FEB 24 2006

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ASCENSION HEALTH

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February 24, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention CMS-1485-P
P.O. Box 8012
Baltimore, Maryland 21244-1812

Re: January 27, 2006 Proposed Rule - Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy changes, and Clarification

Thank you for the opportunity to comment on the January 27, 2006 proposed rule ("Proposed Rule") impacting long-term care hospitals ("LTCH").

St. Elizabeth Ann Seton Hospital of Central Indiana, Inc. ("SEASH") is writing to express its concern over proposed changes and comments that were contained in the January 27, 2006 Proposed Rule. Specifically, it is SEASH's belief that CMS's proposed change to its treatment of short-stay outliers ("SSOs") will, ultimately, have the unintended effect of creating a strong incentive for some LTCH providers to slow the provision of care in an effort to lengthen a patient's stay to avoid an SSO in hopes of obtaining the full diagnostic related group ("DRG") payment. Additionally, SEASH believes that CMS's concern regarding proliferation of freestanding LTCHs is misplaced, and that concerns over patient-shifting can be more properly addressed through the establishment of clinically appropriate admission criteria.

I. Short Stay Outliers.

By way of background, SEASH is a decade-old faith-based, not-for-profit LTCH system operating 98 beds in central Indiana. Our hospitals admit only very high acuity, long stay patients (e.g., our year-to-date LTCH case mix index ("CMI") is 1.55). SEASH believes that it is among the pioneers in development of an effective long-term, high acuity clinical model and we have demonstrated exceptional quality, outcomes and cost effectiveness.

CMS has, for some time, expressed concern about inappropriate admissions of low acuity patients into LTCHs. SEASH has observed this very behavior at other LTCHs within the industry. It is our experience that many LTCH providers seek to admit chronically ill "slow-recovery" patients as a primary target population. These patients have little difficulty meeting the 25-day LTCH average length of stay

criteria, and while these patients may meet continued stay criteria, we believe many could be cared for in a less acute setting.

In our experience the LTCH model works best when it is applied to a much smaller, more narrowly defined population of patients whose otherwise swift recovery has been impeded by multiple serious physiological complications. With excellent LTCH care some of these patients recover sufficiently to be transferred to a lower level of care in 12 to 20 days, others, of course, take longer. These patients may become SSOs and they are among the real success stories of our industry. We would welcome and were looking forward to refined clinical admission criteria that would stabilize the industry around this patient group. We believe this is what was originally envisioned when the groundwork for LTCHs was laid in 1983 with the introduction of the inpatient prospective payment system.

Unfortunately, the approach taken in the Proposed Rule, most particularly the introduction of a fourth (inpatient prospective payment system ("IPPS") equivalent) SSO payment option, fails to accomplish this goal. Although it may, in fact, reduce some inappropriate admissions, it will actually encourage others while simultaneously drastically reducing payment for clinically appropriate LTCH patients. The proposed regulations also establish a harmful precedent for using payment mechanisms as a substitute for clinical judgment, encourage further case management abuse by some providers and significantly distort the intent of the prospective payment system

The basic premise behind the prospective payment system is to provide an average payment for short and long stay patients, thereby creating incentives for early discharge and efficient operation. The proposed payment mechanism totally inverts this perspective. Consequently, it will provide a VERY strong incentive for some providers to slow down the provision of care in order to LENGTHEN the patient's stay in hopes of avoiding an SSO in favor of the full DRG payment at just 5/6 of the expected length of stay. Such behavior would be in clear opposition to CMS' intent and the public good, yet it would be very easy to do by an unscrupulous provider. The Proposed Rule re-introduces all of the backward incentives associated with the old "cost-based" reimbursement, but at a much higher level since it will encourage not just recovery of additional cost but will actually offer a profit for longer stays. Not coincidentally, this could effectively RAISE costs to the Medicare program.

Historically, LTCHs have had a mortality rate of approximately 20% and many of these deaths occur in such a manner as to make the patient a SSO. These patients do not die of "low acuity." Obviously, these are very sick people. But, in our hospitals at least, their deaths are not easily foreseen and had their complex clinical course not taken their lives, virtually all of them would have gone on to be full stay patients. This group of patients, in fact, accounts for more than 20% of our ministry's SSO population. The assumption that these patients could better be

cared for in a less acute setting simply is not true. And, of course, it is well known that patients consume many expensive resources during an end of life illness. The "IPPS equivalent" payment rate was designed for a population that, by and large, is less acute, experiences fewer co-morbidities and which more typically survives.

Even for non-mortality patients, CMS' assumption that SSO patients, by definition, would be more appropriately placed in a less costly provider setting is erroneous. In our hospitals the CMI of SSO patients is virtually identical to that of our full stay and cost outlier populations. The average length of stay of our SSO patients is over 15 days, almost 3 times the average length of stay in a typical acute care hospital and just 10 days less than the only definition CMS has ever provided for LTCH patients.

It appears that our average "IPPS equivalent" SSO payment is only sufficient to cover the cost of providing 3-4 days of care. The proposed payment mechanism simply fails to provide for any possibility of an appropriate LTCH patient whose stay falls between these extremes. As proposed, the payment incentives further define our industry solely by length of stay. The proposed regulations only serve to reinforce incentives to admit "slow recovery" patients (many of whom might be well cared for in SNF's or with home care) instead of appropriately high acuity complex patients.

It is our belief that the LTCH industry will not be stabilized and allowed to develop its full clinical and economic value until appropriate clinical admission criteria are developed that SPECIFICALLY and EFFECTIVELY limit entry to very high acuity, complex patients. Until this occurs, too many providers will continue to find ways to admit low acuity patients and capture a payment mechanism that was carefully developed to serve complex, high acuity patients. This will continue to offer the high profit margins that drive the rapid growth of LTCHs.

SEASH can actively support the proposed regulations with the exception of the proposed fourth alternate payment calculation for SSOs (IPPS Equivalent). We recommend this specific provision be deleted and that CMS continue development of revised clinical admission criteria to minimize possibly inappropriate LTCH admissions. At the very least, this methodology should be applied only to "very short stay" LTCH patients (as previously proposed by CMS) - perhaps this time defined as patients with lengths of stay of less than 1/6 of the expected Geometric Mean Length of Stay. Though still not an entirely appropriate use of funding methodology, this approach would, at least, be consistent with your stated intent and would minimize the incentive for inappropriately extending patient stays in order to capture a full DRG payment.

II. Freestanding LTCHs.

SEASH also wishes to comment on CMS' observation in the preamble to the Proposed Rule that the construction of new freestanding LTCHs may represent a "gaming" of the 25% admission source rule. This supposition does not appear to be justified. When the admission source rules were introduced in 2005, the regulations were intended to make it more difficult to transfer short-term acute patients to LTCHs. In this regard, the 2005 regulations have been spectacularly successful. But in many, if not most markets, the most appropriate complex LTCH patients originate from just one or two large tertiary medical centers and the location of the LTCH won't change the origin of these patients. If CMS continues to believe patients are being inappropriately transferred (again, a belief with which SEASH would have no argument in many cases) once again they should pursue establishment of clinically appropriate admission criteria instead of imposing arbitrary, complex, expensive and oblique motivators.

I will be happy to discuss any of these comments with you at your convenience if it would be helpful.

Again, thank you for the opportunity to contribute to the ongoing evolution of the Long-Term Care Hospital model of care.

Sincerely,

Peter H. Alexander, Executive Director

Robert A. Ortenzio
Chief Executive Officer

March 1, 2006

BY OVERNIGHT MAIL

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, 71 Fed. Reg. 4648 (January 27, 2006)***

Ladies and Gentlemen:

Select Medical Corporation is writing to comment on certain aspects of the proposed annual payment rate updates, policy changes, and clarifications under the prospective payment system for long-term care hospitals, which were published by CMS on January 27, 2006. In particular, our comments in this letter are limited to the proposed changes to 42 C.F.R. § 412.529(c), which address the method for determining the payment amount for short-stay outlier ("SSO") cases.

As discussed more fully below, CMS's proposed changes to the SSO payment methodology are not grounded on any analysis of relevant data, but rather are based on CMS's demonstrably erroneous and unsubstantiated assumptions that all SSO patients have been inappropriately admitted to LTCHs and inappropriately discharged from general acute care hospitals. The magnitude of the resulting cuts in payments for treating SSO patients are so dramatic (*e.g.*, Select would receive only 57 percent of its actual costs in treating such patients) that the proposal appears to be punitive, even though CMS has produced no study that shows that LTCHs are being paid to treat patients who are inappropriate for LTCH care.

We strongly urge CMS not to implement this baseless and radical change in payment for LTCH services. Rather, we urge CMS to consider alternatives that more appropriately target any cases that, based on a meaningful analysis of data, are likely the result of inappropriate admissions to LTCHs. Among other things, instead of the current proposal, 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.

I. BACKGROUND

Select is a leading operator of LTCHs in the United States. As of January 31, 2006, Select operated 97 LTCHs in 26 states. LTCH patients have specialized needs, and serious and often complex medical conditions, such as respiratory failure, neuromuscular disorders, cardiac

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disorders, non-healing wounds and renal failure. These patients generally require longer lengths of stay than patients in a general acute care hospital and benefit from being treated in a long term care hospital that is designed to meet their unique medical needs.

By statute enacted in 1983, Congress determined that LTCHs – defined as hospitals treating patients with an average length of stay of greater than 25 days and otherwise meeting the Medicare hospital conditions of participation – should be exempt from the Medicare inpatient prospective payment system applicable to general acute care hospitals ("IPPS"). More recently, Congress required the development of a prospective payment system for LTCHs ("LTCH PPS"). On March 22, 2002, CMS published a proposed rule to establish LTCH PPS, and on August 20, 2002, CMS published a final rule instituting LTCH PPS. Generally, the August 2002 Final Rule provided for the payment of a fixed amount for an LTCH case based on the diagnosis related group (the "LTC-DRG") to which the patient is assigned.

In addition, the March 2002 Proposed Rule proposed, and the August 2002 Final Rule adopted, 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. Ultimately, the August 2002 Final Rule provided that, for SSO cases, LTCHs would be paid 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 of the applicable LTC-DRG category (that is, Federal payment rate x 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. 13453. 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 nonshort-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. 56000, 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. 56001.

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. As discussed below, 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 the SSO thresholds; (4) by proposing to pay for SSO patients at IPPS rates, 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 – for Select's LTCHs, fully 43 percent below – their actual costs of providing care.

II. DISCUSSION

A. 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.

The SSO thresholds have nothing at all to do with the appropriateness of an LTCH admission. Rather, the SSO thresholds are simply the mathematical result of the per diem rates that CMS established for cases whose lengths of stay are less than the average for a particular LTC-DRG. As CMS explained in the August 2002 Final Rule, the SSO threshold "corresponds to the day where the full LTC-DRG payment would be reached by paying the specified percentage of the per diem amount for the LTC-DRG." By providing for per diem payments until this point, CMS accomplished its objective of "a gradual increase in payment as the length of stay increases, without producing a 'payment cliff,' which will provide an incentive to discharge a patient one day later because there will be a significant increase in the payment." 67 Fed. Reg. 55996. By setting the per diem rates at 120 percent of the average LTC-DRG specific per diem amount, the SSO threshold necessarily became fixed at 5/6 of the average length of stay for the LTC-DRG. This relationship between the per diem rate and the SSO threshold is illustrated in the preamble to the March 2002 Proposed Rule, where CMS discussed three alternative per diem payment rates: 100 percent of the LTC-DRG specific per diem amount, yielding an SSO threshold equal to the average length of stay for the LTC-DRG; 150 percent of the LTC-DRG specific per diem amount, yielding an SSO threshold equal to 2/3 of the average length of stay for the LTC-DRG; and 200 percent of the LTC-DRG specific per diem amount,

yielding an SSO threshold equal to the 1/2 of the average length of stay for the LTC-DRG. 67 Fed. Reg. 13454-5. It is plain that the SSO threshold was simply derived from the per diem payment amounts and had nothing to do with the appropriateness or inappropriateness of admissions of SSO cases for LTCH care.

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

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

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

B. CMS erroneously assumes that patients below the SSO thresholds have been inappropriately admitted to LTCHs.

CMS's assumption that patients whose lengths of stay fall below the SSO threshold have been inappropriately admitted to the LTCH is flawed on numerous grounds. First, this assumption, which supposes that a majority of patients whose length of stay is below the average were inappropriately admitted, is at odds with the premise of LTCH PPS, which necessarily recognizes that the lengths of stay of about half of all LTCH patients will be below the average. Second, CMS's assumption fails to recognize that, demonstrably, SSO patients require the same intensity of care that LTCHs furnish to inlier patients. Third, CMS erroneously assumes that it is possible to distinguish SSO cases from inlier cases at the time of LTCH admission.

1. The fact that a significant number of LTCH patients fall below the average length of stay in a given LTC-DRG is inherent in the structure of LTCH PPS and does not indicate inappropriateness of LTCH admissions.

In the January 2006 Proposed Rule, CMS noted that 37 percent of LTCH discharges were paid under the SSO payment policy during fiscal year 2004. Although this percentage reflects the significant reduction from the 48.4 percent that CMS predicted in 2002, in the January 2006 Proposed Rule, CMS audaciously states, "[w]e believe that the 37 percent of LTCH discharges (that is, more than one-third of all LTCH patients) that the FY 2004 MedPAR identified as SSO cases continues to be an inappropriate number of patients 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 services." 71 Fed. Reg. 4686. Based on this assumption that SSO cases – representing the vast majority of LTCH patients whose length of stay is less than average – were inappropriately admitted to LTCHs, CMS radically proposes to pay LTCHs for such cases at rates comparable to those paid to IPPS-reimbursed general acute care hospitals, rather than consistent with LTCH PPS rates.

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

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

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

2. Despite their ultimately shorter-than-average length of stay, SSO patients present medical complexities that warrant the LTCH level of care.

SSO patients require the intensive resources and care management available in an LTCH. The diagnoses, medical complexity and severity of illness of SSO patients are generally no different from the overall LTCH patient population. Whether a particular LTCH patient ultimately falls into the category of SSO patients does not in any way suggest that the patient was inappropriately admitted to an LTCH and did not need LTCH care.

In fact, the appropriateness for LTCH admission of all Select LTCH patients – even those who may turn out to be SSO patients – is confirmed at the time of admission by use of a rigorous screening process. Specifically, Select applies the InterQual® Long-Term Acute Care Criteria (McKesson Health Solutions) in order to assess the appropriateness of patients' admissions, their continued stays and ultimate discharges from its facilities. Such criteria are among the patient-level standards that MedPAC has recommended be applied by CMS to define more precisely the level of care furnished by LTCHs ("Report to the Congress: New Approaches in Medicare," June 2004) and are used by many of Medicare's Quality Improvement Organizations to evaluate the appropriateness of LTCH admissions. In fact, Select's application of the InterQual® Criteria identifies and screens a significant number of patients from admission to its LTCHs, thereby ensuring that only those appropriate patients are admitted. Table 1 below demonstrates that, during each quarter of 2005, 50 percent or less of all referrals to Select's LTCHs were admitted because this screening process determined that the remainder was inappropriate for LTCH care.

Table 1: Actual Select LTCH Admissions from Total Referrals

2005	Total Referrals	Actual Admissions	Percentage of Referrals that Result in Admissions
Qtr 1	17,290	8,282	48%
Qtr 2	15,956	7,800	49%
Qtr 3	15,007	7,562	50%
Qtr 4	15,518	7,734	50%

While Select has experienced a significant drop in SSO cases since adopting the InterQual® Criteria – from 46.45 percent of admissions (based upon MedPAR 2000 data) to 35.6 percent of admissions (based upon Select's calendar year 2005 data) – there is no reason to believe, and CMS has presented no date to support its assertion, that the percentage of SSO cases can or should be reduced further, since each of these patients has been determined, based upon widely-accepted, objective criteria, to be appropriate for LTCH admission.

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.

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.

The appropriateness of SSO patients for LTCH care is also demonstrated by the fact that the key indicators of medical complexity for SSO patients are similar to those of LTCH inlier patients. Specifically, Tables 2 and 3 below show that the severity of illness and risk of mortality of patients categorized as SSO cases in Select's LTCHs during 2004 (based on MedPAR data) and 2005 (based on Select data) was comparable to that of inlier patients.

Table 2: Percentage of Select LTCH SSO, Inlier and HCO Patients within Severity of Illness (SOI) Categories

SOI Category	2004				2005			
	SSO	Inlier	HCO	Total	SSO	Inlier	HCO	Total
N/A	1	1	0	1	0	0	0	0
1	3	2	0	2	2	1	0	1
2	22	24	5	19	18	17	50	17
3	46	51	38	47	43	49	35	46
4	28	21	56	31	36	32	60	36
1 and 2 Combined	25	27	6	21	20	18	5	18
3 and 4 Combined	74	72	94	78	80	81	95	82

Table 3: Percentage of Select LTCH SSO, Inlier and HCO Patients within Risk of Mortality (ROM) Categories

ROM Category	2004				2005			
	SSO	Inlier	HCO	Total	SSO	Inlier	HCO	Total
N/A	1	1	0	1	0	0	0	0
1	4	4	1	4	3	3	1	3
2	33	41	16	32	29	33	15	30
3	45	44	51	46	45	47	46	46
4	17	11	31	17	23	17	38	21
1 and 2 Combined	37	45	17	36	32	35	16	32
3 and 4 Combined	62	54	83	63	68	64	84	67

Moreover, retrospective review of Select's patients – including SSO cases – by QIOs further supports the conclusion that the patients admitted to Select's LTCHs have been appropriate for LTCH admission. In fact, as demonstrated in Table 4 below, during calendar years 2004 and 2005, only 5 of Select's LTCH admissions (*i.e.*, less than 1 percent) were found to lack medical necessity. Thus, QIO review of Select LTCH cases further refutes CMS's assumption that SSO patients are overwhelmingly inappropriate for LTCH admission.

Table 4: QIO Review and Denials of Select LTCH Admissions

		Chart Requests	Denials
2004	Qtr 1	57	0
	Qtr 2	70	0
	Qtr 3	70	1
	Qtr 4	65	0

Table 4: QIO Review and Denials of Select LTCH Admissions			
		Chart Requests	Denials
2005	Qtr 1	79	0
	Qtr 2	76	1
	Qtr 3	69	2
	Qtr 4	81	1

Furthermore, the reasons for the cessation of the inpatient stay of certain LTCH patients demonstrate, on their face, the lack of justification for CMS's assumption that SSO cases were inappropriate for LTCH care. In particular, approximately 4.1 percent of Select's LTCH patients die during the first week of their LTCH stay, and approximately 3.4 percent die during the second week. This percentage of patient deaths is a function of the medical complexity and severity of illness of these patients – factors that tend to support the original LTCH admission rather than undermine it. Certainly, there is no basis for CMS to conclude that these patients were inappropriate for LTCH admission or would have received more appropriate treatment at another site.

In addition, another 2 percent of Select's SSO patients are characterized as such because their Medicare coverage expires during their LTCH stay but before they reach the relevant SSO thresholds. Clearly, loss of Medicare coverage bears no relevance whatsoever to whether the patient was appropriate for admission to an LTCH. CMS, itself, recognized this fact in the initial implementation of LTCH PPS, when it decided to count total patient days rather than Medicare-covered days to determine whether an LTCH meets the statutory average length of stay requirement for certification:

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

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

In sum, despite their ultimately shorter-than-average length of stay, an analysis of the data clearly demonstrates that SSO patients present medical complexities that warrant the LTCH level of care. This conclusion stands in stark contrast to CMS's assertions, which are not based on any compilation, evaluation or analysis of relevant data.

3. It is not possible for LTCHs to differentiate between SSO and inlier patients at the time of LTCH admission.

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.) Data show that patients who are ultimately characterized as SSO cases present the same diagnostic mix, same or higher levels of severity and higher risks of mortality than inlier cases. In particular, the similarity of the diagnostic mix of SSO patients and inlier cases is demonstrated by Table 5 below, which shows that the percentages of SSO cases falling into each

of the most common LTC-DRGs is comparable to the percentages of inliers falling into such LTC-DRGs.

Table 5: Comparison of proportion of diagnoses among SSO, Inlier and HCO patients in Select LTCHs									
DRG	DESCRIPTION	SSO		Inlier		HCO		Total	
		Cases	%	Cases	%	Cases	%	Cases	%
475	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	1652	18.44	2206	15.78	475	23.25	4333	17.35
87	PULMONARY EDEMA & RESPIRATORY FAILURE	748	8.35	719	5.14	50	2.45	1517	6.07
79	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	474	5.29	721	5.16	56	2.74	1251	5.01
271	SKIN ULCERS	392	4.38	675	4.83	63	3.08	1130	4.52
416	SEPTICEMIA AGE >17	392	4.38	610	4.36	74	3.62	1076	4.31
466	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	307	3.43	615	4.40	80	3.92	1002	4.01
88	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	314	3.51	538	3.95	40	1.96	892	3.57
89	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	247	2.76	414	2.96	26	1.27	687	2.75
316	RENAL FAILURE	246	2.75	331	2.37	43	2.10	620	2.48
263	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	188	2.10	367	2.63	64	3.13	619	2.48

Similarly, as depicted in Tables 2 and 3, which appear above, the proportion of SSO patients in Select's LTCHs that fall within the highest severity of illness and risk of mortality categories is consistent with the proportion of inlier patients that fall within those categories. Given the high levels of severity of illness and risk of mortality within the SSO patient population, clinicians making admissions decisions cannot and *should not be* required to predict the ultimate length of stay for this subset of medically-complex, severely ill patients. Rather, if LTCHs are successful in establishing and implementing a plan of care that achieves the best clinical outcome for the patient in a shorter-than-average timeframe, the result should be lauded, rather than penalized, as beneficial for all affected parties.

The difficulty of identifying those patients who will ultimately fall in the SSO category is compounded by the fact that many of these patients have already had extended stays at IPPS-reimbursed general acute care hospitals. Table 6 below shows the average length of stay that LTCH SSO patients assigned to the most common LTC-DRGs had in a general acute care hospital prior to LTCH admission.

Table 6: Lengths of stay in IPPS hospital prior to LTCH admission of SSO patients				
DRG	Description	IPPS Hospital ALOS	LTCH Patients	
			Prior IPPS Hospital LOS	LTCH Geo ALOS for All Patient Types
475	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	8.0	27	34.2
87	PULMONARY EDEMA & RESPIRATORY FAILURE	4.9	23	30.4

Table 6: Lengths of stay in IPPS hospital prior to LTCH admission of SSO patients				
DRG	Description	IPPS Hospital ALOS	LTCH Patients	
			Prior IPPS Hospital LOS	LTCH Geo ALOS for All Patient Types
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
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	4.3	9	25.6
249	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	2.6	8	23.9
79	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	6.6	14	23.7
466	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	2.4	15	22.2
Sources: IPPS Hospital and LTCH ALOS data taken from MedPAR file. Prior IPPS Hospital LOS taken from January 2006 proposed rule.				

CMS claims in the January 2006 Proposed Rule that LTCHs may have a financial incentive to admit SSO cases. However, no such incentive can exist where SSO cases are indistinguishable from inlier cases at the time of admission. Even if CMS were justified in changing SSO payment policy in order to incent LTCHs to decline admissions of SSO cases, it will be impossible for LTCHs to respond to this financial incentive where providers are unable to identify such cases at the time of admission.

C. *CMS erroneously assumes that LTCHs function like general acute care hospitals when treating patients below SSO thresholds.*

In the January 2006 Proposed Rule, CMS asserts that, because many LTCH patients are admitted directly from IPPS-reimbursed general acute care hospitals, "the admission of short stay patients at LTCHs may indicate premature and even inappropriate discharges" from the referring hospital. Further, CMS claims that LTCHs behave "like acute care hospitals by having a significant number of cases with lengths of stay commensurate with acute care hospitals." As an indication of inappropriate admissions and premature discharges, CMS points to the fact that approximately one-third of LTCH discharges are SSO cases. However, CMS's concerns and its proposed response are not based on analysis of any data, but rather are derived from the baseless assumption that LTCHs are functioning like general acute care hospitals with respect to patients who ultimately fall within the SSO category. CMS thus crudely concludes that all SSO cases result from inappropriate discharges from a general acute care hospital and inappropriate admissions to an LTCH.

CMS cites the fact that "the vast majority of LTCH patients are admitted directly from IPPS acute care hospitals," 71 Fed. Reg. 4687, to support its conclusion that LTCHs behave like general acute care hospitals when treating SSO patients. CMS's logic fails to acknowledge and account for the simple fact that the very patients that are most appropriate for LTCH care – that is, the sickest patients with the most medically complex cases – would naturally have been initially admitted to a general acute care hospital prior to any determination of their appropriateness for LTCH care. Put differently, patients in nursing facilities or receiving care at home immediately prior to admission to an LTCH are least likely to have the complexities that make their admission to an LTCH necessary. In fact, rather than creating a basis for suspicion that such patients were inappropriate for LTCH care, the fact that most LTCH patients come

from general acute care hospitals would tend to demonstrate that LTCH patients are being identified from among the patient population most likely to be appropriate for LTCH admission.

CMS's assertion that LTCHs behave as general acute care hospitals when treating SSO cases mistakenly assumes that the length of stay of SSO cases is similar to the length of stay in general acute care hospitals. In fact, the length of stay for SSO cases assigned to the most common LTC-DRGs are materially longer than the length of stay for patients with the corresponding DRG in a general acute care hospital. Table 7 below compares the average length of stay in IPPS-reimbursed general acute care hospitals, LTCH PPS average length of stay and the SSO threshold for the most common LTC-DRG into which our SSO cases fall.

Table 7: Comparison of lengths of stay in IPPS hospitals and Select LTCHs

DRG	DESCRIPTION	IPPS Hospital ALOS	LTCH ALOS	SSO THRES-HOLD	LTCH SSO ALOS
475	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	8.1	34.2	28.5	14.46
87	PULMONARY EDEMA & RESPIRATORY FAILURE	4.9	30.4	25.3	12.27
79	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	6.7	23.7	19.8	11.08
271	SKIN ULCERS	5.5	28.4	23.7	12.95
416	SEPTICEMIA AGE >17	5.6	23.9	19.9	9.90
88	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	4.0	20.1	16.8	9.71
466	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	2.7	22.2	18.5	10.41
127	HEART FAILURE & SHOCK	4.1	21.6	18.0	9.62
89	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	4.7	21.2	17.7	9.27
316	RENAL FAILURE	4.9	23.6	19.7	10.39

As the table demonstrates, the average length of stay, the SSO threshold and the average length of stay for SSO cases materially exceed the average lengths of stay in an IPPS-reimbursed general acute care hospital for patients assigned to the same DRGs. 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.

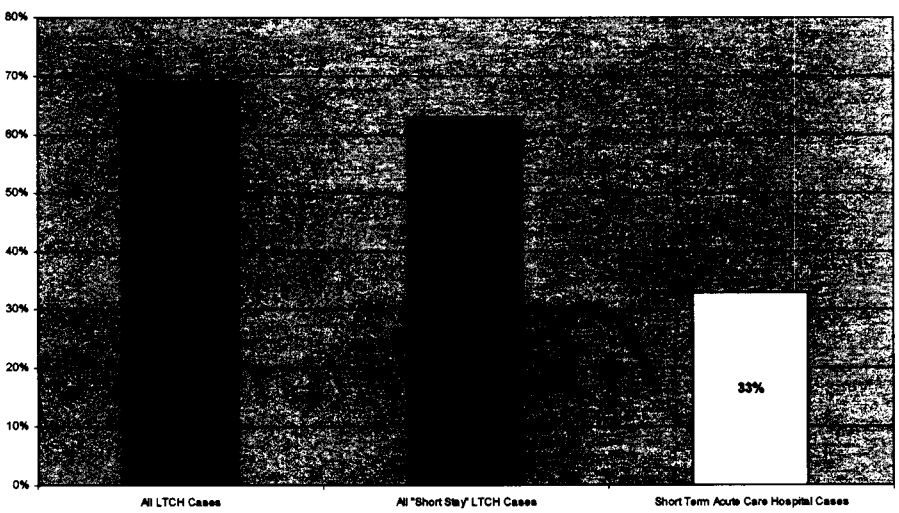
Rather than functioning as general acute care hospitals for SSO cases, in fact, LTCHs provide the same intensive services to SSO patients that LTCHs provide to LTCH inlier patients. These more intensive services are required for the more medically complex patients that LTCHs were meant to serve. Select's data shows that, for each of the most common LTC-DRGs into which our SSO cases fall, the resources used by SSO cases in Select's LTCHs (as measured by the average daily charges for services) are at the same level – or higher – than the resources used by inlier cases in Select's LTCHs (also measured by the average daily charges for services).

Furthermore, an analysis of the APR-DRG severity of illness categories to which SSO cases are assigned shows that, in comparison to IPPS-reimbursed general acute care hospital, LTCHs treat a substantially higher percentage of cases assigned to the highest severity of illness categories. As depicted in Table 8 below, for all LTCHs, 63 percent of all SSO cases fall within the highest severity of illness categories, whereas only 33 percent of IPPS-reimbursed general

acute care hospital cases fall within these categories. Table 9 below shows that for Select's LTCHs, during 2005, 80 percent of all SSO cases fall within the highest severity of illness categories.

Table 8: LTCH Patients are Much Sicker than Average Short Term Hospital Patients

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

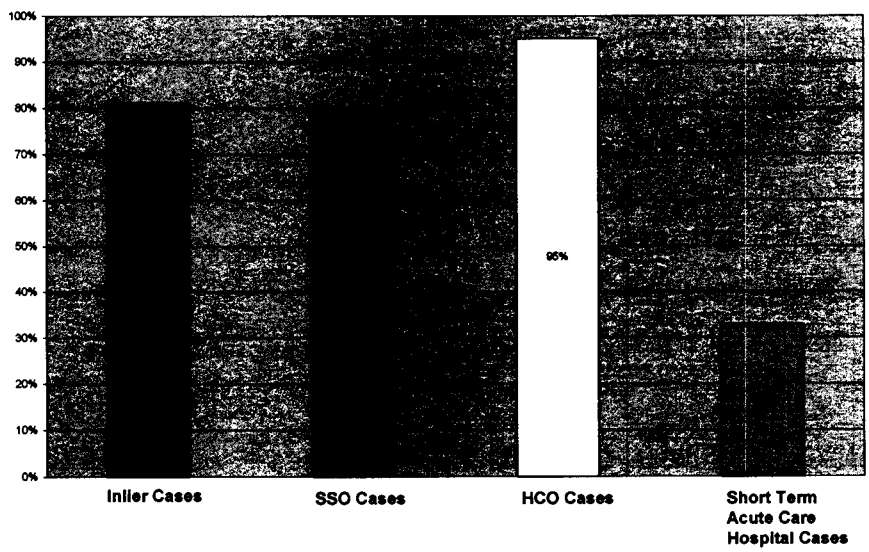


*Source: MedPAR 2004

*Severity of illness from APR-DRG Methodology

Table 9: In 2005 Select treated very Medically Complex Medicare Patients

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

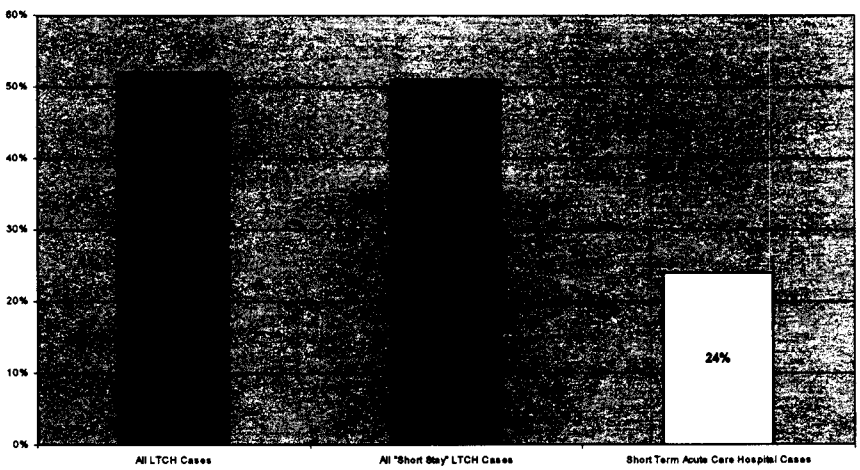


*Source: 2005 Internal Select Data

Similarly, 51 percent of the SSO patients in all LTCH patients fall within the highest APR-DRG risk of mortality categories, whereas only 24 percent of patients in general acute care hospitals fall within these categories, as portrayed in Table 10. Table 11 illustrates that, in Select's LTCHs, 68 percent of the SSO cases fall within the highest risk of mortality categories.

Table 10: LTCH Patients Have a Higher "Risk of Mortality" than Average Short Term Hospital Patients

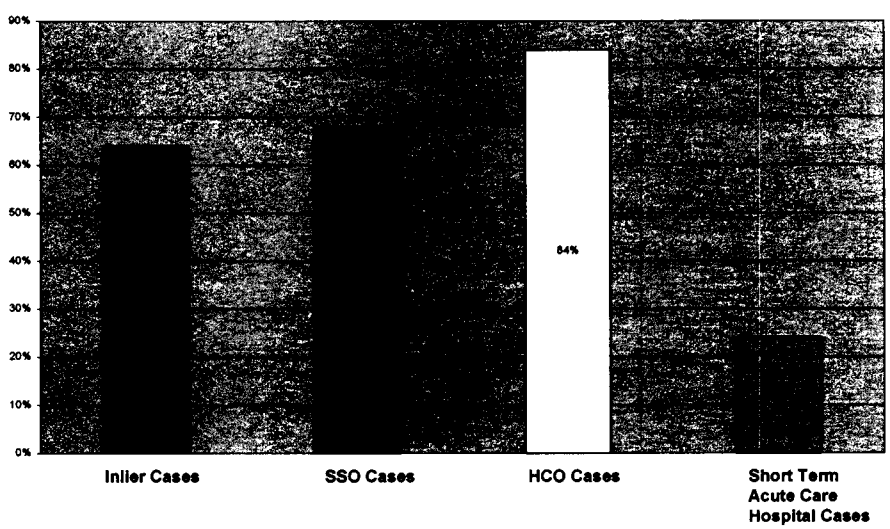
Percentage of Patients in the highest APR-DRG "Risk of Mortality" Categories



*Source: MedPAR 2004
*Risk of Mortality from APR-DRG Methodology

Table 11: In 2005 Select treated very Medically Complex Medicare Patients

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



*Source: 2005 Internal Select Data

These statistics are further evidence that LTCHs generally, and Select's LTCHs in particular, do not merely function as general acute care hospitals when caring for SSO patients.

D. 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.

E. CMS's proposal to pay for SSO patients at IPPS rates would result in LTCHs being paid amounts significantly below their costs of providing 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 Select's LTCHs for SSO cases under the proposed policy would represent only 57 percent of the actual costs that Select incurs in caring for those patients.

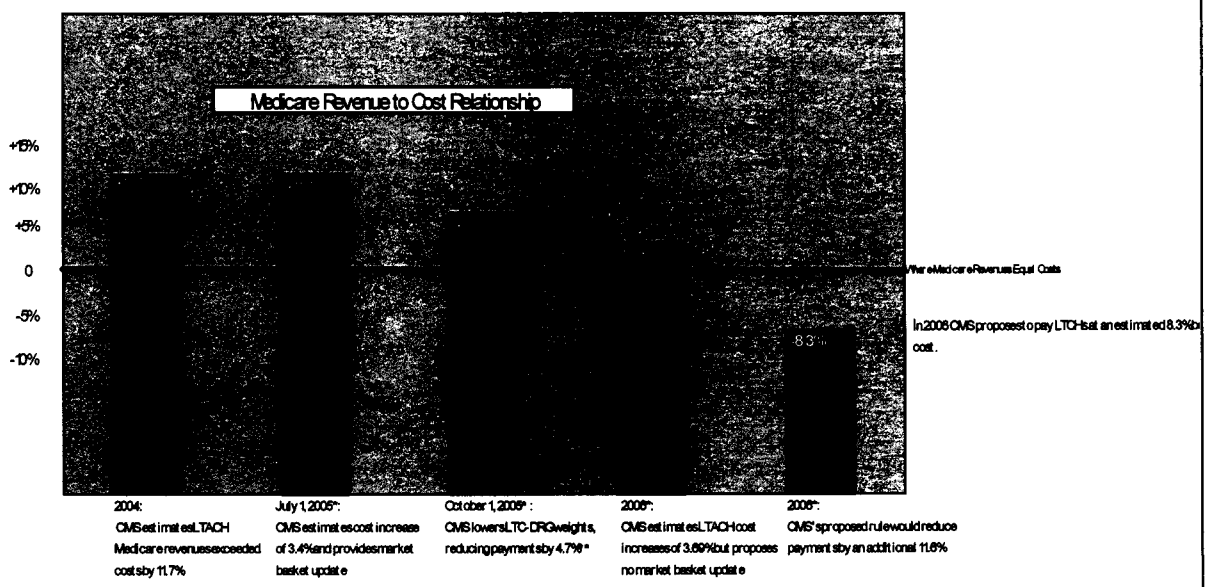
Currently, approximately 17.22 percent of Select's LTCH revenues are attributable to SSO cases. As a result of CMS's proposed revisions, payments for SSO cases will be reduced to

6.22 percent, based on CMS's estimated 11 percent decrease in aggregate LTCH PPS payments in the 2007 LTCH PPS rate year – reflecting a 64 percent cut in payment for those cases.

Overall, CMS's proposal would drastically cut payments to LTCHs by approximately 11 percent. 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, the impact of the proposed revisions to the SSO payment policy will be to pay LTCHs significantly less than it costs them to care for appropriately admitted patients. Patients with complex medical conditions will lose access to needed hospital care, and general acute care hospitals will incur additional costs since they will be unable to discharge these complex patients to a more appropriate setting.

Moreover, LTCHs will not be able to make up these costs from other patients. As depicted in Table 12 below, after giving effect to the proposed SSO payment policy and the lack of any inflationary update, the total payments to LTCHs will fall short of LTCH costs by 8.3 percent.

Table 12: CMS Proposes Rates Well Below the Costs of Caring for the Medically Complex LTCH Population



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

CMS assumes that LTCHs can change their behavior so as to accommodate this dramatic reduction in payments. In particular, CMS claims that LTCHs will decline to admit SSO patients, since the costs of treating such patients will exceed the proposed payment amounts. In fact, as discussed above, LTCHs are not able to predict a patient's length of stay at the time of admission. Therefore, LTCHs cannot change their behavior to accommodate these payment

cuts. Instead, LTCHs will simply be forced to absorb payment rates that bear no reasonable relationship to the costs of furnishing patient care.

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

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

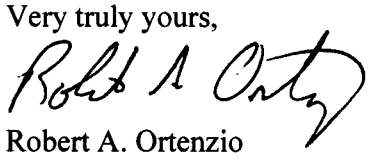
III. CONCLUSION

We strongly urge CMS not to implement this baseless and radical change in payment for LTCH services. Rather, we urge CMS to consider alternatives that more appropriately target any cases that, based on a meaningful analysis of data, are likely the result of inappropriate admissions to LTCHs.

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's 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. Furthermore, any such alternative payment policy should be based on a rigorous and objective analysis of relevant data, and should result in payment amounts that bear a relationship with the LTCH's costs of providing care.

We would welcome the opportunity to meet with CMS's representatives to discuss further CMS's proposed changes to the SSO payment methodology, and appropriate alternatives to address any legitimate concerns.

Very truly yours,



Robert A. Ortenzio
Chief Executive Officer

cc: Mr. Tzvi Hefter (by electronic mail)
Ms. Judy Richter (by electronic mail)

BAY
SPECIAL CARE HOSPITAL

March 7, 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:

Bay Special Care Hospital 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. Bay Special Care Hospital was established on June 30, 1994 and is located at 3250 E. Midland Road, Bay City, MI 48706. It serves a significant percentage of Medicare patients residing in the Bay County, Saginaw, Midland and surrounding counties. CMS' proposed short-stay outlier rule and zero update proposal would drastically reduce payments to Bay Special Care Hospital in fiscal year 2007 by approximately 15 percent, forcing Bay Special Care Hospital to operate at a loss when treating Medicare patients. Bay Special Care Hospital urges CMS to not adopt the proposed short-stay outlier rule and zero update proposal because the continued operation of Bay Special Care Hospital and the patients it serves 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 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 identifies 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.

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

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

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 Bay Special Care Hospital 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 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 defray the cost of bad debts. Ultimately, it will threaten Bay Special Care Hospital's ability to survive.

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

Sincerely,

Cheryl A. Burzynski

Cheryl A. Burzynski, President

WHITTIER
Rehabilitation Hospital
WESTBOROUGH
Member - Whittier Health Network

March 7, 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 Whittier Rehabilitation Hospital 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. The Whittier Rehabilitation Hospital was established in October 1997 and is located at 150 Flanders Road, Westborough, MA. It serves a significant percentage of Medicare patients residing in the Worcester County area. CMS' proposed short-stay outlier rule and zero update proposal would drastically reduce payments to Whittier Rehabilitation Hospital in fiscal year 2007 by approximately 15 percents, forcing Whittier Rehabilitation Hospital to operate at a loss when treating Medicare patients. The Whittier Rehabilitation Hospital urges CMS to not adopt the proposed short-stay outlier rule and zero update proposal because the continued operation of Whittier Rehabilitation Hospital and the patients it serves 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 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.

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

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

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 Whittier Rehabilitation Hospital 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 Whittier Rehabilitation Hospital in jeopardy. At a minimum, it will reduce Whittier Rehabilitation Hospital ability to finance medical care and services provided to indigent populations and defray the cost of bad debts. Ultimately, it will threaten Whittier Rehabilitation Hospital's ability to survive.

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

Sincerely,

Ed Taglieri
Administrator

Form letter #5-

FAX NUMBER: 202-690-6262

2006 MAR -8 AM 12:00

Dear Mr. McClellan:

I am writing to express my deep concern over the recent proposed rule by the Centers for Medicare and Medicaid Services (CMS) regarding payments for long-term care hospitals (LTCH's) which, if fully implemented, will have a devastating impact on the availability of this essential level of care for the Houston/Clear Lake/Webster community's sickest patients.

The proposed CMS rule, if implemented, would cut long-term care hospital payments nearly 15 percent and would not even cover the operating costs of caring for this unique, medically complex patient population. The CMS proposed rule would seriously destabilize this small, but vital, health car sector and risk patient access to the unique care that it provides.

The clear intent of this rule is to severely damage hospitals already providing long-term care services to my community and the patients that we serve everyday. These patients, who are some of the most vulnerable in our society, have medically complex conditions that require aggressive clinical and therapeutic intervention, daily physician monitoring, 24-hour RN care, significant ancillary services support and complicated medication regimens. Rather than apply specific patient and hospital clinical criteria as recommended by the Medicare Payment Advisory Commission (MedPAC), CMS has chosen to ignore MedPAC's recommendations and impose arbitrary payment cuts. LTCH's offer many aging patients the best probability of recovery and return to home and family. CMS should not deny their most vulnerable patients their chance at the best quality of life that technology and I can provide to them. Remember – you, your family and loved ones may at some point need LTCH services to give your or your loved ones the best opportunity to live as independent a life as possible; would you want this decision to be based on a system that may arbitrarily exclude you and your family to this potential life changing continuum of care?

Sincerely,

SHERLEY BAUGH
1302 CHELSEA LANE
PEARLAND, TX 77581

Form letter #6 –

2006 MAR -7 AM 12: 00

FAX NUMBER: 202-690-6262

Dear Mr. McClellan,

Please eliminate a proposed rule from CMS that endangers the future of many Long Term Acute Care hospitals (LTACHs). As you may know, our highly specialized hospitals provide extensive care to some of the sickest patients in U.S. hospitals.

In some cases, our patients require multiple intravenous antibiotics over a two week period (on top of time already spent in an acute care hospital), and others need weeks of care due to ventilator dependence or multi-system failure.

LTACHs are currently required to have an average annual length of stay of 25 days. This enables some short stay patients as well as longer stay patients to receive critical specialized care outside of an ICU or acute care hospital. We are currently paid an LTACH DRG when an expected LTACH length of stay is reached and are paid a prorated amount for shorter stays.

The proposed rule is flawed. According to CMS, LTACHs are to be paid the same fixed DRG rate as a short term acute care (community) hospital if a patient stays less than 25 days. That rate will fall short of our costs by 8%. We can not afford to be paid the same rate as an acute care hospital for patients whose length of stay may fall below 25 days.

Ultimately, some LTACHs will be forced to close. This will limit access to care and harm the most vulnerable and fragile people in the country. We can then also expect ICUs to become full and exacerbate the problem with Emergency Room overcrowding nationally.

Please drop the provision that lowers payment for patients whose stay in our specialized hospitals is shorter than the already required 25 day average.

Sincerely,

Rose Drummond

Rose Drummond
141 Red Oak Lane
Conroe, Texas 77304

Form letter IF 7—

Triumph HealthCare

March 6, 2006

Mark McClellan, Administrator (FAX 202-690-6262)
The Centers for Medicare & Medicaid Services (CMS)

Dear Mr. McClellan:

I am writing this letter today to express my concern over a recently proposed rule by The Centers for Medicare & Medicaid Services (CMS). The proposed rule [Federal Register, January 27, 2006 42 CFR Part 412] if implemented would have a devastating impact on long-term care hospitals (LTCHs) and the quality of care and availability of services for Medicare patients.

As I am sure you know, LTCHs offer a specialized level and type of care to a small subset of critically ill patients needing a long-term acute stay. These services include specialized programs and intensive nursing intervention than are not usually available in a general short-term hospital environment.

However, the proposed rule by CMS, if implemented, would severely damage these hospitals. According to the proposed rule, CMS would set payments significantly below the hospital's cost for 37% of LTCH patients. This will limit access to care and cause untold patient harm.

I understand CMS' concern about cost effective care for Medicare beneficiaries; however, the important issue should be what the patient truly needs not where the patient fits in the length of stay.

I hope you will contact CMS and urge them to drop the Short Stay Outlier (SSO) provision from the current proposed rule on LTCHs. Protect LTCHs that provide unique and clinically necessary benefits to the patients, families, and local communities.

Sincerely,

James Hermes
VP of Financial Operations
5222 Windcroft Court
Houston, TX 77069