mean, would *always* account for about 30 to 40 percent of cases, regardless of expected stay thresholds and LTCH requirements for admission. So, CMS's assumption that a change in its short-stay outlier policy will significantly impact the relatively high proportion of short-stay discharges, currently about 40 percent, is erroneous when pure statistics are applied.

To better predict which patients will have shorter stays, what is truly needed is a carefully refined set of patient assessment and placement criteria. The goal of these criteria would be to assure patients are referred to the most appropriate post-acute setting. Once patient placement becomes more accurate and consistent, post-acute care payment systems' accuracy and fairness should follow suit, doing away with the annual precipitous swings in reimbursement now being experienced.

In contrast to today, a more orderly and clinically based patient placement system will help stabilize the LTCH industry, increase competition and efficiency, and ensure beneficiaries' level of care needs are matched to the most appropriate care setting, not influenced by Medicare budgetary targets.

CHA Recommendations

The CHA urges CMS to take the following actions:

- **In preparing the LTCH-PPS final rule, CMS should drop the proposed changes in short-stay outlier reimbursement which appear in the proposed rule.**

The impact of this sudden and dramatic cut in reimbursement could force many LTCH providers to close their doors, and deprive medically complex Medicare beneficiaries of access to care which is specifically designed to meet their unique needs. Not only would access be harmed, there would likely be shrinkage in the number of LTCH providers, undermining the competitiveness and efficiency of the marketplace.

- **CMS should work in close collaboration with the LTCH industry to develop and achieve consensus on a set of patient assessment and placement criteria which will assure patients are placed in the most appropriate post-acute setting (either LTCHs, skilled nursing facilities, or inpatient rehabilitation facilities).**

Development and use of such criteria is essential to ensure patients are placed in the most appropriate care setting and have the best care outcomes. Just such an effort is already underway, with CMS sponsoring the work of MassPRO, a Medicare Quality Improvement Organization contractor, to formulate a modernized set of patient-level screening criteria for the LTCH industry. MassPRO is also working collaboratively with the National Association of Long Term Care Hospitals (NALTH), testing five sets of NALTH-developed screening criteria to ensure that severity of illness and intensity of treatment are appropriate and valid. According to testimony provided by MassPRO's Laura Moore, "our assessment so far is that these criteria are on the right track – they address the complex medical conditions of long-term care hospital patients, and we believe that providing a standard, consistent measurement tool will not only improve quality of care but also help protect the Medicare Trust Fund by reducing inappropriate admissions."

- **Before issuing the LTCH-PPS final rule for RY 2007, in addition to considering all comments submitted on the proposed rule, CMS should fully review and weigh the data and recommendations of the forthcoming RTI report, as well as data and analyses provided by the LTCH industry, including the recently released report from the Lewin Group.**

The data and conclusions that these forthcoming reports will hold could significantly alter CMS's perspective on what refinements in the LTCH-PPS are truly needed to assure greater payment accuracy, and represents another major reason why CMS should not implement its proposed rule for short-stay outliers.

Conclusion

CHA believes the proposed CMS LTCH-PPS rule for RY 2007 represents an ill advised approach to shifting the mix of patients seen in LTCHs. These dramatic cuts in reimbursement are being proposed in a vacuum regarding what constitutes medically appropriate placement, putting patient health and well being at risk.

Testimony provided to Congress asserts how difficult it is for health professionals to accurately predict which LTCH patients will have long or short-stays. Yet, CMS's proposed rule assumes instituting a blunt financial disincentive will suddenly impart medical

clairvoyance to providers, who are simply using their best professional judgment on where to best place a patient for post-acute care.

In the long run, clinical consensus on patient assessment and placement criteria should result in much great accuracy in assuring the most appropriate post-acute setting, helping to eliminate payment inaccuracies, improving quality, and getting the patient discharged as soon as is medically prudent. The turbulence in post-acute PPS systems which now exists is the result of each provider type operating in a silo, all competing for the same patients, without clear clinical guidelines as to which setting is best for a given patient.

CHA believes the best solution is having a set of patient placement criteria that is uniform across all care settings, not only producing the best quality for patients, but ultimately reducing the payment inaccuracies and inefficiencies which currently exist. CMS must work with all post-acute care providers to develop consistent, accurate, and rational policies for where patients are placed, and give the industry time to implement this new order without fear of precipitous and potentially lethal, anti-competitive CMS policy changes.

Your consideration of CHA's comments is deeply appreciated.

Sincerely,

Michael Rodgers
Senior Vice President
Advocacy and Public Policy

Submitter : **Stephen Mills** **Date: 03/20/2006**

Organization : **Dubuis Hospital Houston**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-1485-P-71-Attach-1.DOC

March 20, 2006

Mark McClellan, M.D., Ph.D.
Administrator, Centers for Medicare & Medicaid Services
Attn: CMS–1485–P
P.O. Box 8011
Baltimore, MD 20244-8011

RE: Comments of Dubuis Health System, Inc.
Docket: CMS-1485-P

Dear Dr. McClellan:

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I am concerned that the proposed [CMS-1485-P] rule continues CMS' pattern of enacting arbitrary payment provisions that will have devastating effects on my hospital and the entire LTCH industry and completely disregards the medical needs of our patients. I am particularly concerned with the ill-advised changes to the short-stay outlier. Rather than assuming that the growth of LTCHs in recent years indicates abuse of the system, CMS should consider whether the growth is in response to a legitimate need as the value of LTCHs has become more apparent.

Allow me to assure you that I fully understand the concerns CMS has expressed that there may be inappropriate admissions of some LTCH patients. Like all hospitals in the Dubuis system, my hospital only accepts patients who are pre-screened by an interdisciplinary team to determine that admission criteria are met. Dubuis worked hard for several years to develop criteria that would ensure that its hospitals make appropriate admissions de cisions. The c riteria s erved a s t he t emplate for t hose l ater r efined and adopted by the National Association of Long Term Hospitals (NALTH). However, not all LTCHs us e t he s ame c riteria. Ne ither t he s hort s tay o utlier p rovision no r t he 25 percent patient cap on hospital-within-hospital LTCHs will do anything to address inappropriate admissions practices. They will, however, irreparably harm hospitals like mine who are attempting to play by the rules and will needlessly place access to LTCH care in jeopardy. Only admission criteria that are standardized industry-wide, along with intensive QIO review, will effectively address the problem.

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In conclusion, I strongly urge CMS to reconsider the misguided changes to the short stay outlier policy and to make a meaningful commitment to the development of facility and patient centered admissions criteria. As mentioned previously, both the short stay outlier policy, and the 25 percent patient cap for hospital-within-hospital LTCHs, are arbitrary policies that will put patient care in severe jeopardy, while making no progress toward MedPAC's goal of ensuring that patients are treated in the most appropriate settings. Utilizing QIO reviews to enforce facility and patient centered admissions criteria, consistent with MedPAC's recommendations, is a viable patient-centered solution that will address CMS' concerns, promote free and fair competition throughout the LTCH industry, and not harm those providers who are admitting patients appropriately.

Thank you for your consideration. Please do not hesitate to call on us if we may be of assistance.

Sincerely,

Stephen Mills
Dubuis Hospital Houston

March 20, 2006

Mark McClellan, M.D., Ph.D.
Administrator, Centers for Medicare & Medicaid Services
Attn: CMS–1485–P
P.O. Box 8011
Baltimore, MD 20244-8011

RE: Comments of Dubuis Health System, Inc.
Docket: CMS-1485-P

Dear Dr. McClellan:

I am the CEO of Dubuis hospital, located in **Houston, Texas**. I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed changes to the regulations governing long-term care hospitals. **Dubuis hospital** is a member of Dubuis Health System. Dubuis is the largest not-for-profit, faith-based, long-term acute care hospital system in the U.S.

I am concerned that the proposed [CMS-1485-P] rule continues CMS' pattern of enacting arbitrary payment provisions that will have devastating effects on my hospital and the entire LTCH industry and completely disregards the medical needs of our patients. I am particularly concerned with the ill-advised changes to the short-stay outlier. Rather than assuming that the growth of LTCHs in recent years indicates abuse of the system, CMS should consider whether the growth is in response to a legitimate need as the value of LTCHs has become more apparent.

Allow me to assure you that I fully understand the concerns CMS has expressed that there may be inappropriate admissions of some LTCH patients. Like all hospitals in the Dubuis system, my hospital only accepts patients who are pre-screened by an interdisciplinary team to determine that admission criteria are met. Dubuis worked hard for several years to develop criteria that would ensure that its hospitals make appropriate admissions de cisions. The c riteria s erved a s t he t emplate for t hose l ater r efined and adopted by the National Association of Long Term Hospitals (NALTH). However, not all LTCHs us e t he s ame c riteria. Ne ither t he s hort s tay o utlier p rovision no r t he 25 percent patient cap on hospital-within-hospital LTCHs will do anything to address inappropriate admissions practices. They will, however, irreparably harm hospitals like mine who are attempting to play by the rules and will needlessly place access to LTCH care in jeopardy. Only admission criteria that are standardized industry-wide, along with intensive QIO review, will effectively address the problem.

CMS seems to be under the impression that LTCH patients are no different than patients being treated as outliers in acute care hospitals. This assumption is simply false. It is true that in many parts of the country where there are no LTCHs, patients are being treated in acute care hospitals. However, one cannot assume these patients are receiving the same quality of care as would be provided in an LTCH, nor can CMS assume they have the

same outcomes. LTCHs offer cost-effective clinical benefit to patients suffering from severe and complex illnesses and provide specialized services that are not always available in acute care hospitals.

Studies have shown that compared to acute care outliers, appropriately admitted LTCH patients have a lower mortality rate, a lower readmission rate, a lower utilization of other post acute services, lower overall costs, and are often discharged with a higher level of functionality. Clearly, CMS is failing to recognize the high level of care patients receive in LTCHs. To provide a parallel example, we note that the vast majority of the country is not served by a children's hospital. In these areas, children are often treated in the pediatric units of acute care hospitals. Does CMS believe that severely ill children are no better off in a children's hospital than an acute care pediatric unit or in a general hospital?

The fundamental principle behind any prospective payment system is the law of averages. By definition, the mean length of stay in any system will see 50 percent of the cases above it and 50 percent of the cases below it. Likewise, $5/6^{th}$ of the mean length of stay will always see approximately 40 percent of cases below it. Because the $5/6^{th}$ threshold is a function of the distribution you should expect to see 40 percent of cases below it. What the rule does not recognize is that LTCH patients are significantly more medically complex than ACH patients. You have not demonstrated that there is any relationship between a SSO patient's LTCH LOS and the patient's level of medical complexity. Yet, you are using one (LOS) as a proxy to represent the other (medical complexity), thereby making the false assumption that all short stay outliers represent inappropriate LTCH admissions. To drastically cut payments for the short stay outliers based on this flawed assumption will undermine the very law of averages on which prospective payment systems are based.

Many times a patient's recovery in the LTAC requires daily coordination among all disciplines of their care team (including physician, nursing, respiratory therapy, physical therapy, occupational therapy, speech therapy, nutritional therapy, and case management). Although acute care hospitals try to provide such coordinated dedication to an individual patient's long term recovery, the reality is that it is interrupted by more urgent, though not necessarily more important priorities. It is the volume and urgency of new, unstable patients throughout the day which greatly limits the acute care provider's attention to the chronic critically-ill patient.

Contrary to CMS' assumptions, the Lewin Group compared the resource use of IPPS cases to LTCH SSO cases for all common DRGs. They used average standardized charge data for LTCH and acute care hospital cases combined and used CMS' methodology for computing relative weights for each LTCH DRG and Acute Care DRG using a common national average charge denominator. The Lewin Group study found that LTCH SSO cases have mean DRG weights that are 76 percent higher than comparable DRG weights for IPPS cases. As a result, they concluded the IPPS payment system is not appropriate for the payment of LTCH SSO cases. This data flies in the face of your assumption that SSO is a proxy for inappropriate LTCH admission. As a result,

should you finalize this policy, you are simply making an arbitrary 11% reduction in payments to LTCHs.

Make no mistake, the financial impact of the proposed short stay outlier changes are severe. The Dubuis system as a whole has forecasted that if we continued to do business exactly the way we do now, our reimbursement would decrease 17%. This is well into the negative range for us. Because of our commitment to charity care and the acuity of patients we serve, we do not have the large profit margins that have been cited.
Properly admitted LTCH patients are by definition the most severe and medically-complicated cases. As such, the expected length of stay will be much longer than that of an acute care hospital, even for common DRG's. Take for example DRG 12 (degenerative nervous system disorder). Under the proposed SSO policy, there is no distinction made for severity of the condition, i.e. a minor stroke that might be treated in an acute care hospital versus a major stroke with complications and residual effects that might be better treated in a LTCH. The LTCH mean length of stay for this DRG is 25.5 days. Therefore, the 5/6th threshold is 21.25 days. The IPPS length of stay is only 4.3 days. A patient with LTCH DRG 12 may stay at a LTCH for 20 days and thus be a short-stay outlier, but that stay is still five times the IPPS length of stay. Is a stay that is 83 percent of the average LOS really an abuse of the short stay outlier? It is simply wrong to reimburse a 20 day LTCH stay at a 4 day acute care level. This policy will severely harm patient care and have no effect on the issues CMS is attempting to address. In fact, some LTCHs may be inclined to keep anyone passing the acute mean LOS up to the LTCH mean regardless of their medical situation, thus ensuring "gaming" of the system for financial benefit. However, let me assure you, our decisions will continue to be guided first and foremost by medical professionals and the best interests of our patients.

The more appropriate approach to ensuring that medical necessity is the sole driving force behind clinical care decisions would be to tie reimbursement under the LTCH PPS system to clinical quality measures, such as those proposed by MedPAC, and admissions criteria such as NALTH's. Dubuis is impressed with the diligent efforts that MedPAC has undertaken and is fully supportive of MedPAC's recommendations to define LTCHs by facility and patient criteria that ensure that patients admitted to these facilities are medically complex and have a good chance of improvement.

CMS' concerns about the potential for inappropriate admissions could easily and appropriately be addressed by adopting a set of criteria with QIO monitoring that would directly address the issue of appropriate care being delivered in appropriate settings throughout the entire provider group. Not only would this result in better care for Medicare beneficiaries, but also it should address all of CMS' concerns about the relationships between acute care hospitals and LTCHs in general. I understand that in the past CMS has expressed a concern over the lack of available funding for additional QIO reviews. I also understand that in response to this concern, NALTH suggested that LTCHs forgo half of their expected market basket increase with the other half being used to fund QIO reviews. Since CMS has proposed no market basket increase for LTCHs in this rule, I can only assume there are now funds available to help defray the cost of QIO reviews if CMS chooses to do so.

proposed SSO proposal will amount to an 11 percent pay-
force many LTCHs to operate at a loss. It is unfair and unreasonable to deny LTCHs any inflation allowance. At a minimum, it will reduce our ability to finance medical care and services provided to indigent populations and defray the cost of bad debts.

In conclusion, I strongly urge CMS to reconsider the misguided changes to the short stay outlier policy and to make a meaningful commitment to the development of facility and patient centered admissions criteria. As mentioned previously, both the short stay outlier policy, and the 25 percent patient cap for hospital-within-hospital LTCHs, are arbitrary policies that will put patient care in severe jeopardy, while making no progress toward MedPAC's goal of ensuring that patients are treated in the most appropriate settings. Utilizing QIO reviews to enforce facility and patient centered admissions criteria, consistent with MedPAC's recommendations, is a viable patient-centered solution that will address CMS' concerns, promote free and fair competition throughout the LTCH industry, and not harm those providers who are admitting patients appropriately.

Thank you for your consideration. Please do not hesitate to call on us if we may be of assistance.

Sincerely,

Stephen Mills
Dubuis Hospital Houston

Submitter : Mrs. S. Kaye Burk **Date: 03/20/2006**

Organization : Long Term Hospital of Dothan, LLC

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1485-P-72-Attach-1.PDF

CMS-1485-P-72-Attach-2.PDF

CMS-1485-P-72-Attach-3.PDF

Long Term Hospital of Dothan

March 17, 2006

Hon. Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & 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 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 the comments and recommendations of Long Term Hospital of Dothan, LLC to the proposed annual payment rate updates, policy changes, and clarifications under the prospective payment system for long-term care hospitals ("LTCH PPS") for fiscal year ("FY") 2007, which were published by the Centers for Medicare & Medicaid Services ("CMS") on January 27, 2006.

Long Term Hospital of Dothan is one of Noland Health Services (NHS) hospitals. NHS is a not-for-profit healthcare organization headquartered in Fairfield, Alabama that operates five Long Term Acute Care Hospitals in Anniston, Birmingham, Dothan, Montgomery and Tuscaloosa, AL. Noland Health Services is a member of the Acute Long Term Hospital Association (ALTHA) and fully supports the comment letter and proposals from ALTHA dated March 11, 2006.

NHS 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. NHS has analyzed the financial impact of the proposed rule on Long Term Hospital of Dothan's operations and has determined that the impact on NHS reimbursement will be a significant reduction in Medicare revenue and operating margin. Like ALTHA, we believe that CMS used materially flawed and incomplete data in developing the proposed changes to LTCH payments for FY 2007.

NHS 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. NHS 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 uses 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 five of Long Term Hospitals, 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.

1108 Ross Clark Circle – 4th Floor, Dothan, Alabama 36301
(334) 699-4300 Fax (334)699-4379

Noland Health Services
www.nolandhealth.com

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 to address the concern 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 seven (7) days).

CMS's proposal to limit the payment for SSO cases at the IPPS payment rate would cause Noland's LTCHs to be significantly underpaid In order to quantify the impact, Noland reviewed all Medicare discharges at all five hospitals for a one year period. For SSO cases, which represent a significant percent of the Medicare patients served by Noland's LTCHs, the proposal would cause payment amounts to fall materially below the actual costs of providing care.

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 Noland *significantly* less than it costs us 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.

CMS assumes that we can change our 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, Noland's LTCHs and physicians are not able to predict a patient's length of stay at the time of admission. Therefore, Noland cannot change their behavior to accommodate these payment cuts. Instead, Noland's 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.

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 is unreasonable for CMS to expect admitting physicians to be able to predict a potential patient death ten (10) or even twenty (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.

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.

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. Noland LTCHs admit patients only after applying an objective and rigorous set of admissions screening criteria, known as the "InterQual Criteria for Long Term Acute Care" 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.

Over the past two (2) years, Long Term Hospital of Dothan has had a number of reviews performed by the Alabama QIO (Alabama Quality Assurance Foundation). All of the QIO reviews have determined that Noland's LTHC admissions were appropriate and medically necessary. Our experience reinforces the experience of Kindred and Select cited in the ALTHA letter. Noland believes that 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.

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 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 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. 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.

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. 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 those 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 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.) 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.

The SSO policy would penalize LTCHs for admitting LTCH-appropriate patients by paying providers below cost most of the time. Currently, Noland's LTCHs uses a patient assessment tools, 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 Alabama's QIO 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 twenty-five (25) days.

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 twenty-five (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 twenty-five (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 twenty-five (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.

NHS 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. NHS 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 twenty-five (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:

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 (*e.g.*, hospice and home health) 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.

CMS should allow a full update to the LTCH PPS federal rate for FY 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.

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. NHS 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 twenty-five (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.

NHS 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.

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.

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, NHS 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.

Conclusion

NHS 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. 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 review of ALTHA's analysis 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 ALTHA provided in their comment letter, and we anticipate reviewing a more effective set of proposals to better define the patients and setting for long-term acute hospital care.

Sincerely,

Kaye Burk

Kaye Burk,
Administrator
Long Term Hospital of Dothan

Long Term Hospital of Dothan

March 17, 2006

Hon. Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & 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 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 the comments and recommendations of Long Term Hospital of Dothan, LLC to the proposed annual payment rate updates, policy changes, and clarifications under the prospective payment system for long-term care hospitals ("LTCH PPS") for fiscal year ("FY") 2007, which were published by the Centers for Medicare & Medicaid Services ("CMS") on January 27, 2006.

Long Term Hospital of Dothan is one of Noland Health Services (NHS) hospitals. NHS is a not-for-profit healthcare organization headquartered in Fairfield, Alabama that operates five Long Term Acute Care Hospitals in Anniston, Birmingham, Dothan, Montgomery and Tuscaloosa, AL. Noland Health Services is a member of the Acute Long Term Hospital Association (ALTHA) and fully supports the comment letter and proposals from ALTHA dated March 11, 2006.

NHS 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. NHS has analyzed the financial impact of the proposed rule on Long Term Hospital of Dothan's operations and has determined that the impact on NHS reimbursement will be a significant reduction in Medicare revenue and operating margin. Like ALTHA, we believe that CMS used materially flawed and incomplete data in developing the proposed changes to LTCH payments for FY 2007.

NHS 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. NHS 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 uses 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 five of Long Term Hospitals, 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.

1108 Ross Clark Circle – 4th Floor, Dothan, Alabama 36301
(334) 699-4300 Fax (334)699-4379

Noland Health Services
www.nolandhealth.com

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 to address the concern 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 seven (7) days).

CMS's proposal to limit the payment for SSO cases at the IPPS payment rate would cause Noland's LTCHs to be significantly underpaid In order to quantify the impact, Noland reviewed all Medicare discharges at all five hospitals for a one year period. For SSO cases, which represent a significant percent of the Medicare patients served by Noland's LTCHs, the proposal would cause payment amounts to fall materially below the actual costs of providing care.

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 Noland *significantly* less than it costs us 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.

CMS assumes that we can change our 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, Noland's LTCHs and physicians are not able to predict a patient's length of stay at the time of admission. Therefore, Noland cannot change their behavior to accommodate these payment cuts. Instead, Noland's 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.

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 is unreasonable for CMS to expect admitting physicians to be able to predict a potential patient death ten (10) or even twenty (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.

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.

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. Noland LTCHs admit patients only after applying an objective and rigorous set of admissions screening criteria, known as the "InterQual Criteria for Long Term Acute Care" 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.

Over the past two (2) years, Long Term Hospital of Dothan has had a number of reviews performed by the Alabama QIO (Alabama Quality Assurance Foundation). All of the QIO reviews have determined that Noland's LTHC admissions were appropriate and medically necessary. Our experience reinforces the experience of Kindred and Select cited in the ALTHA letter. Noland believes that 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.

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 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 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. 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.

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. 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 those 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 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.) 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.

The SSO policy would penalize LTCHs for admitting LTCH-appropriate patients by paying providers below cost most of the time. Currently, Noland's LTCHs uses a patient assessment tools, 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 Alabama's QIO 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 twenty-five (25) days.

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 twenty-five (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 twenty-five (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 twenty-five (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.

NHS 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. NHS 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 twenty-five (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:

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 (*e.g.*, hospice and home health) 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.

CMS should allow a full update to the LTCH PPS federal rate for FY 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.

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. NHS 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 twenty-five (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.

NHS 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.

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 not 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.

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Sincerely,

Kaye Burk

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Administrator
Long Term Hospital of Dothan

Long Term Hospital of Dothan

March 17, 2006

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

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Long Term Hospital of Dothan is one of Noland Health Services (NHS) hospitals. NHS is a not-for-profit healthcare organization headquartered in Fairfield, Alabama that operates five Long Term Acute Care Hospitals in Anniston, Birmingham, Dothan, Montgomery and Tuscaloosa, AL. Noland Health Services is a member of the Acute Long Term Hospital Association (ALTHA) and fully supports the comment letter and proposals from ALTHA dated March 11, 2006.

NHS 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. NHS has analyzed the financial impact of the proposed rule on Long Term Hospital of Dothan's operations and has determined that the impact on NHS reimbursement will be a significant reduction in Medicare revenue and operating margin. Like ALTHA, we believe that CMS used materially flawed and incomplete data in developing the proposed changes to LTCH payments for FY 2007.

NHS 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. NHS 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 uses 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 five of Long Term Hospitals, 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.

1108 Ross Clark Circle – 4th Floor, Dothan, Alabama 36301
(334) 699-4300 Fax (334)699-4379

Noland Health Services
www.nolandhealth.com

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 to address the concern 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 seven (7) days).

CMS's proposal to limit the payment for SSO cases at the IPPS payment rate would cause Noland's LTCHs to be significantly underpaid In order to quantify the impact, Noland reviewed all Medicare discharges at all five hospitals for a one year period. For SSO cases, which represent a significant percent of the Medicare patients served by Noland's LTCHs, the proposal would cause payment amounts to fall materially below the actual costs of providing care.

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 Noland *significantly* less than it costs us 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.

CMS assumes that we can change our 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, Noland's LTCHs and physicians are not able to predict a patient's length of stay at the time of admission. Therefore, Noland cannot change their behavior to accommodate these payment cuts. Instead, Noland's 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.

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 is unreasonable for CMS to expect admitting physicians to be able to predict a potential patient death ten (10) or even twenty (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.

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.

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. Noland LTCHs admit patients only after applying an objective and rigorous set of admissions screening criteria, known as the "InterQual Criteria for Long Term Acute Care" 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.

Over the past two (2) years, Long Term Hospital of Dothan has had a number of reviews performed by the Alabama QIO (Alabama Quality Assurance Foundation). All of the QIO reviews have determined that Noland's LTHC admissions were appropriate and medically necessary. Our experience reinforces the experience of Kindred and Select cited in the ALTHA letter. Noland believes that 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.

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 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 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. 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.

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. 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 those 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 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.) 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.

The SSO policy would penalize LTCHs for admitting LTCH-appropriate patients by paying providers below cost most of the time. Currently, Noland's LTCHs uses a patient assessment tools, 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 Alabama's QIO 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 twenty-five (25) days.

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 twenty-five (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 twenty-five (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 twenty-five (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.

NHS 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. NHS 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 twenty-five (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:

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 (*e.g.*, hospice and home health) 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.

CMS should allow a full update to the LTCH PPS federal rate for FY 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.

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. NHS 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 twenty-five (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.

NHS 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.

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.

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, NHS 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.

Conclusion

NHS 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. 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 review of ALTHA's analysis 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 ALTHA provided in their comment letter, and we anticipate reviewing a more effective set of proposals to better define the patients and setting for long-term acute hospital care.

Sincerely,

Kaye Burk

Kaye Burk,
Administrator
Long Term Hospital of Dothan

Submitter : Mrs. Pamela Clarke **Date:** 03/20/2006

Organization : Delaware Valley Healthcare Council

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

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