NALTH

NATIONAL ASSOCIATION OF LONG TERM HOSPITALS

150 York Street, Stoughton, Massachusetts 02072 (781) 344-0600 Boston line (617) 364-4850 FAX (781) 344-0128

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By Express Mail

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

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

Dear Dr. McClellan:

The National Association of Long Term Hospitals ("NALTH") welcomes the opportunity to submit these comments on proposed rules published on January 27, 2006 at 71 *Fed. Reg.* 4727 *et seq.* NALTH's membership serves approximately one-third of the Medicare beneficiaries who are admitted to long term care hospitals (LTCHs) in the United States. The membership of NALTH is diverse and includes both not for profit and for profit urban LTCHs with Medicare approved teaching programs and over 200 beds, LTCHs located in underserved rural areas, LTCHs which are owned and operated by large integrated health care systems throughout the Untied States, and publicly owned LTCHs.

As an initial matter, NALTH does not object to and supports adoption of the proposed Rehabilitation, Psychiatric, Long Term Care (RPL) market basket. NALTH does object to and offers comments upon the following components of the proposed rule which would: **(1) revise the short-term outlier (SSO) policy to reimburse approximately 80% of all SSO cases at payment levels "equivalent" to short term acute hospital inpatient prospective payment (IPPS) rates; (2) increase the high cost outlier threshold amount from $10,501 to $18,489; (3) impose a zero (0%) update for FY 2007; (4) eliminate the surgical DRG exception to the interrupted stay policy; and (5) revise the manner in which cost to**

charge ratios are calculated. NALTH is requesting that CMS eliminate the one time adjustment to the federal standard amount. Additionally, NALTH is submitting comments on policy matters discussed in the preamble to the proposed rule concerning ongoing research by the Research Triangle Institute (RTI), and on issues related to the independence of LTCHs which receive a significant percentage of patient referrals from a single acute hospital source. These comments are submitted by NALTH on its own behalf and on behalf of its members.

NALTH commissioned the Lewin Group to analyze both the policy justifications and the fiscal effects of key aspects of the proposed rule. The report which NALTH has received from the Lewin Group is entitled "Analysis of Long Term Care Hospitals RY 2007 Prospective Payment System Notice of Proposed Rulemaking" (March 9, 2006) and is included as Appendix "A" to these comments. In the following discussion we refer to this report as the "Lewin Report".

Preliminary Statement

NALTH notes that the financial impact of the proposed rule is unprecedented in the magnitude of payment reductions and the resulting fiscal harm which would befall LTCHs. It is also our view that the proposed rule is antagonistic to the interests, health care needs, and well being of Medicare beneficiaries.

LTCHs serve a critically ill medically unstable patient population who are not progressing or have failed, for example to be weaned from a ventilator and require the multidisciplinary program of long-term care provided in a LTCH.

The most pernicious aspect of the proposed rule concerns CMS' revisions to the current short stay outlier ("SSO") policy. The preamble to the proposed rule states that the proposed SSO policy would result in an 11.3% reimbursement reduction in total payments to LTCHs, most of which results from the proposed SSO payment rules. The proposal to eliminate an update for RY 2007 effectively operates as an additional 3.6% reduction in payments for a total reduction in payments to LTCHs approximating 15%. The Lewin Report has verified CMS' financial impact analysis, and further notes that these payment cuts will result in dramatic reductions in LTCH Medicare margins. Overall, Lewin estimates that LTCH margins will decrease from a projected 9.17% in 2006 to **-4.93** in 2007. Nonprofit LTCHs would experience negative margins of **-8.80** and the margins of publicly owned LTCHs would plummet to **-19.72.** LTCHs in the State of Texas[1] would fare particularly poorly with non-profits in that state. experiencing a negative margin of -13.56%. Moreover, it is estimated that on a national basis, 68.6%

[1] See Lewin Report, Exhibit 2. NALTH is particularly interested in how the proposed policies affect hospitals in the State of Texas in light of the requirement of that state that non-profit hospitals devote a minimum of 5% of their revenues to charity care. The steep reductions in payment by the Medicare program predictably will erode the ability of LTCHs in the State of Texas and throughout the nation to provide care to indigents.

of all LTCHs would have negative margins as a result of the proposed rule. It is accordingly very clear that, if adopted, the proposed rule will require that LTCHs only serve Medicare patients at a steep financial loss. With Medicare beneficiaries accounting for approximately 70% of LTCH admissions, payment cuts of the magnitude proposed by CMS unquestionably threaten the financial viability of all LTCHs and adversely affect Medicare beneficiary access to medically necessary services. There is absolutely no basis to the unsupported conclusion contained in the impact statement to the proposed rule that "[W]e (CMS) do not expect any changes in **. . . .** or access to services for Medicare beneficiaries." 71 *Fed. Reg*. at 4738.

I. Proposed Revisions to SSO Payments

NALTH **strongly objects** to the proposal to revise current SSO payment policies. Our objections are based on empirical, policy and legal grounds. As detailed below, we believe that the proposed SSO policy profoundly distorts the LTCH prospective payment system, and violates important primary directives of the Social Security Act.

A. Background

A Medicare beneficiary is paid as an SSO if the patient is discharged with a length of stay which is less than $5/6^{th}$ of the geometric mean length of stay for the applicable LTCH-DRG (hereinafter the "short stay threshold"). Currently, SSO cases are reimbursed on the lower of the following:

1. 120 percent of patient costs
2. 120 percent of the per diem of the LTC-DRG
3. the full LTC-DRG payment

The proposed rule would modify the first benchmark by changing "120 percent of patient costs" to "100 percent of patient costs." The proposed rule would also add a fourth component to the "lower of" alternatives, namely "an amount under subpart O that is comparable to an amount that otherwise would be paid under the IPPS" to an acute hospital. 71 *Fed. Reg.* at 4688.

The Lewin Group used the same 2004 Medicare Provider Analysis and Review (MedPAR) data that CMS used in its impact analysis and, among other things, determined that approximately 77% of SSO cases and 28% [2]of total LTCH cases would be reimbursed under the newly proposed fourth measure which would become the *de facto* controlling alternative under the "lower of" options. **LTCHs would experience negative margins of -81% for all SSO cases.** See, Lewin Report p. 2. This results in devastating financial consequences to LTCHs. CMS seems to agree with this conclusion

[2] CMS' estimates are that 96% of all SSO cases or 36% of total cases would receive lower payment than under the current policy. 71 Fed. Reg. 4736

given its own finding that the proposed SSO policy is expected to decrease total payments to LTCHs by approximately 11%.

B. The Policy Predicate to the SSO Proposal, that SSO Cases have a Length of Stay Commensurate and Somehow Clinically Comparable with Patients Admitted to Acute Care Hospitals, is Not Stated in Careful Clinical Terms and is Factually Wrong and Logically Flawed.

Given the severe consequences of the proposed SSO policy NALTH, with the assistance of the Lewin Group, has closely reviewed the proffered reasons and rationales for this proposed change in Medicare payment policy. The reasons offered for the rule are steeped in the assumption that SSO patients are the same as patients admitted to acute care hospitals. The stated objective of the proposed SSO policy is to establish a prohibition of the admission of these patients to LTCHs.. In this connection the preamble to the rule is clear in stating that the objective of the proposed SSO policy is to:

> " ...discourage LTCHs from behaving like acute care hospitals by having a significant number of cases with lengths of stay commensurate with acute care hospitals and also to discourage LTCHs from admitting patients that could be premature discharges from acute care hospitals." (emphasis added)
>
> "...LTCHs may be admitting patients that should otherwise be treated in acute care hospitals, as evidenced by lengths of stay more in keeping with an acute care hospital stay than the considerably longer stays characteristic of LTCHs." 71 *Fed. Reg.* at 4687
>
> **"...**We believe this proposed policy is appropriate given that many of **these short-stay patients most likely do not belong** in a LTCH, which in general are intended to treat patients with an ALOS of greater than 25 days." (emphasis added) 71 *Fed. Reg.* at 4736

It is accordingly clear that CMS is attempting to supply through the LTCH payment system a *de facto* exclusionary policy for patient admissions to LTCHs. The **sole** and exclusive reason advanced in support of this position is that patients with a **length of stay** similar to that of an acute care hospital patients should be paid at acute care IPPS rates of payment. In Part I, G of these comments we have presented our views that the engineering of patient access and admission to a hospital, including a LTCH, through mechanisms in a payment system, violates federal law. Even assuming, *arguendo*, that CMS did have this type of authority, CMS still could not rightly proceed to adopt the proposed SSO policy. The current SSO rule was not developed to identify patients admitted to LTCHs who have the same length of stay as patients admitted to acute care hospitals and does not do so. The 5/6th length of stay threshold was adopted in 2002 as part of the initial establishment of the LTCH-PPS. The stated reason for developing an SSO policy was to provide for a *per diem* payment for stays in LTCHs

which were lower than the geometric mean length of stay of Medicare patients treated in LTCHs, not in acute care hospitals. Moreover, in its 2002 rulemaking, CMS correctly determined that since SSO cases are paid on a *per diem* basis it is important that payment levels exceed hospital cost in order to preserve the averaging of over and under payment of costs which is recognized as fundamental to every prospective payment system.[3] The objective of the SSO policy was, therefore, stated to result in payments for cases whose length of stay was below the 5/6th LTCH SSO threshold[4] and to provide payment that:

> "...results in payment-to-cost ratios that are at (or close to) 1.0 ...[to] 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 (August 30, 2002).

We have determined there is absolutely no validity to CMS' assertion that SSO cases have lengths of stay comparable to acute care hospital lengths of stay. The current SSO rule also does not identify whether patients who are admitted to LTCHs use the same or similar medical resources as patients who are admitted to acute care hospitals and was not designed to do so. The Lewin Group examined the average length of stay of SSO cases in comparison with patients assigned to the same DRGs in acute care hospitals. The results were as follows:

The Difference In Average and Geometric Mean Length of Stay Between LPPS SSO Cases and IPPS Cases

	Weighted Average Arithmetic Mean LOS	Weighted Average Geometric Mean LOS
LPPS SSO cases	12.7	10.8
All Acute care hospital IPPS cases	7.4	5.6
Percent difference between LTCH SSO and IPPS Hospitals' LOS	72%	93%

* Averages are weighted according to the number of LTCH SSO cases.

Source: Lewin Group analysis of the 2004 Medicare Provider Analysis and Review (MedPAR) data. Lewin Report, Exhibit 8, p.11.

[3] In part I, E of these comments we have discussed how the proposed SSO policy would destroy the averaging logic which is fundamental to PPS and result in the LTCH systematically paying less than cost rendering the LTCH invalid.

[4] The 5/6th ALOS threshold set for the SSO rule has nothing to do with acute care hospitals or identifying comparable LTCH and acute hospitals' length of stays.

It is clear by any measure that the average length of stay (ALOS) of SSO cases is dramatically different than the ALOS of patients assigned to the same DRG in acute care hospitals. They are clearly not "commensurate" with the ALOS of patients admitted to acute care hospitals. This conclusion is confirmed by an examination of the distribution of SSO cases which have lengths of stay which are both below and above the geometric mean length of stay for patients who are assigned to the same DRGs in an acute (IPPS) hospital. This data are as follows:

Distribution of SSO Cases by Length-of-Stay Status

	Number of SSO Cases	Percentage of Total SSO Cases	2007 Proposed Payment	Percentage of Total SSO Cases
Below IPPS GM-LOS	6,257	14.5%	$36,287,702	10.5%
Between IPPS GM-LOS and 5/6 LTCH GM-LOS	36,957	85.5%	$307,973,429	89.5%
Total SSO Cases	43,214	100.0%	$344,261,131	100.0%

Note: Distribution of short-stay outlier (SSOs) cases with length of stay (LOSs) below the IPPS DRG geometric mean length of stay (IPPS GM-LOS) ,and above the IPPS GM-LOS but below the LTCH DRG geometric mean length of stay (LTCH DRG GM-LOS).

Source: Lewin Group analysis of the 2004 Medicare Provider Analysis and Review (MedPAR) data. Lewin Report, Exhibit 10, p. 12

A review of the ALOS of SSO cases for the top three highest volume LTCH-DRGs reveals length of stays, as follows and highlights that admissions to LTCHs which CMS deems to be "short-stays" are at or exceed the 25-day ALOS and are therefore appropriate admissions as a matter of law by virtue of Section 1886(d)(1)(B)(iv)(I) of the Act.

DRG	DRG Name	SSO ALOS	Acute Care Hospital ALOS
475	**Respiratory System DX with Ventilator Support**	**28.8**	**14.5**
87	**Pulmonary Edema & Respiratory Failure**	**21.2**	**11.7**
271	**Skin Ulcers**	**23.1**	**13.1**

The statutory reference to a length of stay which, on average, exceeds 25[5] days, contemplates a distribution around that average with lengths of stay which are higher and lower than 25 days. CMS' purported rationale for the proposed SSO policy is factually wrong since the length of stay of SSO cases is unrelated to (i.e. not commensurate with)

[5] NALTH notes that Congress, in Section 1886(d)(1)(B)(iv)**(II)** of the Act, has identified another class of hospital, which serves a population of 80% patients with a diagnosis of cancer as a LTCH which is required to meet a lower 20 day ALOS standard. CMS has presented no basis to apply the proposed SSO policy to such a subsection (II) hospital which is entitled to maintain a lower ALOS than other LTCHs.

the length of stay of patients admitted to acute care hospitals. Only 14.5% of SSO cases have an ALOS which is below the geometric mean length of stay of patients in acute care hospitals. The distinct minority of patients with a length of stay which might be described as "commensurate" with that of acute care hospital patients is both understandable and permissible in the **average length of stay** calculation prescribed by Congress, and CMS has no prerogative to adopt a payment adjustment, i.e. the SSO proposal, which is based on the assumption that LTCHs should not admit these patients.

C. LTCH SSO Cases Represent a Different Clinical Population Than Acute Hospital Patients and Use More Intensive Medical Resources.

It should be evident from the -80% negative margins for SSO cases that IPPS rates do not reflect the cost and resource use of these patients. In both the LTCH-PPS and the IPPS payment systems, medical resource use is represented by case mix weights. The fundamental calculation of prospective payments involves multiplying a standard federal amount by the case weight assigned to a DRG. The Lewin Group analyzed and compared the case weights of IPPS cases to LTCH-PPS cases for all common DRGs, and in this manner was able to compare the resource uses for patients in both classes of hospitals. Exhibit 11 to the Lewin Report, reproduced below, demonstrates that LTCH-DRG weights are 76 percent higher than weights for patients admitted to acute care hospitals who are paid under IPPS. We note that the weights presented here are not CMS weights, but a set of weights calculated by the Lewin Group from a pooled data set of IPPS and LTCH cases.

DRG Weight Comparisons for IPPS and LPPS

	DRGs in Common		
	IPPS	**LPPS**	**Percent LPPS>IPPS**
Number of DRGs	183	183	--
Mean DRG Weight	0.8559	1.5074	76
95% Confidence Interval	0.7776 - 0.9342	1.3879 - 1.627	--

Source: Lewin group estimates based on analysis of 2004 Medicare Provider Analysis and Review (MedPAR) data for LPPS data and the Final 2006 After Outliers Removed (AOR) PPS recalibration file for IPPS data. Lewin Report, Exhibit 11, p. 13.

The Lewin Group also used LPPS (i.e. LTCH-DRGs) and IPPS weights to create a case-mix index (CMI) for matched LPPS SSO DRG cases and IPPS DRG cases. Exhibit 12 to the Lewin Report which is reproduced below contains two important findings. First, SSO cases which would be reimbursed at IPPS payment levels have a case-mix index which is 109% greater than the case-mix for patients in acute care

hospitals assigned to the same DRGs. Secondly, even considering SSOs that would not be paid at IPPS rates, the case-mix index for all SSO cases is 72% greater than the case-mix index of patients in acute care hospitals who are assigned to the same DRG. Lewin ran this analysis for just those SSOs that would be paid under the proposed SSO payment policy. Lewin found, as noted above, that the LPPS SSO CMI is 109% percent higher than the all-case IPPS CMI. In the words of the Lewin Group." "[T]hese findings are consistent with above findings indicating that the use of an IPPS payment system to pay for LPPS SSOs is not credible."

Comparison of LPPS SSO Case CMI to IPPS CMI for Matching DRGs

Hospital Type	All Short Stays "CMI"	Short Stays Receiving IPPS Payment "CMI"
LPPS SSO Cases	1.7957	2.0592
IPPS	1.0470	0.9873
Percent Difference	72%	109%

Source: Lewin Group analysis of 2004 Medicare Provider Analysis and Review (MedPAR) data for LPPS data and the Final 2006 After Outliers Removed (AOR) PPS recalibration file for IPPS data. Analyses are standardized to the LPPS case frequencies. Lewin Report, Exhibit 12, p. 14.

Based on the forgoing, the Lewin Group came to the very important conclusion "that the use of IPPS payment rates for LPPS SSO cases is inappropriate because the cost and resource characteristics of IPPS cases and LPPS SSO cases within the same DRG are quite different from each other. We have shown that SSO case LOS, intensity and APR/DRG severity measures are higher than for comparable IPPS DRGs on a DRG-by-DRG and overall aggregate basis.". Lewin Report at p. 14. In Section 123 of the BBRA of 1999 Congress required the establishment of a prospective system of reimbursement for long-term care hospitals which, among other things, is required to be based on a patient classification system which **"reflects the differences in patient resource use and costs"** in LTCHs. The Lewin Group has demonstrated that the case weights contained in the IPPS payment system do not reflect resource use and the cost of SSO patients in LTCHs, and CMS cannot rightly suggest anything to the contrary. IPPS weights and related payment levels, therefore, cannot, as a matter of law be used to reimburse SSO cases. It is noted that recently in the context of recalibrating LTCH-PPS weights for RY 2006 payments, CMS stated that: "[T]he LTC-DRG relative weights are designed to reflect the average of resources used to treat representative cases of the discharges within each LTC-DRG." 70 *Fed. Reg.* 47335 (August 1, 2005). This statement is entirely consistent with the Congressional mandate that LTCH-PPS weights must reflect patient resource use in LTCHs. It is remarkable that in the context of

proposing its new SSO policy CMS has not addressed the way reduced payments for SSO cases undermine the validity of LTCH-PPS weights.

D. CMS Itself Has Dictated That SSO Cases Must Constitute Approximately 35% of LTCH Patients Regardless of Hospital and Physician Patient Selection Policies.

As justification for the SSO proposal, CMS points to its finding that SSO cases account for 37% of LTCH Medicare discharges. According to CMS this is "an inappropriate [high] 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 services." 71 *Fed. Reg.* at 4685 This statement ignores the indisputable mathematical fact that the 5/6th length of stay statistic CMS itself has chosen to define short stay cases will always produce as a mathematical certainty an outcome of approximately 35% of all cases. The Lewin Group applied the 5/6th length of stay criteria to identify SSO cases in acute care hospitals and found that 37.91% of all patients admitted to acute care hospital would be deemed SSO cases. A comparison of SSO cases in acute hospitals and in LTCHs yielded the following:

Short-stay Discharges for IPPS and LPPS Compared

Hospital Type	Discharges	Number of Short Stay Discharges	Percentage of Short Stay Discharges	Number of Short Stay Deaths	Percentage of Short Stay Deaths[6]
IPPS (2003)	13,179,488	4,996,673	37.91%	240,282	4.81%
LPPS (2003)	114,028	47,770	41.89%	9,320	19.51%
LPPS (2004)	117,751	43,214	36.70%	9,516	22.02%

Source: Lewin Group analysis of the 2003 and 2004 Medicare Provider Analysis and Review (MedPAR) data. Lewin Report, Exhibit 3, p. 8.

The point is otherwise made by assuming what would happen if LTCHs were able to avoid SSO cases. The Lewin Group eliminated all SSO cases and then tested data for cases that remained so that the SSO policy would require a recalculation and application of the SSO policy to the remaining previously non-SSO cases. The result is a new calculation which identifies patients who previously were not SSOs as new SSO patients. As is shown below, the 5/6th ALOS threshold definition for SSO cases will identify 35% of previously non-SSO cases as new SSO patients. These would obviously be higher ALOS cases and, thus, be inconsistent with the Congressional 25-day definition of LTCHs.

[6] The demonstrably higher death rate of SSOs in LTCHs indicates these patients are sicker and hence more costly than SSO cases in acute care hospitals. This finding confirms the higher cases mix index of LTCH SSO cases as compared with patients assigned to the same DRGs in acute care hospitals.

Re-estimating the Percent of SSOs After Removing the Original SSOs from the Distribution of LTCH Cases

All LTCH Discharges in 2004	
Number of Discharges	117,751
Current Short Stay Outlier Cases (less than 5/6 geometric mean LOS)	43,214
Percent of Short Stay Outlier Cases	37%
LTCH Cases excluding all current Short Stay Outlier Cases	
Number of Discharges	74,537
New Short Stay Outlier Cases (less than 5/6 geometric mean LOS)	25,773
Percent of Short Stay Outlier Cases	35%

Source: Lewin Group analysis of the 2004 Medicare Provider Analysis and Review (MedPAR) data. Lewin Report, Exhibit 5, p. 10.

In other words, it makes no difference what LTCHs and physicians do to select patients; there will always be approximately 35% SSO cases under the 5/6th ALOS threshold employed by CMS to define SSO cases. This, in fact, will occur as CMS recalculates the geometric means of LTCH-DRGs and assigns each LTCH-DRG a new 5/6th SSO threshold on an annual basis as part of the yearly recalibration of LTCH-DRG weights. If the proposed policy was adopted and was successful, the length of stay of patients treated by LTCHs would become longer and patients in the previous year who were not SSO cases would become the new SSO patients even though they have a longer length of stay. **It is irrefutable that CMS itself (and not LTCH hospital admission behavior) has brought about the fact that 37% of LTCH cases are SSOs; the 37% figure has absolutely nothing to do with whether LTCHs are admitting the "wrong" patients.** There is accordingly no basis for the proposed SSO policy.

E. The Proposed SSO Policy Destroys the Fundamental Averaging of Payments Which as CMS has Acknowledged is Essential to any PPS.

It is well establish that a PPS does not work in the absence of an averaging of payments where hospitals receive payments which both over and underpay the cost or medical resources used by patients. This fundamental premise of how a PPS must operate was made clear by Secretary Schweiker in his seminal report[7] to Congress in 1982 as part of the Health Care Financing Administration's efforts to gain adoption of the IPPS. Since that time CMS has repeatedly acknowledged that the averaging of over and underpayments is a basic premises of a PPS. The preamble to the current proposed rule states this explicitly as follows:

"The basic premise of a PPS recognizes that Medicare pays hospitals an

[7] Schweiker, R.S., "Report to Congress: Hospital Prospective Payment for Medicare," Secretary of the Department of Health and Human Services, December, 1982.

> amount per discharge based on the average costs of delivering care for that diagnosis (which is assigned to a DRG), and some cases require more hospital resources to be expended, where others, require less. Therefore, in some cases, Medicare payments will be lower than the hospital's costs but in other cases, the payments will exceed the costs." 71 *Fed. Reg.* at 4693.

It is significant that in the preamble to virtually every PPS update rule the forgoing averaging requirement is acknowledged as the *sine qua non* for any PPS. The preamble to the final rule which established the LTCH-PPS in 2002 states with regard to the averaging requirement that "hospitals that are efficient will receive fair compensation." 67 *Fed. Reg.* 56006 (August 30, 2002).

The Lewin Group has shown that the geometric mean length of stay for SSO cases is 93% longer than the mean length of stay for comparable DRGs under the IPPS. For these cases, LTCHs would be dramatically and consistently underpaid with no opportunity to recoup the losses. CMS has made no suggestion to the contrary. The Lewin Report contains the finding that:

> "Under the currently proposed rule, averaging is not only taken away – it is reversed. The very cases required to balance the system as averages would be widely underpaid ($14,500 in costs vs. $8,000 in payments), and account for about 40 percent of all LPPS cases. To have 40 percent of cases paid at a –81.2 percent margin, and the other 60 percent paid to barely cover or paid slightly less than costs, is an untenable situation, should CMS intend to ensure the stability of care delivery in the LTCH setting. Thus, from an averaging perspective, the NPRM approach is inconsistent with the underlying principles that make PPSs fair and equitable." Lewin Report, p. 19.

Among its infirmities, the proposed SSO policy strips from the LTCH-PPS the central PPS component of averaging over and underpayments. For CMS to now repudiate the averaging concept that it has consistently advanced in rulemaking and to Congress as the basis for every PPS over the past two decades, makes the proposed rule highly inconsistent and, thus, arbitrary and capricious. The SSO proposal would drain validity from the entire LTCH-PPS, and is simply unsupportable.

F. The SSO Proposal Will Harm Medicare Beneficiaries

The policy objective underlying the proposed SSO rule is to preclude LTCHs and physicians, through the imposition of a serve financial penalty, from admitting a patient who would become a SSO. CMS is making the unilateral medical decision that these patients should not be admitted to LTCHs. The assumption underlying this admission initiative is both unsupported and untrue. In the course of conducting its research and

educational activities, NALTH sponsored a study[8] of the characteristics of patients admitted to LTCHs in respiratory failure with ventilator support. We believe this is the most careful and best-documented clinical study of the efficacy of LTCH care. This multi-site study, conducted by the Barlow Respiratory Hospital Research Center, included data on 1,419 patients who were admitted to 23 LTCHs located throughout the country, which had active ventilator weaning programs. Most, if not all LTCHs embrace the multidisciplinary, rehabilitative model of care for weaning patients from prolonged mechanical ventilation.

Of all the patients studied, predictably 453 or 32% had stays of less than 29 days, which means they would qualify as SSOs because they would be assigned to DRG 475 (respiratory system failure with ventilator support) which has a 5/6 geometric mean length of stay threshold of 28.8 days. Prior to transfer to the LTCH, 93.9% of patients were in an ICU, with an additional 4.2% transferred from "step-down" or monitored units. Patients transferred to LTCHs for weaning from prolonged mechanical ventilation are elderly with severe acute illness superimposed on chronic disease. This population requires extensive, continued treatments and interventions at a long-term care hospital, not only for respiratory failure but also for numerous pre-existing conditions, co-morbidities and complications, the latter predominantly being infections. In short, these patients were failing at acute hospitals and were admitted to long-term care hospitals for ventilation weaning, which could not be done as successfully at acute care hospitals. Despite advanced age and numerous co-morbidities and complications, and despite the fact that all of these **patients already had failed multiple weaning attempts at the acute hospitals,** more than 50% of all patients enrolled in the study were weaned successfully from mechanical ventilation at the long-term care hospitals. The rate of survival to discharge was 74.8%, illustrating that LTCHs with their specialized programs of care, safely can wean a population with exceptional medical challenges. Nearly 30% of patients returned directly home or to assisted living following discharge from the long-term care hospital. Furthermore, at 12-months post-admission to the long-term care hospital, nearly two-thirds of survivors reported good functional status. If the SSO policy were to achieve its object, the 453 Medicare beneficiaries defined as SSO cases and who had failed past weaning attempts in an acute care hospital, would not have been provided the opportunity receive care under the multidisciplinary team and programmatic approach available in LTCHs which resulted in their becoming weaned from their ventilators. The "opportunity cost" of not being admitted to an LTCH are both apparent and tragic for those patients involved.

The ventilator weaning study sponsored by NALTH is illustrative of the broad range of Medicare beneficiary patients such as those who participated in this study who will not improve in the absence of receiving care in a LTCH. When MedPAC made its June 2004 Report to Congress, it stated its significant finding that patients treated in LTCHs have a 26% less frequent readmission rate to acute hospitals then similar patients

[8] This study is entitled Post-ICU Mechanical Ventilation at Long-Term Care Hospitals: A Mechanical Ventilation Outcome Study, Scheinhorn (2005) and has been provided to CMS.

who do not access a LTCH. [9] In order to be readmitted to an acute hospital, a patient's condition must deteriorate and the patient must be medically unstable. Under the proposed SSO rule, the 42,124 SSO Medicare beneficiaries which the Lewin Group found to exist in 2004 would be placed in harms way and, according to MedPACs finding. would face a higher degree of morbidity.

G. The Proposed SSO Policy Reduces Payment for Patients Who Are Not SSO Cases.

One consequence of the short-stay outlier policy is that it would penalize LTCHs when they admit very ill patients who have a long length of stay and exhaust their limited Medicare day benefit prior to reaching 5/6 of the average length of stay for their DRG. CMS labels these decidedly long-stay patients as short-stay patients for billing purposes and drastically underpays the cost of their care. These patients are usually medically indigent. The SSO policy directed at keeping all patients that CMS characterizes as short stay patients for billing purposes out of LTCHs even though they are long stay cases in fact, is not rational.

An especially perverse consequence of the short-stay outlier policy is that so much money would be taken out of the long-term care hospital payment that the cost threshold for treating longer-term, high cost-outlier patients (those whose costs exceed 80% of full LTCH-DRG payment) would be increased from $10,501 to $18,489. Long-term care hospitals, therefore, would be penalized for treating patients CMS defines as both short-stay patients and yet again for patients it acknowledges as extraordinary high-cost (long-stay) patients. CMS has not explained how LTCHs will finance the cost of these high cost and usually long stay patients other than indicating that it is reinstating higher threshold amounts which existed in the past. This is not a valid response in light of the distortion of average payments discussed above in Part I (E) of these comments. The reduction of payments for high cost outliers is another factor which shows that the SSO policy destroys the required averaging of PPS payments and is arbitrary and capricious.

H. No One Can Predict Which Patients Will Become SSOs.

CMS does not suggest any manner in which physicians or LTCHs can predict which patients may become SSOs. LTCHs admit patients under standards and processes required by Quality Improvement Organizations and hospital utilization review committees. CMS well knows that there are no standards which can predict the course of a patient's medical condition when he/she is admitted to any health care provider. When LTCHs are successful in improving a patient to the extent the patient can discharge prior to staying more than 5/6th of the geometric stay for a DRG, they are acting in the best interest of the beneficiary and cannot rightly be penalized by CMS. Similarly, when patients leave LTCHs for, e.g., surgery due to complications of their medical condition, it

[9] See MedPAC June 2004 Report to Congress, Chapter 5, "Defining Long-Term Care Hospitals, p. 127.

is not rational to fault LTCHs. CMS, in effect, is attempting to achieve a complex clinical result with a blunt force regulation. It is inconceivable that this approach can be effective – either patients are harmed, or LTCHs suffer unsustainable financial losses. We point out that prior to establishment of the LTCH-PPS patients were discharged to acute hospitals to receive treatment for such events as a heart attack. The cost of these services are not in the LTCH-PPS base year and are omitted from the LTCH-PPS federal standard amount.

I. The IPPS Alternative for SSO Payments Violates Federal Law

1. Statutory Violations

There can be no dispute that Congress has specifically excluded from the IPPS, "a hospital which has an **average** inpatient length of stay (as determined by the Secretary) of greater than 25 days." Section 1886(d)(1)(B)(iv)(I); 42 U.S.C. §1395ww(d)(1)(B)(iv)(I). A hospital with an ALOS of greater than 25 days has an absolute right to be paid under the payment system mandated by Congress for that class of hospitals, namely the LTCH-PPS which applies to cost-reporting periods beginning on and after October 1, 2002. Public Law 106-113, Section 123.

NALTH's LTCH members qualify for LTCH-PPS reimbursement because they satisfy the sole standard established by Congress entitling them to reimbursement under that system—the greater than 25-day ALOS requirement. All patient stays in an LTCH meeting the 25-day standard must be paid on the basis of LTCH-PPS; Congress has not prescribed any exception either to this legislative mandate or to the statutory requirement that a hospital meeting the 25-day standard is excluded from the IPPS.

Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 842-843 ((1984) establishes a two-part test for assessing the validity of a regulation. The first part of the test involves answering the question whether Congress has in clear language addressed the issue in question. Here Congress has addressed the question of whether CMS may subject LTCHs to IPPS reimbursement and has explicitly answered that question in the negative. Congress has made two clear pronouncements that must be heeded: there exists a class of hospitals with an ALOS in excess of 25 days, and that class of hospitals is excluded from the IPPS. The proposed IPPS reimbursement alternative for SSO cases violates both of these statutory provisions by subjecting NALTH member hospitals to the IPPS for a large percentage of their cases and denying them reimbursement under the LTCH-PPS.

CMS recognizes that it is unlawful to reimburse LTCHs under the IPPS and appears to claim that the words "comparable to" avoid the illegality: "We want to emphasize, however, that such a payment [under the newly proposed IPPS option] is not an IPPS payment but rather, a payment under the LTCH PPS that is generally derived from the IPPS payment methodology." 71 *Fed. Reg.* at 4688. This word play is transparent in underscoring its own error. The IPPS "comparable" payments use IPPS

DRG weights which are derived from acute hospital charges and reflect acute hospital resource use and length of stay. CMS has done nothing to obviate the statutory violations; rather, it underscores the statutory violations. Where immediately following the above quoted sentence CMS acknowledges that IPPS "resource use" (namely IPPS weights) will control the IPPS SSO payment option. That acknowledgement confirms that reimbursement under the IPPS SSO option is, in fact, occurring under the IPPS. Resource use by acute hospitals and LTCHs is different, and it was because of this difference in resource use that Congress mandated the establishment of a PPS unique to LTCHs. See Section 4422 of the Balanced Budget Act of 1997, Public Law 105-33 and Section 123 of the Balanced Budget Refinement Act of 1999, Public Law 106-113 (hereinafter "Section 123). The marked difference between the standard payment amounts under the IPPS and LTCH-PPS is an empirical acknowledgement by CMS of the different resource uses under each reimbursement system that supports Congress' determination that LTCHs were not to be reimbursed under the IPPS.

In addition, CMS expressly acknowledges that it is ". . . applying IPPS principles to achieve a close approximation of payments that would be made under the IPPS . . ." 71 *Fed. Reg.* at 4688. This acknowledgement underscores that to the extent practicable, CMS is incorporating into the SSO IPPS option IPPS payment principles. Given this admission, CMS' claim that the SSO IPPS option is not IPPS reimbursement, rings hollow, and, as shown above, is highly inappropriate from both clinical and payment perspectives.

Throughout the preamble to the proposed rule, CMS repeats the following mantra: ". . . under the broad authority under section 123 of the BBRA as amended by section 307(b) of BIPA . . ." See, *e.g.*, 71 *Fed Reg.* at 4692. In one rhetorical overreach, CMS characterizes the discretionary authority it believes Congress has conferred on the Secretary as "tremendous." 71 *Fed. Reg.* at 4683. Neither the mantra nor self-serving adjectives derogate from the limits that Congress has placed on the Secretary. Specifically, the directive given to the Secretary to "examine" various subjects under section 307(b) of BIPA does not translate into authorization to subject LTCHs to the IPPS. Each of these statutory mandates is unaffected by the BIPA amendments.

CMS may not have it both ways although it certainly tries. CMS may not properly claim that payments made under the SSO IPPS option are not IPPS payments when the thrust of its rationale for imposing the SSO IPPS option is that these cases belong in acute care hospitals and payment should mirror payments to acute care hospitals under the IPPS. Indeed, as noted above, in establishing the SSO IPPS option, CMS makes clear that it is doing everything possible to make that option mirror payments under the IPPS. LTCHs are entitled to be reimbursed based on LTCH-DRG weights derived from LTCH patient resource use and not on the basis of resource use of patients treated in another provider type i.e. an acute hospital under IPPS. It is simply not possible to harmonize making IPPS "comparable" payments to LTCHs when Congress has mandated a separate payment system for all patients admitted to LTCHs, and has

specifically required in Section 123 that payments to LTCHs reflect resource use and costs of LTCH patients.

2. The IPPS Alternative for SSO Payments is Arbitrary and Capricious and Otherwise Illegal

a. The IPPS Payment Option Conflicts with CMS' Acknowledgement that LTCHs Serve a Discrete, Unique Patient Population

CMS has acknowledged that LTCHs treat "seriously ill or medically complex patients" and that the LTCH-PPS was necessary "to reflect the relatively higher costs experienced by LTCHs in treating the most severely ill beneficiaries." See, *e.g.*, CMS' April 29, 2005 press release in connection with LTCH payment changes for rate year 2006.

Given these CMS acknowledgements, there is no rational justification for the IPPS SSO payment option. The "relatively higher costs experienced by LTCHs" and the resource use required by "seriously ill or medically complex" LTCH patients are simply not reflected in the IPPS methodology which, as Congress has made clear, may not be applied to LTCHs.

b. The Presumption that SSO Cases Should Have Remained in Acute Hospitals Is Wrong

The impetus for the IPPS SSO payment option arises from CMS' stated concern that SSO cases "may be inappropriate admissions of patients who are prematurely discharged from acute care hospitals." 71 *Fed. Reg.* at 4688. As an initial matter, NALTH observes (and will amplify below) that a discharge decision is made by a patient's attending physician in the patient's best interests. The medical necessity of any discharge/admission decision may neither be determined nor influenced through a payment mechanism given the statutory provisions that govern medical necessity determinations that NALTH will discuss below.

Secondly, it is misguided for CMS to assume that all SSO cases should remain in acute hospitals since a significant number of SSO admissions to LTCHs do not come from acute hospitals but rather, as directed by a patient's attending physician, may come from the patient's home, a nursing facility, or a skilled nursing facility. It is simply wrong for a payment option to assume that a patient admitted to an LTCH from a non-acute hospital setting at the direction of the patient's attending physician and whose case becomes an SSO, was indeed admitted from an acute care hospital. In this case, the attending physician, exercising medical judgment, regarded an acute hospital admission as inappropriate and admitted the patient directly to a LTCH.

Third, it is illogical to presume that a patient admitted to an LTCH from an acute care hospital who becomes a SSO case due to death, should have remained in the acute

care institution. For example, it is irrational to presume that a patient requiring ventilator services or specialized rehabilitation services not available in an acute care hospital but offered by an LTCH, should have remained in the acute care hospital solely because the resident deceased shortly after admission to the LTCH. As noted above, there are times when patients are languishing in acute care hospitals when they should be (and would benefit from) transferring to a LTCH.

Fourth, the CMS assumption that SSO cases belong in an acute care hospital ignores generally accepted and recognized principles that different health care institutions each play a needed, discrete role in a continuum of care. Admittedly, LTCHs are acute care hospitals for Medicare certification purposes; however, the 25-day ALOS that distinguishes this class of hospitals underscores that the patients served by LTCHs present with different medical issues than those served by acute care hospitals. It is for a physician, exercising medical judgment in the best interests of his/her patients, to determine which institution along the continuum of care may best provide services required by his/her patient.

For the reasons stated, one of the three justifications advanced by CMS for the SSO IPPS option, namely to discourage LTCHs from admitting cases that are premature acute hospital discharges (71 *Fed. Reg.* at 4687), is not substantiated and is most often demonstrably wrong. As noted above, MedPAC data showing that admission to an LTCH reduces a patient's readmission to an acute care hospital by 26% (MedPAC's June 2004 Report to Congress: New Approaches in Medicare, p. 127), further undermines CMS' justification that LTCH SSO cases that are discharges from an acute hospital to an LTCH are premature. Indeed, the fact that only .003% of LTCH discharges related to surgical DRGs, 71 *Fed. Reg.* at 4692-4693, suggests that LTCHS are not, in fact, admitting cases that either are typically associated with acute care hospital services, or cases involving premature discharges from acute care hospitals. Moreover, CMS' premise is also shown to be faulty by the myriad cases where patients admitted from acute care hospitals are discharged from LTCHs to home and nursing homes.

c. The Goals of the SSO Policy Are in Irreconcilable Conflict with the Jurisdiction and Statutory Role of QIOs

In June of 2004, NALTH commented on rules proposed by CMS for hospitals within hospitals ("HwHs") that limited referrals from the host hospital and proposed a ban on common ownership between the HwH and host hospital. CMS characterized its proposals as "admission criteria," 69 *Fed.. Reg*. 28196 at 28326–28327 (May 18, 2004), and NALTH's objections to the proposed rules in part focused on the impropriety of CMS using "admission criteria" to formulate reimbursement rules.

With respect to the IPPS SSO option, CMS avoids the "admission criteria" characterization it previously employed; however, the IPPS payment alternative represents *de facto* admission criteria given CMS' justification for proposing the alternative, namely a stated concern that two payments for one episode of care should be

avoided. 71 *Fed. Reg.* at 4687-4688. Indeed, at one point in the preamble to the proposed rule, CMS acknowledges that it is the intent of the SSO IPPS option to discourage LTCHs from admitting patients for whom an LTCH hospital stay is not "medically necessary." 71 *Fed. Reg.* at 4686.

The questions of whether there is more than one episode of care and whether an admission to any hospital is medically necessary are factually specific medical questions unique to each affected Medicare beneficiary; they are not questions that may be answered by a categorical, unsubstantiated assertion that SSO cases should have remained in an acute care hospital setting. Indeed, as noted above, some SSO cases never involve an acute care hospital and others are the result of a beneficiary's death or the exhaustion of Medicare day benefits. When CMS claims that SSO cases should have remained in an acute care hospital setting, CMS is actually taking issue with the numerous medical necessity decisions made by beneficiaries' attending physicians that the beneficiaries' health care needs would be best served in an LTCH setting. CMS has no statutory authority to second guess the medical judgments of beneficiaries' attending physicians through a reimbursement proposal. CMS may claim that one justification for the SSO IPPS option is to remove inappropriate financial incentives for LTCHs to admit SSO cases, 71 *Fed. Reg.* at 4687; however, what CMS is actually doing is engaging in a categorical assumption that attending physicians are violating their duties to their Medicare beneficiary patients by authorizing admissions to LTCHs from acute care hospitals.

Congress has delegated to QIOs, the "medical necessity" decisions that CMS admits that it is trying to manipulate through a reimbursement rule. The statutory and regulatory scheme which vests QIOs with authority to review the medical necessity of hospital services provided to Medicare beneficiaries is both comprehensive and exclusive. The proposed IPPS SSO option inappropriately intrudes on QIO authority and beneficiary rights explicitly provided in the QIO review process. Decisions regarding the appropriateness of a Medicare beneficiary's admission to an LTCH may not properly be based on a global, arbitrary assertion that all SSO cases should remain in an acute care hospital setting, but rather must be based on standards and criteria applied by QIOs. QIOs are established by Section 1151 of the Act (42 U.S.C. §1320c-3). Under this law, the Secretary has delegated to the QIO the responsibility for determining whether or not a patient needs to be admitted to a hospital. The QIO statute affords specific reconsideration and appeal rights to beneficiaries and providers which are completely incompatible with the proposed IPPS SSO option. See Sections 1154(a)(3)(C) and (D) and 1155. Similarly, the pertinent regulation promulgated under the statute, 42 C.F.R. §476.71(a), provides as follows:

(a) Scope of QIO review. In its review, the QIO must determine (in accordance with the terms of its contract) –

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> (3) Whether those services furnished or proposed to be furnished on an inpatient basis could, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient health care facility of a different type;
>
> ***
>
> (6) The medical necessity, reasonableness and appropriateness of hospital admissions and discharges;

The QIO issues final determinations and its review is binding on the Medicare program. See Section 1154(c) of the Act and 42 C.F.R. §§475.100 et seq. and §476.85.

For over a decade CMS has declined to include LTCH cases within the QIO scope of work. However, it should be noted that in accordance with requirements under the final long term care hospital PPS rule, 42 C.F.R. §412.508(a)(5), CMS has authorized QIOs to begin reviewing the medical necessity, reasonableness and appropriateness of a small sample of approximately 1,400 long term care hospital admissions, continued stays and discharges per year.

QIO processes are totally antithetical to CMS' bald assertion that SSO cases should remain in an acute care hospital. QIOs are comprised of licensed doctors of medicine designated to review services provided to Medicare beneficiaries to determine whether the services are medically necessary, consistent with professionally-recognized standards of care, and furnished in an appropriate setting. See Section 1154(a)(1) of the Act (42 U.S.C. §1320c-3(a)(1)). 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). A categorical, arbitrary assertion that all SSO cases must remain in acute care hospitals not only lacks factual support for the reasons noted above, but also is irreconcilably in conflict with the QIOs' responsibility to establish these criteria which are to operate in the best interest of Medicare beneficiaries.

The QIO provides for a meaningful review process with safeguards in place to protect Medicare beneficiaries' interests. See Section 1154(a)(i) of the Act and Section 4530 of the Peer Review Manual (CMS Pub. 19). The rights secured to beneficiaries and their physicians which are irreconcilably in conflict with the proposed IPPS option for SSO cases, include the right for an attending physician to be afforded the opportunity for discussion with a QIO reviewer prior to a determination. Section 1154(a)(3)(B). The

regulation adopted under the section requires an explanation of, "the nature of the patient's need for health care services, including all factors which preclude treatment of the patient as an outpatient or in an alternative level of care." See 42 C.F.R. §476.93. Moreover, the QIO Manual contains guidelines which encourage an opportunity for discussion between the attending physician and a QIO physician of the same specialty. See Peer Review Organization Manual (CMS Pub. 19), §4530.

The QIO regulatory process also provides for physician-to-physician discussion and appeal rights consistent with the statute which would be impaired by the proposed IPPS SSO option, an option that basically deems all SSO admissions to LTCHs from acute care hospitals to be medically unnecessary:

1) Before making an initial determination or a change as a result of DRG validation, the QIO is required to notify the provider and the patient's attending physician of the proposed determination or DRG change and afford them the opportunity for discussion with the QIO physician advisor. See 42 C.F.R. §476.93.

2) In the event of an initial denial or change in DRG validation, the QIO is required to provide written notice to the patient, attending physician and provider and afford them with a right to request a review or reconsideration of the determination. See Section 1154(a)(3)(C) and (D) and 42 C.F.R. §476.94(a), (b), and (c).

3) If the request for reconsideration results in a denial, and the amount in controversy is $200 or more, a beneficiary has the right to request a hearing before an Administrative Law Judge of the Office of Hearings and Appeals. See Section 1155 and 42 C.F.R. §478.40.

4) If the Administrative Law Judge ruling is unfavorable, and the amount in controversy is $2000 or more, a beneficiary has the right to seek judicial review. See section 1155; 42 C.F.R. 478.46(b).

To ensure consistency among determinations and avoid confusion among providers and beneficiaries, it is important that any admission to an LTCH be consistent with the QIO screening criteria and utilization review processes. Applying a strict *per se* rule that any admission of a SSO case to an LTCH is presumed inappropriate, is totally antagonistic to QIO procedures and standards, defeats important patient rights, and directly interferes with the professional judgment of clinicians as to the most appropriate provider of care for beneficiaries.

d. The IPPS Payment Option Impermissibly Interferes with the Rights of Medicare Beneficiaries to Freedom of Choice of Providers

The Medicare program should not establish a *per se* rule that conclusively presumes that any admission to an LTCH from an acute hospital of a case that eventually qualifies as a SSO, is medically inappropriate. Such a *per se* dictate is flawed not only

because, as just discussed, the dictate cannot be justified factually or medically, but also because the dictate undermines the freedom of choice that the Medicare Program has consistently recognized as a beneficiary entitlement.

The stated premise behind the proposed IPPS SSO option is that the admission of any SSO case from an acute care hospital to an LTCH is inappropriate because it is not medically necessary. Starting with this bald, unsubstantiated premise that is contrary to attending physician determinations of medical necessity, CMS posits that no SSO case should be admitted to an LTCH; rather, CMS concludes that all such SSO cases should remain in an acute care hospital setting. To abide by CMS' unsubstantiated assumptions, LTCHs should not admit (and are actively discouraged from admitting) any SSO cases.

These consequences are directly contrary to Section 1802(a) of the Act, which provides that any Medicare beneficiary "may obtain health services from any institution, agency, or person qualified to participate under this subchapter if such institution, agency, or person undertakes to provide him such services." In recognition of this statutory requirement, the Medicare program routinely advises program beneficiaries that they "may go to any doctor, specialist, or hospital that accepts Medicare." See CMS Publication Medicare & You, p. 23 (2003). This Medicare publication, which is provided to every Medicare beneficiary, goes on to state: "**[Y]ou have [the right] to … go to Medicare-certified hospitals".** Id. at p. 50. These statements are derived directly from Section 1802(a) of the Act and embody the **freedom of choice guarantee** that the fee-for-service Medicare program has extended to all program beneficiaries. Medicare program beneficiaries are not advised that their ability to receive medically necessary services in an LTCH is categorically inappropriate if they come to the LTCH from an acute care hospital.

The IPPS SSO option is contrary to the freedom of choice compact which the Medicare program has made with program beneficiaries. Full freedom of choice access to LTCHs, and the physicians who practice in LTCHs, cannot be withdrawn or restricted due to the fact that a beneficiary, supported by a medical necessity determination by his/her attending physician, happens to require admission to an LTCH from an acute care hospital. The notion that patients who qualify for medically necessary LTCH services may be forced to remain for treatment in an acute care hospital setting, cannot be reconciled with patients' freedom of choice entitlement.

In NALTH's view, the *per se* dictate that all SSO cases should remain in an acute care hospital setting gives rise to notice of non-coverage issues. Must an LTCH which denies a beneficiary admission for medically necessary care in reliance upon the *per se* dictate proposed by CMS provide a notice of non-coverage to the beneficiary? At a minimum, the Secretary should address both whether and why a notice of non-coverage is or is not necessary. NALTH submits that in the circumstances identified, a notice of non-coverage may be required by 42 C.F.R. §411.404 and Section 414.3(B) of the Medicare Hospital Manual (CMS-Pub. 10). A beneficiary who believes that s/he has been denied covered services, by an LTCH, regardless of whether a notice of non-

coverage is issued, has an unqualified right to request reconsideration by a Quality Improvement Organization (QIO) under Section 1154(a)(3)(D) of the Act (42 U.S.C. §1320c-3(a)(3)(D)). A beneficiary has other appeal rights, including review by an administrative law judge (42 C.F.R. §478.12(b)(2)(i)) and judicial review (42 C.F.R. §478.12(b)(2)(ii)). These appeal rights focus on the medical necessity of services sought by a beneficiary. As noted above, a coverage determination by a QIO is binding on the Medicare program and on a provider. See 42 C.F.R. §§476.71(a) and 476.85. Assuming LTCHs attempt to speculate on which cases may become a SSO and deny admission on that basis it is important that the Secretary, in final rulemaking, address the question of how denials of covered services by LTCHs relate to beneficiaries' rights to receive notices of non-coverage and to the function of QIOs.

NALTH Recommendations

1. In its March 2006 report of Congress MedPAC reiterated a recommendation contained in its June 2004 report that QIOs should review the medical necessity of admissions to LTCH. See March 2006 MedPAC Report to Congress, Chapter 4C, p. 211. MedPAC goes on to note that QIOs have found a 29% denial rate for a small 1400 case sample for which CMS has authorized the QIOs to conduct review. The SSO proposal appears to be a repudiation of this MedPAC recommendation. As noted above a medical review by QIOs is the means the Congress has prescribed for the Medicare program to determine the appropriateness of admissions to hospitals. NALTH recommends that CMS not adopt the SSO proposal and, instead intensify QIO review of LTCHs.

2. As an alternative, we recommend that if CMS wishes to develop another SSO policy that it identify a new class of ultra short stay cases which could represent cases admitted to LTCHs whose length of stay is short, in fact, and not longer than 20% of the geometric length of stay for the applicable LTCH-DRG. Cases discharged due to death would be excluded from the new class of short stay cases and paid under the current SSO methodology. Payment for the new ultra short stay cases would be paid on a basis of less than costs ie. 90% or 80% of costs like cost outliers are now. The amount of money effectively disallowed in this manner would be redistributed in a budget neutral way and increase payments for cases which are not within the ultra short stay category. This is essential to preserve the averaging of payments required for PPS. Cases whose length of stay falls between the 20^{th} percentile of the geometric mean length of stay of the applicable LTCH-DRG and the current $5/6^{th}$ SSO threshold would continue to be paid under the current SSO payment method.

II. In Order to be Consistent With How It Performed a One Time Adjustment in other PPS, CMS Should Eliminate the One Time Adjustment Provided by 42 C.F.R. § 412.523(d)(3)

CMS established the initial standard Federal rate under LTCH PPS based upon the statutory requirement of budget neutrality, *i.e.*, that its estimates of the aggregate payments in the first year under LTCH PPS, fiscal year 2003, be equal to the amount that

would have been paid if the TEFRA rate of increase system had remained in effect. As a tool to enforce budget neutrality, CMS promulgated §412.523(d)(3) to authorize it to make a one-time prospective adjustment to the LTCH PPS rates so that the effect of any significant difference between actual payments and estimated payments for the first year of the LTCH PPS is not perpetuated in the rates for future years. CMS stated its intentions to monitor LTCH PPS payment data to evaluate the ultimate accuracy of its assumptions used in the budget neutrality calculations, such as the inflation factors, intensity of services provided, and behavioral response to the implementation of the LTCH PPS. The regulation provides for the one-time adjustment to be made by October 1, 2006.

In the proposed rule, CMS proposes to defer making the one-time adjustment until July 1, 2008 because CMS still does not have sufficient data to enable it to conduct a comprehensive reevaluation of its budget neutrality calculations. This lack of data is asserted to be due in part to the failure of CMS and its fiscal intermediaries to have completed audits of the FY 2003 cost reports of LTCHs. In the preamble CMS also discusses the interrelationship of the one-time adjustment and the planned reevaluation of various payment adjustments under the LTCH PPS, and the plan to synchronize these data analyses for purposes of determining future proposed payment policies.

NALTH believes it is important that CMS be consistent and conduct the one time adjustment in the same manner and for the same reasons as it has done for all PPSs. The LTCH PPS regulatory scheme is similar to the Inpatient Rehabilitation Facility (IRF) regulatory scheme in that both systems are affected by changes in coding practices during the implementation of the PPS system. In the case of the IRF PPS, CMS performed the one time adjustment when it decreased the standard payment amount by 1.9% for FY 2006 to account for changes in coding practices that did not reflect actual changes in case-mix or intensity based on an analysis performed by the RAND corporation. 70 *Fed. Reg.* 47278, pp. 47904-47906 (August 12, 2005). It is noteworthy that for that same fiscal year 2006, CMS provided IRFs with an update of 3.6% based on the RPL (Rehabilitation, Psychiatric, Long-Term Care Hospital) market basket increase. "The final FY 2006 update for IRF PPS using the FY 2002-based RPL market basket is 3.6 percent." 70 *Fed. Reg.* at 47914. It is inequitable to treat LTCHs in a different manner than IRFs when accounting for payment increases due to changes in coding by potentially penalizing LTCHs twice for these changes, once by providing no update and a second time, by extending the regulatory time frame to establish an adjustment to the standard Federal rate. The 4.0% payment reduction CMS proposes to make this year is a permanent adjustment which *de facto* operates to reduce the rate of increase in the standard amount. Moreover, last year CMS reduced payment in the FY 2006 recalibration process when it reduced LTCH-DRG payment weights which represent another permanent reduction in LTCH-PPS payments. In order to act in an equitable manner which is consistent with the way it has performed the one time adjustment for new PPS systems in the past, CMS should eliminate the one time adjustment as it has

already accomplished the purposes of that adjustment by withholding the FY 2007 Rate of Increase.

III. CMS Should Not Impose The Proposed SSO Policy and also a Zero Update to the Standard Payment Amount

CMS is proposing a zero update to the federal standard rate of $38,086.04. The factual underpinnings for this proposal relate to perceived LTCH profit margins and the notion that the lion's share of the increase in the LTCH Case-mix Index ("CMI") is attributable to improvements in coding and documentation as opposed to real acuity changes. 71 *Fed. Reg.* at 4668-4670. NALTH takes issue with the assumptions utilized by CMS in proposing a zero update. In particular, NALTH disputes CMS' profit margin analysis given the draconian 15% rate reduction being imposed upon LTCHs under the proposed rule.

In its March 2006 report to Congress, MedPAC has recommended a 0% update for LTCHs. This recommendation was based on a projected aggregate positive margin of 7/8% in FY 2006 and, significantly **no change in LTCH payment policies**. See Chapter 4C, MedPAC March 2006 Report to Congress, p. 218. Based on these factors, MedPAC stated that LTCHs "should be able to accommodate cost changes in rate year 2007 **with the Medicare margin they have in 2006**." The proposed SSO policy changes all of MedPAC's assumptions. The Lewin Group has documented that should the SSO policy be implemented, LTCH margins will not be the positive 7/8% which MedPAC relied upon in making its recommendation, but instead will become significantly negative for approximately 70% of all LTCHs. In light of these circumstances, the traditional factors used by MedPAC in assessing the reasonableness of an update allowance, of adequacy of payments to cover cost, access to capital and beneficiary access to care, point decidedly to the need to increase LTCH margins. It is incumbent on CMS to enhance payments by providing an update and eliminating or moderating the proposed SSO policy as recommend by NALTH.

J. <u>CMS has Incorrectly Interpreted Past Data Provided NALTH Concerning Patient Referrals From a Single Source to LTCHs</u>

At page 4697 of the Notice of Proposed Rulemaking, CMS refers to a past study that NALTH commissioned from the Lewin Group and provided to CMS concerning patients admitted to LTCHs from a single source. CMS cites this study as showing that for a large number of cases nationally (71.2%) free-standing LTCHs admit more than 25% of their patients from a single source acute-care hospital. CMS goes on to state its perception that a "danger" exists that free-standing LTCHs may be operating as units.

In light of this statement, the Lewin Group has reviewed its past study and findings. See, Lewin Report p. 16. The previous data provided by NALTH to CMS show that the 25% rule itself is at extreme variance with the demographics of how patients are referred to post-acute hospitals throughout the United States. For example,

CMS did not reveal that the Lewin Group found that 93.7% of free-standing rehabilitation hospitals receive 25% or more of their admissions from a single source acute hospital. CMS has never engaged in an examination of the demographics of referrals to post-acute providers. If it did, it would find that what it perceives as a "high" percentage of admissions from a single acute hospital is many times dictated because there is only one or two acute care hospitals in the area. Many times there is a centralized major or tertiary hospital which receives critically ill patients who later require LTCH services. The point is that CMS cannot properly isolate only LTCHs (and, in particular, hospital-within-hospital LTCH) if it is concerned that a large number of referrals from a single source somehow impedes the independence of hospital decision making. It cannot justify discriminating between free-standing LTCHs and rehabilitation or psychiatric hospitals in making these assessments. The reality is that an extension of the 25% rule to these providers, would create large no-care zones for both LTCH and rehabilitation patients. NALTH requests that CMS correct the public record in the preamble to the final rule and that it fully report the Lewin Group's conclusion which is repeated at pate 16 of the Lewin Report as follows: "... a "25 percent admission restriction would impair existing patterns of post-acute care referrals." The 25 percent rule is arbitrary in its selection of the 25 percent threshold and ignores the way post-acute care referrals have evolved, where one or two hospitals provide the majority of referrals for a given post-acute care provider."

Additionally, as is the case with CMS' proposed SSO rule changes and its 25% rule applicable to HwHs and satellites, the agency's suggestion that a free standing LTCH may be considered a unit of another hospital will simply undermine the responsibilities of discharge planners and utilization review committees that take seriously their duty to identify post-acute providers based upon service, quality, patient safety and well-being, and patient-family access. Also undermined is the guaranty of freedom of choice of providers that Congress has afforded Medicare beneficiaries, and that NALTH discusses in some detail with respect to CMS' IPPS SSO payment option..

In addition to the foregoing, there is no legal basis for CMS to treat any LTCH (whether co-located or free standing) as a unit of another licensed hospital. There is no authority invested in CMS to overrule or alter licensing decisions by state officials and agencies as to whether an institution qualifies as a hospital. In fact, so long as an institution obtains the requisite state hospital license and meets other conditions of Medicare participation applicable to hospitals, CMS is without authority to either designate or characterize the institution as a unit of another hospital where neither the designation nor characterization is recognized under state law.

IV. Elimination of the Surgical DRG Exception to the Interrupted Stay Policy

A. Historical Background

CMS instituted a 3-day or less interrupted stay policy at §412.531(a) to reduce unnecessary Medicare payments and to deter inappropriate admission or discharges of Medicare patients from LTCHs. The 3-day or less interruption of stay is defined as a stay at a LTCH during which the Medicare inpatient is discharged from the LTCH to an acute care hospital, SNF, IRF, or home, and is readmitted to the same LTCH within 3 days of the discharge. For a 3-day or less interrupted stay, Medicare will pay a single LTC-DRG to the LTCH, and any tests or medical treatment provided at the acute care hospital, IRF, or SNF during the 3-day period are to be provided by the LTCH "under arrangements," which means that the LTCH is responsible for compensating the other provider for care rendered to the patient. CMS established a time-limited exception to the "under arrangements" requirement for treatment at an acute care hospital that was grouped to a surgical DRG under the IPPS. In such a case CMS makes a separate payment to the acute care hospital under the IPPS. The reason for this exertion is that the cost of these surgical cases were not incurred by LTCHs prior to LTHC-PPS. These costs are not in the LTCH-PPS base and are not reimbursed.

CMS stated that it needed to collect and analyze further data on this exception, and after examining data for the year ending June 30, 2005, CMS now proposes to eliminate the surgical exception to the 3-day or less interrupted stay policy. In support of its proposal, CMS notes that there were only 459 cases (0.003 percent of total LTCH discharges) that were governed by the surgical DRG exception, and therefore these cases are neither too numerous nor too costly for LTCHs to cover under arrangements; that the surgical treatments of this group, according to CMS, were not major surgical procedures and should have been provided under arrangements; that there seems to be poor documentation in LTCH medical records or poor coding in some of these cases since some LTCH claims include surgical care; and that these cases were paid to LTCHs on a reasonable cost basis when the LTCHs were paid under the TEFRA payment policy prior to the implementation of the LTCH PPS such that these costs were included in the establishment of the LTCH PPS base rate.

B. The Proposed Elimination of the Surgical Exception is Unwarranted

CMS' cited concerns with the surgical exception do not warrant the elimination of the exception. First, the "suggestion" by CMS coders that the LTCH claims may be incorrect (and might involve fraud and abuse issues) because some LTCH claims included surgical care and are grouped to surgical DRGs is a concern that can be dealt with on a case-by-case basis, rather than by a total repeal of the rule. CMS or its FIs could issue informational bulletins reminding LTCHs of the proper coding in these

situations. Also, a QIO or FI may consider a fraud referral if a LTCH repeatedly codes incorrectly or is believed to be gaming the system so as to cause Medicare to pay twice for the same case.

It is questionable whether these surgical costs at IPPS hospitals were correctly reported by LTCHs as under arrangements under the TEFRA reasonable cost payment system, and therefore it is questionable whether these costs were in the LTCH PPS base costs. As CMS frequently has noted, coding for these cases in years prior to the LTCH PPS was not important for correct payment, and many errors that were inadvertently made years ago have been corrected over time. There is no evidence that the costs of these surgical cases provided under arrangements by LTCHs under the TEFRA payment system were included in the LTCH PPS base period costs.

The small number of cases involved with the surgical exception also is not a valid reason for CMS to eliminate the exception and impose the additional financial burden on LTCHs. CMS cavalierly states that "we do not believe that" these cases "would represent a significant financial burden for LTCHs to absorb over a cost-reporting period, given the nature of the LTCH PPS." 71 *Fed. Reg. at* 4694. As noted above, there is no payment for these cases under the LTCH-PPS. Moreover, other proposals by CMS in this rule, such as the 0% update factor and the changes to the SSO rule, will cause LTCHs to experience an approximately 15% reduction in Medicare payments, with virtually all of the LTCHs losing money on treating Medicare beneficiaries. Any further negative financial impacts on LTCHs by this rule, when combined with the unprecedented reductions elsewhere in the rule, certainly will have a strong negative impact on LTCHs and their ability to be able to continue to provide services.

V. Research Triangle Institute Findings

The preamble in the notice of proposed rulemaking ("NPRM") includes a summary of the preliminary report by the Research Triangle Institute ("RTI"). CMS commissioned the RTI report in response to recommendations by MedPAC that the Secretary should: (i) develop facility and patient criteria to ensure patients admitted to long-term care hospitals are medically complex and have a good chance of improvement; and, (ii) increase medical necessity review of long-term care hospital admissions by Quality Improvement Organizations ("QIOs"), which also can monitor whether hospitals comply with the criteria. Therefore, RTI's report is intended to "assist CMS in the development of criteria for assuring appropriate and cost-effective use of LTCHs in the Medicare program" and, in particular, "to evaluate the feasibility of developing patient and facility level characteristics for LTCHs in order to identify and distinguish the role of these hospitals as a Medicare provider." 71 *Fed. Reg.* 4704.

RTI indicates that a critical question is whether the increase in the number of LTCHs "is due to growing patient demand or industry response to generous payment policies." *Id*. The Lewin Group's review found that RTI's report, as summarized in the

preamble, does not answer definitively any of its central questions. In fact, the Lewin Group found that:

> CMS' NPRM proposals appear to far outreach the data and conclusions provided by RTI, resulting in an unnecessarily drastic cut in the LTCH payment rates. CMS appears to perceive its proposed pricing scheme as more accurate in providing for appropriate patient selection than the existing use of patient admission criteria by LTCHs. This is an unproven speculation.

The preliminary RTI report provides a summary of LTCH locations and types of patients. RTI's report notes that LTCH patients are different, in numerous ways, from acute hospital outlier patients and patients treated in other post-acute care settings. However, although the report provides extensive descriptive statistics, the Lewin Group found that it does not provide the reader with a sense of what the observed differences mean in regard to MedPAC's recommendations or CMS' questions about: (i) the appropriateness of growth in the LTCH industry, (ii) case volume, or (iii) patient placement. The Lewin Group found that a much more detailed analysis than that presented in the NPRM would be required to answer these questions. For instance:

- The RTI episode analyses appear not to adjust for selection bias.
- They also appear to be based on descriptive statistics comparisons.
  - Both Lewin and MedPAC analyses have suggested that these types of descriptive analyses do not identify accurately the relative degree of LTCH episode costs as compared to patient's episode costs in alternative settings.
- The report is **silent** on whether patients "have a good chance of improvement."
  - Without this information and further analyses of this central question, there is little basis to conclude that patient placements in LTCHs are not appropriate.
  - The use of a payment method that does not consider the actual resource use by these patients seems inappropriate from a patient health and access perspective.

In fact, one can read the summary of the RTI report, which states that LTCH patients are clinically different from those in acute care and other post-acute care settings, and reasonably conclude that these patients are placed appropriately in LTCHs.

The RTI report speculates that, while the alternative post-acute care settings typically utilize various forms of admission criteria, the accuracy of these criteria, in practice, is not powerful enough to determine "whether a patient belongs in an LTCH or alternative site of care." 71 *Fed. Reg.* 4726. RTI indicates that "[m]ore discussion is

needed to set specific levels of care determinations that include the range of specialists treating these patients." *Id*. With reference to the RTI study, the rule states:

> Although we expect the final RTI report on this project to have a substantial impact on future Medicare policy for LTCHs, we still believe that even with the development of defined patient and perhaps facility-level criteria, that the retention of many of the specific payment adjustment features of the LTCH PPS presently in place may still be both necessary and appropriate for purposes of protecting the integrity of the Medicare Trust Fund. We expect that the RTI's final report will be submitted to us in late Spring 2006.

Id.

The Lewin Group found that "CMS' inference that existing admission criteria are inadequate to appropriately screen LTCH admissions appears not to be supported by the RTI data provided." The data presented do show differences between LTCH and acute hospital patients. However, the degree to which – and how – LTCH admission criteria currently in use are not appropriately working is not well detailed in the RTI summary report. Given the data presented, an alternative conclusion could be reached. In the words of the Lewin Group, this "is true since the RTI report does not address the issue of whether the clinical protocols employed by LTCH clinicians in caring for their patients produces better clinical outcomes than those that would occur in alternative settings."

The statement that future patient and facility-level criteria will not be adequate to ensure appropriate patient placement also is not supported by the data presented by RTI. In short, the NPRM proceeds as if nearly all SSO cases are inappropriately placed but the Lewin Group's analyses indicate that this is a problematic simplification of the circumstances surrounding SSOs.

The Lewin Report concluded that the "range of possible unintended clinical outcomes that could result from the NPRM and CMS' decision to ignore its own rules of averaging is problematic, and inconsistent with CMS' well-tested use of averaging, which has been successfully used in its other PPSs."

VI. Statewide Cost to Charge Ratios.

NALTH does not object in concept to the proposed combination of capital and operating cost to charge ratios (CCR) to create the statewide average cost to charge ratio. We do note that CMS has not provided any impact data and request that it defer adoption of this change until it has done so.

CMS' suggests that consistent with existing policy for discharges occurring on or after October 1, 2006, the CCR applied at the time a claim is processed should be based on either the most recent settled cost report or the most recent tentative settled cost report whichever is from the latest cost reporting period, and that a reconciliation of outlier

payments be based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled. For those LTCH Medicare patients that have extremely long length of stays and may have benefit days that span over a number of cost report years, settling the payment based on date of discharge understates reimbursement that is due and places the LTCH at risk of losing reimbursement. The proposed rule would reimburse the LTCH based on the RCC and the SSO and HCO thresholds that are applicable on the date the patient is actually discharged and not in the year the service was provided. Under the IPPS PPS rules, there is currently no settlement process if the cost reports have been settled and therefore there is no method for the LTCH to get adequately reimbursed for these Medicare patients that have length of stays that span multiple cost report years. This process does not recognize the need for a separate settlement for LTCHs where a patient stay extends beyond one cost reporting period. NALTH, therefore, recommends that CMS provide a settlement process for each cost year to make accurate payments for these patients.

NALTH thanks the Secretary for his consideration of these comments. Please contact the undersigned should you need further assistance.

Sincerely,

Edward D. Kalman
General Counsel

Final Report: *Analysis of Long Term Care Hospitals RY 2007 Prospective Payment System Notice of Proposed Rulemaking*

Prepared for:

National Association of Long Term Hospitals (NALTH)

By:

Allen Dobson, Ph.D.

Randy Haught

Robert Book, Ph.D., M.B.A.

Ted Kirby

Jeannine Dollard, M.P.A.

Ying-Jun Chen, M.B.A.

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I. INTRODUCTION

A. Purpose

The Lewin Group was Commissioned by the National Association of Long Term Hospitals (NALTH), to review and critically appraise the Long Term Care Hospitals RY 2007 Prospective Payment System Notice of Proposed Rulemaking (NPRM) . The Lewin Group scope of work was primarily to simulate and analyze the provisions in the NPRM related to:

- Overall policy considerations
- Revenues
- Margins
- Short stay outlier policies
- Long term care hospital (LTCH) referrals from "single-source acute hospitals"
- Use of averaging
- Overall appropriateness in supporting a viable Long Term Care Hospital (LTCH) industry

In addition, The Lewin Group reviewed and analyzed the summary of the Research Triangle Institute, International (RTI) report contained in the NPRM.

B. Overview of Analysis Conducted and Key Findings

We started our analyses with the construction of a revenue model which was calibrated to match the impact tables presented in the NPRM. This was somewhat more difficult than in prior years because the NPRM proposes that the LTCH Prospective Payment System (LPPS) incorporate a version of the acute care hospital Inpatient Prospective Payment System (IPPS) in the payment of LPPS short stay outliers (SSO), so both the LPPS and IPPS payment systems need to be included in the model.

Once our revenue model was operational and appropriately calibrated, we compared RY 2006 LPPS revenues to the NPRM's proposed RY 2007 LPPS revenues. We did this on a case-by-case and LTCH-by-LTCH basis using 2004 Medicare Provider Analysis and Review (MedPAR) data and the Centers for Medicare and Medicaid Services (CMS) provided impact file information. Our revenue results are provided on an overall and type of hospital basis. As with the NPRM, we note that revenue losses are in the 11 percent range, and primarily attributable to the NPRM's handling of LPPS SSOs.

We then constructed a margin model that matches revenues and costs. We also provide margins on an overall and type of hospital basis. Because the NPRM does not provide for an annual update factor for the standardized payment amount, we predict margins will fall by nearly 15

percentage points, relative to RY 2006. This results in an aggregate overall margin of –4.9 percent, well below the 4 to 6 percent positive margin generally thought to be required to support hospital modernization and refurbishing and allow the hospital to keep current with emerging technologies.

We next determined that the NPRM's SSO payment policies led to most, if not all, of the revenue losses. This closely corresponds to the NPRM Impact Analysis. Given this critical finding, we then conducted analyses investigating the appropriateness of the various CMS SSO payment proposals. We focused on the NPRM's SSO policies given their strong relationship to proposed payment reductions.

We began with an analysis of the distribution of length of stay (LOS) for LPPS cases as compared to IPPS cases, as about 77 percent of SSO payments are based on IPPS payment rules (IPPS represents 28 percent of total cases). We noted that both LOS distributions are highly similar, indicating that there is nothing anomalous about the number, frequency or distribution of IPPS SSO cases and, for that matter, LPPS cases. We then compared LPPS SSO diagnosis related groups (DRG) cases to IPPS DRG cases on length of stay, intensity and severity. We found that LPPS SSO DRGs have a 70 percent higher length of stay, are about 70 percent more intense and are more severe.[1]

We conclude that CMS should reconsider the methodology and proposed payment rates outlined for LTCHs in the NPRM for the following reasons:

- There are significant differences in LOS, intensity and severity between IPPS and LPPS cases, which made the application of IPPS payment methodology to LPPS problematic.
- The proposed payment methodology for SSOs produces a -82 percent margin for all SSO cases which represent approximately 40 percent of all cases.
- The negative impact of the proposed LPPS payment rates for SSOs would result in more than two thirds of the LTCHs having negative Medicare LPPS margins with an overall Medicare LPPS margin of about -5 percent.

C. Revenue and Margin Analyses

We calculated LPPS revenue by applying the proposed payment rules for 2007 in the NPRM to the actual discharge-level data in the 2004 MedPAR file. We also applied the 2006 rules to these same data, and calculated the change in revenue that would occur by switching from the 2006 rules to the proposed 2007 rules.

We estimated revenues based on provider characteristics from the impact file, and discharges in the 2004 MedPAR file. For each hospital, we calculated the adjusted federal DRG rate by adjusting the standard rate based on the labor share of costs, and the regional wage index and

[1] After controlling for differences in the mix of cases by DRG between the two types of hospitals.

cost-of-living adjustment (COLA) factor for that particular hospital. Then, for each discharge, we calculated the DRG payment, taking into account the short-stay and the long-stay outlier payment methods. For purposes of outlier payments, we calculated costs based on Medicare covered charges as reported in MedPAR, which were inflated from 2004 to 2007 by the annual market basket rate of increase, multiplied by the hospital's cost-to-charge ratio as reported in the impact file.

When calculating 2006 revenues, we also took into account the phase-in of PPS and phase-out of the Tax Equity and Fiscal Responsibility Act (TEFRA) for hospitals that will still receive payments partially based on TEFRA in 2006.

When calculating 2007 revenues, we calculated short-stay payments according to the newly proposed rule, by taking the lowest of:

(1) The per-diem payment based on the number of days of the stay; that is, the adjusted federal DRG rate, divided by the geometric mean length of stay for that DRG, multiplied by the number of covered days, times a short-stay factor of 1.2

(2) The cost of the stay, calculated by multiplying Medicare covered charges as reported in MedPAR by that hospital's cost-to-charge ratio as reported in the Medicare Cost Report (MCR)

(3) The payment that the hospital would have received under the acute care IPPS, taking into account the Medicare wage index, COLA, geographic adjustments, Medicaid Disproportionate Share Hospital (DSH) adjustment, and medical education adjustments

(4) The full DRG payment amount

As we note below, the short stay rules apply to about 40 percent of all discharges, and the above-mentioned rules generally reduce the payment to below the DRG rate, thus undermining the assumption that having a standard DRG rate allows losses on long stays to be offset by gains on short stays. Put another way, the short stay rules undermine the basic principal of averaging utilized by CMS when originally establishing 2003 LPPS rates.

We estimated the cost per Medicare patient day for each long term hospital by taking its Medicare costs as reported in its MCR, dividing it by the number of Medicare patient days reported in the MCR, and inflating the resulting cost per day to 2006 and 2007 using the estimated price index for the Excluded Hospital Market Basket. For each discharge in the 2004 MedPAR file, we multiplied the number of Medicare covered days by the cost per day to estimate the cost for that discharge. While this does not account for the cost differences in treating patients with different DRGs for the same number of days, it is appropriate for costs aggregated at the level of the hospital (or hospital group).

Our estimates for the decrease in revenue for all long-term care hospitals, and for various subgroups of those hospitals, are shown in ***Exhibit 1.*** Our revenue loss estimates are close to the CMS impact estimates as reported in the NPRM.

We calculated Medicare margins for LTCHs under the proposed rule, as shown in ***Exhibit 2,*** and found that more than two-thirds of LTCHs will have negative Medicare margins if the

proposed rule is implemented. The average Medicare LPPS margin is estimated at –4.9 percent. The median Medicare LPPS margin is estimated at –6.0 percent.

Exhibit 1: Reconciling Lewin Group and CMS Impact Estimates

LTCH Classification	Number of LTCHs	Number of LTCH Cases	2006 LTCH Payment per case	Proposed 2007 LTCH Payment per case	Percent Decrease in Proposed Payment from 2006 to 2007	
					Lewin's Estimate	CMS' Estimate
All Providers	328	117,751	$32,061	$28,543	-11.0%	-11.3%
By Location						
Rural	16	3,227	25,699	22,528	-12.3%	-12.2%
Large Urban	170	72,645	33,160	29,774	-10.2%	-10.4%
Other Urban	142	41,879	30,645	26,871	-12.3%	-12.8%
By Participation Date						
Before Oct 1983	17	8,177	26,006	22,991	-11.6%	-11.9%
Oct 1983 - Sept 1993	44	22,220	34,571	31,020	-10.3%	-10.4%
Oct 1993 - Sept 2002	233	82,954	32,155	28,607	-11.0%	-11.3%
Other Dates	34	4,400	28,863	25,144	-12.9%	-12.6%
By Ownership Control						
Government	7	2,283	25,992	22,574	-13.2%	-14.2%
Proprietary	215	85,309	32,855	29,481	-10.3%	-10.5%
Unknown	38	4,920	28,882	25,171	-12.8%	-13.2%
Voluntary	68	25,239	30,547	26,571	-13.0%	-13.4%
By Census Region						
New England	14	9,437	26,115	22,967	-12.1%	-12.6%
Middle Atlantic	21	6,878	31,799	28,410	-10.7%	-10.4%
South Atlantic	41	12,194	35,801	31,845	-11.0%	-11.4%
East North Central	59	16,982	35,286	31,687	-10.2%	-10.9%
East South Central	20	5,483	33,719	29,611	-12.2%	-12.4%
West North Central	17	4,808	36,159	32,075	-11.3%	-12.1%
West South Central	120	49,360	29,386	25,941	-11.7%	-12.0%
Mountain	21	6,032	33,554	29,945	-10.8%	-11.0%
Pacific	15	6,577	39,934	37,208	-6.8%	-6.3%
By Bed Size						
Beds: 0 - 24	31	4,460	31,587	27,581	-12.7%	-13.1%
Beds: 25 - 49	164	39,448	31,966	28,214	-11.7%	-12.0%
Beds: 50 - 74	56	19,699	33,027	29,379	-11.0%	-11.3%
Beds: 75 - 124	40	19,414	33,547	30,188	-10.0%	-10.4%
Beds: 125 - 199	25	23,476	30,548	27,239	-10.8%	-11.2%
Beds: 200 +	12	11,254	31,481	28,495	-9.5%	-9.4%

Source: Lewin Group analysis of the 2004 Medicare Provider Analysis and Review (MedPAR) data, taking into account the 2006 payment rules and the proposed 2007 changes as outlined in FR 71, No. 18 on January 27, 2006. The rightmost column is taken from the *Federal Register,* Vol. 71, No. 18, pages 4734-5.

The proposed rule states that:

> *"The provisions of this proposed rule are estimated to result in approximately an 11 percent decrease in estimated payments per discharge in the 2007 LTCH PPS rate year on average to LTCHs (as shown in Table 23). As discussed in greater detail below in this section (and as shown in Table 23), the majority of the approximately 11 percent decrease in estimated payments in the 2007 LTCH PPS rate year as compared to the 2006 LTCH PPS rate year is due to the proposed change in the payment formula for SSO cases (discussed in section V.A.1.a. of the preamble of this proposed rule).* ***We do not believe that this proposed change would result in an adverse impact on affected LTCHs for the reasons discussed below in this section. We believe that, if implemented, the proposed changes to the SSO policy would accomplish our stated goal of removing the incentive for LTCHs to admit patients for whom a long-term hospital stay is not necessary and therefore, for whom the LTCH would not be providing complete treatment.*** [Emphasis added.][2]

We suggest that CMS' conclusion is misguided because CMS defines an SSO case in such a way that it is essentially impossible for LTCHs to admit a smaller percentage of SSOs in any given year. CMS uses a relative measure of "short stay" that guarantees that approximately 30 to 40 percent of cases will always be considered "short." A short stay is defined as a "stay shorter than 5/6 of the geometric mean length of stay." Length of stay generally follows a log-normal distribution, for which the geometric mean is equal to the median length of stay (half of stays are longer, and half shorter). Stays less than 5/6 of the geometric mean will *always* account for about 30 to 40 percent of cases, regardless of the expected-stay threshold the LTCHs require for an admission. By defining a short stay in this manner, it is essentially guaranteed that short stays will account for about 30 to 40 percent of cases. To object that this is "too many" is akin to objecting to the fact that LTCHs have 50 percent of cases that are below the median. The following section addresses these issues in more detail.

Exhibit 2 shows that RY 2007 margins would fall 14.1 percent (9.17%-(-4.93%) relative to RY 2006. While MedPAC has recommended to Congress for FY 2007 that no rate of increase was warranted for LTCH because of the RY 2006 margin (estimated by MedPAC to be 7.8 percent); there was no anticipation by MedPAC that CMS would decrease revenues by over 11 percent and, at the same time, not provide for a rate of increase, which would be worth about 3.3 percent. This represents a total financial "hit" of about 14.3 percent (11%+3.3%), which is more severe than is suggested in the commentary within the NPRM

Under the NPRM, non-profit LTCHs would have a margin of -8.80 percent with public hospitals showing a -19.72 percent margin. LTCHs in the south, at -8.08 percent, and small bed size LTCHs, at -12.62 percent, would also be large losers.

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[2] *Federal Register,* Proposed Rules, Vol. 71, No. 18, Friday, January 27, 2006, page 4727.

The percent of LTCHs with negative margins also shows the restrictive nature of the proposed RY 2007 LPPS. With 68.6 percent of LTCHs showing a less than zero margin, non-profit LTCHs at 83.8 percent less than zero margin, LTCHs in the south at 78.2 percent and small bedsize LTCHs at 86.2 percent, the notion of efficient and economically well-run hospitals having their costs covered would be violated. This contention is further bolstered by margin estimates for the 75th percentile margin LTCHs by hospital group, many of which are negative.

These margin estimates are, in part, driven by proposed by LPPS SSO policies discussed below and the lack of a rate of increase to the standardized payment amount. The combined effect of these policy proposals is to render large parts of the LTCH industry nonviable financially. This is inconsistent with CMS' historical precedent of paying efficient providers in such a way as to afford them sufficient financial return and financial viability.

Exhibit 2: LTCH Medicare LPPS Average, Percent Negative Margin and Percentile Margin by Hospital Type for RY 2006 and 2007

	2006					2007				
	Average	Percent	Percentiles			Average	Percent	Percentiles		
Grouping	Margin	Negative	25th	50th	75th	Margin	Negative	25th	50th	75th
All Hospitals	9.17%	21.1%	1.19%	8.60%	15.16%	–4.93%	68.6%	–15.04%	–6.03%	2.76%
Ownership Type										
Non–Profit	7.42%	31.1%	–0.44%	6.38%	11.59%	–8.80%	83.8%	–17.93%	–10.50%	–2.27%
Profit	10.01%	16.2%	2.89%	9.74%	16.14%	–3.42%	63.4%	–13.55%	–4.12%	4.23%
Public	–2.97%	66.7%	–6.68%	–0.94%	3.43%	–19.72%	77.8%	–29.65%	–18.25%	–6.42%
Texas Facilities										
Non–Profit	4.31%	25.0%	–2.13%	7.96%	11.16%	–13.56%	91.7%	–21.42%	–8.77%	–5.71%
Profit	7.16%	25.5%	–0.64%	8.04%	11.60%	–7.28%	83.0%	–19.52%	–6.25%	–1.16%
Region										
Midwest	13.17%	10.5%	4.36%	11.45%	19.57%	0.36%	52.6%	–12.24%	–0.75%	9.04%
Northeast	13.00%	8.8%	5.77%	10.71%	20.36%	–0.30%	55.9%	–8.44%	–1.57%	12.10%
South	7.12%	27.0%	–0.24%	7.08%	12.78%	–8.08%	78.2%	–17.93%	–8.72%	–1.16%
West	8.18%	26.5%	–0.04%	6.34%	12.78%	–3.38%	67.6%	–13.55%	–7.17%	1.28%
Location Type										
Urban	9.13%	21.5%	1.07%	8.66%	15.17%	–4.93%	67.5%	–15.04%	–5.78%	3.14%
Rural	10.35%	12.5%	1.81%	6.00%	14.21%	–5.09%	87.5%	–14.37%	–8.08%	–2.39%
Bedsize Category										
1: 1–24	4.12%	31.0%	–3.80%	1.57%	7.25%	–12.62%	86.2%	–23.40%	–16.05%	–9.74%
2: 25–49	10.28%	18.5%	2.38%	10.54%	15.90%	–4.26%	65.5%	–13.94%	–5.23%	3.52%
3: 50–74	6.04%	30.0%	–0.64%	6.91%	12.63%	–8.49%	76.0%	–17.05%	–7.11%	–0.06%
4: 75–124	10.33%	17.9%	4.81%	8.66%	17.48%	–3.34%	66.7%	–10.11%	–4.06%	4.96%
5: 125–199	8.54%	16.7%	1.09%	6.92%	14.86%	–4.19%	66.7%	–13.83%	–6.55%	7.48%
6: 200–299	9.78%	25.0%	2.04%	7.04%	19.29%	–4.48%	62.5%	–7.52%	–1.48%	17.61%
7: 300+	13.91%	0.0%	9.63%	18.72%	23.46%	2.69%	33.3%	–2.57%	7.86%	16.32%

Source: Lewin Group analysis of the 2004 Medicare Provider Analysis and Review (MedPAR) data, taking into account the 2006 payment rules and the proposed 2007 changes as outlined in FR 71, No. 18 on January 27, 2006.

D. Short Stay Outlier Analysis

Linking the definition of SSOs to the expected percent of SSO cases

Exhibit 3 presents a comparison of the percentage of SSO cases (defined as "cases with an average LOS less than 5/6 of the geometric mean LOS") to the percentage of acute care hospital (ACH) cases that would be defined as short stay cases using the LPPS definition.

Exhibit 3: Short-stay Discharges for IPPS and LPPS Compared

Hospital Type	Discharges	Number of Short Stay Discharges	Percentage of Short Stay Discharges	Number of Short Stay Deaths	Percentage of Short Stay Deaths
IPPS (2003)	13,179,488	4,996,673	37.91%	240,282	4.81%
LPPS (2003)	114,028	47,770	41.89%	9,320	19.51%
LPPS (2004)	117,751	43,214	36.70%	9,516	22.02%

Source: Lewin Group analysis of the 2003 and 2004 Medicare Provider Analysis and Review (MedPAR) data.

Both types of hospitals show similar proportions of short stay cases. About 38 percent of IPPS discharges were short stays in 2003, while LPPS had about 42 percent such cases that year, and 37 percent in 2004. (We do not have the 2004 MedPAR data for ACHs so the table only shows the short stay cases for these hospitals for 2003.)

While the percentage of short stay cases is similar across settings, the composition is different. In 2003, about 20 percent of the LPPS short stay cases ended with the death of the patient, while less than 5 percent of IPPS short stays ended with deaths. In 2004, about 22 percent of LPPS short stay discharges ended in death. These facts suggest that short-stay patients in LTCHs are more severely ill than their counterparts in ACHs. After observing LTCH operations for many years, we believe that deaths are difficult to predict for LTCH patients, most of whom are medically volatile due to multiple organ failure upon admission.

Exhibit 4 shows the 50 DRGs in the 2004 LTCH MedPAR data with the highest number of short stay cases. This indicates that, by and large, LTCH DRGs show a consistently high percentage of SSO cases -- in the 30 to 45 percent range, which further shows that the large portion of SSO cases is due to the CMS definition of SSOs and not LTCH patient selection.

Exhibit 4: SSOs as a Percent of Total Cases by DRG (Ranked by Number of SSO Cases)

DRG	DRG Name	Total Cases	Short Stay Outlier Cases	Short Stay as a Percent of Total Outlier Cases
475	Respiratory System Dx With Ventilator Support	13,171	5,182	39.34%
87	Pulmonary Edema & Respiratory Failure	5,065	2,257	44.56%
271	Skin Ulcers	5,697	2,054	36.05%
88	Chronic Obstructive Pulmonary Disease	5,020	2,049	40.82%
249	Aftercare, Musculoskeletal System & Connective Tissue	6,290	1,967	31.27%
89	Simple Pneumonia & Pleurisy Age >17 W CC	4,861	1,924	39.58%
12	Degenerative Nervous System Dis	5,843	1,811	30.99%
462	Rehabilitation	5,174	1,748	33.78%
79	Respiratory Infections & Inflammations Age >17 W CC	4,494	1,747	38.87%
466	Aftercare w/o History Of Malignancy As Sec Dx	4,531	1,680	37.08%
416	Septicemia Age >17	4,195	1,602	38.19%
127	Heart Failure & Shock	3,735	1,439	38.53%
263	Skin Graft &/or Debrid For Skn Ulcer or Cellulitis W CC	3,781	1,100	29.09%
430	Psychoses	2,401	1,025	42.69%
316	Renal Failure	2,384	886	37.16%
277	Cellulitis Age >17 W CC	1,921	724	37.69%
418	Postoperative & Post-Traumatic Infections	1,906	666	34.94%
144	Other Circulatory System Dx W CC	1,552	635	40.91%
76	Other Resp System OR Proc W CC	1,763	628	35.62%
452	Complications Of Treatment W CC	1,495	585	39.13%
238	Osteomyelitis	1,820	576	31.65%
130	Peripheral Vascular Dis W CC	1,438	507	35.26%
188	Other Digestive System Dx Age >17 W CC	1,274	478	37.52%
320	Kidney & Urinary Tract Infections Age >17 W CC	1,353	467	34.52%
296	Nutritional & Misc Metabolic Dis Age >17 W CC	1,203	433	35.99%
415	OR Proc For Infectious & Parasitic Diseases	984	338	34.35%
468	Extensive OR Proc Unrelated To Principal Dx	945	338	35.77%
182	Esophagitis, Gastroent & Misc Digest Dis Age >17 W CC	951	337	35.44%
465	Aftercare w/History Of Malignancy As Sec Dx	870	336	38.62%
82	Respiratory Neoplasms	641	334	52.11%
217	Wnd Debrid & Skn Grft Ex Hand,For Muscskelet & Conn Tiss Dis	962	292	30.35%
294	Diabetes Age >35	814	252	30.96%
463	Signs & Symptoms W CC	899	251	27.92%
542	Trach W Mv 96+Hrs or Pdx Exc Face, Mouth & Neck w/o Maj OR	714	247	34.59%
172	Digestive Malignancy W CC	477	242	50.73%
461	OR Proc w/Dx Of Other Contact w/Health Services	689	239	34.69%
34	Other Dis Of Nervous System W CC	606	239	39.44%
126	Acute & Subacute Endocarditis	596	210	35.23%
243	Medical Back Problems	620	191	30.81%
120	Other Circulatory System OR Proc	606	188	31.02%
256	Other Musculoskeletal System & Connective Tissue Dx	495	178	35.96%
204	Dis Of Pancreas Ex Malignancy	426	167	39.20%
132	Atherosclerosis W CC	428	163	38.08%
331	Other Kidney & Urinary Tract Dx Age >17 W CC	415	162	39.04%
20	Nervous System Infection Ex Viral Meningitis	408	159	38.97%
403	Lymphoma & Non-Acute Leukemia W CC	345	159	46.09%
248	Tendonitis, Myositis & Bursitis	364	158	43.41%
203	Malignancy Of Hepatobiliary System or Pancreas	272	154	56.62%
14	Intracranial Hemorrhage or Cerebral Infarction	433	151	34.87%
99	Respiratory Signs & Symptoms W CC	333	146	43.84%

Source: Lewin Group analysis of 2004 Medicare Provider Analysis and Review (MedPAR) data.

Exhibits 3 and ***4*** above indicate that the definition of SSOs (cases with a LOS less than 5/6 of the geometric mean LOS) produces a case frequency of about 40 percent.

To further demonstrate that the frequency of SSOs is about the same regardless of the admission policies of LTCHs, we considered what would happen if LTCHs eliminated *all* cases that are currently considered SSOs, and calculated the percentage of cases that would then be considered SSOs. That is, we excluded all current SSO cases from the LTCH case distribution and recomputed the geometric mean LOS using only remaining non-SSO cases. We then set a new SSO threshold at 5/6 of the new geometric mean LOS. As shown in ***Exhibit 5***, this produces about 35 percent new SSOs. This compares to 37 percent SSOs for the original distribution. As noted above, the fact that LTCHs produce about 40 percent SSOs is to be expected given the LPPS definition of SSOs.

Exhibit 5: Re-estimating the Percent of SSOs After Removing the Original SSOs from the Distribution of LTCH Cases

All LTCH Discharges in 2004	
Number of Discharges	117,751
Current Short Stay Outlier Cases (less than 5/6 geometric mean LOS)	43,214
Percent of Short Stay Outlier Cases	37%
LTCH Cases excluding all current Short Stay Outlier Cases	
Number of Discharges	74,537
New Short Stay Outlier Cases (less than 5/6 geometric mean LOS)	25,773
Percent of Short Stay Outlier Cases	35%

Source: Lewin Group analysis of the 2004 Medicare Provider Analysis and Review (MedPAR) data.

Exhibit 6 provides a DRG-specific example of the above phenomenon. In this instance, the SSO percents are 31 and 29 respectively, again confirming the notion that SSOs as defined by the LPPS are purely distributional in nature and not at the discretion of LTCH managers.

Exhibit 6: Example for DRG 12 – Degenerative Nervous System Disorders

All LTCH Discharges in 2004	
Number Discharges	5,708
Geometric Mean LOS	25.5 days
5/6 Geometric Mean LOS	21.3 days
Percent of Short Stay Outlier Cases	31%
LTCH Cases excluding all current Short Stay Outlier Cases	
Number Discharges	3,939
Geometric Mean LOS	30.9 days
5/6 Geometric Mean LOS	25.8 days
Percent of New Short Stay Outlier Cases	29%

Source: Lewin Group analysis of the 2004 Medicare Provider Analysis and Review (MedPAR) data.

Further evidence of the lack of LTCH hospital manager discretion is shown by the composition of LPPS SSOs below in ***Exhibit 7***. This exhibit shows that 25 percent of LPPS SSO cases end in deaths or are due to patients exhausting their Medicare benefits.

Exhibit 7: Composition of LPPS SSO Cases

	Frequency	Percent
Total SSO Cases	43,214	100%
Number SSO patients because of Mortality	9,516	22%
Number SSO patients because of exhausting Medicare Benefits	1,083	3%

Source: Lewin Group analysis of 2004 Medicare Provider Analysis and Review (MedPAR) data.

Comparison of LPPS case LOS to IPPS case LOS

As noted above, a major feature of the NPRM is to use IPPS payment rules for about 77 percent of SSO cases (and 28 percent of total cases). ***Exhibit 8*** compares the LPPS arithmetic and geometric mean LOS of SSO cases to the IPPS arithmetic and geometric mean LOS. We standardized across DRGs using the frequency of SSO cases. The results show that the LPPS SSO average LOS is about 72 percent higher than the IPPS average LOS and the LPPS geometric mean is about 93 percent higher. ***Appendix B*** provides DRG-specific detail.

Exhibit 8: The Difference In Average and Geometric Mean Length of Stay Between LPPS SSO Cases and IPPS Cases

	Weighted Average Arithmetic Mean LOS	Weighted Average Geometric Mean LOS
LPPS SSO cases	12.7	10.8
All Acute care hospital IPPS cases	7.4	5.6
Percent difference between LTCH SSO and IPPS Hospitals' LOS	72%	93%

* Averages are weighted according to the number of LTCH SSO cases.

Source: Lewin Group analysis of the 2004 Medicare Provider Analysis and Review (MedPAR) data.

Distribution of SSO cases by LOS

Given the importance of SSO cases in LPPS payments and CMS' concerns regarding the appropriateness of SSO cases, we thought it would be important to better understand the distribution of LPPS SSO cases. ***Exhibit 9*** shows this distribution by LOS categories (e.g., 1-4, 5-9, etc.). ***Exhibit 9*** also shows the number and percent of deaths by SSO LOS categories.

The exhibit shows a clustering of SSO cases in the 5-9, 10-14 and 15-19 day LOS categories. The 1-4 LOS category represents only 11.5 percent of cases, of which 37.3 percent are deaths. It is interesting to note that about 67 percent of the SSO cases based on the NPRM's outlier definition have a LOS of 10 days or more.

Exhibit 9: Distribution of SSO Cases by LOS and Death Status

	Number of SSO Cases	SSO Percentage of Total Cases	Number of SSO Deaths	Percentage of SSO Cases Ending in Death
Days: 1 - 4	4,968	11.5%	1,855	37.3%
Days: 5 - 9	9,438	21.8%	2,497	26.5%
Days: 10 - 14	12,059	27.9%	2,189	18.2%
Days: 15 - 19	10,190	23.6%	1,658	16.3%
Days: 20 - 24	4,025	9.3%	742	18.4%
Days: 25 - 29	1,890	4.4%	427	22.6%
Days: 30+	644	1.5%	148	23.0%
	43,214	100.0%	9,516	22.0%

Source: Lewin Group analysis of the 2004 Medicare Provider Analysis and Review (MedPAR) data.

Exhibit 10 extends our understanding of the SSO case LOS distribution by showing the percent of LPPS SSO cases below the IPPS geometric mean LOS and between the IPPS geometric mean LOS and the LPPS SSO cut-off point -- 5/6 of the geometric mean of LTCH case distribution.

An interesting point to be drawn from ***Exhibit 10*** is that only 14.5 percent of LPPS SSOs have a LOS less than the IPPS geometric LOS and LPPS payments for these cases represent 10.5 percent of payments. Given that a geometric LOS is approximately a median if LOS is log-normally distributed, one would expect 50 percent, rather than 85.5 percent, of the LPPS SSO cases to fall below the IPPS case geometric mean LOS. This finding supports the previous finding showing that the resource utilization and intensity at LTCH SSO cases are not comparable to IPPS cases within the same DRGs.

Exhibit 10: Distribution of SSO Cases by Length-of-Stay Status

	Number of SSO Cases	Percentage of Total SSO Cases	2007 Proposed Payment	Percentage of Total SSO Cases
Below IPPS GM-LOS	6,257	14.5%	$36,287,702	10.5%
Between IPPS GM-LOS and 5/6 LTCH GM-LOS	36,957	85.5%	$307,973,429	89.5%
Total SSO Cases	43,214	100.0%	$344,261,131	100.0%

Note: Distribution of short-stay outlier (SSOs) cases with length of stay (LOSs) below the IPPS DRG geometric mean length of stay (IPPS GM-LOS) ,and above the IPPS GM-LOS but below the LTCH DRG geometric mean length of stay (LTCH DRG GM-LOS).

Source: Lewin Group analysis of the 2004 Medicare Provider Analysis and Review (MedPAR) data

The above findings suggest that IPPS payment weights are significantly different, and possibly much lower, than those for LPPS SSO cases. We explore this hypothesis in the next section.

Comparing the intensity of LPPS cases to IPPS SSO cases

Exhibit 11 compares the resource use of IPPS cases to LPPS SSO cases for all common DRGs. In this analysis, we used average standardized charge data for LTCH and ACH cases combined and used the CMS methodology for computing relative weights for each LTCH DRG and ACH DRG using a common national average charge denominator.

As ***Exhibit 11*** shows, LPPS SSO cases have mean DRG weights that are 76 percent higher than comparable DRG weights for IPPS cases with DRGs in common to both payment systems, where the corresponding 95 percent confidence intervals do not overlap -- indicating statistical significance at the .05 level or better. This finding suggests that the IPPS payment system is not appropriate for the payment of LPPS SSO cases.

Appendix A contains a comparison of LPPS and IPPS weights by DRG for all LPPS DRGs where there are SSO cases. Out of 183 DRGs, the LTCH weight is greater than the IPPS weight in 173 instances. This, again, contributes to the contention that IPPS payment weights are not appropriate for the payment of LPPS SSO cases.

Exhibit 11: DRG Weight Comparisons for IPPS and LPPS

	DRGs in Common		
	IPPS	**LPPS**	**Percent LPPS>IPPS**
Number of DRGs	183	183	--
Mean DRG Weight	0.8559	1.5074	76
95% Confidence Interval	0.7776 - 0.9342	1.3879 - 1.627	--

Source: Lewin group estimates based on analysis of 2004 Medicare Provider Analysis and Review (MedPAR) data for LPPS data and the Final 2006 After Outliers Removed (AOR) PPS recalibration file for IPPS data.

The calculations underlying ***Exhibit 11*** findings are as follows:

- Eliminate LTCH discharges without a corresponding IPPS DRG weight and those LTCH cases with zero or missing "Total Charges."
- Eliminate outliers in MedPAR for LPPS cases to match discharges in the "after outliers removed" (AOR) IPPS file.
- Calculate standardized charge for each LTCH short stay discharge based on data from the LTCH impact files released with the NPRM to match the standardized amounts in the AOR.
- Calculate a LPPS DRG-level weighted average standardized payment from LTCH MedPAR data, again to match the AOR level of aggregation.

- Calculate an Overall Average Charge (the denominator in the weight calculation) using data from both the AOR file and the MedPAR data.

  The actual weight calculation for LPPS and IPPS case weights was:

$$\frac{\text{WeightedAverageCharge}_{\text{for.either.LPPS.or.IPPS.DRG.cases}}}{\text{OverallAverageCharge}_{\text{fo.both.IPPS.and.LPPS.DRG.cases}}}$$

Another way to view the information contained in ***Exhibit 11*** is to use the calculated LPPS and IPPS weights to create a case-mix index (CMI) for matched LPPS SSO DRG cases and IPPS DRG cases. As ***Exhibit 12*** indicates, the all-short stay case LPPS CMI is 72 percent greater than the comparable IPPS CMI. We also ran this analysis for just those SSOs that would be paid by the LPPS SSO payment clause in the NPRM. In this instance, the LPPS SSO CMI is 109 percent higher than the all-case IPPS CMI. These findings are consistent with above findings indicating that the use of an IPPS payment system to pay for LPPS SSOs is not credible.

Exhibit 12: Comparison of LPPS SSO Case CMI to IPPS CMI for Matching DRGs

Hospital Type	All Short Stays "CMI"	Short Stays Receiving IPPS Payment "CMI"
LPPS SSO Cases	1.7957	2.0592
IPPS	1.0470	0.9873
Percent Difference	72%	109%

Source: Lewin Group analysis of 2004 Medicare Provider Analysis and Review (MedPAR) data for LPPS data and the Final 2006 After Outliers Removed (AOR) PPS recalibration file for IPPS data. Analyses are standardized to the LPPS case frequencies.

Comparison of LPPS SSO case severity to IPPS case severity

Analysts at Avalere Health LLC provided The Lewin Group with a comparison of all patient refined (APR)-DRG severity measures between LPPS SSO cases and IPPS cases. Their findings show that LPPS SSOs have 63 percent of their cases in the highest APR-DRG severity of illness categories as compared to 33 percent for IPPS cases. This information is highly consistent with the Lewin LOS, case-mix intensity and CMI findings.

Summary of SSO analytic findings

The implication of the above SSO analyses is that the use of IPPS payment rates for LPPS SSO cases is inappropriate because the cost and resource characteristics of IPPS cases and LPPS SSO cases within the same DRG are quite different from each other. We have shown that SSO case LOS, intensity and APR/DRG severity measures are higher than for comparable IPPS DRGs on a DRG-by-DRG and overall aggregate basis. Thus, IPPS DRG payment rates fail to meet the

statutory requirement in Section 123 of the Balanced Budget Refinement Act (BBRA) of 1999 that payments "reflect differences in patient resource use and cost," since they do not reflect either differences across, or absolute amounts in, LTCH patient resource use or cost for a given LTCH SSO DRG case or cases.

Margins for LPPS SSO Cases

The analyses presented thus far for LPPS SSO cases are striking in their portrayal of the differences between LPPS SSO cases and the IPPS cases upon which IPPS payment weights and IPPS payments are based. Given the fact that IPPS case LOS, intensity, CMI and severity are so far below corresponding measures for LPPS cases, one would expect that a system of LPPS SSO payments based on IPPS payment rules and amounts would be far less than actual LPPS SSO case costs. ***Exhibit 13*** shows that this is the case. Overall, the LPPS payment margin for LPPS SSO cases is -81.2 percent. If this were only for a few cases, this could be considered an anomaly, but, as shown above, SSO cases represent about 40 percent of LPPS cases. This would appear to be a critical flaw of the NPRM's proposed LPPS payment system. On a per-case basis, payments are $8,042.22 per case while costs are $14,581.61 per case.

Exhibit 13: Margin of LTCH PPS SSO cases for 2007 (Estimates)

LTCH Classification	Number of SSO Cases	Proposed 2007 Payment Per-case	Estimated Cost Per-case	Margin
All Providers	42,556	$8,048	$14,582	-81.2%
By Location				
Rural	852	$6,916	$11,727	-69.6%
Large Urban	26,586	$8,194	$14,681	-79.2%
Other Urban	15,118	$7,855	$14,567	-85.5%
By Ownership Control				
Government	721	$6,528	$14,181	-117.2%
Proprietary	29,866	$8,260	$14,746	-78.5%
Unknown	1,767	$7,509	$14,822	-97.4%
Voluntary	10,202	$7,631	$14,087	-84.6%
By Bed Size				
Beds: 0 - 24	1,781	$9,173	$16,581	-80.8%
Beds: 25 - 49	16,496	$8,228	$14,709	-78.8%
Beds: 50 - 74	7,711	$8,524	$15,379	-80.4%
Beds: 75 - 124	7,205	$8,034	$14,669	-82.6%
Beds: 125 - 199	4,893	$7,047	$13,331	-89.2%
Beds: 200 +	4,470	$7,234	$13,169	-82.0%

Source: Lewin Group analysis of the 2004 Medicare Provider Analysis and Review (MedPAR) data, and the proposed 2007 changes as outlined in *Federal Register* 71, No. 18 on January 27, 2006.

E. Long Term Care Hospital Referrals from "Single-Source Acute Hospitals"

The NPRM[3] notes that LTCHs frequently receive more than 25 percent of their referrals from a single acute care hospital, regardless of whether there is some common ownership or other formal affiliation between them. Prior Lewin Group analyses indicate that 66.0 percent of free-standing LTCHs receive 25 percent or more of their admissions from a single acute care hospital.[4] This report also notes that 93.7 percent of free-standing rehabilitation hospitals receive 25 percent or more of their admissions from a single acute care hospital. The Lewin Group conclusion from these statistics was that the RY NPRM proposal for a "25 percent admission restriction would impair existing patterns of post-acute care referrals." The 25 percent rule appears arbitrary in its selection of the 25 percent threshold and ignores the way post-acute care referrals have evolved, where one or two hospitals provide the majority of referrals for a given post-acute care provider.

F. Research Triangle Institute, International Report Summary

The Research Triangle Institute, International (RTI) section of the NPRM[5] presents a summary of RTI's preliminary report. The RTI report was commissioned by CMS to assess selected recommendations from the June 2004 Medicare Payment Advisory Commission (MedPAC) Report to Congress. In particular:

1. Define LTCHs by locality and patient criteria to ensure that patients admitted to LTCH facilities are medically complex and have a good chance of improvement.
2. Expand the statement of work for Quality Improvement Organizations (QIO) to enable them to monitor LTCH compliance with any newly-established hospital and patient criteria.

The report's stated goal is to "assist CMS in the development of criteria for assuring appropriate and cost-effective use of LTCHs in the Medicare program."[6] In particular, RTI investigated the "feasibility of developing patient and facility level characteristics for LTCHs, in order to identify and distinguish the role of these hospitals as a Medicare provider."[7] The report indicates that a critical question is "whether the increase (LTCH growth) is due to growing patient demand or industry response to generous payment policies." The report, as summarized in the NPRM, does not definitively answer any of its central questions. CMS' NPRM proposals appear to far outreach the data and conclusions provided by RTI, resulting in an unnecessarily drastic cut in the LTCH payment rates. CMS appears to perceive its proposed pricing scheme as more accurate in providing for appropriate patient selection than the existing use of patient admission criteria by LTCHs. This is an unproven speculation.

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[3] *Federal Register,* Proposed Rules, Vol. 71, No. 18, Friday, January 27, 2006, page 4697.
[4] Unpublished Lewin Group analysis.
[5] *Federal Register,* Proposed Rules, Vol. 71, No. 18, Friday, January 27, 2006, page 4703-4726.
[6] *Federal Register,* Proposed Rules, Vol. 71, No. 18, Friday, January 27, 2006, page 4704.
[7] *Federal Register,* Proposed Rules, Vol. 71, No. 18, Friday, January 27, 2006, page 4704.

The preliminary RTI report provides a summary of LTCH locations and types of patients. It also compares LTCH patients to acute care hospital outlier and other post-acute care patients. LTCH patients are different in numerous ways than acute care outlier patients and patients treated in other post-acute care settings. While the report provides extensive descriptive statistics, it does not, at this time, provide the reader with a sense of what the observed differences mean in regard to the MedPAC recommendations or CMS questions on the appropriateness of growth in LTCHs and case volume or patient placement. A much more detailed analysis than that presented in the NPRM would be required to accomplish this.

For instance, the RTI episode analyses appear not to adjust for selection bias. They also appear to be based on descriptive statistics comparisons. Both Lewin and MedPAC analyses have suggested that these types of descriptive analyses do not accurately identify the relative degree of LTCH episode costs as compared to patient's episode costs in alternative settings.

It is entirely possible to read the summary of the RTI report and conclude that LTCH patients are clinically different from those in acute care and other post-acute care settings and, thus, appropriately placed in LTCHs. To date, the evidence seems open to question on both an empirical and judgmental basis. The report is silent on whether patients "have a good chance of improvement." Without this information and further analyses, there is little basis to conclude that patient placements in LTCHs are not appropriate, rather, there is equal reason to conclude that such LTCH placements represent good value for Trust Fund expenditures.

In order to determine and evaluate levels of care, RTI conducted four types of analyses:

1. Review of existing definitions of intensity for the post-acute care continuum;
2. Review of Medicare certification and conditions of participation for regulations for LTCHs and potential substitute providers;
3. Review of insurance and industry-based definitions of the level of care distinctions that are commonly applied to different Medicare providers; and
4. Review of assessment tools, screening criteria, and intensity measures used by LTCHs to determine appropriateness of admission, intensity of patients served and outcomes expected from treatment.

The RTI report speculates that while the alternative post-acute care settings typically utilize various forms of admission criteria, the accuracy of these criteria, in practice, is not powerful enough to determine "whether a patient belongs in an LTCH or alternative site of care."[8] The report also notes that "proposed levels were already developed by Interqual and other private sector entities, as well as parts of the industry." RTI indicates that more discussion is needed to set specific level of care determinations that include the range of specialists treating these patients.

[8] *Federal Register,* Proposed Rules, Vol. 71, No. 18, Friday, January 27, 2006, page 4726.

With reference to the RTI study, the rule states: "*Although we expect the final RTI report on this project to have a substantial impact on future Medicare policy for LTCHs, we still believe that even with the development of defined patient and perhaps facility-level criteria, that the retention of many of the specific payment adjustment features of the LTCH PPS presently in place may still be both necessary and appropriate for purposes of protecting the integrity of the Medicare Trust Fund. We expect that the RTI's final report will be submitted to us in late Spring 2006.*"[9]

CMS' inference that existing admission criteria are inadequate to appropriately screen LTCH admissions appears not to be supported by the RTI data provided. The data presented show differences between LTCH and acute care setting patients. The degree to which, and how, LTCH admission criteria now in use are not appropriately working is not well detailed in the RTI summary report. Given the data presented, an alternative conclusion could be reached. This is true since the RTI report does not address the issue of whether the clinical protocols employed by LTCH clinicians in caring for their patients produces better clinical outcomes than those that would occur in alternative settings.

The statement that future "defined patient, and perhaps facility-level criteria" will not be adequate to ensure appropriate patient placement is also not supported by the data presented. The NPRM proceeds as if nearly all SSO cases are inappropriately placed. Our analyses above indicate that this is a problematic simplification of the circumstances surrounding SSOs.

Summary Appraisal of RTI Conclusion

The RTI report was commissioned to determine if LTCHs currently use, or could use, patient or facility criteria to ensure that patients admitted to LTCH facilities are medically complex and have a good chance of improvement. The Report Summary presented in the NPRM indicates that LTCH patients are complex, but it is not definitive on whether LTCHs "earn" their higher payment rates. The data presented are not necessarily supportive of the CMS conclusion that existing evidence implies that administered price incentives are required to somehow constrain LTCH patient selection. The largest gap in the CMS logic is lack of evidence on whether LTCH patients "have a good chance of improvement." Until CMS has a clearer understanding of this central question, the use of a payment method that does not consider the actual resource use by these patients seems inappropriate from both a potential patient health and access perspective. The range of possible unintended clinical outcomes that could result from the NPRM and CMS' decision to ignore its own rules of averaging is problematic, and inconsistent with CMS' well-tested use of averaging, which has been successfully used in its other PPSs.

[9] *Federal Register,* Proposed Rules, Vol. 71, No. 18, Friday, January 27, 2006, page 4726.

G. Conclusion: The Proposed SSO Policy Disregards the Fundamental Averaging Logic Underlying PPSs

From the very beginning, the CMS PPSs have been based on systems of averaging. This is fundamental to how PPSs work: standard payments allow losses from high-cost cases to be offset by gains on low-cost cases. This allows for resource use is to be covered "on average" across all of a provider's cases for providers of average efficiency. In the original report to Congress for the acute care hospital PPS, the Health Care Financing Administration (HCFA), now CMS, noted that "in a prospective payment system, hospitals are protected from undue financial risk by the process of averaging -- the law of large numbers"[10]; that is, even though there is a wide variation in costs among all cases, the average cost for any particular subset of cases will show much less variation. This 1982 report to Congress notes that averaging can take place within a DRG and across DRGs for any given hospital and further, that averaging, in and of itself, is not adequate to fully protect hospitals from losses due to cost variation. The use of "features that augment this protection," such as outliers and payment pass-throughs for direct and indirect medical education, is also required to maintain solvency.

The RY 2007 NPRM argues that there are too many "short stays" in long-term care hospitals. As we point out elsewhere, because a short stay is defined as a stay shorter than 5/6 of the geometric mean length of stay, short stays account for about the same percentage of cases (40 percent) for both ACH and LTCH stays. By defining a short stay in this manner, it is essentially guaranteed that short stays will account for 40 percent of cases. To systematically exclude these cases from the prospective payment averaging system is to abandon the principle of averaging. It is widely recognized that including these types of cases is necessary to produce appropriate averaging for the IPPS; it is equally necessary for the LPPS.

CMS originally argued that LPPS short stay cases should be paid such that their costs are just covered. This is a retreat from the original IPPS concept of averaging protection through the law of large numbers, but the LTCH industry has adjusted to this. The use of IPPS payment rates to pay for LPPS SSOs is a retreat from the basic notion that PPSs are based on averages such that hospitals win some cases, lose on some others, and, on average, are not placed at undue financial risk. As we note elsewhere, the LTCH SSO cases require more intensive resource use, by about 70 percent, than the cases that underlie the IPPS payment weights. Indeed, the LTCH SSO cases have an approximately 70 percent longer length of stay than comparable DRGs under IPPS. The PPS was designed to provide incentives for hospitals to reduce lengths of stay and increase efficiencies but also to cover costs of hospitals with average efficiencies.

Under the currently proposed rule, averaging is not only taken away – it is reversed. The very cases required to balance the system as averages would be widely underpaid ($14,500 in costs vs. $8,000 in payments), and account for about 40 percent of all LPPS cases. To have 40 percent of cases paid at a –81.2 percent margin, and the other 60 percent paid to barely cover or paid

[10] Schweiker, R.S., "Report to Congress: Hospital Prospective Payment for Medicare," Secretary of the Department of Health and Human Services, December, 1982.

slightly less than costs, is an untenable situation, should CMS intend to ensure the stability of care delivery in the LTCH setting

Thus, from an averaging perspective, the NPRM approach is inconsistent with the underlying principles that make PPSs fair and equitable.

Appendix A
Comparison of LTCH and ACH DRG Weights by DRG for All SSO Cases

Diagnosis Related Group (DRG)	Number of LTCH Cases	LTCH DRG Weight	Number of ACH Cases	ACH DRG Weight	Diff Between LTCH and ACH DRG Weight
7	113	3.0390	14,782	1.8486	1.1904
9	58	1.6313	1,724	0.9803	0.6510
10	66	1.4084	18,551	0.8634	0.5450
12	1,750	1.2480	52,059	0.6364	0.6116
13	41	0.9573	7,063	0.5701	0.3872
14	144	1.3218	235,629	0.8744	0.4474
15	57	0.9657	92,689	0.6734	0.2923
16	92	1.2891	9,895	0.8785	0.4105
18	121	1.1752	29,545	0.6990	0.4762
19	11	0.9560	8,485	0.4911	0.4649
20	154	1.7316	6,179	1.8929	(0.1613)
23	15	1.1852	11,165	0.5737	0.6114
24	72	1.2414	58,700	0.7014	0.5400
27	11	1.4511	4,447	0.9317	0.5195
28	60	1.4822	13,952	0.9304	0.5518
34	234	1.3440	23,699	0.6916	0.6524
35	19	0.7638	7,411	0.4428	0.3211
64	43	1.5637	3,109	0.9113	0.6524
65	5	0.7358	39,944	0.4010	0.3348
67	1	3.7672	383	0.5427	3.2245
68	20	1.2358	11,465	0.4555	0.7804
73	26	1.4268	7,654	0.5703	0.8565
75	9	2.6586	43,245	2.1226	0.5360
76	608	4.7632	44,348	1.9640	2.7992
78	111	1.3039	39,220	0.8856	0.4184
79	1,710	1.6891	167,196	1.1133	0.5758
80	47	0.9747	7,929	0.5853	0.3894
82	158	1.2138	63,922	0.9560	0.2578
85	95	1.3759	22,136	0.8299	0.5460
86	2	0.7097	2,226	0.4783	0.2315
87	2,163	1.8007	60,498	0.9348	0.8659
88	2,008	1.2142	398,325	0.6271	0.5871
89	1,864	1.3499	525,617	0.7244	0.6255
90	49	0.8806	47,542	0.4276	0.4530
92	109	1.1902	15,657	0.8374	0.3528
94	25	1.0823	12,763	0.7895	0.2928
96	61	1.2468	56,023	0.5205	0.7263
97	15	0.9493	28,360	0.3840	0.5652
99	143	1.5350	21,198	0.4901	1.0448
100	2	0.5292	8,182	0.3643	0.1648

Comparison of LTCH and ACH DRG Weights by DRG for All SSO Cases (continued)

Diagnosis Related Group (DRG)	Number of LTCH Cases	LTCH DRG Weight	Number of ACH Cases	ACH DRG Weight	Diff Between LTCH and ACH DRG Weight
101	136	1.3668	22,194	0.6030	0.7638
102	2	1.0346	5,584	0.3793	0.6553
113	60	3.8085	39,525	2.0303	1.7783
114	18	2.5241	8,280	1.1460	1.3781
120	185	2.4948	38,097	1.6150	0.8797
121	48	1.3892	162,443	1.0968	0.2924
123	23	1.5470	38,308	1.0915	0.4555
126	208	1.6560	5,371	1.7552	(0.0991)
127	1,400	1.2546	667,674	0.7117	0.5430
130	498	1.3147	88,024	0.6558	0.6589
131	21	0.9300	26,812	0.3926	0.5374
132	161	1.2110	141,313	0.4458	0.7652
133	13	0.8132	8,584	0.3879	0.4253
134	32	1.0708	40,950	0.4152	0.6556
135	50	1.0918	7,749	0.6441	0.4478
138	127	1.0221	206,600	0.5812	0.4409
139	11	0.6227	86,760	0.3600	0.2627
141	24	1.0640	108,038	0.5210	0.5430
142	7	0.6541	52,222	0.4019	0.2522
144	615	1.2835	94,294	0.8529	0.4306
145	11	0.6396	7,277	0.4036	0.2359
148	11	4.3224	133,149	2.3720	1.9504
151	1	2.6289	5,108	0.9111	1.7177
170	46	3.4173	15,615	1.9687	1.4486
171	1	1.9987	1,508	0.8305	1.1682
172	136	1.5401	31,193	0.9517	0.5884
173	5	0.9743	2,456	0.5246	0.4497
174	92	1.2301	249,690	0.6982	0.5320
175	6	0.4560	34,572	0.3895	0.0665
176	15	1.3985	13,384	0.7665	0.6320
179	30	1.5018	13,115	0.7589	0.7429
180	86	1.4414	89,518	0.6716	0.7698
182	323	1.4524	270,142	0.5733	0.8791
183	11	0.7272	90,281	0.4017	0.3255
185	6	1.3115	5,350	0.6053	0.7062
188	470	1.7765	83,496	0.7722	1.0042
189	13	0.8060	13,002	0.4173	0.3887

Comparison of LTCH and ACH DRG Weights by DRG for All SSO Cases (continued)

Diagnosis Related Group (DRG)	Number of LTCH Cases	LTCH DRG Weight	Number of ACH Cases	ACH DRG Weight	Diff Between LTCH and ACH DRG Weight
202	72	1.0629	26,597	0.9130	0.1499
203	51	1.2459	29,851	0.9390	0.3069
204	161	1.6195	65,032	0.8124	0.8070
205	74	1.1771	27,308	0.8414	0.3357
207	35	1.2914	32,486	0.8000	0.4914
211	1	0.1411	29,910	0.8679	(0.7268)
213	50	2.8658	9,941	1.3179	1.5479
217	283	2.8227	17,302	2.0906	0.7321
225	14	2.0605	6,458	0.8165	1.2440
233	24	3.2714	9,955	1.3963	1.8751
235	4	1.1596	5,077	0.5240	0.6356
236	28	1.2198	39,734	0.5049	0.7149
238	565	1.7180	8,853	0.9431	0.7749
239	82	1.1457	45,836	0.7293	0.4164
240	44	1.0881	11,991	0.9164	0.1717
242	122	1.7388	2,575	0.8116	0.9273
243	188	1.0084	95,842	0.5242	0.4841
244	41	1.1881	14,536	0.4989	0.6891
245	14	0.9037	5,794	0.3338	0.5699
246	7	1.1017	1,483	0.4229	0.6788
247	27	0.8153	20,262	0.3991	0.4162
248	71	1.1231	13,801	0.5982	0.5249
249	1,922	1.1332	12,889	0.4698	0.6634
253	17	1.0099	21,978	0.5279	0.4820
254	3	0.5843	10,705	0.3110	0.2733
256	174	1.5773	6,679	0.5704	1.0070
263	1,079	2.8294	23,018	1.4324	1.3970
264	58	1.6955	3,859	0.7394	0.9561
265	26	2.2588	4,097	1.1148	1.1441
269	140	3.0307	9,800	1.2373	1.7933
271	2,001	1.6761	19,129	0.7163	0.9599
272	22	1.1947	5,696	0.7094	0.4852
274	9	1.7102	2,283	0.8063	0.9039
277	701	1.2173	99,585	0.6089	0.6085
278	78	0.7974	31,973	0.3775	0.4199
280	59	1.0462	17,758	0.4956	0.5506
281	3	0.2868	7,518	0.3393	(0.0526)
283	23	1.3608	6,010	0.5101	0.8507
285	27	3.2003	6,942	1.4518	1.7485
287	121	2.3060	6,223	1.3171	0.9888
294	244	1.4007	97,377	0.5410	0.8596
296	411	1.3599	277,113	0.5988	0.7611
297	25	0.7324	47,860	0.3537	0.3787

Comparison of LTCH and ACH DRG Weights by DRG for All SSO Cases (continued)

Diagnosis Related Group (DRG)	Number of LTCH Cases	LTCH DRG Weight	Number of ACH Cases	ACH DRG Weight	Diff Between LTCH and ACH DRG Weight
300	25	1.0277	18,635	0.7665	0.2612
301	3	0.8190	3,592	0.4293	0.3897
315	135	2.8792	34,014	1.4505	1.4287
316	853	1.4338	118,639	0.9037	0.5301
317	24	1.4998	2,029	0.5932	0.9066
318	16	1.5144	5,737	0.8261	0.6883
320	438	1.3191	185,666	0.6115	0.7076
321	47	0.9245	30,824	0.3951	0.5295
331	155	1.4582	51,130	0.7395	0.7188
332	6	0.6851	4,964	0.4171	0.2680
334	1	2.3165	10,503	1.0330	1.2834
346	14	1.1964	4,823	0.7118	0.4846
350	30	1.2172	6,669	0.5139	0.7033
357	1	1.4275	5,609	1.5861	(0.1586)
366	22	1.3991	4,555	0.8907	0.5084
368	21	1.5966	3,547	0.8121	0.7845
395	71	1.4058	106,920	0.5770	0.8288
397	38	1.4092	18,865	0.8811	0.5280
398	27	1.2725	18,054	0.8609	0.4117
403	113	1.3262	31,718	1.2678	0.0584
409	65	1.7428	2,155	0.8678	0.8750
413	28	1.4028	5,303	0.9209	0.4820
415	333	2.9569	43,248	2.5272	0.4297
416	1,551	1.5416	190,961	1.1082	0.4335
418	652	1.5435	25,757	0.7420	0.8015
421	26	1.6616	10,646	0.5206	1.1409
423	130	1.6837	8,039	1.2646	0.4192
425	11	0.5728	16,028	0.4726	0.1001
426	12	0.4620	4,549	0.3544	0.1076
428	3	0.7784	793	0.5080	0.2705
429	96	1.2124	27,000	0.5679	0.6445
430	724	0.8735	64,921	0.4732	0.4003
431	8	0.6812	316	0.4605	0.2207
432	1	0.1442	448	0.4542	(0.3099)
439	16	2.6165	1,516	1.2242	1.3924
440	123	2.5308	5,775	1.3162	1.2145
442	37	3.1882	17,534	1.6867	1.5015
443	2	0.4440	3,910	0.6826	(0.2386)
444	40	1.5246	5,723	0.5211	1.0035
445	3	0.8830	2,544	0.3498	0.5332

Comparison of LTCH and ACH DRG Weights by DRG for All SSO Cases (continued)

Diagnosis Related Group (DRG)	Number of LTCH Cases	LTCH DRG Weight	Number of ACH Cases	ACH DRG Weight	Diff Between LTCH and ACH DRG Weight
452	573	1.7898	25,608	0.7280	1.0618
453	22	1.1296	5,670	0.3566	0.7730
461	231	2.6655	4,964	0.8157	1.8498
462	1,528	1.1667	9,653	0.6749	0.4918
463	248	0.9982	26,785	0.4779	0.5203
464	34	0.7624	7,137	0.3473	0.4151
465	335	1.0854	197	0.6196	0.4658
466	1,629	1.1684	1,716	0.5641	0.6044
468	325	4.2355	51,309	2.6472	1.5884
473	22	1.5193	8,064	2.4235	(0.9042)
475	4,959	3.4036	109,073	2.5009	0.9027
477	119	2.9505	26,262	1.3152	1.6353
482	1	3.6175	5,284	2.4243	1.1932
484	1	2.3226	345	3.7689	(1.4463)
487	10	1.3611	3,885	1.3904	(0.0293)
489	113	1.7921	13,365	1.2968	0.4953
490	27	1.1293	5,439	0.7331	0.3962
508	10	1.4059	622	0.9554	0.4505
510	14	1.3835	1,634	0.8220	0.5615
521	13	0.5523	30,580	0.4956	0.0567
523	2	0.4695	15,190	0.2756	0.1939
524	10	0.8570	131,223	0.5104	0.3466
537	11	3.1824	6,861	1.2683	1.9142

Appendix B
Short Stays and Mean Length of Stays by DRG based on 2004 MedPAR Data

		All LTC Hospitals				CMS Nominal			
			Short	Short Stays Only		Short-Stay	LTH	Acute	
DRG	DRG Name	Cases	Stays	ALOS	GMLOS	Threshold*	GMLOS	GMLOS	ALOS
1	Craniotomy Age >17 W CC	2	0			32.1	38.5	7.6	10.1
7	Periph & Cranial Nerve & Other Nerv Syst	330	114	23.3	22.3	31.4	37.7	6.7	9.7
8	Periph & Cranial Nerve & Other Nerv Syst	4	1	4.0	4.0	20.7	24.8	2	3
9	Spinal Dis & Injuries	168	59	17.3	14.4	28.1	33.7	4.5	6.4
10	Nervous System Neoplasms W CC	242	101	11.5	9.8	20.4	24.5	4.6	6.2
11	Nervous System Neoplasms w/o CC	17	7	11.1	9.0	17.8	21.3	2.9	3.8
12	Degenerative Nervous System Dis	5843	1811	12.8	10.9	21.3	25.5	4.3	5.5
13	Multiple Sclerosis & Cerebellar Ataxia	111	42	11.3	10.1	19.3	23.1	4	5
14	Intracranial Hemorrhage or Cerebral Infarc	433	151	12.7	10.2	21.7	26	4.5	5.8
15	Nonspecific Cva & Precerebral Occlusion	156	64	10.6	7.8	22.3	26.8	3.7	4.6
16	Nonspecific Cerebrovascular Dis W CC	261	95	10.1	8.3	19.6	23.5	5	6.5
17	Nonspecific Cerebrovascular Dis w/o CC	10	5	7.2	5.7	15.8	19	2.5	3.2
18	Cranial & Peripheral Nerve Dis W CC	327	122	11.2	9.7	19.7	23.6	4.1	5.3
19	Cranial & Peripheral Nerve Dis w/o CC	31	12	11.3	9.9	17.7	21.2	2.7	3.5
20	Nervous System Infection Ex Viral Mening	408	159	14.1	12.4	22.7	27.2	8	10.4
21	Viral Meningitis	9	2	17.5	17.3	20.7	24.8	4.9	6.3
22	Hypertensive Encephalopathy	6	3	10.0	9.7	24.7	29.6	4	5.2
23	Nontraumatic Stupor & Coma	49	17	10.6	9.7	21.2	25.4	3	3.9
24	Seizure & Headache Age >17 W CC	194	78	10.9	9.6	18.8	22.6	3.6	4.8
25	Seizure & Headache Age >17 w/o CC	22	12	7.5	5.6	15.8	19	2.5	3.1
27	Traumatic Stupor & Coma, Coma >1 Hr	32	12	15.4	14.6	22.6	27.1	3.2	5.2
28	Traumatic Stupor & Coma, Coma <1 Hr A	158	64	14.9	12.1	25.2	30.2	4.4	5.9
29	Traumatic Stupor & Coma, Coma <1 Hr A	16	10	9.2	7.9	17.8	21.3	2.6	3.4
31	Concussion Age >17 W CC	3	1	15.0	15.0	20.7	24.8	3	4
34	Other Dis Of Nervous System W CC	606	239	12.2	9.9	21.1	25.3	3.7	4.8
35	Other Dis Of Nervous System w/o CC	59	20	11.1	8.8	20.2	24.2	2.4	3
40	Extraocular Proc Ex Orbit Age >17	3	0			24.7	29.6	3	4.1
44	Acute Major Eye Infections	9	3	10.7	9.9	17.8	21.3	3.9	4.8
46	Other Dis Of The Eye Age >17 W CC	14	10	8.2	7.2	17.8	21.3	3.2	4.2
61	Myringotomy w/Tube Insertion Age >17	1	0			20.7	24.8	3.3	5.4
63	Other Ear, Nose, Mouth & Throat OR Proc	7	2	11.5	4.7	24.7	29.6	3	4.5
64	Ear, Nose, Mouth & Throat Malignancy	140	61	9.9	7.7	21.8	26.2	4.1	6.1
65	Dysequilibrium	11	5	10.4	9.2	15.8	19	2.3	2.8
67	Epiglottitis	1	1	17.0	17.0	20.7	24.8	2.9	3.7
68	Otitis Media & Uri Age >17 W CC	58	23	10.3	9.7	15	18	3.2	4
69	Otitis Media & Uri Age >17 w/o CC	13	5	8.4	7.7	15.8	19	2.5	3
73	Other Ear, Nose, Mouth & Throat Dx Age	54	26	12.2	11.4	18.3	21.9	3.3	4.4
75	Major Chest Proc	21	9	16.3	14.4	32.1	38.5	7.6	9.9
76	Other Resp System OR Proc W CC	1763	628	23.8	21.8	36.6	43.9	8.4	11.1
77	Other Resp System OR Proc w/o CC	2	1	32.0	32.0	32.1	38.5	3.3	4.7
78	Pulmonary Embolism	301	118	11.0	9.8	18.3	21.9	5.4	6.4
79	Respiratory Infections & Inflammations Ag	4494	1747	11.5	9.8	19.1	22.9	6.7	8.5
80	Respiratory Infections & Inflammations Ag	115	53	8.9	6.9	18.1	21.7	4.4	5.5
82	Respiratory Neoplasms	641	334	7.4	5.7	16.8	20.1	5.1	6.8
83	Major Chest Trauma W CC	12	3	11.0	10.3	17.8	21.3	4.2	5.3
84	Major Chest Trauma w/o CC	1	1	4.0	4.0	17.8	21.3	2.6	3.2
85	Pleural Effusion W CC	216	97	10.7	8.8	17.7	21.2	4.8	6.3
86	Pleural Effusion w/o CC	5	2	9.5	8.4	15.8	19	2.8	3.6
87	Pulmonary Edema & Respiratory Failure	5065	2257	11.7	9.4	21.2	25.4	4.9	6.4
88	Chronic Obstructive Pulmonary Disease	5020	2049	9.8	8.5	16.3	19.6	4	4.9
89	Simple Pneumonia & Pleurisy Age >17 W	4861	1924	10.1	8.6	17.3	20.8	4.7	5.7
90	Simple Pneumonia & Pleurisy Age >17 w/o	127	59	8.0	6.9	14.8	17.8	3.2	3.8

Short Stays and Mean Length of Stays by DRG based on 2004 MedPAR Data (continued)

DRG	DRG Name	All LTC Hospitals				CMS Nominal			
			Short	Short Stays Only		Short-Stay	LTH	Acute	
		Cases	Stays	ALOS	GMLOS	Threshold*	GMLOS	GMLOS	ALOS
92	Interstitial Lung Disease W CC	268	116	8.7	7.1	16.8	20.2	4.8	6.1
93	Interstitial Lung Disease w/o CC	7	4	13.3	12.3	17.8	21.3	3.1	3.9
94	Pneumothorax W CC	55	25	8.7	8.1	14.2	17	4.6	6.2
95	Pneumothorax w/o CC	3	2	10.0	8.7	15.8	19	2.9	3.6
96	Bronchitis & Asthma Age >17 W CC	140	65	10.0	8.7	16.2	19.4	3.6	4.4
97	Bronchitis & Asthma Age >17 w/o CC	25	19	7.8	6.3	17.8	21.3	2.8	3.4
99	Respiratory Signs & Symptoms W CC	333	146	10.5	8.4	19.3	23.2	2.4	3.1
100	Respiratory Signs & Symptoms w/o CC	8	2	7.5	3.7	20.7	24.8	1.7	2.1
101	Other Respiratory System Dx W CC	367	137	10.1	8.5	17.6	21.1	3.3	4.3
102	Other Respiratory System Dx w/o CC	3	2	13.5	13.5	15.8	19	2	2.5
110	Major Cardiovascular Proc W CC	3	1	20.0	20.0	20.7	24.8	5.7	8.4
113	Amputation For Circ System Dis Ex Upper	201	65	23.7	22.8	32.8	39.3	10.8	13.7
114	Upper Limb & Toe Amputation For Circ Sy	62	18	18.4	17.3	27.7	33.2	6.7	8.9
115	No Longer Valid	13	0					15.8	15.8
116	No Longer Valid	19	0					9.3	9.3
117	Cardiac Pacemaker Revision Ex Device R	5	3	18.7	18.6	24.7	29.6	2.6	4.2
118	Cardiac Pacemaker Device Replacement	4	2	17.5	17.3	24.7	29.6	2.1	3
119	Vein Ligation & Stripping	1	0			20.7	24.8	3.3	5.5
120	Other Circulatory System OR Proc	606	188	18.2	17.0	26.4	31.7	5.9	9.2
121	Circ Dis w/Ami & Major Comp, Discharged	95	49	11.4	9.4	19.3	23.2	5.3	6.6
122	Circ Dis w/Ami w/o Major Comp, Discharg	10	2	5.0	4.0	17.8	21.3	2.8	3.5
123	Circ Dis w/Ami, Expired	42	23	8.1	7.3	17	20.4	2.9	4.8
124	Circ Dis Ex Ami, w/Card Cath & Complex I	24	13	16.1	12.8	24.7	29.6	3.3	4.4
125	Circ Dis Ex Ami, w/Card Cath w/o Comple	2	1	2.0	2.0	20.7	24.8	2.1	2.7
126	Acute & Subacute Endocarditis	596	210	12.1	10.1	21.1	25.3	9.4	12
127	Heart Failure & Shock	3735	1439	9.7	8.0	17.7	21.2	4.1	5.2
128	Deep Vein Thrombophlebitis	16	4	10.3	8.1	17.8	21.3	4.4	5.2
129	Cardiac Arrest, Unexplained	1	1	5.0	5.0	20.7	24.8	1.7	2.6
130	Peripheral Vascular Dis W CC	1438	507	11.1	9.4	19.3	23.2	4.4	5.5
131	Peripheral Vascular Dis w/o CC	66	23	10.3	9.0	17	20.4	3.2	3.9
132	Atherosclerosis W CC	428	163	10.9	9.1	18.2	21.8	2.2	2.8
133	Atherosclerosis w/o CC	67	43	9.3	8.1	15.8	19	1.8	2.2
134	Hypertension	106	36	11.8	9.7	20.7	24.8	2.4	3.1
135	Cardiac Congenital & Valvular Dis Age >1	152	52	9.7	7.5	19.8	23.7	3.2	4.3
136	Cardiac Congenital & Valvular Dis Age >1	4	2	3.0	2.2	17.8	21.3	2.2	2.8
138	Cardiac Arrhythmia & Conduction Dis W C	300	130	9.7	7.8	17.1	20.5	3	3.9
139	Cardiac Arrhythmia & Conduction Dis w/o	26	13	7.1	5.0	17.8	21.3	2	2.4
140	Angina Pectoris	10	4	6.3	5.3	15.8	19	2	2.4
141	Syncope & Collapse W CC	68	27	9.3	7.7	15.3	18.3	2.7	3.5
142	Syncope & Collapse w/o CC	20	9	9.1	8.6	15.3	18.3	2	2.5
143	Chest Pain	15	8	3.5	2.7	15.8	19	1.7	2.1
144	Other Circulatory System Dx W CC	1552	635	10.6	9.0	18.1	21.7	4.1	5.8
145	Other Circulatory System Dx w/o CC	31	12	7.6	5.6	15.2	18.2	2.1	2.6
148	Major Small & Large Bowel Proc W CC	35	12	25.1	24.3	34.1	40.9	10	12.3
150	Peritoneal Adhesiolysis W CC	2	1	22.0	22.0	24.7	29.6	8.9	11
151	Peritoneal Adhesiolysis w/o CC	1	1	17.0	17.0	17.8	21.3	4	5.1
152	Minor Small & Large Bowel Proc W CC	1	0			20.7	24.8	6.7	8
154	Stomach, Esophageal & Duodenal Proc A	19	7	23.0	21.9	32.1	38.5	9.9	13.3
157	Anal & Stomal Proc W CC	9	3	10.3	10.0	24.7	29.6	4.1	5.8
161	Inguinal & Femoral Hernia Proc Age >17 W	1	0			32.1	38.5	3.1	4.4
168	Mouth Proc W CC	2	1	16.0	16.0	24.7	29.6	3.3	4.9
170	Other Digestive System OR Proc W CC	149	49	20.4	18.3	29.9	35.9	7.8	11

Short Stays and Mean Length of Stays by DRG based on 2004 MedPAR Data (continued)

DRG	DRG Name	All LTC Hospitals				CMS Nominal			
			Short	Short Stays Only		Short-Stay	LTH	Acute	
		Cases	Stays	ALOS	GMLOS	Threshold*	GMLOS	GMLOS	ALOS
171	Other Digestive System OR Proc w/o CC	2	1	15.0	15.0	15.8	19	3.1	4.1
172	Digestive Malignancy W CC	477	242	9.0	7.2	18.2	21.8	5.1	7
173	Digestive Malignancy w/o CC	7	5	10.4	7.2	17.8	21.3	2.7	3.6
174	G.i. Hemorrhage W CC	229	95	10.0	8.0	18.5	22.2	3.8	4.7
175	G.i. Hemorrhage w/o CC	12	8	4.9	2.9	15.8	19	2.4	2.9
176	Complicated Peptic Ulcer	32	15	9.4	8.2	17.9	21.5	4.1	5.2
177	Uncomplicated Peptic Ulcer W CC	15	4	8.5	8.3	20.7	24.8	3.6	4.4
178	Uncomplicated Peptic Ulcer w/o CC	1	0			20.7	24.8	2.6	3.1
179	Inflammatory Bowel Disease	83	30	11.5	9.6	20	24	4.5	5.9
180	G.i. Obstruction W CC	224	88	10.4	8.7	19.6	23.5	4.2	5.4
181	G.i. Obstruction w/o CC	13	6	9.2	6.5	20.7	24.8	2.8	3.3
182	Esophagitis, Gastroent & Misc Digest Dis A	951	337	10.7	9.1	18.8	22.6	3.4	4.4
183	Esophagitis, Gastroent & Misc Digest Dis A	37	16	6.7	6.0	14	16.8	2.3	2.9
185	Dental & Oral Dis Ex Extractions & Restora	25	7	10.1	8.2	20.7	24.8	3.2	4.5
188	Other Digestive System Dx Age >17 W CC	1274	478	11.2	9.6	20	24	4.2	5.6
189	Other Digestive System Dx Age >17 w/o C	39	14	8.9	7.5	15.2	18.2	2.4	3.1
191	Pancreas, Liver & Shunt Proc W CC	17	8	17.4	16.9	24.7	29.6	9	12.9
193	Biliary Tract Proc Ex Only Cholecyst W or	1	0			20.7	24.8	9.9	12.1
195	Cholecystectomy W C.d.e. W CC	1	0			20.7	24.8	8.8	10.6
197	Cholecystectomy Ex By Laparoscope w/o	4	3	11.7	10.0	20.7	24.8	7.5	9.2
200	Hepatobiliary Dxnostic Proc For Non-Malig	2	0			32.1	38.5	6.5	9.8
201	Other Hepatobiliary or Pancreas OR Proc	28	13	24.5	23.9	30.1	36.1	9.9	13.7
202	Cirrhosis & Alcoholic Hepatitis	153	74	8.5	7.0	17.2	20.6	4.7	6.2
203	Malignancy Of Hepatobiliary System or Pa	272	154	7.4	5.6	16.3	19.5	4.9	6.5
204	Dis Of Pancreas Ex Malignancy	426	167	10.6	9.2	18.9	22.7	4.2	5.6
205	Dis Of Liver Ex Malig,Cirr,Alc Hepa W CC	190	77	9.3	7.6	17.1	20.5	4.4	6
206	Dis Of Liver Ex Malig,Cirr,Alc Hepa w/o CC	9	5	10.0	9.1	17.8	21.3	3	3.9
207	Dis Of The Biliary Tract W CC	80	36	9.9	8.3	17.9	21.5	4.1	5.3
208	Dis Of The Biliary Tract w/o CC	1	0			17.8	21.3	2.3	2.9
210	Hip & Femur Proc Ex Major Joint Age >17	21	6	21.5	20.5	32.1	38.5	6.1	6.9
211	Hip & Femur Proc Ex Major Joint Age >17	2	1	2.0	2.0	24.7	29.6	4.4	4.7
213	Amputation For Musculoskeletal System &	170	53	20.3	19.0	28.3	34	7.2	9.7
216	Biopsies Of Musculoskeletal System & Co	18	5	18.2	17.8	24.7	29.6	3.3	5.8
217	Wnd Debrid & Skn Grft Ex Hand,For Musc	962	292	22.6	21.1	31.7	38	9.3	13.2
218	Lower Extrem & Humer Proc Ex Hip,Foot,	17	10	24.7	24.0	32.1	38.5	4.4	5.6
219	Lower Extrem & Humer Proc Ex Hip,Foot,	1	0			15.8	19	2.6	3.1
223	Major Shoulder/elbow Proc, or Other Uppe	3	0			20.7	24.8	2.3	3.2
225	Foot Proc	34	14	16.8	14.3	23.7	28.4	3.7	5.2
226	Soft Tissue Proc W CC	43	15	17.9	17.3	24.6	29.5	4.5	6.5
227	Soft Tissue Proc w/o CC	3	2	10.0	4.4	20.7	24.8	2.1	2.6
228	Major Thumb or Joint Proc,or Oth Hand or	10	3	11.7	11.5	24.7	29.6	2.8	4.1
230	Local Excision & Removal Of Int Fix Devic	5	2	29.5	29.5	32.1	38.5	3.7	5.6
233	Other Musculoskelet Sys & Conn Tiss OR	59	24	21.3	19.9	28.8	34.6	4.6	6.8
235	Fractures Of Femur	20	5	14.2	14.1	20.7	24.8	3.8	4.8
236	Fractures Of Hip & Pelvis	123	37	11.1	9.0	21	25.2	3.8	4.6
237	Sprains, Strains, & Dislocations Of Hip, Pe	6	2	12.5	12.2	15.8	19	3	3.7
238	Osteomyelitis	1820	576	14.7	12.8	23.6	28.3	6.7	8.7
239	Pathological Fractures & Musculoskeletal	262	104	10.6	8.7	19.7	23.6	5	6.2
240	Connective Tissue Dis W CC	122	45	10.7	8.8	20.7	24.8	5	6.7

Short Stays and Mean Length of Stays by DRG based on 2004 MedPAR Data (continued)

DRG	DRG Name	All LTC Hospitals				CMS Nominal			
			Short	Short Stays Only		Short-Stay	LTH	Acute	
		Cases	Stays	ALOS	GMLOS	Threshold*	GMLOS	GMLOS	ALOS
241	Connective Tissue Dis w/o CC	13	3	10.7	10.3	15.8	19	3	3.7
242	Septic Arthritis	364	127	14.5	12.5	22.1	26.5	5.1	6.7
243	Medical Back Problems	620	191	11.8	10.1	19.5	23.4	3.6	4.5
244	Bone Diseases & Specific Arthropathies W	151	45	12.9	12.0	18.5	22.2	3.6	4.5
245	Bone Diseases & Specific Arthropathies w	54	14	10.5	9.7	17	20.4	2.5	3.1
246	Non-Specific Arthropathies	25	8	9.9	8.8	15.8	19	2.8	3.6
247	Signs & Symptoms Of Musculoskeletal Sy	70	28	10.5	9.5	18.3	21.9	2.6	3.3
248	Tendonitis, Myositis & Bursitis	364	158	10.7	9.5	18.8	22.6	3.8	4.8
249	Aftercare, Musculoskeletal System & Conr	6290	1967	12.8	11.3	20.6	24.7	2.7	3.9
250	Fx, Sprn, Strn & Disl Of Forearm, Hand, F	11	4	8.8	6.1	17.8	21.3	3.2	3.9
251	Fx, Sprn, Strn & Disl Of Forearm, Hand, F	4	2	14.5	14.5	15.8	19	2.3	2.8
253	Fx, Sprn, Strn & Disl Of Uparm,Lowleg Ex	66	21	11.7	10.1	21.9	26.3	3.8	4.6
254	Fx, Sprn, Strn & Disl Of Uparm,Lowleg Ex	13	4	7.0	4.7	17.8	21.3	2.6	3.1
256	Other Musculoskeletal System & Connecti	495	178	12.9	11.2	21.1	25.3	3.9	5.1
259	Subtotal Mastectomy For Malignancy W C	1	0			17.8	21.3	1.8	2.8
261	Breast Proc For Non-Malignancy Ex Biops	2	2	1.0	1.0	20.7	24.8	1.6	2.2
262	Breast Biopsy & Local Excision For Non-M	1	1	15.0	15.0	15.8	19	3.3	4.8
263	Skin Graft &/or Debrid For Skn Ulcer or Ce	3781	1100	21.4	19.5	32.9	39.5	8.6	11.4
264	Skin Graft &/or Debrid For Skn Ulcer or Ce	175	60	16.6	14.7	26.7	32	5	6.5
265	Skin Graft &/or Debrid Ex For Skin Ulcer o	88	26	20.5	19.9	27.6	33.1	4.4	6.8
266	Skin Graft &/or Debrid Ex For Skin Ulcer o	7	3	8.3	4.8	20.7	24.8	2.3	3.2
268	Skin, Subcutaneous Tissue & Breast Plast	6	4	10.3	4.1	32.1	38.5	2.4	3.5
269	Other Skin, Subcut Tiss & Breast Proc W	445	142	20.6	19.2	30.1	36.1	6.2	8.6
270	Other Skin, Subcut Tiss & Breast Proc w/o	12	3	8.7	6.6	20.7	24.8	2.7	3.9
271	Skin Ulcers	5697	2054	13.1	10.9	23.1	27.7	5.6	7.1
272	Major Skin Dis W CC	78	33	10.2	7.8	18.8	22.6	4.5	5.9
273	Major Skin Dis w/o CC	5	3	10.7	10.5	15.8	19	2.9	3.7
274	Malignant Breast Dis W CC	81	42	10.8	8.2	20.7	24.8	4.7	6.3
276	Non-Malignant Breast Dis	13	9	11.7	10.2	17.8	21.3	3.5	4.5
277	Cellulitis Age >17 W CC	1921	724	10.7	9.4	17.5	21	4.6	5.6
278	Cellulitis Age >17 w/o CC	201	82	8.9	7.4	14.8	17.8	3.4	4.1
280	Trauma To The Skin, Subcut Tiss & Breas	185	62	11.5	9.4	20.3	24.3	3.2	4.1
281	Trauma To The Skin, Subcut Tiss & Breas	19	4	3.3	2.7	15.8	19	2.3	2.9
283	Minor Skin Dis W CC	74	25	12.9	11.2	19.9	23.9	3.5	4.6
284	Minor Skin Dis w/o CC	8	6	6.3	5.1	15.8	19	2.4	3
285	Amputat Of Lower Limb For Endocrine,Nu	102	27	19.8	18.7	29.7	35.6	8.2	10.5
287	Skin Grafts & Wound Debrid For Endoc, N	402	123	19.2	17.8	28.3	33.9	7.8	10.4
288	OR Proc For Obesity	12	4	11.0	8.1	24.7	29.6	3.2	4.1
290	Thyroid Proc	1	0			32.1	38.5	1.6	2.1
292	Other Endocrine, Nutrit & Metab OR Proc	36	12	13.4	11.3	26.4	31.7	7.3	10.3
293	Other Endocrine, Nutrit & Metab OR Proc	1	0			17.8	21.3	3.2	4.5
294	Diabetes Age >35	814	252	12.1	10.6	20.8	25	3.3	4.3
295	Diabetes Age 0-35	16	8	9.1	6.6	20.7	24.8	2.8	3.7
296	Nutritional & Misc Metabolic Dis Age >17 V	1203	433	10.9	9.2	19.3	23.1	3.7	4.8
297	Nutritional & Misc Metabolic Dis Age >17 v	54	30	7.5	5.6	15.3	18.4	2.5	3.1
299	Inborn Errors Of Metabolism	22	17	11.2	8.7	24.7	29.6	3.7	5.2
300	Endocrine Dis W CC	76	30	10.1	9.0	17.7	21.2	4.6	6

Short Stays and Mean Length of Stays by DRG based on 2004 MedPAR Data (continued)

DRG	DRG Name	All LTC Hospitals				CMS Nominal			
			Short	Short Stays Only		Short-Stay	LTH	Acute	
		Cases	Stays	ALOS	GMLOS	Threshold*	GMLOS	GMLOS	ALOS
301	Endocrine Dis w/o CC	13	5	10.6	9.7	15.8	19	2.7	3.4
303	Kidney,Ureter & Major Bladder Proc For N	2	1	21.0	21.0	24.7	29.6	5.8	7.4
304	Kidney,Ureter & Major Bladder Proc For N	9	4	18.5	16.5	32.1	38.5	6.1	8.6
305	Kidney,Ureter & Major Bladder Proc For N	1	1	9.0	9.0	15.8	19	2.6	3.2
306	Prostatectomy W CC	3	0			17.8	21.3	3.6	5.5
308	Minor Bladder Proc W CC	9	2	13.0	12.0	20.7	24.8	3.9	6.1
310	Transurethral Proc W CC	9	2	16.5	16.3	24.7	29.6	3	4.5
312	Urethral Proc, Age >17 W CC	2	1	15.0	15.0	15.8	19	3.2	4.8
315	Other Kidney & Urinary Tract OR Proc	364	137	18.0	16.7	26.3	31.6	3.6	6.8
316	Renal Failure	2384	886	10.0	8.3	18.9	22.7	4.9	6.4
317	Admit For Renal Dialysis	77	24	10.3	7.6	21	25.2	2.4	3.5
318	Kidney & Urinary Tract Neoplasms W CC	100	47	8.2	6.4	16.8	20.2	4.2	5.8
319	Kidney & Urinary Tract Neoplasms w/o CC	1	0			15.8	19	2.1	2.8
320	Kidney & Urinary Tract Infections Age >17	1353	467	11.0	9.7	18.5	22.2	4.2	5.2
321	Kidney & Urinary Tract Infections Age >17	116	53	9.9	8.6	15.8	19	3	3.6
323	Urinary Stones W CC, &/or Esw Lithotripsy	13	8	18.0	16.6	24.7	29.6	2.3	3.1
325	Kidney & Urinary Tract Signs & Symptoms	20	8	9.5	8.6	17.8	21.3	2.9	3.7
326	Kidney & Urinary Tract Signs & Symptoms	3	2	11.5	11.4	15.8	19	2.1	2.6
328	Urethral Stricture Age >17 W CC	1	0			15.8	19	2.6	3.5
331	Other Kidney & Urinary Tract Dx Age >17	415	162	10.7	9.1	19.3	23.1	4.1	5.5
332	Other Kidney & Urinary Tract Dx Age >17	17	6	9.0	8.1	17.8	21.3	2.4	3.1
334	Major Male Pelvic Proc W CC	1	1	15.0	15.0	17.8	21.3	3.5	4.3
336	Transurethral Prostatectomy W CC	2	0			17.8	21.3	2.5	3.3
339	Testes Proc, Non-Malignancy Age >17	8	2	15.5	15.4	24.7	29.6	3.2	5.1
341	Penis Proc	3	0			24.7	29.6	1.9	3.2
344	Other Male Reproductive System OR Proc	2	2	12.5	12.4	15.8	19	1.7	2.7
345	Other Male Reproductive System OR Proc	17	6	15.8	12.7	32.1	38.5	3.1	4.8
346	Malignancy, Male Reproductive System, W	97	50	8.0	6.2	17.2	20.6	4.2	5.7
347	Malignancy, Male Reproductive System, w	1	0			17.8	21.3	2.2	3.1
348	Benign Prostatic Hypertrophy W CC	4	0			17.8	21.3	3.2	4.1
350	Inflammation Of The Male Reproductive S	74	32	11.3	9.7	18.3	21.9	3.5	4.5
352	Other Male Reproductive System Dx	28	10	11.0	9.2	19.5	23.4	2.9	4
357	Uterine & Adnexa Proc For Ovarian or Adr	1	1	7.0	7.0	24.7	29.6	6.5	8.1
360	Vagina, Cervix & Vulva Proc	2	0			24.7	29.6	2	2.6
364	D&C, Conization Ex For Malignancy	1	0			32.1	38.5	3	4.2
365	Other Female Reproductive System OR P	9	2	29.0	28.8	32.1	38.5	5.3	7.7
366	Malignancy, Female Reproductive System	95	44	7.9	6.1	16.9	20.3	4.8	6.6
367	Malignancy, Female Reproductive System	1	1	2.0	2.0	20.7	24.8	2.3	3
368	Infections, Female Reproductive System	50	21	12.4	11.9	17.3	20.7	5.2	6.7
369	Menstrual & Other Female Reproductive S	14	3	10.0	8.3	20.7	24.8	2.4	3.3
394	Other OR Proc Of The Blood And Blood F	9	6	21.3	20.6	32.1	38.5	4.5	7.4
395	Red Blood Cell Dis Age >17	185	74	10.5	8.4	18.3	22	3.2	4.3
397	Coagulation Dis	87	39	10.4	9.0	19.1	22.9	3.7	5.1
398	Reticuloendothelial & Immunity Dis W CC	72	31	11.9	10.6	19.8	23.7	4.4	5.7
399	Reticuloendothelial & Immunity Dis w/o CC	4	1	13.0	13.0	17.8	21.3	2.7	3.3
401	Lymphoma & Non-Acute Leukemia W Oth	11	3	9.0	8.4	32.1	38.5	8	11.3

Short Stays and Mean Length of Stays by DRG based on 2004 MedPAR Data (continued)

DRG	DRG Name	All LTC Hospitals				CMS Nominal			
			Short	Short Stays Only		Short-Stay	LTH	Acute	
		Cases	Stays	ALOS	GMLOS	Threshold*	GMLOS	GMLOS	ALOS
403	Lymphoma & Non-Acute Leukemia W CC	345	159	8.6	7.0	17.8	21.3	5.8	8.1
404	Lymphoma & Non-Acute Leukemia w/o CC	13	9	5.0	4.1	17.8	21.3	3	4.2
406	Myeloprolif Disord or Poorly Diff Neopl w/M	2	1	20.0	20.0	24.7	29.6	7	9.9
408	Myeloprolif Disord or Poorly Diff Neopl w/C	6	2	16.5	15.6	24.7	29.6	4.8	8.2
409	Radiotherapy	160	66	12.5	11.1	19.6	23.5	4.3	5.8
410	Chemotherapy w/o Acute Leukemia As Se	40	18	15.9	15.2	22	26.4	3	3.8
413	Other Myeloprolif Dis or Poorly Diff Neopl I	137	71	8.8	6.6	17.1	20.5	5	6.8
415	OR Proc For Infectious & Parasitic Diseas	984	338	20.0	18.6	29.7	35.6	11	14.8
416	Septicemia Age >17	4195	1602	10.7	8.8	19.6	23.5	5.6	7.5
418	Postoperative & Post-Traumatic Infections	1906	666	12.1	10.5	20.6	24.7	4.8	6.2
419	Fever Of Unknown Origin Age >17 W CC	20	11	12.5	10.1	24.7	29.6	3.4	4.4
420	Fever Of Unknown Origin Age >17 w/o CC	1	1	5.0	5.0	24.7	29.6	2.7	3.4
421	Viral Illness Age >17	61	26	15.6	13.4	22.8	27.3	3.1	4.1
423	Other Infectious & Parasitic Diseases Dx	322	135	10.7	9.1	18.2	21.8	6	8.4
424	OR Proc w/Principal Dx Of Mental Illness	9	1	13.0	13.0	20.7	24.8	7.3	12.4
425	Acute Adjustment Reaction & Psychosocia	36	17	8.6	7.3	17.8	21.3	2.6	3.5
426	Depressive Neuroses	70	24	7.0	5.2	17.3	20.7	3	4.1
427	Neuroses Ex Depressive	35	15	10.1	7.7	19.8	23.8	3.2	4.7
428	Dis Of Personality & Impulse Control	15	4	9.3	8.7	15.8	19	4.6	7.3
429	Organic Disturbances & Mental Retardatio	422	143	14.7	12.9	22.3	26.8	4.3	5.6
430	Psychoses	2401	1025	12.8	10.8	20.2	24.2	5.8	7.9
431	Childhood Mental Dis	20	8	11.0	10.4	15.8	19	4	5.9
432	Other Mental Dis Dx	4	1	3.0	3.0	17.8	21.3	2.9	4.3
433	Alcohol/drug Abuse or Dependence, Left A	3	2	4.0	3.5	17.8	21.3	2.2	3
439	Skin Grafts For Injuries	50	16	19.4	18.3	29.7	35.6	5.4	8.9
440	Wound Debridements For Injuries	370	124	20.0	17.8	30.1	36.1	5.9	9.2
441	Hand Proc For Injuries	3	3	8.7	8.2	15.8	19	2.3	3.4
442	Other OR Proc For Injuries W CC	103	37	20.0	18.8	27.8	33.4	6	8.9
443	Other OR Proc For Injuries w/o CC	5	2	1.0	1.0	20.7	24.8	2.6	3.4
444	Traumatic Injury Age >17 W CC	124	40	13.5	11.8	21.9	26.3	3.2	4.1
445	Traumatic Injury Age >17 w/o CC	17	4	10.8	10.3	15.8	19	2.2	2.8
447	Allergic Reactions Age >17	3	1	9.0	9.0	17.8	21.3	1.9	2.6
449	Poisoning & Toxic Effects Of Drugs Age >	28	10	9.4	5.8	20.7	24.8	2.6	3.7
452	Complications Of Treatment W CC	1495	585	13.3	11.4	21.1	25.3	3.5	4.9
453	Complications Of Treatment w/o CC	60	22	10.8	9.2	19.8	23.8	2.2	2.8
454	Other Injury, Poisoning & Toxic Effect Dx V	10	3	14.3	13.5	20.7	24.8	2.9	4.1
455	Other Injury, Poisoning & Toxic Effect Dx w	1	1	5.0	5.0	20.7	24.8	1.7	2.2
461	OR Proc w/Dx Of Other Contact w/Health	689	239	20.0	18.0	28.3	34	3	5.1
462	Rehabilitation	5174	1748	11.2	9.7	18.7	22.4	8.9	10.8
463	Signs & Symptoms W CC	899	251	10.9	9.3	19.8	23.8	3.1	3.9
464	Signs & Symptoms w/o CC	114	34	9.0	6.7	20.1	24.1	2.4	2.9
465	Aftercare w/History Of Malignancy As Sec	870	336	10.9	9.5	18.3	21.9	2.4	3.8
466	Aftercare w/o History Of Malignancy As Se	4531	1680	10.8	9.3	18.3	21.9	2.8	5.3
467	Other Factors Influencing Health Status	9	6	8.3	5.9	20.7	24.8	2	2.7
468	Extensive OR Proc Unrelated To Principal	945	338	22.6	21.1	33.5	40.2	9.7	13.2
471	Bilateral or Multiple Major Joint Procs Of L	2	0			32.1	38.5	4.5	5.1
473	Acute Leukemia w/o Major OR Proc Age >	74	42	7.3	5.2	16.7	20	7.4	12.7
475	Respiratory System Dx With Ventilator Sup	13171	5182	14.5	11.4	28.8	34.6	8.1	11.3
476	Prostatic OR Proc Unrelated To Principal D	26	8	18.9	16.9	24.7	29.6	7.4	10.5
477	Non-Extensive OR Proc Unrelated To Prin	361	123	19.8	17.8	29.4	35.3	5.8	8.7
478	No Longer Valid	122	0					0	0

Short Stays and Mean Length of Stays by DRG based on 2004 MedPAR Data (continued)

DRG	DRG Name	All LTC Hospitals				CMS Nominal			
		Cases	Short Stays	Short Stays Only		Short-Stay Threshold*	LTH GMLOS	Acute	
				ALOS	GMLOS			GMLOS	ALOS
482	Tracheostomy For Face,Mouth & Neck Dx	1	1	21.0	21.0	32.1	38.5	9.6	12.1
484	Craniotomy For Multiple Significant Traum	1	1	11.0	11.0	17.8	21.3	9.3	12.8
486	Other OR Proc For Multiple Significant Tra	3	1	18.0	18.0	32.1	38.5	8.5	12.5
487	Other Multiple Significant Trauma	34	11	11.8	9.6	21.7	26	5.3	7.3
488	Hiv w/Extensive OR Proc	5	2	23.0	21.6	32.1	38.5	11.8	16.4
489	Hiv w/Major Related Condition	283	116	9.9	8.3	17.8	21.4	5.9	8.4
490	Hiv w/ or w/o Other Related Condition	68	29	8.2	7.4	13.8	16.6	3.8	5.4
491	Major Joint & Limb Reattach Proc Of Uppe	1	0			32.1	38.5	2.6	3.1
493	Laparoscopic Cholecystectomy w/o C.d.e.	9	5	14.8	14.1	32.1	38.5	4.5	6.1
497	Spinal Fusion Ex Cervical W CC	5	3	15.3	15.3	24.7	29.6	5	5.9
499	Back & Neck Proc Ex Spinal Fusion W CC	12	4	24.0	22.8	32.1	38.5	3.1	4.3
500	Back & Neck Proc Ex Spinal Fusion w/o C	1	0			24.7	29.6	1.8	2.2
501	Knee Proc W Pdx Of Infection W CC	19	3	24.3	23.7	32.1	38.5	8.5	10.4
502	Knee Proc W Pdx Of Infection w/o CC	3	0			24.7	29.6	4.9	5.9
503	Knee Proc w/o Pdx Of Infection	3	1	10.0	10.0	17.8	21.3	2.9	3.8
505	Exten. Burns or Full Burn w/mv 96+Hrs w/	5	0			24.7	29.6	2.4	4.6
506	Full Burn W Skin Graft or Inhal Inj W CC o	10	2	14.0	12.6	24.7	29.6	11.2	15.9
507	Full Burn W Skin Grft or Inhal Inj w/o CC o	2	0			20.7	24.8	5.8	8.5
508	Full Burn w/o Skin Grft or Inhal Inj W CC o	30	10	15.7	13.7	24.5	29.4	5.1	7.4
509	Full Burn w/o Skin Grft or Inh Inj w/o CC ou	7	3	7.3	4.7	15.8	19	3.6	5.2
510	Non-Extensive Burns W CC or Significant	35	14	13.0	11.3	20.5	24.6	4.4	6.4
511	Non-Extensive Burns w/o CC or Significan	4	1	15.0	15.0	15.8	19	2.6	4.1
515	Cardiac Defibrillator Implant w/o Cardiac C	16	6	19.5	18.2	32.1	38.5	2.6	4.3
517	No Longer Valid	4	0					0	0
518	Perc Cardio Proc w/o Coronary Artery Ster	2	1	13.0	13.0	20.7	24.8	1.8	2.5
519	Cervical Spinal Fusion W CC	1	1	32.0	32.0	32.1	38.5	3	4.8
521	Alcohol/drug Abuse or Dependence W CC	38	15	11.3	10.8	16.2	19.4	4.2	5.6
523	Alc/drug Abuse or Depend w/o Rehabi The	9	5	4.6	2.6	15.8	19	3.2	3.9
524	Transient Ischemia	31	11	10.1	9.3	17.6	21.1	2.6	3.2
527	No Longer Valid	1	0					0	0
529	Ventricular Shunt Proc W CC	2	0			32.1	38.5	5.3	8.3
531	Spinal Proc W CC	15	10	12.0	11.0	20.7	24.8	6.5	9.6
532	Spinal Proc w/o CC	2	1	13.0	13.0	20.7	24.8	2.8	3.7
533	Extracranial Proc W CC	19	7	26.0	25.4	32.1	38.5	2.4	3.8
537	Local Excis & Remov Of Int Fix Dev Ex Hip	43	11	19.2	17.8	28.9	34.7	4.8	6.9
539	Lymphoma & Leukemia W Major or Proc W	4	1	11.0	11.0	24.7	29.6	7	10.8
541	Ecmo or Trach W Mv 96+Hrs or Pdx Exc P	175	60	36.9	34.4	54.7	65.6	38.1	45.7
542	Trach W Mv 96+Hrs or Pdx Exc Face, Mou	714	247	25.1	22.5	40.2	48.2	29.1	35.1
543	Craniotomy w/implant Of Chemo Agent or	3	0			32.1	38.5	8.5	12.3
544	Major Joint Replacement or Reattachment	7	2	31.0	31.0	32.1	38.5	4.1	4.5
545	Revision Of Hip or Knee Replacement	18	3	25.3	24.3	32.1	38.5	4.5	5.2
N/A	N/A	37	0	0.0	1.0				

* The short-stay threshold is 5/6 of the nominal LTH GMLOS

Source: Lewin Group analysis of the 2004 Medicare Provider Analysis and Review (MedPAR) data. The CMS nominal values from the IPPS Final Rule for FY 2006.

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MAR 2[illegible] 2006

NANCY L. JOHNSON
5TH DISTRICT, CONNECTICUT

COMMITTEE ON
WAYS AND MEANS

SUBCOMMITTEES:
CHAIRMAN, HEALTH
HUMAN RESOURCES

Congress of the United States
House of Representatives
Washington, DC 20515–0705

WASHINGTON OFFICE:
2409 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-0705
(202) 225-4476

NEW BRITAIN OFFICE:
1 GROVE STREET
NEW BRITAIN, CT 06053-4057
(860) 223-8412

WATERBURY OFFICE:
(203) 573-1418

DANBURY OFFICE:
(203) 790-6856

MERIDEN OFFICE:
(203) 630-1903

March 17, 2006

The Honorable Mark McClellan
Administrator
Centers for Medicare and Medicaid Services
Hubert Humphrey Building, Room 314-G
200 Independence Avenue, SW
Washington, DC 20201

Dear Dr. McClellan,

We are writing today to express our strong reservations about changes to the short-stay outlier (SS0) payment policy included in the Fiscal Year (FY) 2007 long-term care hospital (LTCH) prospective payment system proposed rule. While we share CMS' concern that LTCHs care for appropriate patients, the short-stay outlier payment policy is the wrong tool to achieve this goal.

SSOs cases are ones in which the length of stay is less than $5/6^{th}$ of the mean length of stay for that DRG. Currently, SSO cases are paid the lesser of 120 percent of the cost of the case; 120 percent of the LTC-DRG per diem amount; or the full LTC-DRG payment. CMS has proposed adding a fourth payment option in which SSOs would be paid at the inpatient prospective payment system rate (IPPS) for acute care hospitals. This proposed change represents a substantial cut to LTCHs and will reimburse them at below their costs for these cases. Additionally, it is worth noting that the current SSO definition mathematically assures that approximately 40% of LTCH payments will always be paid at these draconian and clearly inappropriate rates.

Substituting acute care hospital payment rates, where patients' average length of stay, according to The Lewin Group, is 5.6 days, for LTCH payments, where patients' average length of stay is 10.8 days, is completely inappropriate. Additionally, The Lewin Group's analysis estimates that this change will result in a 11.1% payment reduction for LTCHs and all but the largest LTCHs, those with over 300 beds, will have negative Medicare margins in 2007.

We strongly believe that CMS' proposed SSO payment policy is a poor substitution for the use of patient and facility criteria to ensure that the most appropriate patients are being cared for in LTCHs. As such, we urge CMS to exclude the changes in

SSO payment policy in the final LTCH prospective payment system rule and instead work with the provider community to develop patient and facility criteria that can be used to address our shared concern that LTCHs only treat the most appropriate patients for these facilities. This would reflect MedPAC suggested payment policy reform for LTCHs and according to testimony received at our hearing on March 15 the industry is within weeks of a facility and patient criteria proposal that appears to result in significant savings as well but assures that those who need LTCH care receive it.

We would like to thank you in advance for your consideration of our serious reservations about proposed changes to the SSO payment policy. We urge to shelve the proposed SSO policy change and adopt a payment system that utilizes patient and facility criteria that is developed in collaboration with these hospitals that provide critical care to extremely sick Medicare patients.

Very truly yours,

Nancy L. Johnson
Member of Congress

4/6

MAR 2[illegible] 2006

MITCH McCONNELL
KENTUCKY

361-A RUSSELL SENATE OFFICE BUILDING
WASHINGTON, DC 20510-1702
(202) 224-2541

United States Senate

MAJORITY WHIP

COMMITTEES:
AGRICULTURE
APPROPRIATIONS
SUBCOMMITTEE ON FOREIGN OPERATIONS
CHAIRMAN
RULES AND ADMINISTRATION

March 20, 2006

The Honorable Mark McClellan, M.D.
Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Dr. McClellan:

In recent weeks, I have been contacted by Kentuckians concerned about proposed payment changes for long-term care hospitals (LTCH)'s under consideration by the Centers for Medicare and Medicaid Services (CMS). I write to forward those concerns and ask that you take appropriate steps to ensure that the sickest, most medically complex patients can continue to receive the unique care and services that LTCHs provide.

As you know, LTCH's play an important role in providing care to many of the most medically complex patients in our health care system. LTCH patients are sicker, require longer stays and need more intensive services than hospital patients in general. Clearly, this intensive level of care is neither necessary nor appropriate for all patients, but these services are vital for a small percentage of the Medicare population who truly need them. I share CMS' desire to make sure that Medicare patients are treated in the most appropriate setting, and recognize there are concerns about inappropriate patient placement. However, there may be more appropriate ways to address such concerns, such as the development and use of admission screening criteria and medical necessity reviews, than simply reducing reimbursements for LTCH's.

I am also concerned by reports from my constituents that CMS has not yet discussed these changes with the LTCH community nor provided an analysis of the data used to reach its recommendations. These constituents also have expressed apprehension that the proposed changes to the short stay outliers, when coupled with a freeze in reimbursement rates, would cause Medicare payments to fall below their cost of providing services. Obviously, such an arrangement is not sustainable in the long-term and could limit access to care for those patients who need it most. I respectfully request that you carefully consider these concerns as you move forward with this proposed rule.

Thank you in advance for your consideration of these concerns. I respectfully request a response to this letter and ask that you keep me informed as you move forward with the proposed rule. Should you have any questions, please contact Scott Raab in my Washington, D.C. office at (202)224-8289.

Sincerely,

Mitch McConnell

MITCH McCONNELL
UNITED STATES SENATOR

MM/sh

FEDERAL BUILDING
241 EAST MAIN STREET
ROOM 102
BOWLING GREEN, KY 42101
(270) 781-1673

1885 DIXIE HIGHWAY
SUITE 345
FORT WRIGHT, KY 41011
(859) 578-0188

771 CORPORATE DRIVE
SUITE 530
LEXINGTON, KY 40503
(859) 224-8286

300 SOUTH MAIN
SUITE 310
LONDON, KY 40741
(606) 864-2026

601 WEST BROADWAY
SUITE 630
LOUISVILLE, KY 40202
(502) 582-6304

PROFESSIONAL ARTS BUILDING
2320 BROADWAY
SUITE 100
PADUCAH, KY 42001
(270) 442-4554

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MERCY GENERAL
HEALTH PARTNERS

1700 Oak Avenue
Muskegon, MI 49442
Phone 231.773.3311

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

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

Dear Administrator McClellan:

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

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

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

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

Sincerely,

F. Remington Sprague, M.D.

MHA

MISSOURI HOSPITAL ASSOCIATION
Marc D. Smith, Ph.D., President

March 17, 2006

Mark McClellan, M.D., Ph.D., Administrator
Centers for Medicare & Medicaid Services
Attention: 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 Missouri Hospital Association (MHA), on behalf of our member hospitals, health care systems and individual members, appreciates the opportunity to comment on the proposed rule concerning the long-term care hospital (LTCH) prospective payment system (PPS) for rate year 2007. The proposed rule recommends several significant changes that are of concern to MHA — most notably the proposal to omit the 3.6 percent market basket update and change the short-stay outlier policy. The alarming net impact of this proposal — negative 14.7 percent — is excessive and would severely and inappropriately threaten patient access to long-term care.

LTCHs serve a critical role for medically-complex patients who are anticipated to need a long hospital stay, such as ventilator and burn patients. Many LTCHs have developed specific clinical protocols for treating patients with a high severity of illness. Currently, there are about 350 LTCHs, eight in Missouri, which are defined by their long average length-of-stay of 25 days or greater — significantly longer than the average length-of-stay for general acute hospitals, 5.6 days.

Misguided and Excessive Short Stay Outlier Proposal

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 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 the Centers for Medicare & Medicaid Services on many occasions.

In 2003, when the LTCH prospective payment system was introduced, the agency stated in the *Federal Register* that paying for cases treated in excluded hospitals, such as LTCHs, under the inpatient prospective payment system 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. **Therefore, the proposed short-stay outlier 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 short-stay outlier changes. Based on analysis by The Lewin Group, **the combined impact of CMS' recommendations for rate year 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 short-stay outlier policy, which is intended by CMS to discourage LTCHs from admitting short-stay cases. Short-stay outlier cases have a duration that is up to 5/6 of the geometric mean average length-of-stay for a particular LTCH diagnosis-related group (DRG). Currently, short-stay outlier cases are paid the lesser of the following:

- the full LTCH DRG payment
- 120 percent of the LTCH DRG per diem
- 120 percent of the cost of the short-stay outlier case

CMS proposes to modify the current short-stay outlier policy in two ways.

- Lower the short-stay outlier case reimbursement based on 120 percent of cost to 100 percent.

- Add a new, and substantially lower, payment alternative — an amount "comparable" to the DRG rate under inpatient PPS.

The proposed short-stay outlier 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 prospective payment system presumes a range of lengths-of-stay, including cases above and below the average length-of-stay. CMS states its concern that short-stay outlier cases represent 37 percent of all LTCH cases and that short-stay outlier 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 short-stay outlier cases includes 5/6, or 83 percent, of the cases with a length-of-stay below the mean, CMS should presume that a significant proportion of all LTCH cases would fall within the short-stay outlier range. The agency should not expect that the 37 percent rate of short-stay outlier cases would continue to drop indefinitely, given the current short-stay outlier definition. When the LTCH short-stay outlier definition is applied to the inpatient PPS, approximately 40 percent of inpatient PPS cases satisfy the LTCH short-stay outlier definition — a rate similar to the LTCH short-stay outlier rate. Therefore, a short-stay outlier level in the current range should be expected and not viewed

as an indication of misconduct. If CMS wants to see the percentage of short-stay outlier cases decline further, then the definition for short-stay outlier cases needs to be changed.

The LTCH short-stay outlier policy should not be adopted as proposed. CMS' proposal is based on the unsubstantiated bias that all short-stay outlier 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 short-stay outlier 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 short-stay outlier cases, and the case mix treated by hospitals under inpatient PPS. For instance, The Lewin Group has compared common LTCH and inpatient PPS DRGs and found that the case mix index for LTCH short-stay outlier cases is more than double the case mix index for general acute hospitals.

A dramatic difference also is found when comparing average length-of-stay. LTCH short-stay outlier cases have an average length-of-stay that is more than twice as long as the average length-of--stay 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 short-stay outlier 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 short-stay outlier cases highlight the inability of referring general acute hospitals and admitting LTCHs to identify short-stay outlier cases upon admission to the LTCH.** This reality of treating severely ill patients directly challenges CMS' assertion that all short-stay outlier cases result from intentionally inappropriate transfers to LTCHs. In addition, these data make a clear case that the **patients treated in LTCHs, including short-stay outlier 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 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 short-stay outlier 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.

Recommendations

MHA 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 average length-of stay 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 short-stay outlier 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 (length-of stay and referral source) to determine whether an LTCH admission is appropriate.

Develop more specific LTCH criteria. We fully support the June 2004 and March 2006 recommendations by the Medicare Payment Advisory Commission (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.**

Expand QIO review. Also, we strongly endorse the June 2004 MedPAC recommendation to require CMS' Quality Improvement Organizations (QIOs) 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 length-of–stay 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 short-stay outlier 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.

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

- Establish a method for identifying a subset of short-stay outliers — 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 length-of-stay greater than 20 days should be removed from the short-stay outlier definition. Any case of such a substantial duration clearly is not suitable for a downward payment adjustment. Cases with length-of-stay in this range obviously are consistent with the population intended for the LTCH setting and should be eligible for the full LTCH DRG payment.

- Remaining short-stay outlier cases should continue to be paid under the current short-stay outlier policy.

MHA appreciates the opportunity to share its views with the subcommittee. We look forward to working with CMS to ensure that LTCHs preserve the ability to treat patients who are suitable for this important acute setting. To discuss any questions or reactions to our comments, please contact me at 573/893-3700, ext. 1347 or *dfine@mail.mhanet.com*, Gary Toliver, vice president of federal relations, at ext. 1336 or gt*oliver@mail.mhanet.com*, or Sharon Burnett, vice president of licensure, regulations and accreditation, at ext. 1304 or *sburnett@mail.mhanet.com*.

Sincerely,

Dwight L. Fine

Dwight L. Fine
Senior Vice President of Governmental Relations

dlf/cs

Madonna
Rehabilitation Hospital

TherapyPlus
Outpatient
Services

Rehabilitation
Specialists
Physicians Group

Research Institute
Rehabilitation
Science &
Engineering

St. Jane de Chantal
Extended Care
Services

Foundation
Supporting
Madonna
Rehabilitation
Hospital

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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

DELAWARE VALLEY HEALTHCARE COUNCIL
of The Hospital & Healthsystem Association of Pennsylvania

March 20, 2006

Mark McClellan, M.D., Ph.D.
Administrator, Centers for Medicare & Medicaid Services
Att: 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 Delaware Valley Healthcare Council of HAP (DVHC), which represents more than 150 member hospitals, health systems and other health related organizations in Southeastern Pennsylvania, Southern New Jersey and Delaware, I am writing to comment on the proposed rule concerning the long-term care hospital prospective payment system (LTCH PPS) for rate year (RY) 2007. In order to ensure continued access to a continuum of high quality health care services for Medicare beneficiaries in Southeastern PA, adequate hospital payments under the Medicare Prospective Payment System (PPS) is critical. We are concerned that several of the proposed changes to the LTCH PPS would have a negative impact on the financial viability of long-term care hospitals and ultimately threaten patient access to long-term services.

We have estimated that for LTCHs in Southeastern P.A. the proposed rule would decrease reimbursement by approximately $9 million. Specifically, we are concerned about the proposal to omit the 3.6 percent market basket update, to increase the outlier threshold and to implement changes to the short-stay outlier (SSO) policy as these changes would result in payments to LTCHs that are significantly less than what it costs to care for patients appropriately admitted for long-term services. We anticipate that patients with complex medical conditions would lose access to needed hospital care, and general acute care hospitals would incur additional costs since they will be unable to discharge these complex patients to a more appropriate level of care.

Long-term care hospitals serve a critical role for medically complex patients who are anticipated to need a long hospital stay, such as ventilator and burn patients. Long term care hospitals by definition treat patients who require significantly longer lengths of stay as compared to general acute care facilities with LTCHs having an average length of stay (ALOS) of 25 days or greater whereas the ALOS for general acute care facilities is 5.6 days. In Southeastern PA, the ALOS as reported by LTCHs is 44.1 and there were approximately 886 admissions to LTCHs in 2005. Many LTCHs have developed specific clinical protocols for treating patients with co-morbidities and a high severity of illness. It is extremely important that LTCHs continue to receive adequate Medicare funding so that they can provide health care in a safe manner. It is because we believe that it is critical that the Centers for Medicare and Medicaid Services (CMS) sets Medicare PPS payments at a level that covers the cost of providing care that we offer the following comments and recommendations to the proposed rule for the PPS for LTCHs:

Market Basket Update

We believe that an annual inflationary update is essential to all prospective payment systems as it helps to maintain an accurate payment system ensuring that hospitals can continue to provide quality care to patients. Thus it is inappropriate to exclude a market basket update for LTCHs in RY 2007 as per the proposed rule. ***The calculation of a 3.6 percent market basket update under the rehabilitation, psychiatric and long-term care methodology reflects the real inflation costs that LTCHs will fact next year and therefore should be incorporated in the final rule.***

Outlier Threshold

According to the proposed rule, the outlier threshold for services rendered to patients treated in LTCHs would be increased from $10,501 to $18,489 for RY 2007. This change would result in reduced outlier payments to LTCHs. Outlier payments are designed to provide additional reimbursement for high cost, extremely medically complex patients. ***We are concerned with CMS' proposal to increase the threshold by fifty seven percent and respectfully suggest that they reconsider this significant increase and consider lowering the outlier threshold.***

Short Stay Outlier

Although we have stated our concerns about the proposed increase in the outlier threshold, our greatest concern lies with the proposed changes to the LTCH short-stay outlier (SSO) provision, as they would have the greatest financial impact on LTCHs. First of all, we think that CMS has based its proposal on a false assumption that a short-stay outlier case is an inappropriate LTCH admission. We understand that the proposed modifications to the LTCH SSO policy is intended to discourage LTCHs from admitting short-stay cases. The definition of SSO cases includes cases that have duration of up to 5/6 of the ALOS for a particular LTCH diagnostic-related group (DRG). According to the current SSO policy, 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 is proposing to modify the current SSO policy in two ways:

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

We disagree with CMS' proposed method for modifying the current SSO policy. From a policy perspective, we find that applying inpatient PPS rates as a payment alternative is problematic. The inpatient rates, even when adjusted for outliers, are not designed or intended for the high-complexity, long-stay population treated in LTCHs. Thus, we agree with the American Hospital Association that it would be in direct violation of the Medicare principle of establishing payments based on the average cost of treating specific types of patients. Essentially, 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. Furthermore, we would argue that the patient population treated in LTCHs is quite distinct from the general acute care population and that the Medicare payments need to reflect those differences.

Recommendations

In addition to the previously mentioned ***recommendation that the final rule contain a market basket update of 3.6 percent and that CMS re-examine the proposed increase in the outlier threshold and consider decreasing it,*** we have some other suggestions regarding the proposed changes to the PPS for LTCHs. Along with the American Hospital Association (AHA) and the Acute Long Term Hospital Association (ALTHA) we encourage CMS to follow the Medicare Payment Advisory Commission (MedPAC) recommendation in June of 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.***

As MedPAC recommended the development of more specific LTCH criteria that would expand the current facility qualification criterion to target medically-complex long-stay patients would be an improvement to the current system as it would help to ensure that LTCH services are targeted to patients who are clinically appropriate for that level of care.

As for ***the LTCH SSO policy, we recommend that it not be adopted as proposed*** because CMS' proposal is based on the unsubstantiated bias that all SSO cases are inappropriate admissions and would therefore penalize LTCHs for treating patients who are clinically appropriate for that setting. Instead we support the AHA's recommendation that 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 such as those cases with a length of stay well below the mean for all LTCH cases (e.g. 5-7 days) and reimburse those cases at 100 percent of cost.
- The LTCH cases with a LOS of 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 a LOS of 20 or greater are obviously consistent with the population intended for the LTCH setting and should be eligible for the full LTCH DRG payment.
- The remaining cases should continue to be paid under the current SSO policy.

Thank you for the opportunity to express our views on the LTCH PPS proposed rule as the final rule will impact hospital services received by Medicare beneficiaries in the Philadelphia area as well as other parts of the Commonwealth and the nation. We hope that you modify your proposed changes to ensure that Medicare recipients continue to have access to long-term care services in the event that they suffer from highly complex conditions that would warrant such a unique setting as an LTCH. If you or your staff needs further clarification of our views, please do not hesitate to contact me at (215) 735-3295 or Pamela Clarke, DVHC's Vice President of Managed Care at (215) 735-3265.

Sincerely,

Andrew Wigglesworth

Andrew Wigglesworth
President